CALIFORNIA DEPARTMENT OF
Mental Health

CALIFORNIA REGULATIONS

EXCERPTS FROM REGULATIONS RELATED TO MENTAL HEALTH SERVICES

Title 2. Administration

Division 9. Joint Regulations for Handicapped Children

Title 5. Education

Division 1. State Department of Education

Title 9. Rehabilitative and Developmental Services

Division 1. Department of Mental Health

Title 15. Crime Prevention and Corrections

Division 1. Board of Corrections

Division 3. Department of Corrections

Division 4. Department of the Youth Authority

Title 16. Professional and Vocational Regulations

Division 13.1. Board of Psychology

Division 18. Board of Behavioral Sciences

Division 25. Board of Vocational Nurse and Psychiatric Technician Examiners of the State of California

Title 22. Social Security

Division 3. Health Care Services

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Division 6. Licensing of Community Care Facilities

TITLE 2. ADMINISTRATION

Division 9. Joint Regulations for Pupils with Disabilities

Chapter 1. Interagency Responsibilities for Providing Services to Pupils with Disabilities

Article 1. General Provisions

§ 60000. Scope.

The provisions of this chapter shall implement Chapter 26.5, commencing with Section 7570, of Division 7 of Title 1 of the Government Code relating to interagency responsibilities for providing services to pupils with disabilities. This chapter applies to the State Departments of Mental Health, Health Services, Social Services, and their designated local agencies, and the California Department of Education, school districts, county offices, and special education local plan areas.

The intent of this chapter is to assure conformity with the federal Individuals with Disabilities Education Act or IDEA, Sections 1400 et seq. of Title 20 of the United States Code, and its implementing regulations, including Sections 76.1 et seq. and 300.1 et seq. of Title 34 of the Code of Federal Regulations. Thus, provisions of this chapter shall be construed as supplemental to, and in the context of, federal and state laws and regulations relating to interagency responsibilities for providing services to pupils with disabilities.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7570, Government Code.

§ 60010. Education Definitions.

(a) Words shall have their usual meaning unless the context or a definition of a word or phrase indicates a different meaning. Words used in their present tense shall include the future tense; words in the singular form shall include the plural form; and use of the masculine gender shall include the feminine gender.

(b) "Administrative designee" means the individual who fulfills the role as described in paragraph (1) of subsection (b) of Section 56341 of the Education Code and paragraph (1) of subsection (a) of Section 300.344 of Title 34 of the Code of Federal Regulations.

(c) "Assessment" means an individual evaluation of a pupil in all areas of suspected disability in accordance with Sections 56320 through 56329 of the Education Code and Sections 300.530 through 300.534 of Title 34 of the Code of Federal Regulations.

(d) "Assessment plan" means a written statement that delineates how a pupil will be evaluated and meets the requirements of Section 56321 of the Education Code.

(e) "Confidentiality" means the restriction of access to verbal and written communications, including clinical, medical and educational records, to appropriate parties under Section 99.3 of Title 45 of the Code of Federal Regulations, Section 300.560 et seq. of Title 34 of the Code of Federal Regulations, Sections 827, 4514, 5328, and 10850 of the Welfare and Institutions Code, Section 2890 of Title 17 of the California Code of Regulations, and Sections 49060 through 49079 of the Education Code.

(f) "County superintendent of schools" means either an appointed or elected official who performs the duties specified in Chapter 2 (commencing with Section 1240) of Part 2 of Title 1 of the Education Code.

(g) "Day" means a calendar day pursuant to Section 56023 of the Education Code.

(h) "Designated instruction and services" means specially designed instruction and related services described in subsection (b) of Section 56361 and subsection (b) of Section 56363 of the Education Code, and Section 3051 of Title 5 of the California Code of Regulations, as may be required to assist a pupil with a disability to benefit educationally.

(i) "Individualized education program," hereinafter "IEP," means a written statement developed in accordance with Section 7575 of the Government Code, Sections 56341 and 56342 of the Education Code and Sections 300.340 through 300.350 of Title 34 of the Code of Federal Regulations, which contains the elements specified in Section 56345 of the Education Code and Section 300.347 of Title 34 of the Code of Federal Regulations.

(j) "Individualized education program team," hereinafter "IEP team," means a group which is constituted in accordance with Section 56341 of the Education Code and Title 20, United States Code Section 1414(d)(1)(B).

(k) "Local education agency," hereinafter "LEA," means a school district or county office of education which provides special education and related services.

(*l*) "Local interagency agreement" means a written document negotiated between two or more public agencies which defines each agency's role and responsibilities for providing services to pupils with disabilities and for facilitating the coordination of these services in accordance with the provisions of Section 56220 of the Education Code.

(m) "Necessary to benefit from special education" means a service that assists the pupil with a disability in progressing toward the goals and objectives listed in the IEP in accordance with subsection (d) of Section 7572 and paragraph (2) of subsection (a) of Section 7575 of the Government Code.

(n) "Nonpublic, nonsectarian agency" means a private, nonsectarian establishment or individual that is certified by the California Department of Education and that provides related services and/or designated instruction and services necessary for a pupil with a disability to benefit educationally from the pupil's IEP. It does not include an organization or agency that operates as a public agency or offers public service, including but not limited to, a state or local agency, or an affiliate of a state or local agency, including a private, nonprofit corporation established or operated by a state or local agency, a public university or college, or a public hospital.

(o) "Nonpublic, nonsectarian school" means a private, nonsectarian school that enrolls individuals with exceptional needs pursuant to an IEP, employs at least one full–time teacher who holds an appropriate credential authorizing special education services, and is certified by the California Department of Education. It does not include an organization or agency that operates as a public agency or offers public services, including but not limited to, a state or local agency, or an affiliate of a state or local agency, including a private, nonprofit corporation established or operated by a state or local agency or a public university or college.

(p) "Parent" includes any person having legal custody of a child. "Parent," in addition, includes any adult pupil for whom no guardian or conservator has been appointed and the person having custody of a minor if neither the parent nor legal guardian can be notified of the educational action under consideration. "Parent" also includes a parent surrogate who has been appointed in accordance with Section 7579.5 of the Government Code and Section 56050 of the Education Code. The term "Parent" does not include the state or any political subdivision of government.

(q) "Pupil" or "Pupil with a disability" means those students, birth through 21 years of age, as defined in Section 300.7 of Title 34 of the Code of Federal Regulations, including those with mental retardation or autism, who meet the requirements of Section 56026 of the Education Code and Sections 3030 and 3031 of Title 5 of the California Code of Regulations and who, because of their impairments, need special education and related services as defined in subsections (22) and (25) of Section 1401 of Title 20 of the United States Code. This term includes handicapped children, children with disabilities and individuals with exceptional needs as defined in Section 56026 of the Education Code. The determination that an individual is a pupil with a disability is made only by an IEP team pursuant to Section 56342 of the Education Code.

(r) "Qualified" means that a person has met federal and state certification, licensing, registration, or other comparable requirements which apply to the area in which he or she is providing special education or related services, or, in the absence of such requirements, meets the state–education–agency–approved or recognized requirements and adheres to the standards of professional practice established in federal and state law or regulation, including the standards contained in the California Business and Professions Code.

(s) "Related services" means those services that are necessary for a pupil with a disability to benefit from his or her special education program in accordance with paragraph Title 20, United States Code Section 1401(22).

(t) "Special education" means specially designed instruction and related services to meet the unique needs of a pupil with a disability, as described in Section 56031 of the Education Code and Section 300.26 of Title 34 of the Code of Federal Regulations.

(u) "Special education local plan" means a plan developed in accordance with Sections 56200 through 56218 of the Education Code which identifies each participating LEA's roles and responsibilities for the provision of special education and related services within the service area.

(v) "Special education local plan area," hereinafter "SELPA," means the service area covered by a special education local plan, and is the governance structure created under any of the planning options of Section 56200 of the Education Code.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7570 and 7579.5, Government Code; Section 5328, Welfare and Institutions Code; Sections 1240, 49060–49079, 56023, 56026, 56028, 56031, 56034, 56035, 56050, 56200–56220, 56320–56329, 56341 and 56325, Education Code; Clovis Unified School District (1990, Ninth Circuit) 903 F.2d 635; Section 1401, Title 20, United States Code; and Sections 300.7, 300.326, 300.330, 300.340–300.350, 300.530–300.534 and 300.560, Title 34, Code of Federal Regulations.

§ 60020. Mental Health Definitions.

(a) "Community mental health service" means a mental health program established by a county in accordance with the Bronzan–McCorquodale Act, Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code.

(b) "County of origin" for mental health services is the county in which the parent of a pupil with a disability resides. If the pupil is a ward or dependent of the court, an adoptee receiving adoption assistance, or a conservatee, the county of origin is the county where this status currently exists. For the purposes of this program the county of origin shall not change for pupils who are between the ages of 18 and 22.

(c) "Expanded IEP team" means an IEP team constituted in accordance with Section 7572.5 of the Government Code. This team shall include a representative of the community mental health service authorized to make placement decisions.

(d) "Host county" means the county where the pupil with a disability is living when the pupil is not living in the county of origin.

(e) "Local mental health director" means the officer appointed by the governing body of a county to manage a community mental health service.

(f) "Medication monitoring" includes all medication support services with the exception of the medications or biologicals themselves and laboratory work. Medication support services include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals necessary to alleviate the symptoms of mental illness.

(g) "Mental health assessment" is a service designed to provide formal, documented evaluation or analysis of the nature of the pupil's emotional or behavioral disorder. It is conducted in accordance with California Code of Regulations, Title 9, Section 543(b), and Sections 56320 through 56329 of the Education Code by qualified mental health professionals employed by or under contract with the community mental health service.

(h) "Mental health assessment plan" means a written statement developed for the individual evaluation of a pupil with a disability who has been referred to a community mental health service to determine the need for mental health services in accordance with Section 56321 of the Education Code.

(i) "Mental health services" means mental health assessments and the following services when delineated on an IEP in accordance with Section 7572(d) of the Government Code: psychotherapy as defined in Section 2903 of the Business and Professions Code provided to the pupil individually or in a group, collateral services, medication monitoring, intensive day treatment, day rehabilitation, and case management. These services shall be provided directly or by contract at the discretion of the community mental health service of the county of origin.

(j) "Qualified mental health professional" includes the following licensed practitioners of the healing arts: a psychiatrist; psychologist; clinical social worker; marriage, family and child counselor; registered nurse, mental health rehabilitation specialist, and others who have been waivered under Section 5751.2 of the Welfare and Institutions Code. Such individuals may provide mental health services, consistent with their scope of practice.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 56320, Education Code; and Sections 542 and 543, Title 9, California Code of Regulations.

§ 60025. Social Services Definitions.

(a) "Care and supervision" as defined in Welfare and Institutions Code Section 11460, includes food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation.

(b) "Certified family home" as defined in Welfare and Institutions Code Section 11400(c), means a family residence certified by a foster family agency licensed by the California Department of Social Services and issued a certificate of approval by that agency as meeting licensing standards, and is used only by that foster family agency for placements.

(c) "Certified, license–pending home" as described in Welfare and Institutions Code Sections 361.2(h), 727(b), and 16507.5(b), is a home that is pending application for licensure as a foster family home, has been certified by the county as meeting the minimum standards for foster family homes, and is lacking any deficiencies which would threaten the physical health, mental health, safety or welfare of the pupil.

(d) "Community care facility" is a facility licensed by the California Department of Social Services as defined in Health and Safety Code Section 1502(a). For the purposes of this chapter, a community care facility means those facilities listed and defined in this article that provide 24–hour residential care to children.

(e) "Community treatment facility" as defined in Health and Safety Code Section 1502(a)(8), means any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure containment. The facility's program components shall be subject to program standards developed and enforced by the State Department of Mental Health pursuant to Section 4094 of the Welfare and Institutions Code.

(f) "Foster family agency" as defined in Welfare and Institutions Code Section 11400(g) and Health and Safety Code Section 1502(a)(4), means any individual or organization engaged in the recruiting, certifying, and training of, and providing professional support to, foster parents, or in finding homes or other places for placement of children for temporary or permanent care who require that level of care as an alternative to a group home. Private agencies shall be organized and operated on a nonprofit basis.

(g) "Foster family home" as defined in Health and Safety Code Section 1502(a)(5) means any residential facility providing 24–hour care for six or fewer foster children that is owned, leased, or rented and is the residence of the foster parent or parents, including their family, in whose care the foster children have been placed. It also means a foster family home described in Health and Safety Code Section 1505.2. For the purpose of this Chapter a foster family home includes a small family home pursuant to Education Code Section 56155.5(b), or the approved home of a relative.

(h) "Group home" as defined in title 22 of the California Code of Regulations, Section 80001(g)(1) means any facility of any capacity, that provides 24–hour care and supervision to children in a structured environment with such services provided at least in part by staff employed by the licensee. The care and supervision provided by a group home shall be nonmedical except as permitted by Welfare and Institutions Code, Section 17736(b). For the purposes of this Chapter, a group home is a nondetention facility that is organized and operated on a nonprofit basis in accordance with Welfare and Institutions Section 11400(h).

(i) "Licensed children's institution" as defined in Education Code Section 56155.5(a), for the purposes of this Chapter, means the following community care facilities licensed by the California Department of Social Services: a group home, foster family agency, and community treatment facility.

(j) "Small family home" as defined in Health and Safety Code Section 1502(a)(6), means any residential facility, in the licensee's family residence, that provides 24–hour care for six or fewer foster children who have mental disorders or developmental or physical disabilities and who require special care and supervision as a result of their disabilities. A small family home may accept children with special health care needs, pursuant to subdivision (a) of Section 17710 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 7587, Government Code; and Sections 10553, 10554, 11462(i) and (j) and 11466.1, Welfare and Institutions Code. Reference: Sections 361.2(h), 727(b), 4094, 11400(c), 11400(g), 11400(h), 11402(a), 16507.5(b), 17710, 17736(b) and 18350, Welfare and Institutions Code; Section 1502(a), Health and Safety Code; Section 56155.5, Education Code; and Section 80001(g)(1), Title 22, California Code of Regulations.

Article 2. Mental Health Related Services

§ 60030. Local Mental Health and Education Interagency Agreement.

(a) Each community mental health service and each SELPA within that county shall develop a written local interagency agreement in order to facilitate the provision of mental health services.

(b) The local mental health director, the county superintendent of schools and/or the local SELPA director, or their designees, shall review the local interagency agreement(s) according to a schedule developed at the local level between the agencies but no less frequently than every three years and ensure that the agreement or agreements are revised as appropriate, to assure compliance with this chapter. This provision does not preclude revision of the local interagency agreement at any time that they determine a revision is necessary. The content of the agreement will remain in effect until the agencies mutually agree upon any revisions.

(c) The local interagency agreement shall identify a contact person for each agency and include, but not be limited to, a delineation of the procedures for:

(1) Monitoring compliance with the time lines specified in paragraph (a) of Section 56321 and Section 56344 of the Education Code. This system shall designate each participating agency's responsibilities and identify who will be responsible for monitoring the system;

(2) Resolving interagency disputes at the local level, including procedures for the continued provision of appropriate services during the resolution of any interagency dispute, pursuant to Government Code Section 7585(f). For purposes of this subdivision only, the term "appropriate" means any service identified in a pupil's IEP, or any service the pupil actually was receiving at the time of the interagency dispute;

(3) Delivery of a completed referral package to the community mental health service pursuant to subsection (d) of Section 60040 as well as any other relevant pupil information in accordance with procedures ensuring confidentiality within five (5) business days;

(4) A host county to notify the community mental health service of the county of origin within two (2) working days when a pupil with a disability is placed within the host county by courts, regional centers or other agencies for other than educational reasons;

(5) Development of a mental health assessment plan and its implementation;

(6) The participation of qualified mental health professionals at the IEP team meetings pursuant to subsections (d) and (e) of Section 7572 and Section 7572.5 of the Government Code;

(7) At least ten (10) working days prior notice to the community mental health service of all IEP team meetings, including annual IEP reviews, when the participation of its staff is required;

(8) The development, review or amendment of the portions of the IEP relating to mental health services, including the goals and objectives of mental health services in accordance with Title 20, United States Code Section 1414(d)(1)(A)(vi);

(9) The provision of mental health services as soon as possible following the development of the IEP pursuant to Section 300.342 of Title 34 of the Code of Federal Regulations;

(10) Description of the length and duration of mental health services and transportation beyond the traditional school year including the extended year program;

(11) The transportation of pupils with disabilities when necessary for the provision of mental health services pursuant to the IEP and Section 60200(d)(1)(2);

(12) The provision of space, support staff and services at the school site, as appropriate, for the delivery of mental health services;

(13) The identification of a continuum of placement options. These options may include day, public, and state certified nonpublic, nonsectarian school programs, and residential facilities as listed in Section 60025. The community mental health service and the SELPA shall identify a list of mental health, education, and community services that may serve as alternatives to a residential placement for a pupil with a disability who is seriously emotionally disturbed;

(14) The provision of a system for monitoring contracts with nonpublic, nonsectarian schools to ensure that services on the IEP are provided;

(15) The development of a resource list composed of qualified mental health professionals who conduct mental health assessments and provide mental health services. The community mental health service shall provide the LEA with a copy of this list and monitor these contracts to assure that services as specified on the IEP are provided;

(16) The residential placement of a pupil pursuant to Section 60100;

(17) Mutual staff development for education and mental health staff pursuant to Section 7586.6(a) of the Government Code.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 5608, Welfare and Institutions Code; Sections 56140, 56321 and 56344, Education Code; and Section 1414(d), Title 20, United States Code.

§ 60040. Referral to Community Mental Health Services for Related Services.

(a) A LEA, IEP team, or parent may initiate a referral for assessment of a pupil's social and emotional status pursuant to Section 56320 of the Education Code. Based on the results of assessments completed pursuant to Section 56320, an IEP team may refer a pupil who has been determined to be an individual with exceptional needs or is suspected of being an individual with exceptional needs as

defined in Section 56026 of the Education Code and who is suspected of needing mental health services to a community mental health service when a pupil meets all of the criteria in paragraphs (1) through (5) below. Referral packages shall include all documentation required in subsection (b) and shall be provided within five (5) working days of the LEA's receipt of parental consent for the referral of the pupil to the community mental health service.

(1) The pupil has been assessed by school personnel in accordance with Article 2, commencing with Section 56320, of Chapter 4 of Part 30 of the Education Code.

(2) The LEA has obtained written parental consent for the referral of the pupil to the community mental health service, for the release and exchange of all relevant information between the LEA and the community mental health service, and for the observation of the pupil by qualified mental health professionals in an educational setting.

(3) The pupil has emotional or behavioral characteristics that:

(A) Are observed by qualified educational staff as defined in subsection (x) of Section 3001 of Title 5 of the California Code of Regulations in educational and other settings, as appropriate.

(B) Impede the pupil from benefiting from educational services.

(C) Are significant, as indicated by their rate of occurrence and intensity.

(D) Are associated with a condition that cannot be described solely as a social maladjustment as demonstrated by deliberate noncompliance with accepted social rules, a demonstrated ability to control unacceptable behavior and the absence of a treatable mental disorder.

(E) Are associated with a condition that cannot be described solely as a temporary adjustment problem that can be resolved with less than three months of school counseling.

(4) As determined using educational assessments, the pupil's functioning, including cognitive functioning, is at a level sufficient to enable the pupil to benefit from mental health services.

(5) The LEA has provided counseling, psychological, or guidance services to the pupil pursuant to Section 56363 of the Education Code, and the IEP team has determined that the services do not meet the pupil's educational needs; or, in cases where these services are clearly inappropriate, the IEP team has documented which of these services were considered and why they were determined to be inappropriate.

(b) When referring a pupil to a community health service in accordance with subsection (a), the LEA or the IEP team shall provide the following documentation:

(1) Copies of the current IEP, all current assessment reports completed by school personnel in all areas of suspected disabilities pursuant to Article 2, commencing with Section 56320, of Chapter 4 of Part 30 of the Education Code, and other relevant information, including reports completed by other agencies.

(2) A copy of the parent's consent obtained as provided in subsection (a)(2).

(3) A summary of the emotional or behavioral characteristics of the pupil, including documentation that the pupil meets the criteria in paragraphs (3) and (4) of subsection (a).

(4) A description of the school counseling, psychological, and guidance services, and other interventions that have been provided to the pupil, including the initiation, duration and frequency of the services, or an explanation of why a service was considered for the pupil and determined to be inappropriate.

(c) Based on preliminary results of assessments performed pursuant to Section 56320 of the Education Code, a LEA may refer a pupil who has been determined to be or is suspected of being an individual with exceptional needs, and is suspected of needing mental health services, to a community mental health service when a pupil meets the criteria in paragraphs (1) and (2) below. Referral packages shall include all documentation required in subsection (d) and shall be provided within one (1) working day to the community mental health service.

(1) The pupil meets the criteria in paragraphs (2) through (4) of subsection (a).

(2) School counseling, psychological and guidance services are clearly inappropriate in meeting the pupil's needs.

(d) When referring a pupil to a community mental health service in accordance with subsection (c), the LEA shall provide the following documentation:

(1) Results of preliminary assessments, including those conducted by school personnel in accordance with Article 2, commencing with Section 56320, of Chapter 4 of Part 30 of the Education Code, to the extent they are available, and other relevant information, including reports completed by other agencies.

(2) A copy of the parent's consent obtained as provided in paragraph (2) of subsection (a).

(3) A summary of the emotional or behavioral characteristics of the pupil, including documentation that the pupil meets the criteria in paragraphs (3) and (4) of subsection (b).

(4) An explanation as to why school counseling, psychological and guidance services are clearly inappropriate in meeting the pupil's needs.

(e) The procedures set forth in this chapter are not designed for use in responding to psychiatric emergencies or other situations requiring immediate response. In these situations, a parent may seek services from other public programs or private providers, as appropriate. Nothing in this subsection changes the identification and referral responsibilities imposed on local education agencies under Article 1, commencing with Section 56300, of Chapter 4 of Part 30 of the Education Code.

(f) The community mental health service shall accept all referrals for mental health assessments made pursuant to subsections (a) and (c).

(g) If the community mental health service receives a referral for a pupil with a different county of origin, the community mental health service receiving the referral shall forward the referral within one (1) working day to the county of origin, which shall have programmatic and fiscal responsibility for providing or arranging for provision of necessary services. The procedures described in this subsection shall not delay or impede the referral and assessment process.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 56026, 56300 et seq., 56320 et seq. and 56363, Education Code; and Section 3001, Title 5, California Code of Regulations.

§ 60045. Assessment to Determine the Need for Mental Health Services.

(a) Within five (5) days of receipt of a referral, pursuant to subsections (a), (c) or (g) of Section 60040, the community mental health service shall review the recommendation for a mental health assessment and determine if such an assessment is necessary.

(1) If no mental health assessment is determined to be necessary, or the referral is inappropriate, the reasons shall be documented by the community mental health service. The community mental health service shall notify the parent and the LEA of this determination within one (1) working day.

(2) If the referral is determined to be incomplete, the reasons shall be documented by the community mental health service. The community mental health service shall notify the LEA within one (1) working day and return the referral.

(b) If a mental health assessment is determined to be necessary, the community mental health service shall notify the LEA, develop a mental health assessment plan, and provide the plan and a consent form to the parent, within 15 days of receiving the referral from the LEA, pursuant to Section 56321 of the Education Code. The assessment plan shall include, but is not limited to, the review of the pupil's school records and assessment reports and observation of the pupil in the educational setting, when appropriate.

(c) The community mental health service shall report back to the referring LEA or IEP team within 30 days from the date of the receipt of the referral by the community mental health service if no parental consent for a mental health assessment has been obtained.

(d) Upon receipt of the parent's written consent for a mental health assessment, the community mental health service shall contact the LEA within one (1) working day to establish the date of the IEP meeting. The LEA shall schedule the IEP meeting to be held within fifty (50) days from the receipt of the written consent pursuant to Section 56344 of the Education Code.

(e) The mental health assessment shall be completed in sufficient time to ensure that an IEP meeting is held within fifty (50) days from the receipt of the written parental consent for the assessment. This time line may only be extended upon the written request of the parent.

(f) The community mental health service assessor shall review and discuss the mental health service recommendation with the parent and appropriate members of the IEP team. The assessor shall also make a copy of the mental health service assessment report available to the parent at least two days prior to the IEP team meeting.

(1) If the parent disagrees with the assessor's mental health service recommendation, the community mental health service shall provide the parent with written notification that they may require the assessor to attend the IEP team meeting to discuss the recommendation. The assessor shall attend the meeting if requested to do so by the parent.

(2) Following the discussion and review of the community mental health service assessor's recommendation, it shall be the recommendation of the IEP team members attending on behalf of the LEA.

(g) The community mental health service shall provide to the IEP team a written assessment report in accordance with Education Code Section 56327.

(h) For pupils with disabilities receiving services under this Chapter, the community mental health service of the county of origin shall be responsible for preparing statutorily required IEP reassessments in compliance with the requirements of this Section.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 56321, 56327 and 56344, Education Code.

§ 60050. Individualized Education Program for Mental Health Services.

(a) When it is determined, in accordance with Section 7572 of the Government Code, that a mental health service is necessary for a pupil with a disability to benefit from special education, the following documentation shall be included in the mental health portion of the IEP:

(1) A description of the present levels of social and emotional performance;

(2) The goals and objectives of the mental health services with objective criteria and evaluation procedures to determine whether they are being achieved;

(3) A description of the types of the mental health services to be provided; and

(4) The initiation, duration and frequency of the mental health services.

(5) Parental approval for the provision of mental health services. This signed consent for treatment is in addition to the signed IEP.

(b) When completion or termination of IEP specified health services is mutually agreed upon by the parent and the community mental health service, or when the pupil is no longer participating in treatment, the community mental health service shall notify the parent and the LEA which shall schedule an IEP team meeting to discuss and document this proposed change if it is acceptable to the IEP team.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 300.347, Title 34, Code of Federal Regulations.

§ 60055. Transfers and Interim Placements.

(a) Whenever a pupil who has been receiving mental health services, pursuant to an IEP, transfers into a school district from a school district in another county, the responsible LEA administrator or IEP team shall refer the pupil to the local community mental health service to determine appropriate mental health services.

(b) The local mental health director or designee shall ensure that the pupil is provided interim mental health services, as specified in the existing IEP, pursuant to Section 56325 of the Education Code, for a period not to exceed thirty (30) days, unless the parent agrees otherwise.

(c) An IEP team, which shall include an authorized representative of the responsible community mental health service, shall be convened by the LEA to review the interim services and make a determination of services within thirty (30) days of the pupil's transfer.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 56325, Education Code.

Article 3. Residential Placement

§ 60100. LEA Identification and Placement of a Seriously Emotionally Disturbed Pupil.

(a) This article shall apply only to a pupil with a disability who is seriously emotionally disturbed pursuant to paragraph (i) of Section 3030 of Title 5 of the California Code of Regulations.

(b) When an IEP team member recommends a residential placement for a pupil who meets the educational eligibility criteria specified in paragraph (4) of subsection (c) of Section 300.7 of Title 34 of the Code of Federal Regulations, the IEP shall proceed in the following manner:

(1) An expanded IEP team shall be convened within thirty (30) days with an authorized representative of the community mental health service.

(2) If any authorized representative is not present, the IEP team meeting shall be adjourned and be reconvened within fifteen (15) calendar days as an expanded IEP team with an authorized representative from the community mental health service participating as a member of the IEP team pursuant to Section 7572.5 of the Government Code.

(3) If the community mental health service or the LEA determines that additional mental health assessments are needed, the LEA and the community mental health service shall proceed in accordance with Sections 60040 and 60045.

(c) Prior to the determination that a residential placement is necessary for the pupil to receive special education and mental health services, the expanded IEP team shall consider less restrictive alternatives, such as providing a behavioral specialist and full–time behavioral aide in the classroom, home and other community environments, and/or parent training in the home and community environments. The IEP team shall document the alternatives to residential placement that were considered and the reasons why they were rejected. Such alternatives may include any combination of cooperatively developed educational and mental health services.

(d) When the expanded IEP team recommends a residential placement, it shall document the pupil's educational and mental health treatment needs that support the recommendation for residential placement. This documentation shall identify the special education and related mental health services to be provided by a residential facility listed in Section 60025 that cannot be provided in a less restrictive environment pursuant to Title 20, United States Code Section 1412(a)(5).

(e) The community mental health service case manager, in consultation with the IEP team's administrative designee, shall identify a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost–effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment.

(f) The residential placement shall be in a facility listed in Section 60025 that is located within, or in the county adjacent to, the county of residence of the parents of the pupil with a disability, pursuant to paragraph (3) of subsection (a) of Section 300.552 of Title 34 of the Code of Federal Regulations. When no nearby placement alternative which is able to implement the IEP can be identified, this determination shall be documented, and the community mental health service case manager shall seek an appropriate placement which is as close to the parents' home as possible.

(g) Rates for care and supervision shall be established for a facility listed in Section 60025 in accordance with Section 18350 of the Welfare and Institutions Code.

(h) Residential placements for a pupil with a disability who is seriously emotionally disturbed may be made out of California only when no in–state facility can meet the pupil's needs and only when the requirements of subsections (d) and (e) have been met. Out–of–state placements shall be made only in residential programs that meet the requirements of Welfare and Institutions Code Sections 11460(c)(2) through (c)(3). For educational purposes, the pupil shall receive services from a privately operated non–medical, non–detention school certified by the California Department of Education.

(i) When the expanded IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in residential care, the community mental health service shall ensure that:

(1) The mental health services are specified in the IEP in accordance with Title 20, United States Code Section 1414(d)(1)(A)(vi).

(2) Mental health services are provided by qualified mental health professionals.

(j) When the expanded IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a facility listed in Section 60025, the expanded IEP team shall ensure that placement is in accordance with admission criteria of the facility.

NOTE: Authority cited: Section 7587, Government Code. Sections 10553, 10554, 11462(i) and (j) and 11466.1, Welfare and Institutions Code. Reference: Sections 7576(a) and 7579, Government Code; Sections 11460(c)(2)–(c)(3), 18350 and 18356, Welfare and Institutions Code; Sections 1412 and 1414, Title 20, United States Code; and Sections 300.7 and 300.552, Title 34, Code of Federal Regulations.

§ 60110. Case Management for a Pupil with a Disability Who Is Seriously Emotionally Disturbed and Is in a Residential Placement.

(a) Upon notification of the expanded IEP team's decision to place a pupil with a disability who is seriously emotionally disturbed into residential care, the local mental health director or designee shall immediately designate a case manager who will perform case management services as described in subsections (b) and (c).

(b) The case manager shall coordinate the residential placement plan of a pupil with a disability who is seriously emotionally disturbed as soon as possible after the decision has been made to place the pupil in a residential placement, pursuant to Section 300.342 of Title 34 of the Code of Federal Regulations.

(1) The residential placement plan shall include provisions, as determined in the pupil's IEP, for the care, supervision, mental health treatment, psychotropic medication monitoring, if required, and education of a pupil with a disability who is seriously emotionally disturbed.

(2) The LEA shall be responsible for providing or arranging for the special education and non– mental health related services needed by the pupil.

(3) When the expanded IEP team determines that it is necessary to place a pupil with a disability who is seriously emotionally disturbed in a community treatment facility, the casemanager shall ensure that placement is in accordance with admission and, continuing stay, and discharge criteria of the community treatment facility.

(c) Case management shall include, but not be limited to, the following responsibilities:

(1) To convene a meeting with the parents and representatives of public and private agencies, including educational staff, and to identify an appropriate residential placement from those defined in Section 60025 and excluding local inpatient, private psychiatric, and state hospital facilities.

(2) To identify, in consultation with the IEP team's administrative designee, a mutually satisfactory placement that is acceptable to the parent and addresses the pupil's educational and mental health needs in a manner that is cost–effective for both public agencies, subject to the requirements of state and federal special education law, including the requirement that the placement be appropriate and in the least restrictive environment.

(3) To complete the payment authorization in order to initiate payments for residential placement in accordance with Section 18351 of the Welfare and Institutions Code.

(4) To assure the completion of the community mental health service and LEA financial paperwork or contracts for the residential placement of a pupil with a disability who is seriously emotionally disturbed.

(5) To develop the plan and assist the family with the pupil's social and emotional transition from home to the residential placement and the subsequent return to the home.

(6) To facilitate the enrollment in the residential placement of a pupil with a disability who is seriously emotionally disturbed.

(7) To notify the LEA that the placement has been arranged and to coordinate the transportation of the pupil to the facility if needed.

(8) To conduct quarterly face–to–face contacts at the residential facility with a pupil with a disability who is seriously emotionally disturbed to monitor the level of care and supervision and the provision of the mental health services as required by the IEP. In addition, for children placed in a community treatment facility, an evaluation shall be made within every 90 days of the residential placement of the pupil to determine if the pupil meets the continuing stay criteria as defined in Welfare and Institutions Code Section 4094 and implementing mental health regulations.

(9) To notify the parent and the LEA or designee if there is a discrepancy between the level of care, supervision, or provision of mental health services and the requirements of the IEP.

(10) To schedule and attend the next expanded IEP team meeting with the expanded IEP team's administrative designee within six months of the residential placement of a pupil with a disability who is seriously emotionally disturbed and every six months thereafter as long as the pupil remains in residential placement.

(11) To facilitate placement authorization from the county's interagency placement committee pursuant to Section 4094.5(e)(1) of the Welfare and Institutions Code, by presenting the case of a pupil with a disability who is seriously emotionally disturbed prior to placement in a community treatment facility.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 4094, Welfare and Institutions Code; Section 300.342, Title 34, Code of Federal Regulations; and Section 3061, Title 5, California Code of Regulations.

Article 4. Financial Provision for Mental Health Services, Special Education and Residential Placement

§ 60200. Financial Responsibilities.

(a) The purpose of this article is to establish conditions and limitations for reimbursement for the provision of special education instruction, designated instruction and services, related services, and residential placement described in Articles 2 and 3 of this chapter.

(b) Special education instruction, designated instruction and services, related services, and residential placements are to be provided at no cost to the parent.

(c) The community mental health service of the county of origin shall be responsible for the provision of assessments and mental

health services included in an IEP in accordance with Sections 60045, 60050, and 60100. Mental health services shall be provided either directly by the community mental health service or by contractors. All services shall be delivered in accordance with Section 523 of Title 9 of the California Code of Regulations.

(1) The host county shall be responsible for making its provider network available and shall provide the county of origin a list of appropriate providers used by the host county's managed care plan who are currently available to take new referrals. Counties of origin shall negotiate with host counties to obtain access to limited resources, such as intensive day treatment and day rehabilitation.

(2) The county of origin may also contract directly with providers at a negotiated rate.

(d) The LEA shall be financially responsible for:

(1) The transportation of a pupil with a disability to and from the mental health services specified on the pupil's IEP and in accordance with subsection (a) of Section 300.13 of Title 34 of the Code of Federal Regulations;

(2) The transportation of a pupil to and from the residential placement as specified on the IEP and in accordance with Section 56221 of the Education Code; and

(3) The special education instruction, non–mental health related services, and designated instruction and services agreed upon in the nonpublic, nonsectarian school services contract or a public program arranged with another SELPA or LEA.

(e) The community mental health service shall be responsible for authorizing payment to the facilities listed in Section 60025 based upon rates established by the Department of Social Services in accordance with Sections 18350 through 18356 of the Welfare and Institutions Code.

(f) Upon receipt of the authorization from the community mental health service, pursuant to subsection (e), including documentation that the pupil is eligible for residential placement as a seriously emotionally disturbed pupil, the county welfare department shall issue payments in accordance with Section 18351 of the Welfare and Institutions Code to providers of residential placement.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 18350–18356, Welfare and Institutions Code; and Section 300.13, Title 34, Code of Federal Regulations.

Article 5. Occupational Therapy and Physical Therapy

§ 60300. California Children's Services (CCS) Medical Therapy Program Definitions.

(a) "Assessment for medically necessary occupational therapy and physical therapy" means the comprehensive evaluation of the physical and functional status of a pupil who has a medical therapy program eligible condition.

(b) "Asessment plan" for the CCS Medical Therapy Program for pupils with a disability who have an IEP means a written statement describing proposed:

(1) Procedures necessary for determination of medical eligibility for the CCS medical therapy program; or

(2) Procedures necessary for the redetermination of need for medically necessary physical therapy or occupational therapy for a pupil known to be eligible for the CCS medical therapy program.

(c) "Assessment report for therapy" means a written document of the results of a pupil's assessment for medically necessary occupational therapy or physical therapy.

(d) "CCS Panel" means that group of physicians and other medical providers of services who have applied to and been approved by CCS.

(e) "Dependent county agency" means the CCS administrative organization in a county that administers the CCS program jointly with the State pursuant to Sections 123850 and 123905 of the Health and Safety Code.

(f) "Documented physical deficit" refers to a pupil's motor dysfunction recorded on the referral for special education and related services by the Local Education Agency and documented in the pupil's CCS medical record.

(g) "Independent county agency" means the CCS administrative organization in a county that administers the CCS program independently pursuant to Section 123850 of the Health and Safety Code.

(h) "Medical therapy conference" means a team meeting held in the medical therapy unit where medical case management for the pupil's medical therapy program eligible condition is provided by the medical therapy conference team as described in (i).

(i) "Medical therapy conference team" means a team composed of the pupil, parent, physician and occupational therapist and/or physical therapist, or both. The team may include, with the consent of the pupil's parent(s), an education representative who is present for the purpose of coordination with medical services.

(j) "Medical therapy program eligible condition" are those diagnoses that make a pupil eligible for medical therapy services and include the following diagnosed neuromuscular, musculoskeletal, or muscular diseases:

(1) Cerebral palsy, a nonprogressive motor disorder with onset in early childhood resulting from a lesion in the brain and manifested by the presence of one or more of the following findings:

(A) Rigidity or spasticity;

(B) Hypotonia, with normal or increased deep tendon reflexes and exaggeration or persistence of primitive reflexes beyond the normal age;

(C) Involuntary movements, athetoid, choreoid, or dystonic; or

(D) Ataxia, incoordination of voluntary movement, dysdiadochokinesia, intention tremor, reeling or shaking of trunk and head, staggering or stumbling, and broad–based gait.

(2) Other neuromuscular diseases that produce muscle weakness and atrophy, such as poliomyelitis, myasthenias, muscular dystrophies;

(3) Chronic musculoskeletal diseases, deformities or injuries, such as osteogenesis imperfecta, arthrogryposis, rheumatoid arthritis, amputation, and contractures resulting from burns.

(k) "Medical therapy services" are occupational therapy or physical therapy services that require a medical prescription and are determined to be medically necessary by CCS. Medical therapy services include:

(1) "Treatment", an intervention to individuals or groups of pupils in which there are occupational therapy or physical therapy services as per California Business and Professions Code, Chapter 5.7, Article 2, Section 2620.

(2) "Consultation", an occupational therapy or physical therapy activity that provides information and instruction to parents, care givers or LEA staff, and other medical services providers;

(3) "Monitoring", a regularly scheduled therapy activity in which the therapist reevaluates the pupil's physical status, reviews those activities in the therapy plan which are provided by parents, care givers or LEA staff, and updates the therapy plan as necessary; and

(4) Medical therapy conference as defined in (h).

(*l*) "Medical therapy unit" means a CCS and LEA approved public school location where medical therapy services, including comprehensive evaluations and medical therapy conferences, are provided by CCS.

(m) "Medical therapy unit satellite" means a CCS and LEA approved extension of an established medical therapy unit where medical therapy services may be provided by CCS. Comprehensive evaluations and medical therapy conferences are not a part of medical therapy unit satellite services.

(n) "Medically necessary occupational therapy or physical therapy services" are those services directed at achieving or preventing further loss of functional skills, or reducing the incidence and severity of physical disability.

(o) "Necessary equipment" means that equipment, provided by the LEA, which is required by the medical therapy unit staff to provide medically necessary occupational therapy and/or physical therapy services to a pupil with a medical therapy program eligible condition.

(p) "Necessary space" means the facilities, which are provided by the LEA for a medical therapy unit or a medical therapy unit satellite, and enable the medical therapy unit staff to provide medically necessary therapy services to a pupil with a medical therapy program eligible condition.

(q) "Occupational therapy and physical therapy" mean services provided by or under the supervision of occupational therapists and physical therapists pursuant to California Code of Regulations, Title 5, Section 3051.6(b).

(r) "Therapy plan" means the written recommendations for medically necessary occupational therapy or physical therapy services based on the results of the therapy assessment and evaluation and is to be included in the individualized education program or individualized family service plan.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7575, Government Code; Sections 123825, 123850, 123875 and 123905, Health and Safety Code; Sections 3001(x) and 3051.6(b) of Title 5, California Code of Regulations; and Section 2620 of Chapter 5.7, Article 2, California Business and Professions Code.

§ 60310. Local Interagency Agreements Between CCS and Education Agencies.

(a) In order to facilitate the provision of services described in subdivisions (a), (b), (d), and (e) of Section 7572 of the Government Code and subdivisions (a), (b), and (d) of Section 7575 of the Government Code, each independent county agency and each authorized dependent county agency of CCS shall appoint a liaison for the county agency of CCS. The county Superintendent of Schools or SELPA director shall ensure the designation of a liaison for each SELPA in each local plan.

(b) In the event of multi–SELPA counties or multi–county SELPAs, the liaisons representing education and CCS shall develop a process for interagency decision making that results in a local interagency agreement.

(c) Each independent county agency and each dependent county agency of CCS and the county Superintendent of Schools or SELPA director shall ensure the development and implementation of a local interagency agreement in order to facilitate the provision of medically necessary occupational therapy and physical therapy which shall include at a minium a delineation of the process for:

(1) Identifying a contact person within each LEA in the SELPA and within each CCS county agency;

(2) Referring pupils, birth to twenty–one years of age, who may have or are suspected of having a neuromuscular, musculoskeletal, or other physical impairment who may require medically– necessary occupational therapy or physical therapy.

(3) Exchanging between the agencies the educational and medical information concerning the pupil with a disability upon receiving the parent's written, informed consent obtained in accordance with Section 300.500 of Title 34 of the Code of Federal Regulations.

(4) Giving 10 days notice to the county CCS agency of all IEP team meetings for pupils served by CCS medical therapy program;

(5) Giving 10 days notice to the LEA and the parent of an impending change in the CCS medical therapy program services which may necessitate a change in the IEP;

(6) Describing the methods of participation of CCS in the IEP team meetings pursuant to Government Code Section 7572(e);

(7) Developing or amending the therapy services indicated in the pupil's IEP in accordance with Section 56341 of the Education Code;

(8) Transporting pupils with disabilities to receive medically–necessary occupational therapy or physical therapy services at the medical therapy unit or medical therapy unit satellite;

(9) Determining the need for and location of medical therapy units or medical therapy unit satellites, or other off–site facilities authorized by state CCS and the California Department of Education;

(10) Approving the utilization of designated therapy space when not in use by CCS staff.

(11) Planning for joint staff development activities;

(12) Resolving conflicts between the county CCS agency and the LEA; and

(13) Annually reviewing the local interagency agreement and modifying it as necessary.

(d) The local interagency agreement shall also include:

(1) The name of the LEA responsible for the provision, maintenance, and operation of the facilities housing the medical therapy unit or medical therapy unit satellite during the CCS work day on a twelve–month basis;

(2) The name of the LEA having the fiscal/administrative responsibility for the provision and maintenance of necessary space, equipment, and supplies; and

(3) The process for change in fiscal/administrative responsibility for the provision and maintenance of necessary space, equipment, and supplies.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7572 and 7575, Government Code; Section 123875, Health and Safety Code; Section 300.500 of Title 34, Code of Federal Regulations; and Section 56341, Education Code.

§ 60320. Referral and Assessment.

(a) Pupils referred to the LEA for assessment of fine and gross motor or physical skills shall be considered for assessment either by the LEA or by CCS depending on the information contained in the referral and the pupil's documented physical deficit pursuant to Section 7572 of the Government Code.

(b) If the LEA determines that a referral to CCS is not appropriate, the LEA shall propose an assessment plan to the parents.

(c) If the pupil is referred to CCS by the LEA, the referral must be accompanied by:

(1) The pupil's medical diagnosis;

(2) Current medical records;

(3) Parental permission for exchange of information between agencies; and

(4) Application for the CCS program if the pupil is unknown to CCS.

(d) If medical eligibility cannot be determined by medical records submitted, CCS shall:

(1) Notify the parent and LEA within 15 days of the receipt of the referral;

(2) Seek additional medical information; and

(3) If the additional medical information sought in subdivision (2) does not establish medical eligibility, and if the pupil's diagnosis is cerebral palsy, then refer the pupil to a CCS panel physician for a neurological examination.

(e) If CCS determines that the pupil is ineligible because the pupil's medical condition is not a medical therapy program eligible condition, CCS shall notify the parent and LEA within five days of the determination of eligibility status for the medical therapy program.

(f) If CCS determines the pupil has a medical therapy program eligible condition, CCS shall propose a therapy assessment to the parents and obtain written consent for the assessment of the need for medically–necessary occupational therapy or physical therapy. This assessment for therapy shall be implemented not more than 15 days following the determination of whether the pupil has a medical therapy program eligible condition.

(g) Upon receipt of the parent's written consent for an assessment, the CCS agency shall send a copy of the parent's consent to the LEA which shall establish the date of the IEP team meeting. The LEA shall schedule an IEP team meeting to be held within 50 days from the date parental consent is received by CCS.

(h) When CCS determines a pupil needs medically necessary

occupational therapy or physical therapy, CCS shall provide the LEA and the parent a copy of the completed assessment report for therapy or a proposed therapy plan prior to the scheduled IEP meeting.

(i) When CCS determines a pupil does not need medically–necessary physical therapy or occupational therapy, the LEA and the parent shall be provided with the completed assessment report for therapy and a statement which delineates the basis for the determination.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7572 and 7575(a), Government Code; Sections 123830, 123860 and 123875, Health and Safety Code; Section 300.532 of Title 34, Code of Federal Regulations; Sections 56320, 56321, 56329 and 56344, Education Code; and Section 3051.6 of Title 5, California Code of Regulations.

§ 60323. Medical Therapy Program Responsibilities.

(a) The Medical Therapy Conference shall assess the pupil's need for occupational therapy and physical therapy. The determination of medical necessity shall be based on the pupil's physical and functional status.

(b) The Medical Therapy Conference shall review the therapy plan to ensure the inclusion of measurable functional goals and objectives for services to be performed by occupational therapists and physical therapists, as well as activities that support the goals and objectives to be performed by parents or LEA staff to maintain or prevent loss of function.

(c) The Medical Therapy Conference team shall be responsible for approval of therapy plans and either the Medical Therapy Conference physician shall write the prescription for those services provided to pupils under his supervision or review those prescriptions submitted by the pupil's private physician for compliance with (a) and (b) of this section.

(d) Medically necessary therapy services are provided at a level dependent on the pupil's physical and functional status as determined and prescribed by the CCS paneled physician of the specialty appropriate for treating the pupil's Medical Therapy Program eligible condition and who has been authorized by the program to supervise the pupil's Medical Therapy Program eligible condition.

(e) The medical necessity of occupational therapy or physical therapy services delivered to pupils not participating in a Medical Therapy Conference because there is not a Medical Therapy Conference in their geographical area shall be determined by the state program medical consultant or CCS designee.

(f) Medical therapy services must be provided by or under the supervision of a registered occupational therapist or licensed physical therapist in accordance with CCS regulations and requirements. This therapy does not include fine and gross motor activities which can be provided by qualified personnel, pursuant to California Code of Regulations, Title 5, Section 2620.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7575, Government Code; Sections 123825, 123850 and 123905, Health and Safety Code; and Section 3001(x) of Title 5, California Code of Regulations.

§ 60325. Individualized Education Program for Therapy Services.

(a) CCS shall provide a copy of the assessment and evaluation report and the proposed therapy plan to the IEP team which shall include:

(1) A statement of the pupil's present level of functional performance;

(2) The proposed functional goals to achieve a measurable change in function or recommendations for services to prevent loss of present function and documentation of progress to date;

(3) The specific related services required by the pupil, including the type of physical therapy or occupational therapy intervention, treatment, consultation, or monitoring;

(4) The proposed initiation, frequency, and duration of the services to be provided by the medical therapy program; and

(5) The proposed date of medical evaluation.

(b) CCS shall participate in the IEP team as set forth in Government Code Section 7572(e).

(c) CCS shall notify the IEP team and parent in writing within 5 days of a decision to increase, decrease, change the type of intervention, or discontinue services for a pupil receiving medical therapy services. If the parent is present at time the decision is made, he or she will also be verbally informed of the decision.

(d) The IEP team shall be convened by the LEA pursuant to subsection (c) of this section or when there is an annual or triennial review or a review requested by the parent or other authorized persons.

(e) The LEA shall convene the IEP team to review all assessments, request additional assessments if needed, determine whether fine or gross motor or physical needs exist, and consider designated instruction and services or related services that are necessary to enable the pupil to benefit from the special education program.

(f) When the IEP team determines that occupational therapy or physical therapy services are necessary for the pupil to benefit from the special education program, goals and objectives relating to the activities identified in the assessment reports shall be written into the IEP and provided by personnel qualified pursuant to the California Code of Regulations, Title 5, Section 3051.6.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7572(e) and 7575, Government Code; Section 56345, Education Code; and Section 3051.6 of Title 5, California Code of Regulations.

§ 60330. Space and Equipment for Occupational Therapy and Physical Therapy.

(a) The medical therapy unit shall have necessary space and equipment to accommodate the following functions: administration, medical therapy conference, comprehensive evaluation, private treatment, activities of daily living, storage, and modification of equipment. The specific space and equipment requirements are dependent upon local needs as determined by joint agreement of state CCS, county CCS, and LEAs, and approved by both the California Department of Education and the State Department of Health Services.

(b) The space and equipment of the medical therapy unit and medical therapy unit satellites shall be for the exclusive use of the CCS' staff when they are on site. The special education administration of the LEA in which the units are located shall coordinate with the CCS' staff for other use of the space and equipment when the CCS' staff is not present.

(c) All new construction, relocation, remodeling or modification of medical therapy units and medical therapy unit satellites shall be mutually planned and approved by the California Department of Education and the State Department of Health Services.

NOTE: Authority Cited: Section 7587, Government Code. Reference: Section 7575(d), Government Code.

Article 6. Home Health Aide

§ 60400. Specialized Home Health Aide.

(a) The Department of Health Services shall be responsible for providing the services of a home health aide when the local education agency (LEA) considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:

(1) The California Medical Assistance Program (Medi–Cal) provides life–supporting medical services via a home health agency during the time the pupil would be in school or traveling between school and home.

(2) The medical services provided require that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

(b) For purposes of this section, "life supporting medical services" means services to a pupil with a disability that is dependent on a medical technology or device that compensates for loss of the normal use of vital bodily function and who requires daily skilled nursing care to divert further disability or death.

(c) The department shall determine the appropriate level of care–giver, based on medical necessity, to provide the services.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7575(e), Government Code; and Section 51337 of Title 22, California Code of Regulations.

Article 7. Exchange of Information Between Education and Social Services

§ 60505. Community Care Facilities.

(a) The Department of Social Services shall biannually provide the Superintendent of Public Instruction a current rates list of group homes and foster family agencies.

(b) The Superintendent of Public Instruction shall biannually provide each county office of education a current list of licensed children's institutions pursuant to Section 56156 of the Education Code.

(c) The county superintendent of schools, in accordance with Section 56156(d) of the Education Code, shall biannually provide the SELPA director a current list of the licensed children's institutions within the county.

(d) The county office of education shall notify the director of each licensed children's institution of the appropriate person to contact regarding pupils with disabilities.

(e) The SELPA director and the administrator of the LEA in which a group home or small family home is located shall provide the facility licensee the following information:

(1) The types and locations of public and state certified nonpublic, nonsectarian special education programs available within the SELPA; and

(2) The ability of the LEAs within the SELPA to absorb, expand, or to open new programs to meet the needs of the pupil population given the limitations of instructional personnel service units, available school facilities, funds, and staff.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7580, Government Code; and Section 56156, Education Code.

§ 60510. Prior Notification.

(a) The court, regional center for the developmentally disabled, or public agency other than an educational agency shall notify the SELPA director, in writing or by telephone, prior to placing a pupil with a disability in a facility listed in Section 60025, and provide the following relevant information within ten days:

(1) The name of the last school attended, the contact person at that school, and the available educational records, including the current IEP.

(2) A copy or summary of the most recent psychological and medical records relevant to educational planning which are maintained by the agency.

(3) The name, address and telephone number of the parent who has the responsibility to represent the pupil in educational matters and to sign the IEP for special education, designated instruction and services and related services.

(4) The name, address and telephone number of the individual with designated responsibility to sign for consent for non–emergency medical services.

(5) The name of the administrator/designee, address, telephone number, and licensing status of a home under consideration for the pupil.

(6) A description of any special considerations related to transporting the pupil.

(7) Signed consents by the parent to exchange information relevant to IEP planning and individual program planning.

(8) When an agency makes an emergency placement to protect the physical, mental health or safety of a pupil, the agency shall furnish the SELPA director the required information within three days after the placement.

(b) The SELPA director shall provide the placing agency with information about the availability of an appropriate special education program in the SELPA in which the home is located. This should occur within seven days of receipt of the notice of placement.

(1) If no appropriate special education placements exist within the SELPA, and the placement options are home instruction or in a public or nonpublic facility located in another SELPA, the placing agency should make every effort to place the pupil in another SELPA that has appropriate available residential and educational programs.

(2) When the agency places a pupil in a licensed children's institution, as defined in this Chapter which has an on–grounds, certified, nonpublic, nonsectarian school, the pupil may attend the education program only if the SELPA's IEP team has determined that there is no appropriate public education program in the community and that the on–grounds program is appropriate and can implement the pupil's IEP.

(3) When the IEP team makes the determination that the on–grounds program is appropriate, the LEA may then contract for educational services with the nonpublic school.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7579 and 7580, Government Code; and Section 56156, Education Code.

Article 8. Procedural Safeguards

§ 60550. Due Process Hearings.

(a) Due process hearing procedures apply to the resolution of disagreements between a parent and a public agency regarding the proposal or refusal of a public agency to initiate or change the identification, assessment, educational placement, or the provision of special education and related services to the pupil.

(b) Upon receiving a request for a due process hearing regarding the services provided or refused by another agency, the Superintendent of Public Instruction or designee shall send the state and local agency involved a copy of the hearing request, the name of the assigned mediator, and the date of the mediation meeting in accordance with Section 56503 of the Education Code. Nothing in this section shall preclude any party from waiving mediation.

(c) If the mediator cannot resolve the issues, a state level hearing shall be conducted by a hearing officer in accordance with Section 56505 of the Education Code.

(d) Each agency which is identified by the State Superintendent of Public Instruction or designee as a potentially responsible party and which has been involved in a proposal or refusal to provide a service is responsible for preparing documentation and providing testimony for the hearing officer.

(e) The hearing officer shall be knowledgeable in the laws governing administrative hearings. In addition, the hearing officer shall be knowledgeable about the provisions of Chapter 26.5 of the Government Code and applicable laws relevant to special education, community mental health and the California Children's Services Program. For hearings related to the provision of occupational and/or physical therapy, the hearing officer shall rule according to Government Code Section 7575(a) which specifies:

(1) "Notwithstanding any other provision of law, the State Department of Health Services, or any designated local agency administering the California Children Services, shall be responsible for the provision of medically necessary occupational therapy and physical therapy, as specified by Article 2, commencing with Section 123825 et. seq. of the Health and Safety Code, by reason of medical diagnosis and when contained in the pupil's IEP.

(2) Related services or designated instruction and services not

deemed to be medically necessary by the State Department of Health Services, which the IEP team determines are necessary in order to assist a pupil to benefit from special education, shall be provided by the LEA by qualified personnel whose employment standards are covered by the Education Code and implementing regulations."

(f) The hearing decision shall be the final administrative determination regarding the provision of educational and related services, and is binding on all parties.

(g) Nothing in this article shall preclude the Department of Social Services from instituting, maintaining and concluding an administrative action to revoke or temporarily suspend a license pursuant to the Community Care Facilities Act, Health and Safety Code Section 1500 et. Seq.

(h) Nothing in this article shall interfere with the discharge of a pupil placed in a community treatment facility who does not meet admission or continuing stay criteria and/or does meet discharge criteria as defined in Welfare and Institutions Code Section 4094 and implementing CCL regulations.

(i) The California Department of Education is fiscally responsible for services provided by the mediator and the hearing officer in response to a parent's request for a due process hearing.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7586, Government Code; Sections 56501–56507, Education Code; Section 3082 of Title 5, California Code of Regulations; Section 4094, Welfare and Institutions Code; *Corbett v. Regional Center of the East Bay Inc. and Linda McMahon, Director of the Department of Social Services*, (1988) 9th Cir. 699 F. Supp. 230; *In re Roger S.* (1977) 19 Cal.3d. 921; and *In re Michael E.* (1975) 15 Cal.3d. 183.

§ 60560. Compliance Complaints.

Allegations of failure by an LEA, Community Mental Health Services or CCS to comply with these regulations, shall be resolved pursuant to Chapter 5.1, commencing with Section 4600, of Division 1 of Title 5 of the California Code of Regulations.

NOTE: Authority cited: Section 7587, Government Code. Reference: Section 7585, Government Code; and Section 4650, Title 5, California Code of Regulations.

Article 9. Interagency Dispute Resolution

§ 60600. Application of Procedures.

(a) The procedures of this article apply as specified in Government Code 7585, when there is a dispute between or among the California Department of Education or a LEA or both and any agency included in Sections 7575 and 7576 of the Government Code over the provision of related services, when such services are contained in the IEP of a pupil with a disability. This article also applies when the responsibility for providing services, ordered by a hearing officer or agreed to through mediation pursuant to Sections 56503 and 56505 of the Education Code, is in dispute among or between the public agencies.

(b) A dispute over the provision of services means a dispute over which agency is to deliver or to pay for the services when the service is contained in the IEP, mediation agreement, or due process hearing decision. The IEP of a pupil with a disability, and, when appropriate, a copy of the mediation agreement negotiated through the mediator or decision of the hearing officer shall accompany the request for a state interagency dispute resolution.

(c) As specified in Section 7585 of the Government Code, when a service has been included in an IEP by an IEP team without the recommendation of the qualified professional in accordance with Section 7572 of the Government Code, the LEA shall be solely responsible for the provision of the service. In such circumstances, the dispute, if any, is between the parent and the LEA and shall be resolved pursuant to Title 5 of the California Code of Regulations.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7572 and 7585, Government Code; and Sections 56503 and 56505, Education Code.

§ 60610. Resolution Procedure.

(a) Whenever notification is filed pursuant to subsection (a) of Section 7585 of the Government Code, the dispute procedures shall not interfere with a pupil with a disability's right to receive a free, appropriate public education.

(1) If one of the departments or local agencies specified in Sections 7575, 7576, 7577, and 7578 of the Government Code has been providing the service prior to notification of the failure to provide a related service or designated instruction and service, that department or local agency shall pay for, or provide, at it's discretion, the service until the dispute resolution proceedings are completed.

(2) If no department or local agency specified in this section has provided the service prior to the notification of the dispute, the State Superintendent of Public Instruction shall ensure that the LEA provides the service in accordance with the IEP, until the dispute resolution proceedings are completed.

(3) Arrangements, other than those specified in paragraphs (1) and (2) of subsection (a), may be made by written agreement between the involved public agencies, provided the pupil with disabilities' IEP is not altered, except as to which agency delivers or pays for the service if such specification is included in the IEP.

(b) In resolving the dispute, the State Superintendent of Public Instruction and Secretary of the Health and Welfare Agency or their designees shall meet to resolve the issue within 15 days of receipt of the notice.

(c) Once the dispute resolution procedures have been completed, the department or local agency determined responsible for the service shall pay for, or provide the service, and shall reimburse the other agency which provided the service pursuant to subsection (a) of this section, if applicable.

(d) A written copy of the resolution shall be mailed to affected parties pursuant to Section 7585 of the Government Code.

(e) The resolution of the dispute shall be communicated to the originating party within 60 days from the receipt of the complaint by either agency.

NOTE: Authority cited: Section 7587, Government Code. Reference: Sections 7575, 7576, 7577, 7578 and 7585, Government Code.

TITLE 5. EDUCATION

Division 1. State Department of Education

Chapter 3. Handicapped Children

Subchapter 1. Special Education

Article 3.1. Individuals with Exceptional Needs

§ 3030. Eligibility Criteria.

A pupil shall qualify as an individual with exceptional needs, pursuant to Section 56026 of the Education Code, if the results of the assessment as required by Section 56320 demonstrate that the degree of the pupil's impairment as described in Section 3030 (a through j) requires special education in one or more of the program options authorized by Section 56361 of the Education Code. The decision as to the whether or not the assessment results demonstrate that the degree of the pupil's impairment requires special education shall be made by the individualized education program team, including personnel in accordance with Section 56341(d) of the Education Code. The individualized education program team shall take into account all the relevant material which is available on the pupil. No single score or product of scores shall be used as the sole criterion for the decision of the individualized education program team as to the pupil's eligibility for special education. The specific processes and procedures for implementation of these criteria shall be developed by each Special Education Local Plan Area and be included in the local plan pursuant to Section 56220(a) of the Education Code.

(a) A pupil has a hearing impairment, whether permanent or fluctuating, which impairs the processing of linguistic information through hearing, even with amplification, and which adversely affects educational performance. Processing linguistic information includes speech and language reception and speech and language discrimination.

(b) A pupil has concomitant hearing and visual impairments, the combination of which causes severe communication, developmental, and educational problems.

(c) A pupil has a language or speech disorder as defined in Section 56333 of the Education Code, and it is determined that the pupil's disorder meets one or more of the following criteria:

(1) Articulation disorder.

(A) The pupil displays reduced intelligibility or an inability to use the speech mechanism which significantly interferes with communication and attracts adverse attention. Significant interference in communication occurs when the pupil's production of single or multiple speech sounds on a developmental scale of articulation competency is below that expected for his or her chronological age or developmental level, and which adversely affects educational performance.

(B) A pupil does not meet the criteria for an articulation disorder if the sole assessed disability is an abnormal swallowing pattern.

(2) Abnormal Voice. A pupil has an abnormal voice which is characterized by persistent, defective voice quality, pitch, or loudness.

(3) Fluency Disorders. A pupil has a fluency disorder when the flow of verbal expression including rate and rhythm adversely affects communication between the pupil and listener.

(4) Language Disorder. The pupil has an expressive or receptive language disorder when he or she meets one of the following criteria:

(A) The pupil scores at least 1.5 standard deviations below the mean, or below the 7th percentile, for his or her chronological age or developmental level on two or more standardized tests in one or more of the following areas of language development: morphology, syntax, semantics, or pragmatics. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified on the assessment plan, or

(B) The pupil scores at least 1.5 standard deviations below the mean or the score is below the 7th percentile for his or her chronological age or developmental level on one or more standardized tests in one of the areas listed in subsection (A) and displays inappropriate or inadequate usage of expressive or receptive language as measured by a representative spontaneous or elicited language sample of a minimum of fifty utterances. The language sample must be recorded or transcribed and analyzed, and the results included in the assessment report. If the pupil is unable to produce this sample, the language, speech, and hearing specialist shall document why a fifty utterance sample was not obtainable and the contexts in which attempts were made to elicit the sample. When standardized tests are considered to be invalid for the specific pupil, the expected language performance level shall be determined by alternative means as specified in the assessment plan.

(d) A pupil has a visual impairment which, even with correction, adversely affects a pupil's educational performance.

(e) A pupil has a severe orthopedic impairment which adversely affects the pupil's educational performance. Such orthopedic impairments include impairments caused by congenital anomaly, impairments caused by disease, and impairments from other causes.

(f) A pupil has limited strength, vitality or alertness, due to chronic or acute health problems, including but not limited to a heart condition, cancer, leukemia, rheumatic fever, chronic kidney disease, cystic fibrosis, severe asthma, epilepsy, lead poising, diabetes, tuberculosis and other communicable infectious diseases, and hematological disorders such as sickle cell anemia and hemophilia which adversely affects a pupil's educational performance. In accordance with Section 5626(e) of the Education Code, such physical disabilities shall not be temporary in nature as defined by Section 3001(v).

(g) A pupil exhibits any combination of the following autistic–like behaviors, to include but not limited to:

(1) An inability to use oral language for appropriate communication.

(2) A history of extreme withdrawal or relating to people inappropriately and continued impairment in social interaction from infancy through early childhood.

(3) An obsession to maintain sameness.

(4) Extreme preoccupation with objects or inappropriate use of objects or both.

(5) Extreme resistance to controls.

(6) Displays peculiar motoric mannerisms and motility patterns.

(7) Self–stimulating, ritualistic behavior.

(h) A pupil has significantly below average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affect a pupil's educational performance.

(i) Because of a serious emotional disturbance, a pupil exhibits one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance:

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors.

(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(3) Inappropriate types of behavior or feelings under normal circumstances exhibited in several situations.

(4) A general pervasive mood of unhappiness or depression.

(5) A tendency to develop physical symptoms or fears associated with personal or school problems.

(j) A pupil has a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an impaired ability to listen, think, speak, read, write, spell, or do mathematical calculations, and has a severe discrepancy between intellectual ability and achievement in one or more of the academic areas specified in Section 56337(a) of the Education Code. For the purpose of Section 3030(j):

(1) Basic psychological processes include attention, visual processing, auditory processing, sensory–motor skills, cognitive abilities including association, conceptualization and expression.

(2) Intellectual ability includes both acquired learning and learning potential and shall be determined by a systematic assessment of intellectual functioning.

(3) The level of achievement includes the pupil's level of competence in materials and subject matter explicitly taught in school and shall be measured by standardized achievement tests.

(4) The decision as to whether or not a severe discrepancy exists shall be made by the individualized education program team, including assessment personnel in accordance with Section 56341(d), which takes into account all relevant material which is available on the pupil. No single score or product of scores, test or procedure shall be used as the sole criterion for the decisions of the individualized education program team as to the pupil's eligibility for special education. In determining the existence of a severe discrepancy, the individualized education program team shall use the following procedures:

(A) When standardized tests are considered to be valid for a specific pupil, a severe discrepancy is demonstrated by: first, converting into common standard scores, using a mean of 100 and standard deviation of 15, the achievement test score and the ability test score to be compared; second, computing the difference between these common standard scores; and third, comparing this computed difference to the standard criterion which is the product of 1.5 multiplied by the standard deviation of the distribution of computed differences of students taking these achievement and ability tests. A computed difference which equals or exceeds this standard criterion, adjusted by one standard error of measurement, the adjustment not to exceed 4 common standard score points, indicates a severe discrepancy when such discrepancy is corroborated by other assessment data which may include other tests, scales, instruments, observations and work samples, as appropriate.

(B) When standardized tests are considered to be invalid for a specific pupil, the discrepancy shall be measured by alternative means as specified on the assessment plan.

(C) If the standardized tests do not reveal a severe discrepancy as defined in subparagraphs (A) or (B) above, the individualized education program team may find that a severe discrepancy does exist, provided that the team documents in a written report that the severe discrepancy between ability and achievement exists as a result of a disorder in one or more of the basic psychological processes. The report shall include a statement of the area, the degree, and the basis and method used in determining the discrepancy. The report shall contain information considered by the team which shall include, but not be limited to:

1. Data obtained from standardized assessment instruments;
2. Information provided by the parent;
3. Information provided by the pupil's present teacher;
4. Evidence of the pupil's performance in the regular and/or special education classroom obtained from observations, work samples, and group test scores;
5. Consideration of the pupil's age, particularly for young children; and
6. Any additional relevant information.

(5) The discrepancy shall not be primarily the result of limited school experience or poor school attendance.

NOTE: Authority cited: Statutes of 1981, Chapter 1094, Section 25(a); and Section 56100(a), (g) and (i), Education Code. Reference: 20 USC 1401(a)(15) and 1412(5); 34 CFR 300.5(b)(7) and (9), 300.532(a)(2), (d) and (e), 300.533, 300.540, 300.541–43; and Sections 56026, 56320, 56333 and 56337, Education Code.

§ 3031. Additional Eligibility Criteria for Individuals with Exceptional Needs—Age Birth to Four Years and Nine Months.

(a) A child, age birth to four years and nine months, shall qualify as an individual with exceptional needs pursuant to Education Code Section 56026(c)(1) and (2) if the Individualized Education Program Team determines that the child meets the following criteria:

(1) Is identified as an individual with exceptional needs pursuant to Section 3030, and

(2) Is identified as requiring intensive special education and services by meeting one of the following:

(A) The child is functioning at or below 50% of his or her chronological age level in any one of the following skill areas:

1. gross or fine motor development;
2. receptive or expressive language development;
3. social or emotional development;
4. cognitive development; and
5. visual development.

(B) The child is functioning between 51% and 75% of his or her chronological age level in any two of the skill areas identified in Section 3031(2)(A).

(C) The child has a disabling medical condition or congenital syndrome which the Individualized Education Program Team determines has a high predictability of requiring intensive special education and services.

(b) Programs for individuals with exceptional needs younger than three years of age are permissive in accordance with Section 56001(c) of the Education Code except for those programs mandated pursuant to Section 56425 of the Education Code.

NOTE: Authority cited: Statutes of 1981, Chapter 1094, Section 25(a); and Section 56100(a), (g) and (i), Education Code. Reference: 20 USC 1401(a)(15); 34 CFR 300.5; Statutes of 1981, Chapter 1094, Section 25(a); and Sections 56026, 56030.5, 56333, and 56337, Education Code.

Chapter 5.1. Uniform Complaint Procedures

Subchapter 1. Complaint Procedures

Article 1. Definitions

§ 4600. General Definitions.

As used in this chapter, the term:

(a) "Appeal" means a request made in writing to a level higher than the original reviewing level by an aggrieved party requesting reconsideration or a reinvestigation of the lower adjudicating body's decision.

(b) "Beginning of the year or semester" means the first day classes necessary to serve all the students enrolled are established with a single designated certificated employee assigned for the duration of the class, but not later than 20 working days after the first day students attend classes for that semester.

(c) "Complainant" means any individual, including a person's duly authorized representative or an interested third party, public agency, or organization who files a written complaint alleging violation of federal or state laws or regulations, including allegations of unlawful discrimination in programs and activities funded directly by the state or receiving any financial assistance from the state.

(d) "Complaint" means a written and signed statement alleging a violation of federal or state laws or regulations, which may include an allegation of unlawful discrimination. If the complainant is unable to put the complaint in writing, due to conditions such as a disability or illiteracy, the public agency shall assist the complainant in the filing of the complaint.

(e) "Complaint investigation" means an administrative process used by the Department or local educational agency for the purpose of gathering data regarding the complaint.

(f) "Complaint procedure" means an internal process used by the Department or local educational agency to process and resolve complaints.

(g) "Days" means calendar days unless designated otherwise.

(h) "Department" means the California Department of Education.

(i) "Direct state intervention" means the steps taken by the Department to initially investigate complaints or effect compliance.

(j) "Educational institution" means a public or private preschool, elementary, or secondary school or institution, the governing board of a school district, or any combination of school districts or counties recognized as the administrative agency for public elementary or secondary schools.

(k) "Facilities that pose an emergency or urgent threat to the health or safety of pupils or staff" means a condition as defined in paragraph (1) of subdivision (c) of section 17592.72 and any other emergency conditions the school district determines appropriate.

(*l*) "Good repair" means the facility is maintained in a manner that assures that it is clean, safe, and functional as determined pursuant to an interim evaluation instrument developed by the Office of Public School Construction pursuant to Education Code section 17002(d)(2), and is available from the Department of General Services, Office of Public School Construction.

(m) "Instructional materials" means all materials that are designed for use by pupils and their teachers as a learning resource and help pupils to acquire facts, skills, or opinions or to develop cognitive processes. Instructional materials may be printed or nonprinted, and may include textbooks, technology–based materials, other educational materials, and tests.

(n) "Local agency" means a school district governing board or a local public or private agency which receives direct or indirect funding or any other financial assistance from the state to provide any school programs or activities or special education or related services.

(o) "Local educational agency" (LEA) includes any public school district and county office of education or direct–funded charter school.

(p) "Mediation" means a problem solving activity whereby a third party assists the parties to the dispute in resolving the complaint.

(q) "Misassignment" means the placement of a certificated employee in a teaching or services position for which the employee does not hold a legally recognized certificate or credential or the placement of a certificated employee in a teaching or services position that the employee is not otherwise authorized by statute to hold.

(r) "Public agency" means any local agency or state agency.

(s) "State agency" means the State Departments of Mental Health or Health Services or any other state administrative unit that is or may be required to provide special education or related services to children with disabilities pursuant to Government Code section 7570 et seq.

(*t*) "State mediation agreement" means a written, voluntary agreement approved by the Department, which is developed by the parties to the dispute, which resolves the allegations of the complaint.

(u) "Subject matter competency" means the teacher meets the applicable requirements of Chapter 6, article 1, subchapter 7 of these regulations, commencing with section 6100, for the course being taught.

(v) "Sufficient textbooks or instructional materials" means that each pupil, including English learners, has a textbook or instructional materials, or both, to use in class and to take home but does not require two sets of textbooks or instructional materials for each pupil. Sufficient textbooks or instructional materials does not include photocopied sheets from only a portion of a textbook or instructional materials copied to address a shortage.

(w) "Superintendent" means the Superintendent of Public Instruction or his or her designee.

(x) "Teacher vacancy" means a position to which a single designated certificated employee has not been assigned at the beginning of the year for an entire year or, if the position is for a one–semester course, a position of which a single designated certificated employee has not been assigned at the beginning of a semester for an entire semester.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200, 201, 210.1, 220, 17002(d), 17592.72, 33126(b)(5)(A) and (B) and 60010, Education Code; and Sections 11135 and 11138, Government Code.

Article 2. Purpose and Scope

§ 4610. Purpose and Scope.

(a) This Chapter applies to the filing, investigation and resolution of a complaint regarding an alleged violation by a local agency of federal or state law or regulations governing educational programs, including allegations of unlawful discrimination. The purpose of this chapter is to establish a uniform system of complaint processing for specified programs or activities that receive state or federal funding.

(b) This chapter applies to the following programs administered by the Department:

(1) Adult Education programs established pursuant to Education Code sections 8500 through 8538 and 52500 through 52616.4;

(2) Consolidated Categorical Aid Programs as listed in Education Code section 64000(a);

(3) Migrant Education established pursuant to Education Code sections 54440 through 54445;

(4) Career Technical and Technical Education and Career Technical and Technical Training Programs established pursuant to Education Code sections 52300 through 52480;

(5) Child Care and Development Programs established pursuant to Education Code sections 8200 through 8493;

(6) Child Nutrition Programs established pursuant to Education Code sections 49490 through 49570; and

(7) Special Education Programs established pursuant to Education Code sections 56000 through 56885 and 59000 through 59300.

(c) This chapter also applies to the filing of complaints which allege unlawful discrimination against any protected group as identified under Education Code section 200 and 220 and Government Code section 11135, including actual or perceived sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, religion, color, or mental or physical disability, or age, or on the basis of a person's association with a person or group with one or more of these actual or perceived characteristics, in any program or activity conducted by a local agency, which is funded directly by, or that receives or benefits from any state financial assistance.

(d) Nothing in these regulations shall prevent a local educational agency from using its local uniform complaint procedure to address complaints not listed in this section.

(e) The Department will develop a pamphlet for parents that will explain the Uniform Complaint Procedures in a user friendly manner and post this pamphlet on the Department's Web site.

NOTE: Authority cited: Sections 221.1, 8261, 33031, 49531, 49551, 54445, 52355, 52451, and 56100(a) and (j), Education Code; and Section 11138, Government Code. Reference: Sections 200, 220, 260, and 49556, Education Code; Sections 11135 and 11138, Government Code; and 34 CFR 106.1–106.8 and 299.10–299.11.

§ 4611. Referring Complaint Issues to Other Appropriate State or Federal Agencies.

The following complaints shall be referred to the specified agencies for appropriate resolution and are not subject to the local and Department complaint procedures set forth in this chapter unless these procedures are made applicable by separate interagency agreements:

(a) Allegations of child abuse shall be referred to the applicable County Department of Social Services (DSS), Protective Services Division or appropriate law enforcement agency. However, nothing in this section relieves the Department from investigating complaints pursuant to section 4650(a)(8)(C) herein.

(b) Health and safety complaints regarding a Child Development

Program shall be referred to Department of Social Services for licensed facilities, and to the appropriate Child Development regional administrator for licensing–exempt facilities.

(c) Employment discrimination complaints shall be sent to the State Department of Fair Employment and Housing (DFEH) pursuant to title 22, CCR, section 98410. The complainant shall be notified by first class mail of any DFEH transferral.

(d) Allegations of fraud shall be referred to the responsible Department Division Director who may consult with the Department's Legal and Audits Branch.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200, 220 and 48987, Education Code; Sections 11135, 11136, 11138 and 12960, Government Code; Section 11166, Penal Code; and 34 CFR 106.1–106.8.

Article 3. Local Educational Agency Compliance

§ 4620. Local Educational Agency Responsibilities.

Each local educational agency shall have the primary responsibility to insure compliance with applicable state and federal laws and regulations. Each local educational agency shall investigate complaints alleging failure to comply with applicable state and federal laws and regulations and/or alleging discrimination, and seek to resolve those complaints in accordance with the procedures set out in this chapter and in accordance with the policies and procedures of the governing board.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Section 200, 220 and 260, Education Code; Section 11135, Government Code; and 34 CFR 106.8.

§ 4621. District Policies and Procedures.

(a) Each local educational agency shall adopt policies and procedures not inconsistent with sections 4600–4695 of this chapter for the investigation and resolution of complaints. Local policies shall ensure that complainants are protected from retaliation and that the identity of a complainant alleging discrimination remain confidential as appropriate. School Districts and County Offices of Education shall submit their policies and procedures to the local governing board for adoption.

(b) Each local educational agency shall include in its policies and procedures the person(s), employee(s) or agency position(s) or unit(s) responsible for receiving complaints, investigating complaints and ensuring local educational agency compliance. The local educational agency's policies shall ensure that the person(s), employee(s), position(s) or unit(s) responsible for compliance and/or investigations shall be knowledgeable about the laws/programs that he/she is assigned to investigate.

(c) Except for complaints under sections 4680–4687 regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancies or misassignments, the local educational agency may provide a complaint form for persons wishing to file a complaint to fill out and file. A complaint form shall be provided for complaints regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancies or misassignments. However, a person is not required to use the complaint form furnished by the local educational agency in order to file a complaint.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200, 220 and 260, Education Code; Section 11135, Government Code; and 34 CFR 106.8 and 299.10–299.11.

§ 4622. Notice.

Each local educational agency shall annually notify in writing, as applicable, its students, employees, parents or guardians of its students, the district advisory committee, school advisory committees, appropriate private school officials or representatives, and other interested parties of their local educational agency complaint procedures, including the opportunity to appeal to the Department and the provisions of this chapter. The notice shall include the identity (identities) of the person(s) responsible for processing complaints. The notice shall also advise the recipient of any civil law remedies that may be available under state or federal discrimination laws, if applicable, and of the appeal pursuant to Education Code section 262.3. This notice shall be in English, and when necessary, in the primary language, pursuant to section 48985 of the Education Code, or mode of communication of the recipient of the notice. Copies of local educational agency complaint procedures shall be available free of charge.

NOTE: Authority cited: Sections 200, 220, 221.1, 262.3 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135 and 11138, Government Code; and 34 CFR 106.8 and 299.11.

Article 4. Local Complaint Procedures

§ 4630. Filing a Local Complaint; Procedures, Time Lines.

(a) Except for complaints under sections 4680–4687 regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancies or misassignments, and complaints that allege discrimination, any individual, public agency or organization may file a written complaint with the district superintendent or his or her designee alleging a matter which, if true, would constitute a violation by that local educational agency of federal or state law or regulation governing a program listed in section 4610(b) of this chapter.

(b) An investigation of alleged unlawful discrimination shall be initiated by filing a complaint not later than six months from the date the alleged discrimination occurred, or the date the complainant first obtained knowledge of the facts of the alleged discrimination unless the time for filing is extended by the district superintendent or his or her designee, upon written request by the complainant setting forth the reasons for the extension. Such extension by the district superintendent or his or her designee shall be made in writing. The period for filing may be extended by the district superintendent or his or her designee for good cause for a period not to exceed 90 days following the expiration of the six month time period. The district superintendent shall respond immediately upon a receipt of a request for extension.

(1) The complaint shall be filed by one who alleges that he or she has personally suffered unlawful discrimination, or by one who believes an individual or any specific class of individuals has been subjected to discrimination prohibited by this part.

(2) The complaint shall be filed with the local educational agency in accordance with the complaint procedures of the local educational agency.

(3) An investigation of a discrimination complaint shall be conducted in a manner that protects confidentiality of the parties and maintains the integrity of the process.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136, and 11138, Government Code; and 34 CFR 106.8.

§ 4631. Responsibilities of the Local Educational Agency.

(a) Except for complaints regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancies or misassignments, which must be processed in accordance with sections 4680–4687, within 60 days from the date of the receipt of the complaint, the local educational agency person responsible for the investigation of the complaints or his or her designee shall conduct and complete an investigation of the complaint in accordance with the local procedures adopted pursuant to section 4621 and prepare a written Local Educational Agency Decision. This time period may be extended by written agreement of the complainant.

(b) The investigation shall include an opportunity for the complainant, or the complainant's representative, or both, to present the complaint(s) and evidence or information leading to evidence to support the allegations of non–compliance with state and federal laws and/or regulations.

(c) Refusal by the complainant to provide the investigator with documents or other evidence related to the allegations in the complaint, or to otherwise fail or refuse to cooperate in the investigation or engage in any other obstruction of the investigation, may result in the dismissal of the complaint because of a lack of evidence to support the allegations.

(d) Refusal by the local agency to provide the investigator with access to records and/or other information related to the allegation in the complaint, or to otherwise fail or refuse to cooperate in the investigation or engage in any other obstruction of the investigation, may result in a finding based on evidence collected that a violation has occurred and may result in the imposition of a remedy in favor of the complainant.

(e) The local educational agency should issue a Decision (the Decision) based on the evidence. The Decision shall be in writing and sent to the complainant within 60 days from receipt of the complaint by the local educational agency. The Decision should contain:

(1) the findings of fact based on the evidence gathered,

(2) conclusion of law,

(3) disposition of the complaint,

(4) the rationale for such disposition,

(5) corrective actions, if any are warranted,

(6) notice of the complainant's right to appeal the local educational agency Decision to the Department, and

(7) procedures to be followed for initiating an appeal to the Department.

(f) Nothing in this chapter shall prohibit the parties from utilizing alternative methods to resolve the allegations in the complaint, including, but not limited to, mediation.

(g) Nothing in this chapter shall prohibit a local educational agency from resolving complaints prior to the formal filing of a written complaint.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136, and 11138, Government Code; and 34 CFR 106.8.

Article 4.5. Appeal of Local Educational Agency Decision

§ 4632. Appeal of Local Educational Agency Decision — Grounds.

(a) Except for complaints under sections 4681 and 4682 regarding instructional materials and teacher vacancies or misassignments, a complainant may appeal a Decision to the Department by filing a written appeal within 15 days of receiving the Decision.

(b) The complainant shall specify the basis for the appeal of the Decision and whether the facts are incorrect and/or the law is misapplied.

(c) The appeal shall be accompanied by:

(1) a copy of the locally filed complaint; and

(2) a copy of the Decision.

(d) If the Department determines the appeal raises issues not contained in the local complaint, the Department will refer those new issues back to the local educational agency for resolution as a new complaint under section 4630 or 4631.

(e) If the Department determines that the Decision failed to address an issue raised by the complaint, the Department shall refer the matter to the local educational agency to make the necessary findings and conclusions on any issue not addressed. The local educational agency will address the issue within 20 days from the date of the referral.

NOTE: Authority cited: Sections 200, 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 11135, 11136 and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4633. Appeal of Local Educational Agency Decision.

(a) If the Decision is appealed, the Department shall notify the local educational agency of the appeal. Upon notification by the Department that the Decision has been appealed, the local educational agency shall forward the following to the Department:

(1) A copy of the original complaint;

(2) A copy of the Decision;

(3) A summary of the nature and extent of the investigation conducted by the local educational agency, if not covered in the Decision;

(4) A copy of the investigation file, including but not limited to, all notes, interviews and documents submitted by the parties or gathered by the investigator;

(5) A report of any action taken to resolve the complaint;

(6) A copy of the local educational agency complaint procedures; and

(7) Such other relevant information as the Department may request.

(b) The Department shall not receive evidence from the parties that could have been presented to the local educational agency investigator during the investigation, unless requested by the Department. Any confidential information or pupil information in the investigative file shall remain confidential and shall not be disclosed by the Department.

(c) The Department may contact the parties for further information, if necessary.

(d) The Department shall review the investigation file, the summary of the nature and extent of the investigation conducted by the local educational agency, the complaint procedures, documents and any other evidence received from the local educational agency and determine whether substantial evidence exists:

(1) That the local educational agency followed its complaint procedures; and

(2) That the relevant findings of fact in the Decision which are the subject of the appeal are supported by the evidence.

(e) The Department shall review the conclusions of law which are the subject of the appeal and determine whether they are correct.

(f) If the Department determines that the Decision is deficient because it lacks findings of fact and conclusions of law regarding the subject of the appeal, the Department may return the Decision to the local educational agency in order to correct the deficiencies within 20 days of the return.

(g) If the Department finds that the Decision is supported by substantial evidence, and that the legal conclusions are not contrary to law, the appeal shall be denied.

(h) If the Department finds the grounds for the appeal have merit:

(1) The Department may, if there is a lack of substantial evidence or a procedural defect in the investigation, remand the investigation to the local educational agency for further investigation of the allegations which are the subject of the appeal; or

(2) The Department may issue a decision based on the evidence in the investigation file received from the local educational agency; or

(3) If the Department determines that it is in the best interest of the parties, conduct a further investigation of the allegations which are the basis for the appeal and issue a decision following further investigation.

(i) If the Department finds merit in the appeal, the Department's decision on appeal shall contain the following:

(1) A finding that the local educational agency complied or did not comply with its complaint procedures;

(2) The Department's findings of fact and conclusions of law regarding the issue on appeal; and

(3) Where a determination is made that the local educational agency failed to comply with the applicable state or federal law or regulation, remedial orders and/or required actions to address the violation(s).

NOTE: Authority cited: Sections 221.1 and 33031; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136 and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

Article 5. State Complaint Procedures

§ 4640. Filing a State Complaint That Has Not First Been Filed at the Local Educational Agency; Time Lines, Notice, Appeal Rights.

Referral to the Local Educational Agency for Local Resolution.

(a) If a complaint is erroneously filed with the Department without first being filed with and investigated by the local educational agency, the Department shall immediately forward the complaint to the local educational agency for processing in accordance with article 4 of this chapter, unless extraordinary circumstances exist necessitating direct state intervention as described at section 4650.

(b) A letter shall be sent by first class mail to the complainant(s) notifying him, her, or them that:

(1) The Department does not have jurisdiction, at this time, over the complaint and that the complaint should have been filed with the local educational agency in the first instance;

(2) That the complaint has been transferred to the local educational agency requesting the local educational agency to process and investigate the allegation in the complaint; and

(3) That the complainant may file an appeal to the Department following the issuance of the Decision, if he or she believes as a matter of fact or law the Decision is incorrect.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136, and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

Article 6. Direct State Intervention

§ 4650. Basis of Direct State Intervention.

(a) Except for complaints under sections 4680, 4681, 4682 and 4683 regarding instructional materials, teacher vacancies or misassignments, and condition of a facility, the Department shall directly intervene without waiting for local educational agency investigation if one or more of the following situations exist:

(1) The complaint includes an allegation, and the Department verifies, that a local educational agency failed to comply with the complaint procedures required by this Chapter and its local rules and regulations, including, but not limited to, the failure or refusal of the local educational agency to cooperate with the investigation;

(2) The complaint relates to an agency that is not a local educational agency funded through the Child Development or Child Nutrition Programs;

(3) The complainant requests anonymity because he or she would be in danger of retaliation and would suffer immediate and irreparable harm if he or she filed a complaint with the local educational agency;

(4) The complainant alleges that the local educational agency failed or refused to implement the final decision resulting from its local investigation or local mediation agreement;

(5) The complainant alleges and the Department verifies that through no fault of the complainant, no action has been taken by the local educational agency within 60 calendar days of the date the complaint was filed. Prior to direct intervention, the Department shall attempt to work with the local educational agency to allow it to complete the investigation and issue a Decision.

(6) The complainant alleges and the Department verifies that he or she would suffer immediate and irreparable harm as a result of an application of a district–wide policy that is in conflict with state or federal law covered by this Chapter, and that filing a complaint with the local educational agency would be futile.

(7) For complaints relating to special education, any one of the following shall be a condition for direct state intervention:

(A) The complainant alleges that a public agency, other than a local educational agency, as specified in Government Code section 7570 et seq., fails or refuses to comply with an applicable law or regulation relating to the provision of free appropriate public education to individuals with disabilities;

(B) The complainant alleges that the local educational agency or public agency fails or refuses to comply with the due process procedures established pursuant to federal and state law and regulation; or has failed or refused to implement a due process hearing order;

(C) The complainant alleges facts that indicate that the child or group of children may be in immediate physical danger or that the health, safety or welfare of a child or group of children is threatened.

(D) The complainant alleges that an individual with a disability is not receiving the special education or related services specified in his or her individualized educational program (IEP).

(E) The complaint involves a violation of federal law governing special education, 20 U.S.C. section 1400 et seq., or its implementing regulations.

(b) The complaint shall identify the basis, as described in subdivision (a) above, for filing the complaint directly to the Department. The complainant must present the Department with clear and verifiable evidence that supports the basis for the direct filing, except as in subdivision (a)(7).

NOTE: Authority cited: Section 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136, and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4651. Notification.

When the Department receives a complaint requesting direct State intervention, the Department shall determine whether the complaint meets one or more of the criterion specified in section 4650 for direct State intervention and shall immediately notify the complainant by first class mail of the determination to accept the complaint without a local educational agency investigation and/or Decision. If the complaint is not accepted, it shall be referred to the local educational agency for local investigation, or referred to another agency pursuant to section 4611.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136 and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4652. Appealing Local Agency Decisions.

NOTE: Authority cited: Sections 232 and 33031, Education Code; Section 11138, Government Code. Reference: Sections 11135, 11136, and 11138, Government Code; 34 CFR 76.780–76.783 and 106.8.

Article 7. State Investigation Procedures

§ 4660. Department Resolution Procedures.

(a) When the Department determines that direct State intervention is warranted pursuant to any provision of section 4650, the following procedures shall be used to resolve the issues of the complaint:

(1) The Department shall consider alternative methods to resolve the allegations in the complaint.

(2) If both parties request mediation, the Department shall offer to mediate the dispute which may lead to a state mediation agreement.

(3) The Department shall conduct an investigation, including an on–site investigation if necessary, into the allegations in the complaint unless a settlement agreement has been reached between the parties that disposes of all the issues in the complaint.

NOTE: Authority cited: Sections 200, 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections

11135, 11136 and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4661. Mediation Procedures; State Mediation Agreements; Notice.

NOTE: Authority cited: Sections 232 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 11135, 11136, and 11138, Government Code; and 34 CFR 106.8.

§ 4662. Investigation Timeline.

(a) Each party in the dispute shall be sent written notification by the Department of the name(s) of the investigator(s) and the investigation date(s), if known. The notice shall explain the investigation process.

(b) An investigation will be completed within 60 days after receiving a request for direct intervention or an appeal request, unless the parties have agreed to extend the time lines. The Department may grant extensions for the investigation if exceptional circumstances exist that constitute good cause with respect to the particular complaint, and provided that the complainant is informed of the extension and the reasons therefore and provided that the facts supporting the extension are documented and maintained in the complaint file.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136, and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4663. Department Investigation Procedures.

(a) The investigator(s) shall request all documentation and other evidence regarding the allegations in the complaint.

(b) The investigation shall include an opportunity for the complainant, or the complainant's representative, or both, to present the complaint(s) and evidence or information leading to evidence to support the allegations of non–compliance with state and federal laws and/or regulations.

(c) Refusal by the complainant to provide the investigator with documents or other evidence related to the allegations in the complaint, or to otherwise fail or refuse to cooperate in the investigation or engage in any other obstruction of the investigation may result in the dismissal of the complaint because of a lack of evidence to support the allegations.

(d) Refusal by the local educational agency to provide the investigator with access to records and/or other information related to the allegation in the complaint, or to otherwise fail or refuse to cooperate in the investigation or engage in any other obstruction of the investigation may result in a finding based on evidence collected that a violation has occurred and may result in the imposition of a remedy in favor of the complainant.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136 and 11138, Government Code; 34 CFR 76.1 and 106.8; and 34 CFR 299.10(a)(2).

§ 4664. Department Investigation Report.

(a) An investigation report shall be issued. The investigation report shall include the following:

(1) A summary of the allegations in the complaint;

(2) A description of the general procedures of the investigation;

(3) Citations of applicable law and regulations;

(4) Department findings of facts;

(5) Department conclusions;

(6) LEA required actions, if applicable;

(7) LEA recommended specific actions, if applicable;

(8) Time line for corrective actions, if applicable; and

(9) Notice that any party may request reconsideration of the Department's report from the Superintendent of Public Instruction within 35 days of the receipt of the report.

(10) For those programs governed by Part 76 of Title 34 of the Code of Federal Regulations, the parties shall be notified of the right to appeal to the United States Secretary of Education.

(b) An investigation report shall be mailed to the parties within 60 days from the conclusion of the investigation.

NOTE: Authority cited: Sections 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 221, Education Code; Sections 11135, 11136 and 11138, Government Code; 34 CFR 106.8; and 34 CFR 299.10(a)(2).

§ 4665. Discretionary Reconsideration of Department Investigation Report.

(a) Within 35 days of receipt of the Department investigation report, either party may request reconsideration by the Superintendent. The request for reconsideration shall designate the finding(s), conclusion(s), or corrective action(s) in the Department's report to be reconsidered and state the specific basis for reconsidering the designated finding(s), conclusion(s) or corrective action(s). The request for reconsideration shall also state whether the findings of fact are incorrect and/or the law is misapplied.

(b) Within 35 days of the receipt of the request for reconsideration, the Superintendent or his or her designee may respond in writing to the parties modifying the specific finding(s), conclusion(s), or corrective action(s) for which reconsideration is requested, or denying the request for reconsideration. Pending the Superintendent's reconsideration, the Department report remains in effect and enforceable.

(c) Appeals by private agencies regarding Child Care Food Programs shall be made to the State Office of Administrative Hearings in accordance with applicable laws and regulations.

(d) Appeals from investigations of complaints involving Child Development contractors, whether public or private, shall be made to the Superintendent of Public Instruction as provided in subsection (a) except as otherwise provided in division 19 of title 5 of the Code of California Regulations.

(e) For those programs governed by part 76 of title 34 of the Code of Federal Regulations, the parties shall be notified of the right to appeal to the United States Secretary of Education.

NOTE: Authority cited: Sections 200, 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Sections 200 and 220, Education Code; Sections 11135, 11136 and 11138, Government Code; 34 CFR 76.1 and 106.8.

Article 8. Enforcement—State Procedures to Effect Compliance

§ 4670. Enforcement.

(a) Upon determination that a local agency violated the provisions of this chapter, the Department shall notify the local agency pursuant to section 4664(b) that it must take corrective action to come into compliance. If corrective action is not taken, the Department may use any means authorized by law to effect compliance, including, but not limited to:

(1) The withholding of all or part of the local agency's relevant state or federal fiscal support in accordance with state or federal statute or regulation;

(2) Probationary eligibility for future state or federal support, conditional on compliance with specified conditions;

(3) Proceeding in a court of competent jurisdiction for an appropriate order compelling compliance.

(b) No decision to curtail state or federal funding to a local agency under this chapter shall be made until the Department has determined that compliance cannot be secured by other means.

(c) If the Department determines that a Child Development Contractor's Agreement shall be terminated, the procedures set forth in sections 8257(d) or 8400 et seq. of the Education Code and the regulations promulgated pursuant thereto (chapter 19 of title 5, CCR, commencing with section 17906), shall be followed.

(d) If the Department determines that a local educational agency

has failed to comply with any provision of sections 49550 through 49554 of the Education Code, the Department shall certify such noncompliance to the Attorney General for investigation pursuant to section 49556 of the Education Code.

NOTE: Authority cited: Sections 200, 221.1 and 33031, Education Code; and Section 11138, Government Code. Reference: Section 49556, Education Code; Sections 11135, 11136 and 11138, Government Code; and 34 CFR 76.783 and 106.8.

§ 4671. Federal Review Rights.

NOTE: Authority cited: Sections 232 and 33031, Education Code; Section 11138, Government Code. Reference: 34 CFR 76.780–76.783.

Article 9. Williams Complaints

§ 4680. Complaints Regarding Instructional Materials, Teacher Vacancy or Misassignment, and School Facilities.

(a) Complaints regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancy or misassignment shall be filed with the principal of the school, or his or her designee, in which the complaint arises. A complaint about problems beyond the authority of the school principal shall be forwarded in a timely manner, but not to exceed 10 working days, to the appropriate school district official for resolution.

(b) Complaints regarding instructional materials, emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, and teacher vacancy or misassignment may be filed anonymously. A complainant who identifies himself or herself is entitled to a response if he or she indicates that a response is requested. If a response is requested, the response shall be made to the mailing address of the complainant indicated on the complaint.

(c) The school shall have a complaint form available for such complaints. The complaint form shall identify the place for filing the complaint and include a space to indicate whether a response is requested. However, the complainant need not use a complaint form.

(d) All complaints and responses are public records.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4681. Contents of Complaints Regarding Instructional Materials.

(a) A complaint related to instructional materials may allege as follows:

(1) A pupil, including an English learner, does not have standards–aligned textbooks or instructional materials or state adopted or district adopted textbooks or other required instructional materials to use in class.

(2) A pupil does not have access to textbooks or instructional materials to use at home or after school. This does not require two sets of textbooks or instructional materials for each pupil.

(3) Textbooks or instructional materials are in poor or unusable condition, having missing pages, or are unreadable due to damage.

(4) A pupil was provided photocopied sheets from only a portion of a textbook or instructional materials to address a shortage of textbooks or instructional materials.

(b) A complaint related to instructional materials shall identify:

(1) the school;

(2) the course or grade level in which the deficiency(ies) in instructional materials exist;

(3) the teacher of the course or grade level; and

(4) the specific nature of the deficiency or deficiencies as specified in subsection (a).

(c) A complaint may include as much text to explain the deficiency or deficiencies in instructional materials as complainant feels necessary. A complaint may contain more than one allegation of deficiency or deficiencies in the instructional material.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4682. Contents of Complaints Regarding Teacher Vacancy or Misassignment.

(a) A complaint related to teacher vacancy or misassignment may allege as follows:

(1) A semester begins and a teacher vacancy exists (a position to which a single designated certificated employee has not been assigned at the beginning of the year for an entire year or, if the position is for a one–semester course, a position of which a single designated certificated employee has not been assigned at the beginning of a semester for an entire semester).

(2) A teacher who lacks credentials or training to teach English learners is assigned to teach a class with more than 20 percent English learner pupils in the class. This subparagraph does not relieve a school district from complying with state or federal law regarding teachers of English learners.

(3) A teacher is assigned to teach a class for which the teacher lacks subject matter competency.

(b) A complaint regarding a teacher vacancy or misassignment shall identify:

(1) the course or grade level in which the teacher vacancy or misassignment exists;

(2) the specific nature of the vacancy or misassignment as specified in subdivision (a); and

(3) if it is a misassignment, the name of the teacher who is misassigned.

(c) A complaint may include as much text to explain the teacher vacancy or misassignment as complainant feels necessary. A complaint may contain more than one allegation of teacher vacancy or misassignment.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4683. Contents of Complaints Regarding the Condition of a Facility.

(a) A complaint related to the conditions of facilities that pose an emergency or urgent threat to the health or safety of pupils or staff shall identify the specific school in which the condition exists. The complaint shall specify:

(1) the location of the facility;

(2) describe emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff; and

(3) how the condition poses a threat to the health or safety of pupils or staff.

(b) A complainant may include as much text to explain the emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff, as complainant feels necessary. A complaint may contain more than one allegation of emergency or urgent facilities conditions that pose a threat to the health or safety of pupils or staff.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4684. Notice.

(a) In order to identify appropriate subjects of complaint, a notice shall be posted in each classroom in each school in the school district notifying parents and guardians of the following:

(1) There should be sufficient textbooks and instructional materials. For there to be sufficient textbooks and instructional materials each pupil, including English learners, must have a textbook or instructional materials, or both, to use in class and to take home.

(2) School facilities must be clean, safe, and maintained in good repair.

(3) There should be no teacher vacancies or misassignments. There should be a teacher assigned to each class and not a series of substitutes or other temporary teachers. The teacher should have the proper credential to teach the class, including the certification required to teach English learners if present.

(4) The location at which to obtain a form to file a complaint in case of a shortage. Posting a notice downloadable from the Web site of the Department shall satisfy this requirement.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4685. Investigation.

The principal or the designee of the district superintendent, as applicable, shall make all reasonable efforts to investigate any problem within his or her authority. The principal, or, where applicable, district superintendent or his or her designee shall remedy a valid complaint within a reasonable time period but not to exceed 30 working days from the date the complaint was received. The principal, or where applicable, district superintendent or his or her designee, shall report to the complainant the resolution of the complaint within 45 working days of the initial filing, if complainant identifies himself or herself and requested a response. If the principal makes this report, the principal shall also report the same information in the same timeframe to the district superintendent or his or her designee.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4686. Responsibilities of Governing Board.

(a) A complainant who is not satisfied with the resolution of the principal or the district superintendent or his or her designee, has the right to describe the complaint to the governing board of the school district at a regularly scheduled meeting of the governing board.

(b) A school district shall report summarized data on the nature and resolution of all complaints on a quarterly basis to the county superintendent of schools and the governing board of the school district. The summaries shall be publicly reported on a quarterly basis at a regularly scheduled meeting of the governing board of the school district. The report shall include the number of complaints by general subject area with the number of resolved and unresolved complaints.

(c) The complaints and written responses shall be available as public records.

NOTE: Authority cited: Section 33031, Education Code. Reference: Section 35186, Education Code.

§ 4687. Appeal of Facilities Complaint to Superintendent.

(a) A complainant who is not satisfied with the resolution proffered by the principal, or the district superintendent or his or her designee, involving a condition of a facility that poses an emergency or urgent threat, as defined in paragraph (1) of subdivision (c) of section 17592.72, has the right to file an appeal to the Superintendent of Public Instruction within 15 days of receiving the report.

(b) Complainant shall comply with the appeal requirements of section 4632.

(c) The Superintendent of Public Instruction or his or her designee shall comply with the requirements of section 4633.

(d) The Superintendent of Public Instruction shall provide a written report to the State Board of Education describing the basis for the complaint, the school district's response to the complaint and its remedy or proposed remedy and, as appropriate, a proposed remedy for the issue described in the complaint, if different from the school district's remedy.

NOTE: Authority cited: Section 33031, Education Code. Reference: Sections 17592.72 and 35186, Education Code.

TITLE 9. REHABILITATIVE AND DEVELOPMENTAL SERVICES

Division 1. Department of Mental Health

Chapter 2. Conflict of Interest Code

§ 400. General Provisions.

The Political Reform Act, Government Code Sections 81000, et seq., requires state and local government agencies to adopt and promulgate Conflict of Interest Codes. The Fair Political Practices Commission has adopted Section 18730 of Title 2, California Code of Regulations (CCR), containing the terms of a standard Conflict of Interest Code. Section 18730 may be incorporated by reference, and may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act after public notice and hearings. Therefore, the terms of Section 18730 of Title 2, CCR and any amendments to it duly adopted by the Fair Political Practices Commission, along with the attached Appendices (in which officials and employees are designated and disclosure categories are set forth), are hereby incorporated by reference. These terms, amendments and Appendices constitute the Conflict of Interest Code of the Department of Mental Health.

Designated employees shall file statements of economic interests with the Department of Mental Health. The Director's original statement shall be sent to the Fair Political Practices Commission and a copy retained by the filing officer.

NOTE: Authority cited: Sections 87300 and 87306, Government Code. Reference: Section 87300, *et seq.*, Government Code.

Appendix A

Designated Employees	*Assigned Disclosure Categories*
DIRECTOR'S OFFICE	
Director	1
Chief Deputy Director	1
Assistant Director, External Affairs	1
Special Assistant to the Director	1
Consumer Liaison	2
All Staff Counsels	1
Career Executive Assignments (CEA)	
Assistant Director, Clinical Services	1
Assistant Director, Legislation	1
Chief, Office of Multicultural Services	1
Chief, Office of Human Rights	3
Chief Counsel	1
California Mental Health Planning Council	
Executive Officer	1
SYSTEMS OF CARE	
CEA	
Deputy Director, Systems of Care	1
Assistant Deputy Director, Systems of Care	1
Chief, Evaluation Statistics and Support	2, 3 & 4
Chief, Program Policy and County Operations	2, 3 & 4
Chief, Medi–Cal Mental Health Policy	2 & 3
Program Support/County Operations — North and South	
Mental Health Program Supervisor	2
ADMINISTRATIVE SERVICES	
CEA	
Deputy Director, Administrative Services	1
Chief, Human Resources	3
Chief, Financial Services	1 & 4
Chief, County Financial Program Support	3
Chief, Information Technology	3
Human Resources	
Staff Services Manager	3
Associate Business Management Analyst	3
Health and Safety Officer	2
Business Services Officer	3
Financial Services	
Accounting Administrators	2
Associate Budget Analyst	4
Information Technology	
Data Processing Managers	3
LONG TERM CARE SERVICES	
CEA	
Deputy Director, Long Term Care	1
Assistant Deputy Director, Long Term Care	1
Chief, Hospital Operations	1 & 3
Chief, Hospital Security	1 & 3
Chief, Forensic Services	2
Chief, Sex Offender Commitment Program	3
Chief, Program Policy & Fiscal Support	2, 3 & 4
Forensic Services	
Mental Health Program Supervisors	2
State Hospitals	
CEA	
Executive Director	1
Medical Director	1 & 6
Hospital Administrator	1 & 3
Clinical Administrator	1 & 6
Accounting Administrators	2
Accounting Officers	2
Assistant Hospital Administrator	3 & 6
Chief, Physician and Surgeon	3 & 6
Chiefs of Plant Operations	3
Chief of Professional Education	3 & 6
Data Processing Managers	2
Director of Dietetics	3
Assistant Director of Dietetics	3
Hospital General Services Administrators	3 & 6
Patient Benefit and Insurance Officers	1
Pharmacy Services Manager	3 & 6
Senior Special Investigators	4, 5 & 6
Training Officers	3
PROGRAM COMPLIANCE	
Deputy Director, Program Compliance	1
Mental Health Program Supervisor	2
Supervising Governmental Auditors	1
*All Department Consultants**	1

*Consultants should be included in the list of designated employees and should disclose pursuant to the broadest disclosure category in the Code subject to the following limitation:

With respect to Consultants, the Director, however, may determine in writing that a particular consultant, although a "designated person", is hired to perform a range of duties that are limited in scope and thus not required to comply with the disclosure requirements described in this Section. Such determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure requirements. Nothing herein excuses any such consultant from any other provision of this Economic Interest Code.

Appendix B

Disclosure Categories

Category 1

Designated employees assigned to this category must report:

Interests in real property located within one mile of any hospital subject to the Department jurisdiction, and all investments and business positions in business entities and sources of income, including loans, gifts, and travel payments.

Category 2

Designated employees assigned to this category must report:

All investments and business positions in business entities and sources of income, including loans, gifts, and travel payments.

Category 3

Designated employees assigned to this category must report:

Investments and business positions in business entities and sources of income, including loans, gifts, and travel payments, of the type to contract with the Department of Mental Health.

Category 4

Designated employees assigned to this category must report:

Investments and business positions in business entities and sources of income, including loans, gifts, and travel payments, of the type to be eligible to receive grants or other monies (excluding monies received pursuant to the contracts as specified above in Category 3 disclosure).

Category 5

Designated employees assigned to this category must report:

Investments and business positions in business entities and sources of income, including loans, gifts, and travel payments, that are regulated by the division of the Department of Mental Health in which the designated employee holds his or her position.

Category 6

Designated employees assigned to this category must report:

Investments and business positions in business entities and sources of income, including gifts, loans, and travel payments, of the type to be eligible to receive patient referrals for the delivery of health care services or supplies by the hospital to which the employee is assigned.

Chapter 3. Community Mental Health Services Under the Short–Doyle Act

Article 1. Application

§ 500. Application of Subchapter.

Subchapter 3 shall apply to Community Mental Health Services and Local Mental Health Services as defined in and for which state reimbursement is claimed under the provisions of Part 2 of Division 5 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Section 5750, Welfare and Institutions Code.

§ 501. Section Headings.

Article 2. Definitions

§ 510. Act.

''Act'' means Part 2 of Division 5 of the Welfare and Institutions Code, known as the Short–Doyle Act.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5600 and 5750, Welfare and Institutions Code.

§ 511. Local Director.

''Local director'' means the administrator or director of the Local Mental Health Service appointed by the governing body.

NOTE: Authority cited: Sections 5607, 5751 and 5751.1, Welfare and Institutions Code. Reference: Sections 5607 and 5650, Welfare and Institutions Code.

§ 512. Local Mental Health Service.

''Local Mental Health Service'' means community mental health services established under the Short–Doyle Act.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Section 5602, Welfare and Institutions Code.

§ 513. Department.

''Department'' means the State Department of Mental Health.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 4001, 4011 and 5750, Welfare and Institutions Code.

§ 514. May, Shall and Should.

''May'' is permissive. ''Shall'' is mandatory. ''Should'' means desirable.

§ 515. General Hospital.

§ 516. Psychiatric Hospital.

§ 517. County Plan.

''County Plan'' means the County Short–Doyle Plan which must be adopted by each county, or counties acting jointly, in accordance with Section 5650 of the act.

NOTE: Authority cited: Sections 5650 and 5750, Welfare and Institutions Code. Reference: Sections 5651, 5651.1, 5651.2, 5651.5, 5651.7, 5652 and 5653, Welfare and Institutions Code.

Article 3. General Provisions

§ 520. Establishment of Local Services.

§ 521. Supervision by Local Director.

The Local Director shall maintain general supervision over all Local Mental Health Services through direct operation of the services or by written arrangement with the person or agency providing the service. Such arrangement shall permit the Local Director to supervise and specify the kind, quality and amount of the services and criteria for determining the persons to be served.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5607, 5608, 5609 and 5609.5, Welfare and Institutions Code.

§ 522. Medical Responsibility.

A physician meeting the qualifications of Section 620 (a) shall assume responsibility for all those acts of diagnosis, treatment, or prescribing or ordering of drugs which may only be performed by a licensed physician.

NOTE: Authority cited: Sections 5751 and 5751.1, Welfare and Institutions Code. Reference: Sections 5751 and 5751.1, Welfare and Institutions Code.

§ 523. Contracts for Service.

(a) Where a person or agency is providing treatment services for the Local Mental Health Service, the service shall be provided through written agreement. The provider of services and the Local Mental Health Service shall comply with the provisions of this subchapter.

(b) All applications to provide services by written agreement shall be made in writing to the Local Mental Health Director within such time as is necessary to permit a thorough review by the Local Mental Health Director and such county administrative officers as the board of supervisors may require to allow an orderly review, prior to the submission of the annual county plan to the Department.

(c) When a treatment service being provided through written agreement is terminated during the fiscal year or a new service is initiated, applications will be accepted to provide the service during the fiscal year if the Local Mental Health Director desires to continue the service or to initiate a new service.

(d) In evaluating the applications of potential providers of service, the ocal Mental Health Director shall consider, but not be limited to, the following characteristics to determine the appropriateness and desirability of the written agreement:

(1) Compatibility with county plan.

(2) Assurance of continuity of care to patients being served.

(3) Local availability, accessibility and degree of acceptability to population to be served.

(4) Unique service to target group of special importance.

(5) Appropriate business and administrative practices which show evidence of ability to comply with the Act's requirements, regulations, accounting, reporting and auditing standards.

(6) Degree of citizens' participation in the planning and implementation of the proposed contract.

(7) Evidence of demonstrated competence and experience in the area of the program proposal.

(e) Written agreements shall be consummated in compliance with all local rules and regulations. All written agreements shall be

approved by the Local Mental Health Director or his or her designee and, when fully negotiated, a copy of such written agreements shall be forwarded by the county to the Department to be filed with the annual county plan.

NOTE: Authority cited: Sections 5600.5 and 5750, Welfare and Institutions Code. Reference: Sections 5609.5, 5650 and 5651, Welfare and Institutions Code.

§ 524. Fee Schedules.

Fees for service to an individual shall be charged in accordance with the ability of the patient or responsible relative to pay, but not in excess of actual costs. Fees shall be charged in accordance with a uniform fee schedule adopted by the Director of the state Mental Department of health pursuant to this Act.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5717 and 5718, Welfare Institutions Code.

§ 525. Auxiliary Personnel.

Each Local Mental Health Service should have sufficient clerical personnel, and such accounting and statistical assistance as may be necessary to maintain adequate records.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Section 5751, Welfare and Institutions Code.

§ 526. Admission Policies.

Each Local Mental Health Service shall have admission policies which shall be in writing and available to the public. Such policies shall include a provision that patients will be accepted for care without unlawful discrimination on the basis of ethnic group identification, color, religion, age, sex, physical or mental disability. This section shall apply to services provided by contract as well as those provided directly by the Local Mental Health Service.

NOTE: Authority cited: Section 11138, Government Code; and Section 5750, Welfare and Institutions Code. Reference: Section 11135, Government Code; and Selection 5325.1, Welfare and Institutions Code.

§ 527. Discriminatory Practices.

The Local Mental Health Service shall not employ unlawful discriminatory practices in the admission of patients, assignment of accommodations, employment of personnel, or in any other respect on the basis of color, religion,age, sex, or physical or mental disability. This section shall apply to services provided by contract as well as those provided directly by the Local Mental Health Service.

NOTE: Authority cited: Section 11138, Government Code; and Section 5750, Welfare and Institutions Code. Reference: Section 11135, Government Code; and Section 5325.1, Welfare and Institutions Code.

§ 529. Mental Health Advisory Board Composition.

(a) The composition of the Mental Health Advisory Board shall reflect the minority populations found in the county.

(b) Each county shall indicate in the county mental health plan the minority group affiliations of current board members.

(c) Each county shall describe in the plan efforts being made to place presently unrepresented and under–represented minority group members on the Board, including a timetable to achieve equitable representation.

(d) Each county may reimburse mental health advisory board members for reasonable expenses incurred incident to the performance of their official duties and responsibilities. Such expenses may include travel, lodging, child care, and meals for the members of the advisory board while on official business as may be approved by the director of the local mental health program.

NOTE: Authority cited: Sections 5604, 5604.5, 5606.1, 5715, and 5750, Welfare and Institutions Code. Reference: Sections 5604, 5604.5, 5606, 5606.1, 5606.2, and 5715, Welfare and Institutions Code.

§ 530. Mental Health Advisory Board Committee Composition.

(a) The composition of various standing committees and other advisory groups addressed in the county mental health plan whose function it is to assist and advise the County Mental Health Advisory Board shall reflect the minority populations found in the county.

(b) Each county mental health plan submitted to the State Department of Mental Health shall list the standing committees of and advisory groups to the County Mental Health Advisory Board that have participated in the development of the county mental health plan. The minority group affiliations of current committee and group members shall be listed.

(c) The Department shall waive all or part of the requirements of this section where it is agreed by the Department and the county that there is not a significant number of any minority group in the county.

NOTE: Authority cited: Sections 5606.1 and 5750, Welfare and Institutions Code. Reference: Sections 5604, 5606, 5606.1 and 5606.2, Welfare and Institutions Code.

Article 3.5. Standards for the Certification of Social Rehabilitation Programs

§ 531. Program Standards and Requirements.

(a) To be certified as a Short–Term Crisis Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (e) or (f) of section 541 as an alternate to hospitalization for individuals experiencing an acute psychiatric episode or crisis. The planned length of stay in the program shall be in accordance with the client's assessed needs, but not to exceed thirty (30) days, unless circumstances require a longer length of stay to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond thirty (30) days shall be documented in the client's case record. Under no circumstances may the length of stay exceed three (3) months.

(2) Scheduling of staff which provides for at least two (2) staff members to be on duty 24 hours a day, seven (7) days per week. If program design results in some clients not being in the facility during specific hours of the day, scheduling adjustments may be made so that coverage is consistent with and related to the number and needs of clients in the facility. During the night time hours, when clients are sleeping, only one of the two on duty staff members need be awake, providing the program does not accept admissions at that time. There shall be a staffing ratio of at least one (1) full–time equivalent direct service staff for each 1.6 clients served.

(b) To be certified as a Transitional Residential Treatment Program, a program shall provide:

(1) Services as specified in either subsection (h) or (i) of section 541 which shall provide a therapeutic environment in which clients are supported in their efforts to acquire and apply interpersonal and independent living skills. The program shall also assist the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability for independent living upon discharge from the program. The planned length of stay in the program shall be in accordance with the client's assessed need, but not to exceed one (1) year; however, a length of stay not exceeding a maximum total of 18 months is permitted to ensure successful completion of the treatment plan and appropriate referral. The reasons for a length of stay beyond one (1) year shall be documented in the client's case record.

(2) Greater number of staff shall be present during times when there are greater numbers of clients in programmed activities. Staff schedules shall be determined by the program based on the number of clients in the program during specific hours of the day, level of care provided by the program, and the range of services provided within the facility.

At least one staff member shall be present at any time there are clients at the facility. There shall be a staffing ratio of at least one (1)

full–time equivalent direct service staff for each 2.5 clients served. All scheduled hours in the facility shall be considered part of this required full–time equivalent staffing ratio.

(c) To be certified as a Long–Term Residential Treatment Program, a program shall provide:

(1) Services as specified in subsection (j) of section 541 in order to provide a 24–hour therapeutic residential setting with a full range of social rehabilitation services, as defined in section 532 of these regulations, including day programming for individuals who require intensive support in order to avoid long–term hospitalization or institutionalization. The planned length of stay shall be in accordance with the client's assessed needs but under no circumstances may that length of stay be extended beyond eighteen (18) months.

(2) Scheduling of staff which provides for the maximum number of staff to be present during the times when clients are engaged in structured activities. At least one direct service staff shall be on the premises 24–hours a day, seven (7) days per week. Additional staff, including part–time or consulting services staff, shall be on duty during program hours to provide specialized services and structured evening services. When only one staff member is on the premises there shall be staff on call who can be contacted by telephone if an additional staff person is needed, and can be at the facility and on duty within 60 minutes after being contacted. There shall be a staffing ratio of at least one (1) full–time equivalent direct service staff member for each 2.8 clients served.

(d) "Direct service staff" shall mean employees whose duties include the treatment, training, care and/or supervision of the program's clients.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532. Service Requirements.

(a) Structured day and evening services shall be available seven (7) days a week. Services in all programs shall include, but not be limited to:

(1) Individual and group counseling;

(2) Crisis intervention;

(3) Planned activities;

(4) Counseling, with available members of the client's family, when indicated in the client's treatment/rehabilitation plan;

(5) The development of community support systems for clients to maximize their utilization of non–mental health community resources;

(6) Pre–vocational or vocational counseling;

(7) Client advocacy, including assisting clients to develop their own advocacy skills;

(8) An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and,

(9) Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills.

(b) In addition to the services in subsection (a), Transitional Residential Treatment Programs shall provide services which emphasize the development of vocational skills, and linkages to services offering transitional employment or job placement.

(c) In addition to the services in subsection (a), Long–Term Residential Treatment Programs shall provide pre–vocational and vocational services. These services shall be designed to provide a continuum of vocational training and experience including volunteer activities, supported employment, transitional employment and job placement. When any of these vocational services are provided by outside agencies or programs, written agreements or documented treatment plans shall be developed consistent with the treatment goals and orientation of the program. Long–Term Residential Treatment Programs shall also include provisions for special education services and learning disability assessment and remediation.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.1. Medical Requirements.

Medical and psychiatric policies and practices of all programs shall be in writing and shall include, but not be limited to:

(a) A plan for the monitoring of medications by a person licensed to prescribe or dispense prescription drugs which will include but not be limited to the name and qualifications of the person or persons who will conduct the monitoring, its frequency and procedures;

(b) Screening for medical complications which may contribute to disability conducted by a physician, nurse practitioner or physician's assistant and a plan for follow–up. The screening for medical complications shall occur within 30 calendar days prior to, or after admission. If a client refuses a screening for medical complications, the program shall document the refusal in the client case record.

(c) Client education, provided by program staff or consultants, about the role of medications and their potential side effects, with the goal of enabling the client to become responsible for his or her own medication;

(d) Entries in client case records indicating all prescribed and non–prescribed medications;

(e) Provisions for program staff to discuss medication issues with a person licensed to prescribe or dispense prescription drugs;

(f) Provisions for central storage of medication when necessary; and,

(g) Encouragement to clients, when part of the treatment/rehabilitation plan, to be personally responsible for holding, managing and safeguarding all of their medications.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.2. Treatment/Rehabilitation Plan and Documentation Requirements.

(a) Each program shall have an admission agreement, signed on entry by the client or an authorized representative and program representative, describing the services to be provided and the expectations and rights of the client regarding house rules, client involvement in the program, and fees. The client shall receive a copy of the signed admission agreement.

(b) There shall be a written assessment of each client on admission which includes at least:

(1) Health and psychiatric histories;

(2) Psychosocial skills;

(3) Social support skills;

(4) Current psychological, educational, vocational and other functional limitations;

(5) Medical needs, as reported; and,

(6) Meal planning, shopping and budgeting skills.

(c) The program and client shall together develop a written treatment/rehabilitation plan specifying goals and objectives and the staff and client's responsibilities for their achievement. Clients shall be involved in an on–going review of progress towards reaching established goals and be involved in the planning and evaluation of their treatment goals. The plan shall contain at least the following elements:

(1) Statement of specific treatment needs and goals.

(2) Description of specific services to address identified treatment needs.

(3) Documentation of reviews by staff and client of the treatment/rehabilitation plan adhering to the following schedule:

(A) Short–term Crisis Residential Treatment Program: at least weekly.

(B) Transitional Residential Treatment Program: at least once every 30 days.

(C) Long Term Residential Treatment Program: at least once every 60 days.

(4) Anticipated length of stay needed to accomplish identified goals, and methods to evaluate the achievement of these goals.

(d) If an individual treatment/rehabilitation plan requires services to be provided by another program or agency, there shall be documented evidence in the client's case record of communication between all persons responsible for carrying out specific aspects of the treatment/rehabilitation plan.

(e) The agency or program shall arrange for clients to attend community programs when needs are identified in the treatment/rehabilitation plan which cannot be met by the facility, but can be met in the community.

(f) There shall be a written discharge summary prepared by staff and client, which includes an outline of services provided, goals accomplished, reason and plan for discharge, and referral follow–up plans.

(g) The admission assessment, treatment/rehabilitation plan, and discharge summary shall be prepared by staff who have received training in the development and preparation of these documents.

(1) Training required to be provided by the facility shall include:

(A) A minimum of one hour of instruction on the development and preparation of the admission assessment.

(B) A minimum of one hour of instruction on the development and preparation of the treatment/rehabilitation plan.

(C) A minimum of one hour of instruction on the development and preparation of the discharge summary.

(D) Subject matter for all training provided for in this subsection shall include the expected content of documentation, methods used to prepare the document, timeframes for completion of documentation, and consultative sources to be utilized in preparing the document.

(2) Training provided for in this subsection shall consist of one or more of the following presentation methods:

(A) Formal classroom instruction;

(B) Oral presentation;

(C) Videotape, film, or audiovisual presentation;

(D) Audiotape presentation; or

(E) Performing the duties, on the job, under the direct supervision of the instructor.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.3. Admission/Discharge Criteria.

(a) Admission and discharge criteria of all programs shall be written and consistent with program goals.

The program's exclusionary criteria shall also be written and clearly defined.

(b) The program shall have written policies and procedures for orienting new clients to the service.

(c) The range of services provided shall be discussed prior to admission with the prospective client or an authorized representative so that the program's services are clearly understood.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.4. Client Involvement Requirements.

(a) Clients shall be involved in the development and implementation of his/her treatment/rehabilitation plan.

(b) Clients shall be involved, depending on capability, in the operation of the household. This shall include participation in the formulation and monitoring of house rules, as well as in the daily operation of the facility, including but not limited to cooking, cleaning, menu planning and activity planning.

(c) Clients shall be encouraged to participate in program evaluations and reviews.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.5. Physical Environmental Requirements.

(a) Programs shall meet the facility requirements of section 5453(a) of the Welfare and Institutions Code.

(b) Program location shall allow for access by clients to community resources and public transportation.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 532.6. Staff Characteristics, Qualifications and Duty Requirements.

(a) Programs shall meet the staffing requirements of section 5453(b) of the Welfare and Institutions Code.

(b) The program shall document the use of multi– disciplinary professional consultation and staff when necessary to meet the specific diagnostic and treatment needs of the clients.

(c) Paraprofessionals and persons who have been consumers of mental health services shall be utilized in the program when consistent with the program design and services provided.

(d) All social rehabilitation facilities shall have a program director.

(e) The program director shall be on the premises the number of hours necessary to manage and administer the program component of the facility in compliance with applicable laws and regulations.

(f) The program director of a certified Short–Term Crisis Residential Treatment Program shall have the following qualifications prior to employment.

(1) A Bachelor's Degree in Psychology, Social Work or any other major which includes at least 24 semester college units in one or more of the following subject areas:

(A) Psychology

(B) Social Work

(C) Sociology

(D) Behavioral Sciences

(E) Psychiatric Nursing; and

(2) Two (2) years of full–time work experience in a community program that serves clients who have a mental illness. Such experience must be in the direct provision of services to clients, of which one (1) year must be in the position of supervising direct care staff, or

(3) As an alternative to the Bachelor Degree and experience required in paragraph (1) and (2) of this subsection, a total of four (4) years of experience in a community program providing direct services to persons with mental disabilities, of which one (1) year must be in the position of supervising direct care staff, and graduation from high school or possession of a GED may be substituted.

(g) The program director of a certified Transitional Residential Treatment Program or a certified Long–Term Residential Treatment Program shall have the following qualifications prior to employment.

(1) A Bachelor's Degree in Psychology, Social Work or any other major which includes at least 24 semester college units in one or more of the following subject areas:

(A) Psychology

(B) Social Work

(C) Sociology

(D) Behavioral Sciences

(E) Psychiatric Nursing; and

(2) One (1) year of full–time work experience in a community program that serves clients who have a mental illness. Such experience must be in the direct provision of services to clients, of which four (4) months must be in a position of supervising direct care staff.

(3) As an alternative to the Bachelor's Degree and experience required in paragraphs (1) and (2) of this subsection, a total of three years of experience in providing direct services in the community to

persons with mental illnesses, of which six (6) months must be in a position of supervising direct care staff, and graduation from high school or possession of a GED may be substituted.

(h) All direct care staff shall have graduated from high school or possess a GED and have a minimum of one (1) year of full–time experience, or its part–time equivalent, working in a program serving persons with mental disabilities. Such experience must be in the direct provision of services to clients. If the employee does not have the required experience, the program shall document a specific plan of supervision and in–service training for the employee which will guarantee the ongoing qualification of the employee to perform the job. The plan should include but not be limited to the frequency and number of hours of training, the subjects to be covered, and a description of the supervision to be provided.

(i) Program directors and all direct care staff of social rehabilitation programs as of the date that this section is adopted shall be considered as meeting all of the requirements of this section until two (2) years after the effective date of this section, at which time the requirements of this section shall be met in full.

(j) The program director must provide and document a specific plan of supervision and at least 20 hours of in–service training per year for the employee to ensure the ongoing qualifications of the individual to perform the job.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 533. Administrative Policies and Procedures.

(a) The organizational entity legally responsible for program administration, under applicable law and regulation, shall:

(1) Have written policies defining the purpose, goals, and services of the organization.

(2) Establish and maintain financial records in accordance with generally accepted accounting principles and an annual budget.

(b) Each program shall be directed by a designated individual who is responsible for its overall administration and management.

(c) Each residential program shall have an individual(s) designated as the administrator of the facility. The program shall identify the qualifications, experience, skills, and knowledge required of an individual who is designated the facility administrator. These requirements shall at least satisfy the minimum requirements established by the Community Care Licensing Division of the Department of Social Services for this position.

(d) The agency or program shall have a financial plan of operation that is consistent with the goals and purpose of the organization and in accordance with generally accepted accounting practices and legal requirements.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 534. Program Certification.

(a) All Social Rehabilitation Programs, as defined in section 5458 of the Welfare and Institutions Code, must be certified by the Department of Mental Health, or its delegated agent, prior to being licensed by the Department of Social Services.

(1) The Department of Mental Health shall provide written notice by certified mail to an applicant, within 30 calendar days of the receipt of the application for certification, that the application is complete and accepted for filing, or that the application is deficient and shall specify the missing information required to complete the application.

(2) The Department of Mental Health shall approve or deny any application for certification within 60 calendar days of receipt of a completed application. The 60 days shall not begin until all information required for certification is received. The Department of Mental Health shall provide written notice to the applicant by certified mail of its decision concerning the request for certification.

(b) All certified programs are also governed by the provisions in Title 22, division 6 General Licensing Requirement section 80000 – 80088.

(c) All Social Rehabilitation Programs, defined in section 5458 of the Welfare and Institutions Code, must be recertified on an annual basis by the Department of Mental Health, or its delegated agent, prior to being issued a renewal license by the Department of Social Services.

(d) The Department of Mental Health, or its delegated agent, shall have the responsibility of conducting initial and annual site visits for the purpose of certifying that programs are in compliance with the provisions of this article.

(e) The Department of Mental Health, or its delegated agent, shall initiate an action to rescind the certification of a program whenever a determination is made that the program is not in compliance with the provisions of this article.

(f) Actions initiated to withhold certification or to rescind certification shall be subject to notice and review in accordance with section 535.

(g) The Department shall provide the Department of Social Services any documents pertaining to certification, recertification or decertification.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 535. Review Procedures.

(a) When the Department of Mental Health or its delegated agent withholds or rescinds the certification of a program, the program shall be given written notice of the action by certified mail. The notice shall be accompanied by a written statement setting forth the reasons and justifications for the action including any documents or information relied upon.

(b) A program may request review of an action to withhold or rescind certification by sending a written request for review by certified mail to the Deputy Director, Division of Community Programs, Department of Mental Health, 1600 9th Street, Room 250, Sacramento, California 95814. A request for review must be postmarked no later than fifteen (15) days after receipt of the notification required by subsection (a).

(c) A program requesting review in accordance with this section shall be responsible for submitting in writing all documents, information, and arguments which the program wishes to be considered during the review. The documents, information, and arguments which the program wishes to be considered may be submitted with the request for review or sent separately by certified mail, but shall be postmarked no later than thirty (30) days after receipt of the notice required in subsection (a).

(d) The Deputy Director, Division of Community Programs, Department of Mental Health or a designee shall review the notice and written justification for the action required by subsection (a), the request for review submitted by the program, and the documents, information and arguments submitted by the program. If deemed necessary for completion of the review, the Deputy Director, Division of Community Programs may request clarification or additional information from the program.

(e) A proposed decision to either affirm or reverse the action to withhold or rescind the certification of the program shall be prepared and submitted to the Director of Mental Health.

(f) The Director of Mental Health may adopt the proposed decision as written, order the proposed decision rewritten, or direct that additional information be obtained.

(g) A proposed decision shall become final when adopted by the Director of Mental Health. Notice of the decision and a copy of the decision shall be sent to the program by certified mail. A decision adopted by the Director of Mental Health which affirms the action to withhold or rescind the certification of the program shall become effective upon receipt by the program.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

§ 536. Waivers and Exceptions.

NOTE: Authority cited: Section 5458.1, Welfare and Institutions Code. Reference: Sections 5450, 5453, 5454 and 5458, Welfare and Institutions Code.

Article 4. Services Subject to State Reimbursement

§ 540. Reimbursement Conditions.

Subject to the provisions of the Act and of these regulations, state reimbursement will be made for expenditures for the services described in this article.

NOTE: Authority cited: Sections 5705.1(a) and 5715, Welfare and Institutions Code. Reference: Sections 5401, 5651, 5705, 5712, 5714, 5714.1 and 5715, Welfare and Institutions Code.

§ 541. 24–Hour Services.

24–Hour Services mean services designed to provide a therapeutic environment of care and treatment within a residential setting for adults and minors. Depending on the severity of the disorder, dangerousness to self or others, and the need for related medical care, treatment is provided through one of the following service functions:

(a) State Hospital, which means a health facility as defined in Section 1250 of the Health and Safety Code which is operated by the Departments of Mental Health or Developmental Services, and which provides treatment services for the mentally disordered.

(b) Local Hospital, which means an acute psychiatric hospital as defined in Section 1250 of the Health and Safety Code, or a distinct acute psychiatric part of a general hospital as defined in Section 1250 of the Health and Safety Code which is approved by the Department of Health Services to provide psychiatric services.

(c) Psychiatric Health Facility, which means a health facility as defined in Section 1250.2 of the Health and Safety Code, or such facility which has a waiver of licensure from the Department, which provides intensive care.

(d) Intensive Skilled Nursing Facility, which means a health facility as defined in Section 1250 of the Health and Safety Code, and staffed to provide intensive psychiatric care.

(e) Short–Term–Crisis Residential Service (Less than 14 Days), which means a licensed residential community care facility available for admissions 24–hours a day, 7 days a week, and staffed to provide crisis treatment as an alternative to hospitalization. Admissions are generally limited to a stay of less than 14 days for voluntary patients without medical complications requiring nursing care. Twenty–four hour capability for prescribing and supervising medication must be available for patients requiring this level of care. The prescribing capability shall be provided by written agreement.

(f) Short–Term Crisis Residential Service (Less than 30 Days), which means a licensed residential community care facility available for admissions 24–hours a day, 7 days a week, and staffed to provide mental health treatment services for voluntary patients without medical complications requiring nursing care and who generally require an average stay of 14–30 days for crisis resolution or stabilization. Twenty–four hour capability for prescribing and supervising medication must be available. The prescribing capability shall be provided by written agreement. Respite care, in accordance with Welfare and Institutions Code, Chapter 5, up to a maximum of 30 days, may be provided within this definition.

(g) Jail Inpatient Unit, which means a distinct unit within an adult or juvenile detention facility, designated by a County Board of Supervisors pursuant to Section 5404 of the Welfare and Institutions Code and staffed to provide intensive psychiatric treatment of inmates. Treatment services on the unit shall be under the control of the Local Mental Health Director.

(h) Transitional Residential On–Site Service, which means a licensed residential community care facility, designed to provide a comprehensive program of care consisting of a therapeutic residential community plus an all–inclusive structured treatment and rehabilitation program for individuals recovering from an acute stage of illness who are expected to move towards a more independent living situation, or higher level of functioning, within a 3–to–12–month period.

(i) Transitional Residential Off–Site Service, which means a licensed residential community care facility, designed to provide, for a 3–to–12–month period, a therapeutic residential community including a range of social rehabilitation activities for individuals who are in remission from an acute stage of illness, and interim support to facilitate movement towards the highest possible level of functioning. Individuals may receive day, outpatient and other treatment services outside the transitional residence.

(j) Long–Term Services, which mean services provided in a variety of community facilities for individuals who require care, supervision, resocialization, rehabilitation, and life–enrichment for up to 3 years. Consistent with individual level of care needs, services shall be provided in skilled nursing facilities, intermediate care facilities, residential community care facilities, or other similar facilities.

(k) Semi–Supervised Living Services, which mean services provided for persons living alone or together in small cooperative housing units, who require support in case of emergencies, as well as regular assessment and evaluation of the problems of daily living. Services may include provision of a rent subsidy. This service provides a transition to independent living or an indefinite arrangement.

(*l*) Independent Living Services, which mean services, including psychological support and rent subsidy, if necessary, provided to persons who require only minimal support to remain in the community.

NOTE: Authority cited: Section 5705.1, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 542. Day Services.

Day Services mean services designed to provide alternatives to 24–hour care and supplement other modes of treatment and residential services. These service functions are the following:

(a) Day Care Intensive Services, which mean services designed and staffed to provide a multidisciplinary treatment program of less than 24 hours per day as an alternative to hospitalization for patients who need active psychiatric treatment for acute mental, emotional, or behavioral disorders and who are expected, after receiving these services, to be referred to a lower level of treatment, or maintain the ability to live independently or in a supervised residential facility.

(b) Day Care Habilitative Services, which mean services designed and staffed to provide counseling and rehabilitation to maintain or restore personal independence at the best possible functional level for the patient with chronic psychiatric impairments who may live independently, semi–independently, or in a supervised residential facility which does not provide this service.

(c) Vocational Services, which mean services designed to encourage and facilitate individual motivation and focus upon realistic and obtainable vocational goals. To the extent possible, the intent is to maximize individual client involvement in skill seeking and skill enhancement, with the ultimate goal of meaningful productive work.

(d) Socialization Services, which mean services designed to provide life–enrichment and social skill development for individuals who would otherwise remain withdrawn and isolated. Activities should be gauged for multiple age groups, be culturally relevant, and focus upon normalization.

NOTE: Authority cited: Section 5705.1, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 543. Outpatient Services.

Outpatient Services mean services designed to provide short–term or sustained therapeutic intervention for individuals experiencing

acute or ongoing psychiatric distress. These service functions are the following:

(a) Collateral Services, which mean sessions with significant persons in the life of the patient, necessary to serve the mental health needs of the patient.

(b) Assessment, which means services designed to provide formal documented evaluation or analysis of the cause or nature of the patient's mental, emotional, or behavioral disorder. Assessment services are limited to an intake examination, mental health evaluation, physical examination, and laboratory testing necessary for the evaluation and treatment of the patient's mental health needs.

(c) Individual Therapy, which means services designed to provide a goal directed therapeutic intervention with the patient which focuses on the mental health needs of the patient.

(d) Group Therapy, which means services designed to provide a goal directed, face–to–face therapeutic intervention with the patient and one or more other patients who are treated at the same time, and which focuses on the mental health needs of the patients.

(e) Medication, which includes the prescribing, administration, or dispensing of medications necessary to maintain individual psychiatric stability during the treatment process. This service shall include evaluation of side effects and results of medication.

(f) Crisis Intervention, which means immediate therapeutic response which must include a face–to–face contact with a patient exhibiting acute psychiatric symptoms to alleviate problems which, if untreated, present an imminent threat to the patient or others.

NOTE: Authority cited: Section 5705.1, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 544. Emergency Services.

§ 545. Outreach Services.

Outreach Services, which means a program of services delivered to the community–at–large, special population groups, human services agencies, and to individuals and families for whom there is no case record. The purposes of these services are to: (1) enhance the mental health of the general population, (2) prevent the onset of mental health problems in individuals and communities; and (3) assist those persons experiencing stress who are not reached by traditional mental health treatment services to obtain a more adaptive level of functioning. Outreach program services are provided through the following service functions:

(a) Mental Health Promotion, which means activities and projects directed toward:

(1) strengthening individuals' and communities' skills and abilities to cope with stressful life situations before the onset of such events; and

(2) enhancing and expanding agencies' or organizations' mental health knowledge and skills in relation to the community–at–large or special population groups.

(b) Community Client Services, which means activities directed toward:

(1) strengthening individuals' coping skills and abilities during a stressful life situation; and

(2) enhancing or expanding knowledge and skills of human services agency staff to handle the mental health problems of particular clients.

NOTE: Authority cited: Section 5705.1, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 546. Diagnostic Services.

§ 547. Rehabilitative Services.

§ 548. Continuing Care Services.

Continuing Care Services, which means services designed and staffed to provide, directly or indirectly, the mental health and other community–based assistance required to assure continuity of care and maintenance for adults and minors whose mental or emotional disabilities preclude independent functioning. These services are provided through the following:

(a) Case Management, which means services designed and staffed to provide continuity of care within the mental health system, to prevent neglect or exploitation of the mentally disabled, and to the extent possible, to prevent rehospitalization. The intent is to identify individuals in need, track and monitor progress and movement within the system, and to intervene as needed, directly, or indirectly, to assure the availability and adequacy of treatment services and necessary mental health social services.

(b) Conservatorship, which means services designed for the financial and personal protection of individuals deemed to be gravely disabled under the provisions of the Act. Conservatorship services are:

(1) Conservatorship Investigation, which means services provided by a designated investigator or agency to collect, assess, and document for the court of jurisdiction the psychosocial and financial information necessary to support or deny a finding of grave disability consistent with established statutory criteria, evaluate the feasibility of available alternatives to conservatorship, and make a recommendation to the court about conservatorship status and continuing care needs.

(2) Conservatorship Administration, which means services provided by a designated conservator to manage a conservatee's financial resources and to assure the availability and adequacy of necessary treatment services and mental health social services.

NOTE: Authority cited: Section 5705.1, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 549. Supplemental Residential Care Services.

Supplemental Residential Care Services mean services designed to augment basic living and care services for mentally disordered adults in licensed community care facilities, as defined in Section 1502 of the Health and Safety Code. These supplemental services include, but are not limited to, supportive, supervisory, and rehabilitative services, as identified in the client's service plan, and are provided in addition to the basic care and supervision required for licensure as a community care facility. Supplemental services are intended to facilitate the movement of clients to less restrictive levels of care.

(a) Facilities eligible to be certified for payment for supplemental services from county mental health programs shall be licensed community care facilities authorized by the State Department of Social Services to provide care and supervision to mentally disordered adults. Such facilities shall be certified for participation by the county, and services shall be provided through written agreement. These facilities shall agree to:

(1) Cooperate with county staff in developing a facility program plan to meet the goals, objectives, and activities outlined in the client's service plan subsequent to referral and authorization by the county. The service plan shall be developed with the client and the facility administrator by the county's designated case manager.

(2) Participate in the county's training activities.

(3) Obtain a minimum of 20 hours of training per year for supervisory staff in relevant mental health programming, certified by a recognized residential care association, or approved by the county.

(4) Maintain individual client records in accordance with county requirements.

(5) Allow access to the facility, to the extent authorized by law, by county and state staff for client assessment, monitoring, record review, and consultation.

(6) Maintain the capability to meet the specialized needs of mentally disordered adults, as identified by the county and in the facility's program plan.

(7) Participate in the county's management information system.

(b) Supplemental services shall consist of, but not be limited to, some but not necessarily all of the following components, as specified in the client's service plan:

(1) Providing or arranging transportation to meet the client's mental health needs and for participation in planned programs.

(2) Encouraging the client to take increasing responsibility for the client's own treatment by supporting self–established goals and the use of support and treatment system.

(3) Encouraging the client's use of public transportation, use of leisure time in a constructive manner, and maintenance of adequate grooming.

(4) Assisting the client to learn social relationship skills, such as communication with others and the appropriate expression of feelings.

(5) Participating with county staff in meetings in the facility.

(6) Assisting the client in developing skills of budgeting, personal shopping, monetary transactions, menu planning, and shopping for,and the preparation of, basic meals.

(7) Assisting the client in becoming responsible for self–medication, as prescribed by the treating physician.

(8) Providing close supervision of, and intensive interactions with, clients who require the management of difficult behavioral problems, consistent with the client's service plan.

The services described in paragraphs (1) and (5) of this subdivision shall constitute supplemental services only if performed in conjunction with one or more services described in paragraphs (2), (3), (4), (6), (7) and (8).

(c) Clients who receive supplemental services shall be assessed and monitored by the county's designated case management staff initially, and at least every 90 days thereafter, utilizing a standardized assessment procedure established by the Department. This procedure shall be used to assist in the determination of the functional ability and programmatic needs of mentally disordered clients, and the appropriate placement in facilities providing supplemental services.

(d) Each county shall apply for these funds within the county's Short–Doyle Plan in accordance with Section 5651 of the Welfare and Institutions Code, or within proposals for negotiated net amount contracts in accordance with Section 5705.2(c) of the Welfare and Institutions Code. In applying for these funds within the Short–Doyle Plan or within proposals for negotiated net amount contracts, the county shall describe a client monitoring system which is integrated with case management services. The county shall also evaluate and certify facilities annually in accordance with the criteria identified in Subsections (a) and (b).

(e) Rates of payment for supplemental services to clients shall be established in accordance with Section 4075 of the Welfare and Institutions Code. The total amount of reimbursement to a county for providing supplemental services shall be limited to the amount allocated to the county for such services in each fiscal year. Payment for supplemental services shall only be made after facility certification and client assessment by the county.

(f) Reimbursement rates shall be fixed by the Department in accordance with Section 4075 of the Welfare and Institutions Code, and shall not be subject to cost adjustment. Facilities providing supplemental services shall submit budgetary data and claims for reimbursement, and report service and cost data to the county in the manner and form prescribed by the county. The county shall provide the Department with service units and related cost data as required for fixed (negotiated) rate services.

(g) The county may claim reimbursement for costs incurred in the administration of these services, subject to the Department's approval, utilizing existing claiming procedures.

NOTE: Authority cited: Provisions 15 and 16, Item 4440–101–001, Budget Act of 1985 (Chapter 111 of the Statutes of 1985); and Section 4075, Welfare and Institutions Code. Reference: Sections 4076, 4077, 5600, 5675, 5676 and 5677, Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 550. Training.

Training services shall mean:

(a) Staff development programs for employees which are designed to improve existing skills, knowledge and attitudes or to provide new skills, knowledge and attitudes, to increase the employee's effectiveness or to develop potential for more responsible positions.

(b) Preservice education programs designed to provide the categories of treatment, professionals, and other mental health personnel needed to staff programs.

(c) Post–graduate professional education programs designed to provide the categories of personnel in professional sub–specialties needed to staff programs in Local Mental Health Services.

NOTE: Authority cited: Sections 5712 and 5751, Welfare and Institutions Code. Reference: Sections 5601(g), 5651(c) and 5751, Welfare and Institutions Code.

§ 551. Research and Evaluation.

(a) Research services shall mean:

(1) Basic research is directed toward the increase of knowledge to understand the particular subject under study. Its purpose is to expand existing knowledge about the nature, cause, prevention, and treatment of mental, emotional or behavioral disorders, including mental retardation and alcoholism, for the purpose of improving the ability of professional personnel to predict and control these disorders and to maximize human effectiveness.

(2) Clinical Research is concerned with identification, implementation, development and evaluation of therapeutic techniques and agents. These are studies directed toward the effectiveness of the treatment program and the development of new methods of diagnosis, treatment and rehabilitation. The acquisition of normative and base rate data is an essential aspect of clinical research.

(3) Program Research is concerned with identification, development, and evaluation of consultative, educational or community organizational techniques in mental health services.

(4) Socio–cultural Research is concerned with investigating the relationship between mental, emotional or behavioral disorders, including mental retardation and alcoholism, and the cultural and personal impact of community disorganization, social change and socio–cultural deprivation. This includes the relationship between various social and cultural factors and post–hospital adjustment and demographic and epidemiological investigation.

(b) Evaluation services shall mean:

(1) Studies of the effectiveness and efficiency of specific programs in Local Mental Health Services in achieving the goals of the program and the process by which such efforts are organized. Such management analysis will include studies of the relative cost and effectiveness of services and the efficient use of manpower, facilities and equipment.

(2) Studies of the effectiveness or state of progress of the local community in achieving overall mental health goals or the process by which such goals are defined or pursued.

§ 552. Equipment Expense.

(a) The following definitions of equipment shall apply:

(1) Equipment shall mean moveable personal property of a relatively permanent nature and of significant value, such as furniture, machines, tools and vehicles.

(A) "Relatively permanent" is defined as a useful life of one year or longer.

(B) "Significant value" is defined as a minimum value of $100 to $1,000 as established by the County Auditor.

(b) All plans for equipment expenditures shall be submitted as part of the annual county plan.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5651 and 5715, Welfare and Institutions Code.

§ 553. Remodeling Expense.

Remodeling shall include only the changing or improving of existing structures. Remodeling expense shall be determined by local option and by the State of California's financial participation subject to approval by the state Department of Mental Health. All plans for remodeling shall be submitted as part of the annual county plan.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5671 and 5715, Welfare and Institutions Code.

§ 554. 72–Hour Detoxification Treatment and Evaluation Service.

Article 5. Limitations on Reimbursements

§ 560. Inpatient Service.

Reimbursement for inpatient service shall be limited to reimbursement for those services set forth in Section 541, including the prescribing or furnishing of necessary drugs, together with such general medical and surgical procedures as are necessary in the treatment of the psychiatric condition, but excluding other medical treatment or other surgery.

§ 561. Other Mental Health Services.

Reimbursement for mental health services (other than inpatient service) shall be limited to reimbursement for those services set forth in Article 4, including the prescribing or furnishing of necessary drugs but excluding other medical care or treatment not necessary to evaluation of psychiatric disorders.

NOTE: Authority cited: Section 5712, Welfare and Institutions Code. Reference: Sections 5401, 5703, 5704, 5712 and 5715, Welfare and Institutions Code.

§ 562. Non–State–Reimbursable Charges.

§ 563. Reimbursement for Services.

§ 565.5. Funding.

Short–Doyle funding for acute inpatient psychiatric services shall be used only when the following sources of reimbursement are unavailable or have been exhausted:

(a) Patient payment in accordance with Welfare and Institutions Code Section 5718;

(b) Private third party payors; and,

(c) Other governmental third party payors.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 5705, 5713 and 5718, Welfare and Institutions Code.

Article 5.5. Maximum Allowable Rates

§ 570. Application of Article.

The maximum allowable rates established in accordance with the provisions of this Article shall apply to all mental health treatment services provided in accordance with the approved county Short–Doyle plans, except when exempted by statute, unless the Director of the State Department of Mental Health approves either a waiver of the maximum allowable rates, pursuant to subdivision (c) of Section 5705.1, Welfare and Institutions Code, or a negotiated net amount or rate, pursuant to Section 5705.2, Welfare and Institutions Code.

NOTE: Authority cited: Sections 5705.1 and 5750, Welfare and Institutions Code. Reference: Sections 5600, 5705.1 and 5705.2, Welfare and Institutions Code.

§ 571. Reimbursement.

Reimbursement for services specified in the approved county plans shall be the lower of either the individual provider's actual cost or the maximum allowable rates established in accordance with the provisions of this Article. However, the total reimbursement to a county for any one fiscal year pursuant to this provision shall not exceed the final county Short–Doyle allocation for that fiscal year.

NOTE: Authority cited: Sections 5705.1 and 5750, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 572. Maximum Allowable Rate Determination and Publication.

NOTE: Authority cited: Sections 5705.1 and 5750, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

§ 573. Monitoring Compliance.

Compliance with the maximum allowable rates shall be monitored through the budget, cost report, and audit processes. Local Directors shall ensure that individual providers rates are within the established maximum allowable rates for the various service functions. If the county's year–end cost report indicates that a provider's rate is in excess of the established maximum allowable rate and no waiver or statutory exemption applies, the state's final payment to the county (cost report settlement) shall be based on the maximum allowable rate, as established in accordance with the provisions of this Article.

NOTE: Authority cited: Sections 5705.1 and 5750, Welfare and Institutions Code. Reference: Sections 5600, 5705.1 and 5705.2, Welfare and Institutions Code.

§ 574. County Augmentation.

Nothing in the provisions of this Article shall prohibit a county from using county general funds, other than those required for the county match mandated by the Short–Doyle Act, to augment or offset any amount by which an individual provider exceeds the maximum allowable rates.

NOTE: Authority cited: Sections 5705.1 and 5750, Welfare and Institutions Code. Reference: Section 5600, Welfare and Institutions Code.

Article 6. Utilization Review of Short–Doyle Funded Acute Inpatient Psychiatric Services

§ 590. Review Process.

Counties shall comply with the Department's Quality Assurance Standards and Guidelines section titled Utilization Review of Short–Doyle Funded Acute Inpatient Psychiatric Services—Requirements and Procedures (March 1, 1984). Review of patient admission and continued stay necessity shall be performed concurrently with hospitalization. Admission and continued stay reviews for acutely ill patients shall determine the existence and continuance of the necessity for acute inpatient psychiatric treatment. Continued stay reviews shall be performed at least as often as indicated by the length of stay intervals specified in the Department's Requirements and Procedures. Admission and continued stay reviews for non–acutely ill patients shall determine the existence and continuance of special administrative circumstances as categorized in Section 591. Continued stay reviews shall be performed at five (5) working day intervals and must include review of the continuing efforts being made to resolve the administrative circumstances preventing discharge.

At each continued stay review, Short–Doyle funded inpatients shall be re–evaluated for eligibility for other funding as required by Section 565.5.

All patients admitted to and provided services within Short–Doyle funded acute inpatient psychiatric facilities shall be included in the utilization review process pursuant to this Article.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 4070 and 5624, Welfare and Institutions Code.

§ 591. Administrative Days.

All patients served in acute inpatient psychiatric facilities and funded by Short–Doyle must have a diagnosable mental disorder. If, however, symptoms do not meet the admission or continued stay criteria specified in the Department's Requirements and Procedures, the following categories of special circumstances warrant Short–Doyle funded acute inpatient psychiatric care:

(a) The patient is hospitalized due to the action of an authority over whom the local mental health director has no direct control and without the concurrence of whom the patient cannot be discharged;

(b) Alternative community care is not immediately available due to

(1) temporary lack of placement funds, or

(2) temporary lack of a therapeutically appropriate facility.

For patients in the above situations, continued stay reviews shall be conducted at five (5) working day intervals. Discharge shall occur at the earliest opportunity following resolution of the above circumstances.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 4070, 4071, 4072 and 5624, Welfare and Institutions Code.

§ 592. Documentation and Reporting.

Utilization review activities shall be documented, including review of administrative days, in accordance with the Department's Requirements and Procedures. In accordance with the Requirements and Procedures, special circumstances justifying administrative days must be documented, aggregated and reported quarterly to the local mental health director. These reports shall address the following factors of utilization:

(a) number of inpatients who do not meet the test of medical necessity;

(b) number of patient–days so used; and

(c) reasons other than medical necessity that inpatient care is required. Documentation of administrative days must reflect continuing efforts to resolve the circumstances preventing discharge.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 4070 and 5624, Welfare and Institutions Code.

§ 593. Compliance.

Counties shall amend existing utilization review plans to include these requirements. Counties shall be responsible for complying with these regulations ninety (90) days from the effective date of this Article.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 4071 and 5624, Welfare and Institutions Code.

§ 594. Enforcement.

The Department shall enforce utilization review by counties of Short–Doyle funded acute inpatient psychiatric services through the following means:

(a) Review and approval/disapproval of the utilization review plans;

(b) Onsite visits to evaluate required systems, audit clinical and administrative documentation, and request corrective action;

(c) Sanctions for non–compliance which can include any or all of the following:

(1) Wihholding future allocations until compliance is achieved;

(2) Requiring increased resources to be channeled into quality assurance activities from existing allocations;

(3) Recouping inappropriately used Short–Doyle funds from current allocations.

Counties shall be allowed the opportunity to appeal both clinical and administrative audit decisions and financial penalties.

NOTE: Authority cited: Section 4073, Welfare and Institutions Code. Reference: Sections 4071, 4072, 5655 and 5712, Welfare and Institutions Code.

Article 7. Claims for Reimbursement

§ 600. Forms and Information.

§ 601. Approval of Reimbursements.

Reimbursement for any fiscal year shall be limited to the amount fixed by the Director of Mental Hygiene when the plan is approved, unless additional expenditure is authorized after filing of a supplementary application. Expenditures incurred in support of new activities prior to approval of a plan by the Director of Mental Hygiene or for costs or expenditures not included in the approved plan may not be subject to reimbursement. Actual and necessary expenses incurred by members of the California Conference of Local Mental Health Directors at meetings called to implement the Act and for attendance at meetings, pursuant to Section 5760 of the Act, prior to approval of local plans, shall be subject to reimbursement in accordance with the Act. Actual and necessary expenses incurred by members of the local mental health advisory boards in the performance of official duties, pursuant to Section 5715 of the Act, shall be subject to reimbursement in accordance with the Act.

Article 8. Professional and Technical Personnel Standards

§ 620. Director of Local Mental Health Services.

Where the Local Mental Health Director is other than the local health officer or medical administrator of the county hospital, he or she shall be one of the following:

(a) A physician and surgeon licensed in the State of California showing evidence of having completed the required course of graduate psychiatric education as defined in Section 623 to be supplemented by an additional period of two years of training or practice limited to the field of psychiatry, one year of which shall have been administrative experience.

(b) A psychologist who shall be licensed in the State of California and shall possess a doctorate degree in psychology from an institution of higher education. In addition, the psychologist shall have had at least three years of acceptable clinical psychology experience, two years of which shall be administrative experience.

(c) A clinical social worker who shall possess a master's degree in social work or higher and shall be a licensed clinical social worker under provisions of the California Business and Professions Code, and shall have had at least five years mental health experience, two years of which shall have been administrative experience.

(d) A marriage, family, and child counselor who shall have a master's degree in an approved behavioral science course of study, and who shall be a licensed marriage, family, and child counselor and have received specific instruction, or its equivalent, as required for licensure on January 1, 1981. In addition, the marriage, family, and child counselor shall have had at least five years of mental health experience, two years of which shall have been administrative experience. The term, specific instruction, contained in Sections 5751 and 5751.3 of the Welfare and Institutions Code, shall not be limited to school, college, or university classroom instruction, but may include equivalent demonstrated experience in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions.

(e) A nurse who shall possess a master's degree in psychiatric or public health nursing and shall be licensed as a registered nurse by the Board of Registered Nursing in the State of California, and shall have had at least five years mental health experience, two of which shall have been administrative experience. Additional post–baccalaureate experience in a mental health setting may be substituted on a year–for–year basis for the educational requirements.

(f) An administrator who shall have a master's degree in hospital administration, public health administration, or public administration from an accredited college or university, and who shall have at least three years experience in hospital or health care administration, two of which shall have been in the mental health field. Additional qualifying experience may be substituted for the required education on a year–for–year basis with the approval of the Department of Mental Health.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5607, 5751, 5751.1 and 5751.3, Welfare and Institutions Code.

§ 620.1. Acting Director of Local Mental Health Services.

If a county is unable to secure the services of a person who meets the standards set forth in Section 620, the county may select an Acting

Director of Local Mental Health Services with appointment limited to a 12–month period subject to the approval of the Director of the state Department of Mental Health.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Sections 5751 and 5751.1, Welfare and Institutions Code.

§ 621. Medical Program Responsibility.

If the Local Director does not meet the qualifications of Section 620 (a), the local mental health service shall provide a psychiatrist licensed to practice medicine in this State as defined in Section 623 who shall have the medical responsibility as defined in Section 522.

§ 622. Requirements for Professional Personnel.

Wherever in these regulations the employment of a particular professional person is required, the minimum qualifications for that person shall be as hereinafter specified in this Article. Required experience shall mean full time equivalent experience. It is intended that these minimum qualifications shall apply to the head or chief of a particular service or professional discipline but not necessarily to subordinate employees of the same profession.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Section 5751, Welfare and Institutions Code.

§ 623. Psychiatrist.

A psychiatrist who directs a service shall have a license as a physician and surgeon in this state and show evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association or the American Osteopathic Association.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5751 and 5751.1, Welfare and Institutions Code.

§ 624. Psychologist.

A psychologist who directs a service shall have obtained a California license as a psychologist granted by the State Board of Medical Quality Assurance or obtain such licensure within two years following the commencement of employment, unless continuously employed in the same class in the same program or facility as of January 1, 1979; and shall have two years of post doctoral experience in a mental health setting.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5600.2, 5751 and 5751.3, Welfare and Institutions Code.

§ 625. Social Worker.

A social worker who directs a service shall have a California license as a clinical social worker granted by the State Board of Behavioral Science Examiners or obtain such licensure within three years following the commencement of employment, unless continuously employed in the same class in the same program or facility as of January 1, 1979, or enrolled in an accredited doctoral program in social work, social welfare, or social science; and shall have two years of post master's experience in a mental health setting.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5600.2, 5751 and 5751.3, Welfare and Institutions Code.

§ 626. Marriage, Family and Child Counselor.

A marriage, family, and child counselor who directs a service shall have obtained a California license as a marriage, family, and child counselor granted by the State Board of Behavioral Science Examiners and have received specific instruction, or its equivalent, as required for licensure on January 1, 1981, and shall have two years of post master's experience in a mental health setting. The term, specific instruction, contained in Sections 5751 and 5751.3 of the Welfare and Institutions Code, shall not be limited to school, college, or university classroom instruction, but may include equivalent demonstrated experience in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5751 and 5751.3, Welfare and Institutions Code.

§ 627. Nurses.

A nurse shall be licensed to practice as a registered nurse by the Board of Nursing Education and Nurse Registration in this State and possess a master's degree in psychiatric or public health nursing, and two years of nursing experience in a mental health setting. Additional post baccalaureate nursing experience in a mental health setting may be substituted on a year–for–year basis for the educational requirement.

§ 628. Licensed Vocational Nurse.

A licensed vocational nurse shall have a license to practice vocational nursing by the Board of Vocational Nurse and Psychiatric Technician

Examiners and possess six years of post license experience in a mental health setting. Up to four years of college or university education may be substituted for the required vocational nursing experience on a year–for–year basis.

§ 629. Psychiatric Technician.

A psychiatric technician shall have a current license to practice as a psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners and six years of post license experience in a mental health setting. Up to four years of college or university education may be substituted for the required psychiatric technician experience on a year–for–year basis.

NOTE: Authority cited: Sections 4011 and 5750, Welfare and Institutions Code. Reference: Sections 5600 and 5767, Welfare and Institutions Code.

§ 630. Mental Health Rehabilitation Specialist.

A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year–for–year basis; up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting.

§ 631. Administrative Support Responsibility.

Any local mental health service which serves a population in excess of 100,000 shall have at least one administrative person who does not have clinical program responsibility and who shall be responsible for all administrative and supportive services as defined in Section 5751.2 of the Welfare and Institutions Code.

After March 1, 1976 new personnel employed into these positions shall have three years of experience with increasing responsibility performing health administration or staff administrative services such as accounting, auditing, budgeting, administrative analysis, or personnel and have a minimum education equivalent to graduation with a baccalaureate degree from an accredited college or university. Additional qualifying experience may be substituted for the required education on a year–for–year basis.

NOTE: Authority cited: Sections 5751 and 5751.2, Welfare and Institutions Code. Reference: Sections 5751 and 5751.2, Welfare and Institutions Code.

§ 632. Other Mental Health Personnel.

The definitions of professional, administrative, and technical personnel listed above shall not be construed as limiting the establishment of positions in other categories. If, after persistent recruitment, persons with qualifications specified above cannot be

obtained, the Department may permit exceptions to the requirements upon receiving a written request describing the recruitment efforts. Such exceptions to the personnel requirements shall be limited to a 12–month period subject to annual renewal by the Department.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Sections 5751 and 5751.1, Welfare and Institutions Code.

Article 9. Accounting and Records

§ 640. Financial Records.

Records shall be kept so that they clearly reflect the cost of each type of service for which reimbursement is claimed. Where apportionment of costs is necessary, such as for inpatient psychiatric service in a general hospital, such apportionment shall be made according to accepted accounting principles in order to reflect the true cost of the services rendered.

§ 641. Patient Records.

§ 642. Statistical Data.

Statistical data shall be kept and reports made as required by the department. Reports shall be made on forms provided by the department.

Article 10. Requirements for Inpatient Services

§ 660. Admission Procedures.

§ 661. Medical–Surgical Services.

§ 662. Discharges and Transfers.

§ 663. Minimum Staff.

Inpatient services shall be under an administrative director who qualifies under Section 620(d), 623, 624, 625, or 627. In addition to the director of the service, the minimum professional staff shall include a psychiatrist if the administrative director of the service is not a psychiatrist, who shall assume medical responsibility as defined in Section 522; a psychologist, social worker, registered nurse, and other nursing personnel under supervision of a registered nurse. Nursing personnel shall be present at all times. Physicians, psychiatrists, registered nurses and other mental health personnel shall be present or available at all times. Psychologists and social workers may be present on a time–limited basis.

Rehabilitation therapy, such as occupational therapy, should be available to the patients.

The minimum ratio of the full–time professional personnel to resident patients shall be as follows:

Personnel	*Ratio per 100 Patients*
Physicians	5
Psychologists	2
Social Workers	2
Registered Nurses	20
Other Mental Health Personnel	25
Total	54

NOTE: Authority cited: Sections 4011 and 5750, Welfare and Institutions Code. Reference: Secs. 5600 and 5767, W. & I. Code. Additional authority cited: Sections 5650, 5703.1, 5751, Welfare and Institutions Code. Additional references: Sections 5650, 5703.1, 5751, 5751.1, 5751.2, Welfare and Institutions Code.

Article 11. Requirements for Outpatient Services

§ 680. Basic Requirements.

Outpatient services in Local Mental Health Services shall include:

(a) Minimum Professional Staff. Outpatient services shall be under the direction of a person who qualifies under Section 623, 624, 625, 626, 627, 628, 629 or 630. In addition to the director, the minimum professional staff shall include a psychiatrist, psychologist, and social worker, except that under special circumstances the Department may authorize the operation of an outpatient service with less personnel. In addition, the staff may include qualified registered nurses and other professional disciplines.

A psychiatrist must assume medical responsibility as defined in Section 522, and be present at least half–time during which the services are provided except that under special circumstance the Department may modify this requirement.

In developmental disabilities and substance abuse programs a physician other than a psychiatrist may be substituted when this would be more appropriate to the treatment needs of the patient upon approval of the Department.

(b) Availability of Service. Outpatient services shall be reasonably available and accessible.

(c) Care and Staffing. A program of outpatient services should provide for continuity of care and flexibility of staffing to meet the needs of the individual patients.

(d) Integration of Staff Services. The services of the various professional disciplines shall be integrated through regular staff meetings and other conferences for joint planning and evaluation of treatment.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5600.5, 5704, 5712, 5751 and 5751.3, Welfare and Institutions Code.

Article 12. Requirements for Partial Hospitalization Services

§ 690. Minimum Professional Staff.

Partial hospitalization service shall be under the direction of a person who qualifies under Section 623, 624, 625, 626, 627, 628, 629 or 630. In addition to the director the minimum professional staff shall include personnel necessary to achieve program objectives, such as psychiatrists, psychologists, social workers, nurses, educators, occupational therapists, mental health rehabilitation therapists, recreational therapists, psychiatric technicians, psychiatric aides, and other such personnel deemed necessary. Participation by different disciplines may vary according to program design and objectives.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5600.5, 5704, 5712, 5751 and 5751.3, Welfare and Institutions Code.

§ 691. Medical Responsibility.

Article 13. Requirements for Emergency Services

§ 700. Basic Requirement.

The emergency service shall be readily available and accessible 24 hours a day, seven days a week.

Article 14. Purposes, Processes and Requirements of Consultation, Education and Information Services

§ 710. Purpose of Consultation Services.

The purpose of consultation services with professionals and community agencies shall be to expand to their potential for:

(a) The promotion of mental health.

(b) The prevention of emotional disorders.

(c) The identification and resolution of mental health problems.

(d) The development and sustenance of the effectiveness of social systems.

NOTE: Authority cited: Sections 4012, 5651 and 5751, Welfare and Institutions Code. Reference: Sections 4012, 5453, 5601, 5651, 5661.5 and 5751, Welfare and Institutions Code.

§ 711. Process of Consultation Services.

The process for providing consultation services may include:

(a) Interaction with an agency or professional person in planning for collaboratively evaluating the client.

(b) Assistance to agencies in focusing their service functions and internal relationships.

(c) Involvement with other community agencies, groups, and

individuals in planning, developing, integrating, coordinating, and evaluating a broad range of community services.

NOTE: Authority cited: Sections 4012, 5651 and 5751, Welfare and Institutions Code. Reference: Sections 4012, 5453, 5601, 5651, 5661.5 and 5751, Welfare and Institutions Code.

§ 712. Purpose of Education Services.

The purpose of education services shall be:

(a) To motivate such individuals and groups to accept responsibility for personal and community mental health.

(b) To develop attitudes and practices facilitating positive interpersonal relationships.

§ 713. Process of Education Services.

The process of education services may be characterized by:

(a) The systematic structuring of experiences which will result in learning about mental health concepts.

(b) Involving as participants those individuals and groups, who, by reason of their functional role in the community, have a significant potential for affecting the mental health of others.

(c) A high degree of interpersonal interacting between participants of seminars, workshops, classes, and discussion groups to facilitate change.

(d) A major focusing on general aspects of a subject rather than on solutions of specific case problems.

(e) Assisting professionals in developing mental health knowledge and skills in the detection of emotional disorders and management of problems appropriate to their work.

§ 714. Purpose of Information Services.

The purpose of information services is to inform the general public as to:

(a) Basic facts of mental health and emotional disorders.

(b) Mental health needs of the community.

(c) Existing community services and their utilization.

NOTE: Authority cited: Sections 4012, 5651 and 5751, Welfare and Institutions Code. Reference: Sections 4012, 5601, 5651, 5651.7, 5661.5 and 5751, Welfare and Institutions Code.

§ 715. Process of Information Services.

§ 716. Direction and Supervision.

Consultation, education, and information services shall be provided by mental health personnel under the general direction of a person who qualifies under Sections 623, 624, 625, 626, or 627.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5600.5, 5704, 5712, 5751 and 5751.3, Welfare and Institutions Code.

Article 15. Requirements for Diagnostic Services

§ 730. Basic Requirements.

Where diagnostic services are reimbursable as a separate service under this subchapter, this service may include diagnosis, evaluation, referral, pre–petition screening and conservatorship recommendations.

NOTE: Authority cited: Sections 5600.5, 5712 and 5751, Welfare and Institutions Code. Reference: Sections 5150, 5151, 5008(a), (d), (f), 5152, 5202, 5352, 5352.5, 5458(a) and 5651(b), Welfare and Institutions Code.

Article 16. Requirements for Rehabilitative Services

§ 740. Psychiatric Direction and Supervision.

(a) Direction and Supervision. Rehabilitative services provided by a local mental health service or by contract shall be under the general direction of a person who qualifies under Section 623, 624, 625, 626, 627, 628, 629 or 630.

(b) Medical Responsibility. For rehabilitative services provided, a physician shall assume responsibility for all those acts of diagnosis, treatment, or prescribing or ordering of drugs which may only be performed by a licensed physician as authorized by Section 2051 of the Business and Professions Code.

NOTE: Authority cited: Sections 5600.5 and 5751, Welfare and Institutions Code. Reference: Sections 5453(c), 5600, 5651(f) and 5705.5, Welfare and Institutions Code.

§ 741. Treatment Plan for Patients.

A diagnosis taken from the Diagnostic and Statistical Manual of Mental Disorders is required for all patients served in rehabilitative services. At its inception, part of the treatment plan of each patient shall include an assessment of is potential for rehabilitation and the place of rehabilitative services in his total program. This plan should be reviewed and modified according to the patient's progress.

§ 742. Minimum Staff.

Article 17. Requirements for Precare and Aftercare Services

§ 750. Referral to Provide Continuity of Care.

Article 18. Requirements for Training Services

§ 760. Reimbursement for Training Services.

Training services in the Local Mental Health Service may be reimbursable as a separate service under this subchapter.

When the Training service is included in one of the other services in this subchapter as a reimbursable item it may include administrative costs, stipends and scholarships.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Section 5761, Welfare and Institutions Code.

§ 761. Minimum Staff.

Article 19. Requirements for Research and Evaluation Services

§ 770. Standards for Research Personnel.

§ 771. Contracting for Services.

The Local Mental Health Service may contract for Research and Evaluation studies through public and private agencies, including the Department of Mental Hygiene. Personnel providing Research or Evaluation services by contract should have qualifications equal to similar personnel providing a direct Research or Evaluation service to the Local Mental Health Service.

§ 772. Method of Program Evaluation.

§ 773. Local Mental Health Service Research Committee.

NOTE: Authority cited for Sections 773 through 780: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5000 through 5767, Welfare and Institutions Code.

§ 774. Research Funds.

Local Mental Health Services may apply directly to the grantor for non–state research funds, singly or collectively. When Local Mental Health Services apply with a facility of the Department for non–departmental research grant support, these grants shall come under the general administration of the Department of Mental Hygiene and require the approval of the Local Director before submission to the grantor. The application for the grant must include all direct and indirect costs of the proposed research, unless a specific exception to this requirement is authorized by the Department of Mental Hygiene.

§ 775. Local Research Trust Fund.

§ 776. Application Review.

§ 777. Scientific Merit of Research Study.

The Local Director in charge of the local mental health service in which a research study is to be conducted in order to insure the

scientific merit and relevance of the research shall obtain a written description of the proposed research study and determine the competence and integrity of the researchers prior to the commencement of a research study.

§ 778. Personal Safety and Welfare of Research Subjects.

The local mental health service shall develop uniform policies, procedures, and forms prior to undertaking any research, to provide for the personal safety and welfare of all subjects involved in research conducted at any of the facilities under its jurisdiction. The participation of subjects in research shall be on the basis of informed consent. Satisfactory evidence of compliance with these procedures will be a necessary condition for Department of Mental Hygiene research support or reimbursement. To meet this condition, the local mental health service may comply with the department's policies and procedures pertaining to research subjects. These safeguards concerning human rights and welfare shall apply to all research at the facility.

§ 779. Confidential Nature of Information and Records.

All personal data and information obtained from medical records in the course of research studies shall be confidential and may be disclosed only to qualified professional persons providing services to the patient or to other research personnel engaged in the study. No information obtained in the course of research may be released through publication or other research communication unless the person studied is unidentifiable.

§ 780. Requirement of Oath of Confidentiality.

In order to perform research in facilities all researchers shall sign an oath of confidentiality, as follows:

_____
Date

As a condition of doing research concerning persons who have received services from _____ (fill in the facility, agency or person), I, _____, agree not to divulge any information obtained in the course of such research to unauthorized persons, and not to publish or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I recognize that unauthorized release of confidential information may make me subject to a civil action under provisions of the Welfare and Institutions Code.

_____ Signed

Article 20. Requirements for 72–Hour Detoxification, Treatment and Evaluation Service for Inebriates

NOTE: Authority cited: Section 5400, Welfare and Institutions Code. Reference: Sections 5170–5176, Welfare and Institutions Code.

Article 21. Intensive Treatment for Chronic Alcoholics

NOTE: Authority cited: Section 5400, Welfare and Institutions Code. Reference: Sections 5170–5176, Welfare and Institutions Code.

Article 22. Requirements for Social and Rehabilitation Services

Chapter 3.5. Mental Health Rehabilitation Centers

Article 1. Application

§ 781.00. Application of Chapter.

This chapter shall apply to programs authorized by Welfare and Institutions Code Section 5768, hereinafter denoted as mental health rehabilitation centers.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 2. Definitions

§ 782.00. Application of Definitions.

The definitions included in this article shall apply to the regulations contained in this chapter.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.10. Meaning of Words.

Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. Words used in the present tense include the future; words in the singular number include the plural number; words in the plural number include the singular number. Shall means mandatory. May means permissive. Should means suggested and recommended.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.11. Activity Coordinator.

Activity Coordinator means a person who is an occupational therapist, music therapist, art therapist, dance therapist or recreation therapist, as defined in this chapter.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.12. Alteration.

Alteration means any construction work other than maintenance in an existing building which does not increase the floor area or roof area or the volume of enclosed space.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.13. Art Therapist.

Art therapist means a person who is registered or eligible for registration as an art therapist with the American Art Therapy Association.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.14. Client.

Client means a person, 18 years of age or older, admitted to a mental health rehabilitation center for evaluation, observation, diagnosis, rehabilitation and treatment.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.15. Client Record.

Client record means a record that organizes all information on the care, treatment and rehabilitation rendered to a client in a mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.16. Conservator.

Conservator means a person appointed by a court pursuant to Section 5350 et seq. of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.17. Controlled Drugs.

Controlled drugs means those drugs covered under the Federal Comprehensive Drug Abuse Prevention Control Act of 1970, as amended, or the California Uniform Controlled Substances Act.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.18. Dance Therapist.

Dance therapist means a person who is registered or eligible for registration as a dance therapist by the American Dance Therapy Association.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.19. Department.

Department means the State Department of Mental Health (see Section 4000 et seq. of the Welfare and Institutions Code).

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.20. Dietitian.

Dietitian means a person who is registered or eligible for registration as a dietitian by the American Dietetic Association.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.21. Director.

Director means the Director of the State Department of Mental Health.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.22. Drug.

(a) Drug means the following:

(1) Articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals.

(2) Articles (other than food) intended to affect the structure or any function of the body of man or other animals.

(3) Articles intended for use as a component of any article designated in subdivision (1) and (2) of this section.

(b) Legend drug means any of the following:

(1) Any drug labeled with the statement "Caution: Federal Law prohibits dispensing without prescription" or words of similar import.

(2) Any dangerous drug under Section 4022 of the Business and Professions Code.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.23. Drug Administration.

Drug administration means the act in which a single dose of a prescribed drug or biological is given to a client. The complete act of administration entails removing an individual dose from a container (including a unit dose container), verifying the dose with the prescriber's orders, giving the individual dose to the client and promptly recording the time and dose given.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.24. Drug Dispensing.

Drug dispensing means the act entailing the following of a prescription order for a drug or biological and the proper selection, measuring, packaging, labeling and issuance of the drug or biological to a client.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.25. Mental Health Rehabilitation Center Director.

Mental health rehabilitation center director means the licensee, or the adult designated by the licensee to act in his/her behalf in the overall administration or management of the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.26. Licensed Mental Health Professional.

Licensed mental health professional means any of the following:

(a) A licensed psychologist as defined in these regulations.

(b) A physician as defined in these regulations.

(c) A licensed clinical social worker as defined in these regulations.

(d) A licensed marriage, family and child counselor as defined in these regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.27. Licensed Nursing Staff.

Licensed nursing staff means a licensed registered nurse, licensed vocational nurse or a licensed psychiatric technician as defined in this chapter, and employed by a mental health rehabilitation center to perform functions within their scope of practice.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.28. Licensed Psychiatric Technician.

Licensed psychiatric technician means a person licensed as a psychiatric technician by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.29. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as a licensed vocational nurse by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.30. Licensee.

Licensee means the person, persons, firm, partnership, association, organization, company, corporation, business trust, political subdivision of the state, or other governmental agency to whom a license has been issued.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.31. Local Bank.

Local bank means a bank or branch of that bank which is in the same neighborhood, community, city or county in which the mental health rehabilitation center is physically located.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.32. Marriage, Family and Child Counselor.

Marriage, Family and Child Counselor means a person licensed as a marriage, family and child counselor by the California Board of Behavioral Science Examiners, or persons granted a waiver pursuant to Section 5751.2 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.33. Medication.

For the purposes of this chapter, medication shall mean the same as drug as defined in Section 782.22.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.34. Mental Health Rehabilitation Center.

Mental health rehabilitation center means a 24–hour program, licensed by the Department, which provides intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self–sufficient and capable of increasing levels of independent functioning.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.35. Mental Health Rehabilitation Specialist.

Mental Health Rehabilitation Specialist means a person who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year–to–year basis; up to two years of post associate arts clinical experience may be substituted for the required education.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.36. Music Therapist.

Music therapist means a person who has a bachelor's degree in music therapy and who is registered or eligible for registration as a music therapist by the National Association for Music Therapy.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.37. Occupational Therapist.

Occupational therapist means a person who is registered or who is eligible for registration as an occupational therapist by the American Occupational Therapy Association.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.38. Pharmacist.

Pharmacist means a person licensed as a pharmacist by the California Board of Pharmacy.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.39. Physician.

Physician means a person licensed as a physician and surgeon by the California Medical Board or by the Board of Osteopathic Examiners.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.40. Program Director.

Program director means an individual designated in writing by the licensee who meets the criteria of Sections 623, 624, 625, 626, 627, 628, 629, or 630 of Title 9 of the California Code of Regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.41. Postural Support.

Postural support means devices that are applied to assist persons in achieving proper body position or balance, whether to prevent injury to those who cannot sit or lie in bed without falling, or to improve a person's mobility and independent functioning.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.42. Psychologist.

Psychologist means a person licensed as a psychologist by the California Board of Psychology, or persons granted a waiver pursuant to Section 5751.2 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.43. Recreation Therapist.

Recreation therapist means a person who is registered or eligible for registration as a recreation therapist by the California Board of Parks and Recreation Certification or the National Council for Therapeutic Recreation Certification.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.44. Registered Nurse.

Registered nurse means a person licensed as a registered nurse by the California Board of Registered Nursing.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.45. Restraint.

Restraint, for the purposes of the regulations included in this chapter, shall mean:

(a) Behavioral restraint which means any form of restraint employed to control a client in order to prevent the person from causing harm to self or others. Only the following types of behavioral restraint may be used in a mental health rehabilitation center:

(1) Belts and cuffs, which are well padded; and

(2) Soft ties, consisting of cloth.

(b) Chemical restraint means a drug used to control behavior and in a manner not required to treat the client's physical symptoms.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.46. Seclusion.

Seclusion means the involuntary confinement of a client in a room or area, where the client is prevented from physically leaving, for any period of time.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.47. Self Administration of Medication.

Self administration of medication by clients means clients' shall be responsible for the control, management and use of his or her own medication.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.48. Social Worker.

Social worker means a person who is licensed as a clinical social worker by the California Board of Behavioral Science Examiners, or persons granted a waiver pursuant to Section 5751.2 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.49. Standing Orders.

Standing orders means those written instructions which are used or intended to be used in the absence of a prescriber's specific order for a specified client.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.50. Supervision.

(a) Supervision means to instruct an employee or subordinate in

their duties and to oversee or direct work, but does not necessarily require the immediate presence of the supervisor.

(b) Direct supervision means the supervisor shall be present in the same building as the person being supervised, and available for consultation and assistance.

(c) Immediate supervision means that the supervisor shall be physically present while a task is being performed by the person being supervised.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.51. Therapeutic Diet.

Therapeutic diet means any diet modified from a regular diet in a manner essential to the treatment or control of a particular disease or illness.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.52. Unit Dose Medication System.

Unit dose medication system means a system in which single dosage units of drugs are prepackaged and prelabeled in accordance with all applicable laws and regulations governing these practices and be made available separated as to client and by dosage time. The system shall also comprise, but not be limited to, all equipment and appropriate records deemed necessary to make the dose available to the client in an accurate and safe manner. A pharmacist shall be in charge of and responsible for the system.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.53. Standing Orders.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.54. Supervision.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.55. Therapeutic Diet.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 782.56. Unit Dose Medication System.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 3. License

§ 783.00. Application Required.

(a) Whenever either of the following circumstances occur, a verified application for a new license completed on forms furnished by the Department (MH8001/95) shall be submitted to the Department.

(1) Establishment of a mental health rehabilitation center.

(2) Change of ownership of a mental health rehabilitation center.

(b) Whenever any of the following circumstances occur, the licensee shall submit to the Department a verified application for a corrected license completed on forms furnished by the Department (MH8001/95).

(1) Construction of a new or replacement mental health rehabilitation center.

(2) Change in licensed bed capacity of a mental health rehabilitation center.

(3) Change of name of a mental health rehabilitation center.

(4) Change of licensed category of a mental health rehabilitation center.

(5) Change of location of a mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.10. Application Requirements.

(a) Any adult, firm, partnership, association, corporation, county, city, public agency, or other governmental entity desiring to obtain a license for a mental health rehabilitation center shall file an application with the Department, except as provided in subsection (b).

(b) A nongovernmental entity proposing a mental health rehabilitation center shall submit a written plan of operation as specified in Section 783.13, to the local mental health director for review and approval. The local mental health director shall have the flexibility to base approval of the plan of operation upon local program need, as well as a determination of whether the plan of operation is complete and meets the requirements of Section 783.13. Evidence that the plan of operation has been approved by the local mental health director shall be in writing. The local mental health director shall forward this approved plan of operation with the application to the Department.

(c) If the applicant is a firm, association, corporation, county, city, public, or other governmental entity, the application shall be signed by the chief executive officer or authorized representative.

(d) An applicant shall cooperate with the Department by providing information and documentation as requested by the Department.

(e) Approval of an application by the Department does not constitute the licensing of a mental health rehabilitation center as a mental health rehabilitation center. The final approval for the licensing of a mental health rehabilitation center as a mental health rehabilitation center will be based on a site visit(s) conducted by the Department, within 30 calendar days following the applicant receiving written notification of approval of the application from the Department.

(f) Each year following the initial licensing of a mental health rehabilitation center, the licensee shall submit any changes to the approved plan of operation to the local mental health director and to the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.11. Application Content.

(a) The application shall, at a minimum, contain the following information:

(1) Name, or proposed name, and address of the mental health rehabilitation center.

(2) Name, residence, and mailing address of applicant.

(A) If the applicant is a partnership, the name and principal business address of each partner.

(B) If the applicant is a corporation or association, the name, title, and business address of each officer and member of the governing board.

(C) Name and address of the owner of the mental health rehabilitation center premises if the applicant is leasing or renting.

(3) Written administrative policies and procedures as specified in Section 784.00 of these regulations.

(4) A written plan of operation as specified in Section 783.13 of these regulations. The plan of operation shall also include program evaluation measures in accordance with the provisions included in Section 5675 of the Welfare and Institutions Code.

(5) A written financial plan including an actual or proposed annual budget, and the most recent financial audit, if available.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.12. Application Process.

(a) Whenever an application is submitted pursuant to these regulations, the Department shall notify the applicant, in writing, within thirty calendar days of receipt of the application, that the application is complete and accepted for filing or that the application is incomplete, and what specific information or documentation is required to complete the application.

(b) If the applicant fails to respond within thirty calendar days to the Department, following receipt of notification pursuant to (a) above, for additional information or documentation, the application shall be deemed to have been withdrawn by the applicant. Any applicant deemed to have withdrawn an application may reapply by submitting a new application.

(c) The Department shall notify an applicant, in writing, within 60 calendar days following the acceptance of an application for filing, of the Department's decision to approve or deny the application.

(1) The sixty days shall not begin until all information or documentation required for completion of the application is received by the Department.

(2) If the Department fails to notify an applicant by the ending calendar date of the 60 day time period, the applicant may request, in writing, a review by the Deputy Director responsible for mental health rehabilitation center licensure, or the designee of the Director, at the principal address of the Department in Sacramento, California. The written request shall include:

(A) An identification of the applicant;

(B) The date upon which the application was submitted;

(C) A copy of any correspondence between the Department and the applicant regarding the application; and

(D) Any other information the applicant wishes to submit regarding the timeliness of the Department's consideration of the application.

(d) An applicant may request a review of a denial or disapproval of an application by sending a written request to the Deputy Director responsible for mental health rehabilitation center licensure, or the designee of the Director, at the principal address of the Department in Sacramento, California.

(1) A request for review must be postmarked no later than fifteen calendar days after receipt of the notification of the denial or disapproval of the application.

(2) An applicant requesting a review shall be responsible for submitting all documents, information, and arguments which the applicant wishes to be considered in the review. The documents, information, and arguments the applicant wishes to be considered may be submitted with the request for review or sent separately, but shall be postmarked no later than thirty calendar days after receipt of the written notification of denial or disapproval of the application.

(3) The Deputy Director or the designee shall review the written notification of application denial or disapproval, and any related information and documents justifying or supporting the application denial or disapproval, the request for review submitted by the applicant, and the information, documents and arguments submitted by the applicant. If deemed necessary for completion of the review, the Deputy Director or the designee may request clarification or additional information from the applicant.

(4) Upon completion of the review a decision to affirm or reverse the application denial or disapproval shall be prepared by the Department. A decision shall become final when adopted by the Deputy Director or designee.

(5) A written notification of the decision to affirm or reverse the action to deny or disapprove an application shall be sent to the applicant. A decision adopted by the Department shall become effective upon receipt by the applicant.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.13. Plan of Operation Requirements.

(a) The plan of operation shall describe the following components for the proposed mental health rehabilitation center:

(1) Summary of Administrative Policies and Procedures as specified in Section 784.00 of these regulations.

(2) Basic Services and Staffing.

(3) Rehabilitation Program and Staffing.

(4) Activity Program and Staffing.

(5) Admissions Process and Criteria.

(6) Discharge Planning and Transition Process.

(7) Health Records and Services Content.

(8) Client Records and Content.

(9) Client Rights and Empowerment.

(10) Pharmaceutical Services and Self–Medication.

(11) Program Space Requirements.

(12) Restraint and Seclusion Policies and Procedures.

(13) Physical Plant or Buildings.

(14) Program Supplies.

(15) Program Equipment.

(16) Clinical Treatment Programs.

(17) Interdisciplinary Treatment Teams.

(18) Psychiatric and Psychological Services.

(b) The plan of operation shall specify each target population group that the proposed mental health rehabilitation center plans to serve. The description of the population group to be served shall include the following:

(1) Age range.

(2) Gender.

(3) Ethnicity.

(4) Degree or level of impairment.

(5) Diagnosis as listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(6) Number of clients to be served.

(7) Identification of the particular needs of the population.

(8) The rehabilitation program designed to meet the identified service needs of the population.

(9) Method and frequency of evaluating client progress.

(c) A specific description of what makes the program innovative compared to existing licensed or certified mental health programs.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.14. Safety, Zoning and Building Clearance.

(a) A license shall not be issued to any applicant which does not conform to the State Fire Marshal's requirements for fire and life safety, the State requirements for environmental impact, and also to local fire safety, zoning, and building ordinances. Evidence of such compliance shall be presented in writing to the Department.

(b) The licensee shall maintain the mental health rehabilitation center in a safe structural condition. If the Department determines, in a written report submitted to the licensee, that an evaluation of the structural condition of a mental health rehabilitation center building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall evaluate the structural condition of the mental health rehabilitation center, and, if necessary, establish a basis for eliminating or correcting the structural conditions which may be hazardous to occupants. The licensee shall eliminate or correct any hazardous conditions.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.15. Separate Licenses.

Separate licenses shall be required for mental health rehabilitation centers which are maintained on separate premises even though they are under the same management. Separate licenses shall not be required for separate buildings on the same grounds or adjacent

grounds, used for the provision of the same program under the requirements of these regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.16. Posting.

The license or a true copy thereof shall be posted in a conspicuous location accessible to public view within the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.17. Report of Changes.

The licensee shall notify the Department in writing of any changes in the following information within 10 calendar days of the changes. This notification shall include information and documentation regarding such changes.

(a) A change of mental health rehabilitation center director occurs. Such notification shall include the name and license number, if applicable, of the new mental health rehabilitation center director.

(b) A change of the mailing address of the licensee. Such notification shall include the new mailing address of the licensee.

(c) A change in the principal officer of a corporate licensee (chairman, president or general manager) occurs. Such notification shall include the name and business address of such officer.

(d) Any decrease in licensed bed capacity of the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.18. Program Flexibility and Monitoring.

All mental health rehabilitation centers shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with provision for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating information and documents supporting the request shall be submitted by the applicant or licensee to the Department.

(a) Any approval of the Department granted under this section, or a true copy thereof, shall be posted immediately adjacent to the center's license.

(b) The local mental health director shall monitor each mental health rehabilitation center providing a program based on a plan of operation, as specified in Section 783.13, and approved by the local mental health director and the Department, pursuant to Welfare and Institutions Code, Section 5768(e)(2).

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.19. Conviction of Crime: Standards for Evaluating Rehabilitation.

When considering the denial, suspension or revocation of a license based on the applicant's or licensee's conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating the applicant's or licensee's rehabilitation:

(a) The nature and the seriousness of the crime(s) under consideration.

(b) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(c) The time which has elapsed since commission of the crime(s) or conduct referred to in subdivision (a) or (b).

(d) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant.

(e) Any rehabilitation evidence submitted by the applicant.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 783.20. Bonds.

The amount of the Bond required in Section 1318 of the Health and Safety Code shall be in accordance with the following schedule:

(a) *Total Amount of Client Monies Handled Per Month*	*Amount of Bond Required*
$750 or less	$1,000
$751 to $1,500	$2,000
$1,501 to $2,500	$3,000

(b) Every further increment of $1,000 or fraction thereof shall require an additional $1,000 on the bond.

(c) Each application for an original license or renewal of license shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles, or will handle, money of clients and the maximum amount of money to be handled for:

(1) Any client.

(2) All clients in any month.

(d) No licensee shall handle money of a client or handle amounts greater than those stated in the affidavit submitted by him/her without first notifying the Department and filing a new or revised bond if requested.

(e) Charges for the surety company bond to handle client monies shall not be paid out of client monies.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 4. General Requirements

§ 784.00. Administration.

The licensee shall be responsible for compliance with licensing requirements and for the organization, management, operation and control of the licensed mental health rehabilitation center. The delegation of any authority by a licensee shall not diminish the responsibilities of the licensee. Written policies and procedures shall be established and implemented for each of the following:

(a) Administration and management of the mental health rehabilitation center.

(b) Personnel policies and procedures which include:

(1) Job descriptions detailing qualifications, duties and limitations of each classification of employee available to all personnel.

(2) Employee orientation to mental health rehabilitation center, job, client population, policies, procedures and staff.

(3) Employee benefits.

(4) Employee health and grooming.

(5) Verification of licensure, credentials and references.

(c) Policies and procedures for client admission, leave of absence, transfer, pass and discharge, categories of clients accepted and retained, rate of charge for services included in the basic rate, charges for extra services, limitations of services, cause for termination of services and refund policies applying to termination of services.

(d) Policies and procedures governing client records which include:

(1) Policies and procedures governing access to, duplication of, and dissemination of, information from client records.

(2) Policies and procedures to ensure the confidentiality of client information, in accordance with applicable laws and regulations.

(e) Procedures for reporting of unusual occurrences.

(f) A written organizational chart showing the major programs of the mental health rehabilitation center, the person in charge of each program, the lines of authority, responsibility and communication and the staff assignments.

(g) Restraint and seclusion policies and procedures.

(h) Informed consent to medical and psychiatric treatment policies and procedures.

(i) Infection control policies and procedures.

(j) Dietary services policies and procedures.

(k) Housekeeping services policies and procedures which include provision for maintenance of a safe, clean environment for clients, employees and the public.

(*l*) All policies and procedures required by these regulations shall be reviewed at least annually and revised as needed, and shall be made available upon request to physicians and involved mental health professionals, clients or their legal representatives, employees, and the public.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.10. Mental Health Rehabilitation Center Director and Staff.

Each mental health rehabilitation center shall employ or otherwise provide a mental health rehabilitation center director to be responsible for the administration and management of the mental health rehabilitation center. The qualifications, experience, skills and knowledge required of the individual identified as the mental health rehabilitation center director shall be established in writing. The director shall primarily be responsible for the administration and management of only one mental health rehabilitation center. Subject to Departmental approval, a director may be responsible for more than one mental health rehabilitation center.

(a) The licensee may act as the director or shall appoint a director. The licensee shall delegate to the designated director, in writing, authority to organize and manage the day–to–day functions of the mental health rehabilitation center. If the director is to be absent for more than 30 calendar days, the licensee shall appoint an acting director to be responsible for the day–to–day functions of the mental health rehabilitation center.

(b) A copy of the current mental health rehabilitation center regulations contained in this chapter shall be maintained by the director and shall be available to all personnel.

(c) The director shall be responsible for informing appropriate staff of the applicable additions, deletions and changes to mental health rehabilitation center regulations.

(d) The director shall be responsible for informing the Department, or its designee, via telephone within 24–hours of any unusual occurrence, as specified in Section 784.15. If the unusual occurrence involves the discontinuance or disruption of services occurring during other than regular business hours of the Department or its designee, a telephone report shall be made immediately upon the resumption of business hours of the Department.

(e) The licensee shall employ the number of qualified personnel needed to comply with all regulatory requirements and shall provide for an initial orientation of all new employees, a continuing in–service training program and supervision. The licensee shall ensure that consumers and family members of persons with mental disabilities have opportunities for employment, including employment as a peer counselor, in each mental health rehabilitation center operated by the licensee.

(f) If any language or communication barriers exist between mental health rehabilitation center staff and clients, arrangements shall be made for interpreters or for the use of other mechanisms to ensure adequate communication between clients and personnel.

(g) The Department reserves the right to require the licensee to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional personnel are needed to provide for the health and safety of clients.

(h) The licensee shall ensure that all employees serving clients or the public shall wear name and title badges.

(i) Each mental health rehabilitation center shall have an orientation program for all newly hired employees. Each new employee shall be provided 20 hours of initial orientation to the mental health rehabilitation center organization, administrative policies and procedures, and plan of operation during the first week of employment for full time employees and the first month for part time employees.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.11. Employee Personnel Records.

(a) Each licensee shall maintain current complete and accurate personnel records for all employees.

(1) The record shall include:

(A) Full name.

(B) Social Security Number.

(C) Professional license or registration number and date of expiration, if applicable.

(D) Employment classification.

(E) Information as to past employment and qualifications.

(F) Date of beginning employment.

(G) Date of termination of employment.

(H) Documented evidence of orientation to the mental health rehabilitation center and in–service training.

(I) Performance evaluations.

(2) Such records shall be retained for at least three (3) years following termination of employment. Employee personnel records shall be maintained in a confidential manner, and shall be made available to authorized representatives of the Department upon request.

(b) Records of hours and dates worked by all employees during at least the most recent 12–month period shall be kept on file at the place of employment or at a central location within the State of California. Upon request, such records shall be made available at a time and location specified by the Department.

(c) A permanent log of the temporary personnel employed in the mental health rehabilitation center shall be kept for three (3) years, and shall include the following:

(1) Employee's full name.

(2) Name of temporary services personnel agency.

(3) Professional license and registration number and date of expiration, if applicable.

(4) Verification of health status.

(5) Record of hours and dates worked.

(d) The above requirements do not apply to contract employees, with the exception of required professional licenses.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.12. Employees' Health Examination and Health Records.

(a) All employees working in the mental health rehabilitation center, including the licensee, shall have a health examination within 90 days prior to employment, or within seven (7) days after employment, and at least annually thereafter by a person lawfully authorized to perform such a procedure. Each such examination shall include a medical history and physical evaluation. The report signed by the examiner shall indicate that the person is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for self, fellow employees, clients, or visitors.

(b) The initial health examination and subsequent annual examination shall include a screening for tuberculosis. The procedure shall conform with the State Department of Health Services' public health tuberculosis screening standards and requirements for employees of health facilities. Satisfactory written evidence of a

tuberculosis screening within 90 days prior to employment shall be considered as meeting the intent of this section.

(c) The mental health rehabilitation center shall maintain a health record of the mental health rehabilitation center director and for each employee which includes reports of all employment–related health examinations. Such records shall be kept for a minimum of three years following termination of employment.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.13. Use of Outside Resources.

(a) If a mental health rehabilitation center does not employ qualified personnel to render a specific service to be provided by the mental health rehabilitation center, there shall be arrangements through a written agreement with outside resources which shall meet the standards and requirements of these regulations.

(b) Copies of affiliation agreements, contracts or written arrangements for advice, consultation, services, training or transportation, with other facilities, organizations or individuals, public or private agencies, shall be on file in the mental health rehabilitation center's administrative office. These shall be readily available for inspection and review by the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.14. Consumer Information to be Posted.

(a) The following consumer information shall be conspicuously posted in a prominent location accessible to the public.

(1) Name, license number and date of employment of the current director of the mental health rehabilitation center.

(2) A listing of all services and special programs provided in the mental health rehabilitation center and those provided through written contracts.

(3) The current and following week's menus for regular and therapeutic diets.

(4) A notice that the mental health rehabilitation center's written admission and discharge policies are available upon request.

(5) A notice that a copy of the most recent licensing visit report and related plan(s) of correction, if any, are available for public review, upon request.

(6) The names and addresses of all previous owners of the mental health rehabilitation center.

(7) A listing of all other mental health rehabilitation centers and other facilities owned by the same person, firm, partnership, association, or corporation.

(8) A statement that an action to revoke the mental health rehabilitation center's license is pending, if such an action has been initiated by the filing of an accusation, pursuant to Section 11503 of the Government Code, and the accusation has been served on the licensee.

(9) A notice of the name, address and telephone number of the Licensing and Certification office, Department of Mental Health, which has jurisdiction over the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.15. Unusual Occurrences.

(a) Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of clients, personnel or visitors shall be reported by the mental health rehabilitation center within 24–hours either by telephone (and confirmed in writing), by electronic or telephonic means, or by telegraph to the legal or authorized representative, local mental health director and the Department.

(1) An unusual occurrence report shall be retained on file by the facility for one year.

(2) The mental health rehabilitation center shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require.

(3) Every fire or explosion which occurs in or on the premises shall be reported within 24–hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

(b) Client deaths shall be reported by the licensee to the Department or its designee by no later than twenty–four (24) hours following a client death.

(c) An unusual occurrence report shall be in writing and shall include detailed information specific to the date, time and setting, description of client physical condition, staff response, and planned follow–up.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.16. Reporting of Communicable Diseases.

All cases of reportable communicable diseases shall be reported to the local health officer in accordance with, Article 1 (commencing with Section 2500), Subchapter 1, Chapter 4, Title 17, California Code of Regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.17. Infectious Diseases.

The facility shall adopt, observe and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as needed.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.18. Storage and Disposal of Solid Waste.

(a) Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either.

(b) Solid waste containers shall be stored and located in a manner that will minimize odors in client or dietary areas.

(c) Before being discarded into waste containers, syringes and needles shall be rendered unusable.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.19. Solid Waste Containers.

(a) All containers used by the mental health rehabilitation center, except movable bins used for storage of solid waste, shall have tight–fitting covers in good repair, external handles and be leakproof and rodent proof.

(b) Movable bins when used for storing or transporting solid waste from the premises shall have approval of the local health Department and shall meet the following requirements:

(1) Have tight–fitting covers, closed when not being loaded.

(2) Be in good condition.

(3) Be leakproof.

(4) Be rodent proof unless stored in a room or screened enclosure.

(c) All containers receiving putrescible wastes shall be emptied at least every four days, or more, if necessary.

(d) Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin shall be accessible and shall have a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.20. Infectious Waste.

Infectious waste, as defined in Section 117690 of the Health and Safety Code, shall be handled and disposed of in accordance with the Medical Waste Management Act, Chapter 2 of Part 14 of Division 104, Health and Safety Code (commencing with Section 117600).

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.21. Cleaning, Disinfecting and Sterilizing.

(a) Each facility shall have a written manual on cleaning, disinfecting and sterilizing procedures. The manual shall include procedures to be used in the care of utensils, instruments, solutions, dressings, articles and surfaces and shall be available for use by facility personnel. All procedures shall be carried out in accordance with the manual.

(b) Each facility shall make provision for the cleaning and disinfecting of contaminated articles and surfaces which cannot be sterilized.

(c) Individual client care supply items designed and identified by the manufacturer to be disposable shall not be reused.

(d) The facility shall provide for:

(1) Effective separation of soiled and contaminated supplies and equipment from clean and sterilized supplies and equipment.

(2) Clean cabinets for the storage of sterile supplies and equipment.

(3) An orderly system of rotation of supplies so that the supplies stored first shall be used first.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.22. Soiled Linen.

(a) Soiled linen shall be handled, stored and processed in a manner that will prevent the spread of infection.

(b) Soiled linens shall be sorted in a separate room by methods affording protection from contamination.

(c) Soiled linen shall be stored and transported in a closed container which does not permit airborne contamination of corridors and areas occupied by clients and precludes cross contamination of clean linen.

(d) When laundry chutes are used to transport soiled linen, they shall be maintained in a clean, sanitary state.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.23. Clean Linen.

(a) Clean linen shall be stored, handled and transported in a way that precludes cross–contamination.

(b) Clean linen shall be stored in clean, ventilated closets, rooms or alcoves, used only for that purpose.

(c) Clean linen from a commercial laundry shall be delivered to a designated clean area in a manner that prevents contamination.

(d) Linens shall not be threadbare and shall be maintained in good repair.

(e) A supply of linen shall be provided sufficient for not less than three complete bed changes for the mental health rehabilitation center's licensed capacity.

(f) A supply of clean wash cloths and towels shall be provided and available to staff to meet the care needs of the clients.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.24. Fire and Internal Disasters.

(a) A written fire and internal disaster plan incorporating evacuation procedures shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the plan shall be available on the premises for review by the staff and the Department.

(b) The written plan shall include at least the following:

(1) Procedures for the assignment of personnel to specific tasks and responsibilities.

(2) Procedures for the use of alarm systems and signals.

(3) Procedures for fire containment.

(4) Priority for notification of staff including names and telephone numbers.

(5) Location of fire–fighting equipment.

(6) Procedures for evacuation and specification of evacuation routes.

(7) Procedures for moving clients from damaged areas of the mental health rehabilitation center to undamaged areas.

(8) Procedures for emergency transfer of clients who can be moved to health facilities, including arrangements for safe and efficient transportation.

(9) Procedures for emergency discharge of clients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow–up inquiry within 24 hours to ascertain that clients are receiving their required care.

(10) A written disaster tag or note containing all pertinent personal and medical information to accompany each client who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining a record of client relocation.

(12) Procedures for handling incoming or relocated clients.

(13) Other provisions as dictated by circumstances.

(c) Fire and internal disaster drills shall be held at least quarterly, under varied conditions for each individual shift of the facility personnel. The actual evacuation of clients to safe areas during a drill is optional.

(d) The evacuation plan shall be posted throughout the mental health rehabilitation center and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

(4) Emergency telephone number of the local fire department.

(e) A dated, written report and evaluation of each drill and rehearsal shall be maintained and shall include signatures of all employees who participated.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.25. External Disaster and Mass Casualty Program.

(a) A written external disaster and mass casualty program plan shall be adopted and followed. The plan shall be developed with the advice and assistance of county or regional and local planning offices and shall not conflict with county and community disaster plans. A copy of the plan shall be available on the premises for review by the Department.

(b) The plan shall provide procedures in event of community and widespread disasters. The written plan shall include at least the following:

(1) Sources of emergency utilities and supplies, including gas, water, food and essential medical supportive materials.

(2) Procedures for assigning personnel and recalling off–duty personnel.

(3) Unified medical command; chart of lines of emergency authority in the mental health rehabilitation center.

(4) Procedures for the conversion of all usable space into areas for client observation and immediate care of emergency admissions.

(5) Prompt transfer of casualties when necessary and after preliminary medical services have been rendered, to the mental health rehabilitation center most appropriate for administering definitive

care. Procedures for moving clients from damaged areas of the mental health rehabilitation center to undamaged areas.

(6) Arrangements for provision of transportation of clients including emergency housing where indicated. Procedures for emergency transfers of clients who need to be moved to health care facilities, including arrangements for safe and efficient transportation and transfer information.

(7) Procedures for emergency discharge of clients who can be discharged without jeopardy into the community, including prior arrangements for their care, arrangements for safe and efficient transportation and at least one follow–up inquiry within 24 hours, to ascertain that clients are receiving required care.

(8) Procedures for maintaining a record of client relocation.

(9) An evacuation plan, including evacuation routes, emergency phone numbers of physicians, health facilities, the fire department and local emergency medical services agencies and arrangements for the safe transfer of clients after evacuation.

(10) A tag containing all pertinent personal and medical information which shall accompany each client who is moved, transferred, discharged or evacuated.

(11) Procedures for maintaining security in order to keep relatives, visitors and curious persons out of the mental health rehabilitation center during a disaster.

(12) Procedures for providing emergency care to incoming clients from other facilities.

(13) Assignment of public relations liaison duties to a responsible individual employed by the mental health rehabilitation center to release information to the public during a disaster.

(c) The plan shall be reviewed at least annually and revised as necessary to ensure that the plan is current. All personnel shall be instructed in the requirements of the plan. There shall be evidence in the personnel files, or the orientation checklist, indicating that all new employees have been oriented to the plan and procedures at the beginning of their employment.

(d) The mental health rehabilitation center shall participate in all local and state disaster drills and test exercises when asked to do so by the local or state disaster or emergency medical services agencies.

(e) A disaster drill shall be held by the mental health rehabilitation center at six (6)–month intervals. There shall be a written report of the mental health rehabilitation center's participation in each drill or test exercise. Staff from all shifts shall participate in drills or test exercises.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.26. Admission of Clients.

The licensee shall:

(a) Have and implement written admission and discharge policies encompassing which licensed mental health professionals can accept clients for admission to the facility, the types of diagnoses for which clients can be admitted, limitations imposed by law or licensure, and staffing limitations. These policies shall be made available to clients or their representatives upon admission, and shall be made available to the public upon request.

(b) Not admit or discharge a client on the basis of race, color, religion, ancestry or national origin. Any bonafide nonprofit religious, fraternal or charitable organization which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this subsection may establish admission policies limiting or giving preference to its own members or adherents and such policies shall not be construed as being in noncompliance with (d) below. Any admission of nonmembers or nonadherents shall be subject to (d) below.

(c) Admit clients who are 18 years of age or older, who are considered seriously and persistently mentally disabled, who otherwise would be placed in a state hospital or other mental health facility, and for whom such a setting is the least restrictive alternative available to meet their needs.

(d) Not admit any person who is nonambulatory, requires a level or levels of medical care not provided, who would be appropriately served by an acute psychiatric hospital, or who is diagnosed only with a substance abuse or eating disorder.

(1) For the purposes of this provision, nonambulatory means the inability to exit the mental health rehabilitation center unassisted under emergency conditions with reasonable accommodations. Every accommodation must be determined on a case–by–case basis, taking into consideration the mental health rehabilitation center's staffing level required pursuant to this chapter.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.27. Admission Records.

(a) For each client a mental health rehabilitation center shall complete an admission record which shall include the following:

(1) Name and Social Security Number.

(2) Current address.

(3) Age and date of birth.

(4) Sex.

(5) Date of admission.

(6) Name, address and telephone number of the legal or authorized authorized representative, person or agency responsible for client and next of kin.

(7) Name, address and telephone number of the practitioner who is primarily responsible for the treatment of the client.

(8) Admission diagnoses.

(9) Medicare and Medi–Cal numbers when appropriate.

(10) An inventory including but not limited to:

(A) Items of jewelry.

(B) Items of furniture.

(C) Radios, television and other appliances.

(D) Prosthetic and orthopedic devices.

(E) Other valuable items, so identified by the client, family or authorized representative.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.28. Clients' Records.

(a) Clients' records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all clients admitted or accepted for care. All health records of discharged clients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of seven (7) years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending physician, the mental health rehabilitation center staff or any authorized officer, agency, or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the clients' records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws.

(c) If a mental health rehabilitation center ceases operation, the Department shall be informed within three (3) business days by the licensee of the arrangements made for the safe preservation of the client's health records.

(d) The Department shall be informed within three business days, in writing, whenever client records are defaced or destroyed prior to expiration of the required retention period.

(e) If the ownership of the mental health rehabilitation center changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the new licensee shall have custody of the clients' records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the licensee for the safe preservation and the location of the clients' records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reason for the unavailability of such records.

(f) Clients' records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each client. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the record shall be authenticated with the date, name, and title of the persons making the entry.

(g) All current clinical information pertaining to clients' stay shall be centralized in clients' records.

(h) Clients' records shall be filed in an accessible manner in the mental health rehabilitation center or in health record storage. Storage of records shall provide for prompt retrieval when needed for continuity of care. Records can be stored off the mental health rehabilitation center premises only with the prior approval of the Department.

(i) Clients' records shall not be removed from the mental health rehabilitation center, except for storage after the client is discharged, unless expressly and specifically authorized by the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.29. Informed Consent to Medical Treatment.

(a) It is the responsibility of a physician to determine what information a reasonable person in the client's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. The disclosure of any material information and obtaining informed consent shall be the responsibility of the a physician.

(b) Informed consent must include a verbal explanation by a physician of the client's right to refuse or accept medical treatment. It must include a written consent form signed by the client indicating the above information has been given. The signed consent form is to be obtained and kept in the client's record as specified in Sections 851 and 852.

(c) No medical treatment may be administered to a client without informed consent except in an emergency situation as defined by Section 853 or circumstances otherwise authorized by law.

(d) The client has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time. Licensed mental health professionals or licensed nursing staff shall verify that the client's health record contains documentation that the client has given informed consent to the proposed treatment or procedure.

(e) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(f) Treatment may be initiated without informed consent if there is documentation within the client's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the client or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in this section, or that is determined by the physician not to require the disclosure of information material to the individual client. Routine nursing care includes, but is not limited to, care that does not require the order of a physician. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the client or incapacitated client's legal representative may revoke his or her consent at any time.

(h) If a client or his or her legal representative cannot communicate with the physician because of language or communication barriers, the mental health rehabilitation center shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the client and his or her legal representative, or someone who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, they shall be physically present and documentation shall be placed in the client record indicating the name of the person who acted as the interpreter and his or her relationship to the client and to the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.30. Temporary Medical Client Transfer.

The licensee shall maintain written transfer agreements with health or other facilities to make the services of those facilities accessible to the mental health rehabilitation center clients. Complete and accurate client information, in sufficient detail to provide for continuity of care, shall be transferred with the client at time of transfer.

(a) When a client is transferred to another facility or setting, the following shall be entered in the client record:

(1) The date, time, condition of the client and a written statement of the reason for the transfer.

(2) Informed written or telephone acknowledgment of the transfer by the client or legal representative except in an emergency as provided in subsection 784.29(f).

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.31. Clients' Rights.

(a) Clients served by a mental health rehabilitation center shall have all the rights guaranteed pursuant to Section 5325 of the Welfare and Institutions Code, a list of which shall be prominently posted in English, Spanish and any other language representing at least five percent of the county population in which the mental health rehabilitation center is located.

(b) Any denial of clients' rights in a mental health rehabilitation center must be for good cause and be in accordance with the requirements included in Sections 860 through 865.5.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.32. Safeguards for Clients' Monies and Valuables.

(a) Each mental health rehabilitation center to whom a clients' monies or valuables have been entrusted shall comply with the following:

(1) No licensee shall commingle clients' monies or valuables with that of the licensee or the mental health rehabilitation center. Clients' monies and valuables shall be maintained separately, intact and free from any liability that the licensee incurs in the use of the licensee's or the mental health rehabilitation center's funds. The provisions of this section shall not be interpreted to preclude prosecution for the fraudulent appropriation of clients' monies or valuables as theft, as defined by Section 484 of the Penal Code.

(2) Each licensee shall maintain safeguards and accurate records of clients' monies and valuables entrusted to the licensee's care including the maintenance of a detailed inventory and at least a quarterly accounting of financial transactions made on clients' behalf.

(A) Records of clients' monies which are maintained as a drawing account shall include a control account for all receipts and expenditures, supporting vouchers and receipts for all expenditures of monies and valuables entrusted to the licensee, an account for each client and supporting vouchers filed in chronological order. Each account shall be kept current with columns for debits, credits and balance. All of these records shall be maintained at the mental health rehabilitation center for a minimum of three years from the date of transaction. At no time may the balance in a client's drawing account be less than zero.

(B) Records of clients' monies and other valuables entrusted to the licensee for safekeeping shall include a copy of the receipt furnished to the client or to the client's authorized representative. Each item of client property entrusted to the licensee shall be clearly identified as belonging to that client.

(3) Clients' monies not kept in the mental health rehabilitation center shall be deposited in a demand trust account in a local bank authorized to do business in California, the deposits which are insured by the Federal Deposit Insurance Corporation, or in a federally insured bank or savings and loan association under a plan approved by the Department. If a facility is operated by a county, such funds may be deposited with the county treasurer. All banking records related to these funds, including but not limited to deposit slips, checks, cancelled checks, statements and check registers, shall be maintained in the mental health rehabilitation center for a minimum of three years from the date of transaction. Identification as a client trust fund account shall be clearly printed on each client's trust account checks and bank statements.

(4) A separate list shall be maintained for all checks from client funds which are, or have been, outstanding for 45 days or more as reflected on the most recent bank statement. Bank statements shall be reconciled monthly with copies of the reconciliation maintained by the mental health rehabilitation center. Any checks on such accounts written off or uncashed shall result in an addition to the appropriate client's account.

(5) Expenditures, for a particular client, from the client fund account as specified in (3) above may not exceed the drawing right that the client has in the account. Expenditures from the client fund account shall only be for the immediate benefit of that particular client. No more than one month's advance payment for care may be received from a client's account.

(6) A person, firm, partnership, association or corporation which is licensed to operate more than one mental health rehabilitation center shall maintain a separate demand trust account as specified in (3) above for each such mental health rehabilitation center. Records relating to these accounts shall be maintained at each mental health rehabilitation center as specified in (2) above. Client funds from one mental health rehabilitation center shall not be mingled with funds from another mental health rehabilitation center.

(7) When the amount of clients' money entrusted to a licensee exceeds $500, all money in excess of $500 shall be deposited in a demand trust account as specified in (3) above unless the licensee provides a fireproof safe and the licensee desires the protection accorded by Section 1860 of the Civil Code.

(8) Upon discharge of the client, all money and valuables of that client which have been entrusted to the licensee and kept within the mental health rehabilitation center shall be surrendered to the client or authorized representative in exchange for a signed receipt. Monies in a demand trust account or with the county treasurer shall be surrendered to the client or authorized representative in exchange for a signed receipt. Monies in a demand trust account or with the county treasurer shall be made available within three (3) normal banking days. Upon discharge, the client or authorized representative shall be given a detailed list of personal property and a current copy of the debits and credits of the client's monies.

(9) Within 30 days following the death of a client, except in a coroner or medical examiner case, all money and valuables of that client which have been entrusted to the licensee shall be surrendered to the person responsible for the client or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a client without known heirs dies, immediate notice, shall be given by the facility to the public administrator of the county as specified by Section 7600.5 of the California Probate Code and documentation of this notice shall be available in the mental health rehabilitation center for review by the Department.

(10) Upon change of ownership of a mental health rehabilitation center, there shall be a written verification by a certified public accountant of all clients' monies which are being transferred to the custody of the owner(s). A signed receipt for the amount of funds in the client's trust account shall be given by the new owner to the previous owner.

(11) Upon closure of a mental health rehabilitation center, a written verification by a public accountant of all clients' funds shall be available for review by the Department. Each client's funds shall be transferred with the client.

(b) If property is purchased for use of more than one client, from client trust funds, the mental health rehabilitation center shall secure a written agreement between all clients whose funds are used, or their authorized representatives. The agreement shall expressly acknowledge consent of all parties and shall provide for disposition of the property in the event of disagreements, discharge, transfer or death.

(c) No licensee, owner, program director, employee or their immediate relative or representative of the aforementioned may act as an authorized representative of clients' funds or valuables, unless the client is a relative within the second degree of consanguinity.

(d) The mental health rehabilitation center shall make reasonable efforts to safeguard clients' property and valuables that are in possession of the client.

(e) For purposes of this section, clients' funds maintained in a financial institution shall be deemed to be entrusted to a mental health rehabilitation center if the licensee, or any agent or employee thereof, is an authorized signatory to said account. Records maintained and provided by the financial institution in accordance with a plan which has obtained the written approval of the Department, may fulfill the obligation of the mental health rehabilitation center with regard to the maintenance of records for such funds.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.33. Liability for Rent and Return of Rental Advance.

(a) Whenever accommodations in a mental health rehabilitation center are rented by, or for, a client on a month–to–month basis, the renter or his heir, legatee or personal representative shall not be liable for any rent due under the rental agreement for accommodations beyond the date on which the client died.

(b) Any advance of rent by the renter shall be returned to the heir, legatee or personal representative of the client no later than two weeks after discharge or death of the client.

(c) The rights described in (a) and (b) above shall not be modified or waived in the rental agreement.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.34. Abuse and Corporal Punishment.

Clients shall not be subjected to verbal or physical abuse of any kind. Corporal punishment of clients is prohibited. Clients shall not discipline other clients.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.35. Restraint and Seclusion.

(a) Restraint and seclusion shall not be used except when necessary to prevent immediate injury to the person or others, and only when there is no less restrictive method to prevent injurious behavior. Restraint and seclusion shall not be used as punishment or for the convenience of the staff, or as a substitute for less restrictive alternate forms of treatment. Clients will be released when they no longer meet the criteria for seclusion or restraint.

(b) Restraint or seclusion shall not be initiated absent the documentation of a separate justification for each intervention.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.36. Orders for Restraint and Seclusion.

(a) Restraint or seclusion shall only be used as authorized by the order of a physician or psychologist within the scope of their license. Those orders shall include the reason for the restraint or seclusion in specific behavioral terms, date and time of the order, specific behaviors that would demonstrate that the person no longer requires seclusion or restraint to prevent immediate injury to self or others, and the orders may be implemented only within the scope of the license of those implementing the orders.

(1) For restraint, the order shall also include the type of restraint and the number of points.

(2) Orders for seclusion or restraint shall not exceed 24–hours in duration.

(b) An order for restraint or seclusion shall be issued only if it is determined that indication for use of restraint or seclusion outweigh medical risks to the person.

(c) At the time restraint or seclusion is initiated, or as soon as practical, but in every case within one (1) hour, information regarding the client's medical condition, including but not limited to, vital signs, medications, current medical treatments and any relevant medical circumstances specific to the client shall be reviewed by an on–duty member of the licensed nursing staff, or the documentation of the reason(s) it was not safe to conduct this evaluation.

(d) In a clear case of emergency, when a physician or psychologist is not available and reasonable less restrictive behavior interventions have been attempted or considered, a client may be placed in restraint or seclusion at the discretion of a licensed nursing staff. A confirming telephone order from a physician or psychologist must be obtained within one (1) hour of the time of the occurrence.

(e) Orders for restraint and seclusion shall not be written on a standing or as needed basis.

(f) Telephone orders for restraint or seclusion must be signed and dated within no longer than five days following the date of issue of the order.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.37. Restrictions on Applying Restraints and Utilizing Seclusion.

(a) Every four (4) hours, when a person is secluded or restrained, the medical director, a physician, a psychologist, a member of the licensed nursing staff or a licensed mental health professional designated by the mental health rehabilitation center director, shall in person assess the client's clinical condition face–to–face and determine if the client meets the criteria for continued restraint or seclusion, and whether the indications for its use outweigh the clinical risks to the person.

(b) As soon as practicable after restraint or seclusion has been initiated both of the following shall take place and be noted in the client's record;

(1) Reasonable attempts to explain to the client the justification for the restraint or seclusion and the types of behaviors that would demonstrate that the client meets the criteria for release.

(2) Inform the client regarding nursing care he or she is entitled to while in restraint or seclusion, and the manner and frequency of assessment for release.

(c) Client's in restraint or seclusion shall be provided all of the following:

(1) Timely and appropriate nursing and medical care and attention to their physical condition, including vital signs at least once per shift, not to exceed eight (8) hours, or more often if indicated by the client's condition.

(2) Regular observation and assessment, which shall include a determination of whether the client meets the criteria for release by authorized staff members, at least every 15 minutes.

(3) The observation and assessment shall include face–to–face interaction with the client unless the staff member determines that it is inappropriate or unnecessary to assure that the client is not in distress.

(4) Regular range of motion exercise of at least 10 minutes every two (2) hours of restraint. When range of motion is not appropriate, a physician or a psychologist shall document the reason in the client's record.

(5) The client shall be repositioned when appropriate.

(6) Prompt and appropriate response to all requests made for assistance and services.

(7) Attention to feeding, hydration, bathing, and toileting needs.

(8) A clean and comfortable environment.

(d) The client shall be released at the time he or she no longer meets the criteria for restraint or seclusion.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.38. Restraint and Seclusion—Documentation and Reporting Policies and Procedures.

(a) Care provided to a client in restraint or seclusion shall be documented in the client record.

(1) The policies and procedures of the mental health rehabilitation center shall describe the manner in which this documentation shall be entered in the client record.

(2) Notations, check marks, and flow charts are allowable if the chart provides opportunity for narrative descriptions by staff, when appropriate, and when sufficient to provide all the necessary information.

(b) The documentation shall include, but not be limited to, all of the following:

(1) Clinical condition, circulation, condition of limbs, and attention to hydration, elimination, and nutrition needs.

(2) Behavioral assessments.

(3) Justification for continued use of restraint or seclusion, the types of behaviors that would facilitate release and evidence that this information was communicated to the client, along with his or her response, if any.

(4) Time placed in and time removed from restraint or seclusion.

(5) 15–minute observations and assessments.

(6) When face–to–face interaction does not occur, documentation of the reason why that interaction was inappropriate or unnecessary and what alternative means were used to determine the client was not in distress.

(c) Quarterly, any facility that uses restraint or seclusion shall report to the local mental health director or designee, who shall transmit copies to the Department, all of the following:

(1) The number of restraint or seclusion incidents, or both.

(2) The number of restraint or seclusion incidents according to age, sex, race and primary diagnosis.

(3) The client's age shall be classified as one of the following:

(A) Age 18 to 64 years, inclusive, and

(B) Age 65 and over.

(d) Facilities that use restraint or seclusion, or both, shall have

written policies and procedures concerning their use. These policies shall include the standards and procedures for all of the following:

(1) Placement of a person in restraint or seclusion, including a list of less restrictive alternatives, the situations in which the use of restraint or seclusion is to be considered and the physician(s) and psychologist(s) who can order its use.

(2) Assessment and release, including guidelines for duration of use of specific behavioral criteria for release.

(3) Provision of nursing care and medical care, including the administration of medication.

(4) Procedures for advocate notification regarding any client restrained or secluded for more than eight (8) hours.

(5) Provision of staff training.

(e) Facilities that use restraint or seclusion shall implement an oversight process to ensure that all incidents of seclusion and restraint are reviewed and that any incidents or patterns of use which do not comply with the mental health rehabilitation center's policies and procedures or other clinical or legal standards are investigated. This oversight process shall ensure that appropriate policies and procedures are developed and implemented, including training of staff. Consumer input into the oversight process shall be incorporated.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.39. Client Capacity.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.40. Client Rooms.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.41. Client's Property Storage and Room Furnishings.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.42. Housekeeping.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.43. Laundry.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.44. Clean Linen.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.45. Soiled Linen.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.46. General Maintenance.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.47. Air Filters.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.48. Storage and Disposal of Solid Waste.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.49. Solid Waste Containers.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.50. Infectious Waste.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.51. Water Supply and Plumbing.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.52. Lighting and Power System.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.53. Maintenance Manual.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.54. Mechanical Systems.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.55. Space.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 784.56. Administrative Policies and Procedures.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 5. Basic Services

§ 785.00. Services—General.

(a) Mental health rehabilitation centers shall provide, at a minimum, the following basic services; physician, nursing, pharmaceutical, and dietary services.

(b) If a service cannot be brought into the mental health rehabilitation center, the mental health rehabilitation center shall assist the client in arranging for transportation to and from a service location.

(c) The mental health rehabilitation center shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated.

(d) Each client shall be encouraged and assisted to achieve and maintain the highest level of self–care and independence. Every effort shall be made to keep clients active, and out of bed for reasonable periods of time, except when contraindicated by physician's orders.

(e) Each client shall be provided with good nutrition and with necessary fluids for hydration.

(f) The weight and height of each client shall be taken and recorded in the client record upon admission, and the weight shall be taken and recorded once a month thereafter.

(g) Each client shall be provided visual privacy during treatment and personal care.

(h) Each client shall be screened for tuberculosis upon admission. The procedure shall conform with the State Department of Health Services public health tuberculosis screening standards and requirements. A tuberculosis screening may not be required if there

is satisfactory evidence available that a tuberculosis screening has been completed within 90 days prior to the date of admission to the mental health rehabilitation center. Subsequent tuberculosis screening procedures shall be determined by a physician.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.10. Medical Director.

(a) The mental health rehabilitation center shall have a physician designated as the medical director who shall be responsible for standards, coordination, surveillance and planning for improvement of medical care in the mental health rehabilitation center.

(b) The medical director shall:

(1) Act as a liaison between administration and other physicians.

(2) Be responsible for reviewing and evaluating administrative and client care policies and procedures.

(3) Act as a consultant to the director of nursing service in matters relating to client care services.

(4) Be responsible for reviewing employees' preemployment and annual health examination reports.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.11. Physician Services—General.

(a) Physician services shall be provided by physicians who are under contract with the mental health rehabilitation center or have been chosen by the client, or the client's legal or authorized representative to direct the client's medical care.

(b) Physician services shall include, but are not limited to:

(1) Client evaluation including a written report of a physical examination within 72 hours following admission, unless a physical has been completed within 30 days prior to admission.

(2) An evaluation of the client and review of orders for care and treatment on change of physicians.

(3) Advice, treatment and determination of appropriate level of care needed for each client.

(4) Written and signed orders for diet, care, diagnostic tests and treatment of clients by others.

(A) Orders for seclusion and restraint shall meet the requirements of Sections 784.36 and 784.38.

(B) Orders for denial of clients' rights shall meet the requirements of Sections 784.31.

(5) Health care progress notes and other appropriate entries in the client record.

(c) Nonphysician practitioners may be permitted to render those medical services which they are legally authorized to perform.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.12. Nursing Service—General.

(a) Licensed nursing staff shall perform the following nursing services within the scope of their license; services shall include, but not be limited to, the following:

(1) Planning of client care which shall include at least the identification of care needs based upon an initial written and continuing evaluation of the client's needs with input, as necessary, from health professionals involved in the care of the client. Initial evaluation shall commence at the time of admission of the client and be completed within seven (7) days after admission.

(2) Implementing of each client's care plan according to the methods indicated which shall include at a minimum, initial assessment and documentation, ongoing evaluations and documentation, and preparing for and attending client care plan conferences.

(3) Ensuring that clients are served the diets as prescribed by physicians.

(4) Obtaining and documenting physician orders for medical care, appointments and laboratory work–ups or tests, administration of medications including PRN (pro rae natae) and immediately authorized or emergency (STAT) medications.

(5) Monitoring of clients' height and weight, and vital signs.

(6) Implementation and evaluation of quality assurance policies and procedures addressing client care.

(7) Writing, review and sign off of weekly progress notes.

(8) Notifying the physician promptly of:

(A) The admission of a client.

(B) Any sudden marked adverse change in signs, symptoms or behavior exhibited by a client.

(C) An unusual occurrence involving a client, as specified in Section 784.15.

(D) A change in weight of five pounds or more within a 30–day period unless a different stipulation has been stated in writing by the client's physician.

(E) Any adverse response or reaction by a client to a medication or treatment.

(F) Any error in the administration of a medication or treatment to a client which is life threatening and presents a risk to the client.

(G) The mental health rehabilitation center's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the client.

(H) All attempts to notify physicians shall be noted in the client's record including the time and method of communication and the name of the person acknowledging contact, if any. If the physician is not readily available, arrangements for emergency medical care shall be completed.

(b) Unlicensed staff services that can be provided by either rehabilitation or activity program staff as specified in Sections 786.12(c) and 786.19(a) shall be supervised and monitored by licensed nursing staff, and may include the following:

(1) Assisting clients with dressing, grooming, bathing and other personal hygiene related activities.

(2) Taking and recording of clients' height and weight and vital signs.

(3) Assisting clients with getting and eating meals.

(4) Based on established nursing service procedure(s), monitor and report on clients' whereabouts and status when in their room or elsewhere in the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.13. Nursing Service—Administration of Medication and Treatment.

(a) Medication and treatment shall be administered as follows:

(1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such order.

(2) Medication and treatment shall be administered as prescribed.

(3) Tests and taking of vital signs, upon which administration of medication or treatment are conditioned, shall be performed as required and the results recorded.

(4) Preparation of doses for more than one scheduled administration time shall not be permitted, except for self–medication in which medications should be prepared for up to 7 days in advance.

(5) All medication and treatment shall be administered only by licensed medical or licensed nursing personnel.

(6) Medication shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(7) Clients shall be identified prior to administration of a drug or treatment.

(8) Drugs may be administered in the absence of a specific duration of therapy on a licensed prescriber's new drug order if the mental health rehabilitation center applies its stop–order policy for such drugs. The prescriber shall be contacted prior to discontinuing therapy as established by stop–order policy.

(b) No medication shall shall be used for any client other than the client for whom it was prescribed.

(c) The time and dose of the medication or treatment administered to the client shall be recorded in the client's individual medication record by the person who administers the drug or treatment. Recording shall include the date, the time and the dosage of the medication or type of the treatment. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.14. Nursing Service—Director of Nursing Service.

(a) The director of nursing service shall be a registered nurse and shall be employed 40 hours per week.

(b) The director of nursing service shall have at least one year of experience in nursing supervision within the last five (5) years.

(c) The director of nursing service shall have, stated in writing, administrative authority, responsibility and accountability for the nursing services within the mental health rehabilitation center and serve only one facility in this capacity at any one time if the mental health rehabilitation center is 42 beds or more.

(d) The director of nursing service shall not have charge nurse responsibilities if the mental health rehabilitation center is 42 beds or more.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.15. Nursing Service—Staff.

(a) Nursing service staff shall be employed, present in the mental health rehabilitation center, awake and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for clients admitted for care.

(1) Each mental health rehabilitation center shall provide for the full time equivalent of nursing staff for the provision of nursing services, as follows:

(A) At a minimum, one licensed nursing staff awake and on duty in the mental health rehabilitation center, at all times, day and night.

(B) For mental health rehabilitation centers of 42 beds or more, 0.6 hours of licensed nursing staff and 0.6 hours of unlicensed staff hours for each client during each 24–hour period, on a seven day (weekly) basis.

(C) For mental health rehabilitation centers with 41 beds or less, the number of licensed nursing staff and unlicensed nursing staff hours for each client shall be provided as specified in (a)(1)(A) above.

(b) Nursing service charge staff on all shifts shall have at least one year of experience or training related to mental health rehabilitation programs, or shall participate in in–service training provided by the facility.

(c) A licensed psychiatric technician may:

(1) Serve as a charge nurse.

(2) Administer medications in a mental health rehabilitation program.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.16. Dietetic Service—General.

(a) The total daily diet for clients shall be of the quality and in the quantity to meet the needs of the clients and shall meet the "Recommended Dietary Allowances", 10th Edition (1989), adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Science, adjusted to the age, activity and environment of the group involved. All food shall be of good quality and be selected, stored, prepared and served in a safe and healthful manner. The following shall apply:

(1) Arrangements shall be made so that each client has available at least three meals per day. Not more than 14 hours shall elapse between the last and first meal.

(2) Client food preferences shall be adhered to as much as possible and shall be from appropriate food groups.

(3) A mental health rehabilitation center shall either purchase, store and prepare the required food for its clients, or it shall purchase prepared meals from other appropriate sources, through a written contract.

(4) Between–meal feeding shall be provided as required by a diet order. Bedtime nourishments shall be made available unless contraindicated.

(5) A person shall be designated by the mental health rehabilitation center director to be responsible for the management and operation of the food service.

(A) This may be provided by a full–time or part–time employee with the mental health rehabilitation center, or through a written contract with an outside supplier or food service.

(B) If this person is not a dietitian, provision shall be made for consultation from a person so qualified, who shall provide this consultation at least four (4) hours every (3) three months.

(C) If the total food service is by contract, a staff member will be designated to monitor the operation of the food service within the mental health rehabilitation center.

(6) If clients participate in food preparation and/or service to the client population as part of their individual service plan, they shall comply with the same policies and procedures as those required for food service personnel.

(7) Supplies of staple foods for a minimum of two days shall be maintained on the premises.

(8) The mental health rehabilitation center shall maintain a written plan to provide clients' food service in emergencies.

(9) Provisions shall be made to provide clients with access to beverages and nourishments at times when the main food service is not in operation.

(b) All kitchen equipment, fixed or mobile, and dishes shall be kept clean and maintained in good condition and free from breaks, open seams, cracks or chips.

(c) All utensils used for eating and drinking and in the preparation of food and drink shall be clean and sanitized after each usage.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.17. Dietetic Service—Therapeutic Diets.

Therapeutic diets shall be provided for each client as prescribed and shall be planned, prepared and served with supervision or consultation from the dietitian.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.18. Dietetic Service—Menus.

(a) Menus for regular and therapeutic diets shall be written at least one week in advance, dated and posted in a conspicuous place in the mental health rehabilitation center and in the kitchen at least one week in advance.

(b) All menus shall be approved by the dietician.

(c) If any meal served varies from the planned menu, the change and the reason for the change shall be noted in writing on the posted menu in the kitchen.

(d) Menus shall provide a variety of foods and indicate standard portions at each meal. Menus shall be varied for the same of consecutive weeks. If a cycle menu is used, the cycle shall be of no less than three weeks duration and shall be revised quarterly.

(e) Menus shall be adjusted to include seasonal commodities.

(f) Menus shall be planned with consideration of cultural background and food habits of clients.

(g) A copy of the menu as served shall be kept on file for at least one year.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.19. Dietetic Service—Staff.

(a) Sufficient staff shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the clients and to maintain the dietetic service areas.

(b) Current work schedules by job titles and weekly time schedules by job titles shall be posted.

(c) Dietetic service personnel shall be trained in basic food sanitation techniques, wear clean clothing, and a cap or a hair net, and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

(d) Under supervision, clients may assist in cooking/kitchen activities as part of their skills training program.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.20. Pharmaceutical Service—General.

(a) Arrangements shall be made with pharmacists licensed by the California Board of Pharmacy to ensure that pharmaceutical services are available to provide clients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage and administration of drugs and biologicals shall be in conformance with state and federal laws.

(c) The mental health rehabilitation center shall not accept money, goods or services free or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.21. Pharmaceutical Service—Requirements.

(a) Pharmaceutical service shall include, but not be limited to, the following:

(1) Obtaining necessary drugs including the availability of 24–hour prescription service on a prompt and timely basis as follows:

(A) Drugs ordered "Stat" that are not available in the mental health rehabilitation center emergency drug supply shall be available and administered within one (1) hour of time ordered during normal pharmacy hours of a local drug store or hospital. For those hours during which a local drug store or hospital pharmacy is closed, drugs ordered "Stat" shall be available and administered within two hours of the time ordered. Drugs ordered "Stat" which are available in the emergency drug supply shall be administered immediately.

(B) Anti–infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered four (4) hours of the time ordered.

(C) Except as indicated above, all new drug orders shall be available on the same day ordered unless the drug would not normally be started until the next day.

(D) Refill of prescription drugs shall be available when needed.

(2) Dispensing of drugs and biologicals.

(3) Monitoring the drug distribution system which includes ordering, dispensing and administering of medication.

(4) Provision of consultative and other services furnished by pharmacists which assist in the development, coordination, supervision and review of the pharmaceutical services within the facility.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.22. Pharmaceutical Service—Labeling and Storage of Drugs.

(a) Containers which are cracked, soiled or without secure closures shall not be used. Drug labels shall be legible.

(b) All drugs obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing. No person other than the dispenser of the drug shall alter any prescription label.

(c) Nonlegend drugs shall be labeled in conformance with state and federal food and drug laws.

(d) Test reagents, germicides, disinfectants and other household substances shall be stored separately from drugs and shall not be accessible to clients.

(e) External use drugs in liquid, table, capsule or powder form shall be stored separately from drugs for internal use.

(f) Drugs shall be stored in appropriate temperatures. Drugs required to be stored at room temperature shall be stored at a temperature between 15ºC (59ºF) and 30ºC (86ºF). Drugs requiring refrigeration shall be stored in a refrigerator between 2ºC (36ºF) and 8ºC (46ºF). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed container clearly labeled "drugs."

(g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.

(h) Dose preparation and administration areas shall be well lighted.

(i) Drugs shall be accessible only to personnel designated in writing by the licensee.

(j) Storage of nonlegend drugs at the bedside shall meet the following conditions:

(1) The manner of storage shall prevent access by other clients. Lockable drawers or cabinets need not be used unless alternate procedures, including storage on a client's person or in an unlocked drawer or cabinet, are ineffective.

(2) The mental health rehabilitation center shall record in the client's health record the bedside medications used by the client, based on observation by nursing personnel and/or information supplied by the client.

(3) The quantity of each drug supplied by the client for bedside storage shall be recorded in the health record each time the drug is so supplied.

(k) Storage of legend drugs at the bedside shall meet the conditions of (a) through (j) above, and shall in addition:

(1) Be specifically ordered by the prescriber of the drugs, and

(2) Be limited to sublingual or inhalation forms of emergency drugs.

(*l*) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

(m) The drugs of each client shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

(n) Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within 90 days of the date the drug order was discontinued, unless the drug is reordered within that time.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.23. Pharmaceutical Service—Stop Orders.

Written policies shall be established and implemented limiting the duration of new drug orders in the absence of a prescriber's specific indication for duration of therapy. The prescriber shall be contacted for new orders prior to the termination time established by the policy. These policies shall include all categories of drugs.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.24. Pharmaceutical Service—Orders for Drugs.

(a) No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.

(b) All drug orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The name, quantity or specific duration of therapy, dosage and time or frequency of administration of the drug, and the route of administration if other than oral shall be specific. "P.R.N." order shall also include the indication for use of a drug.

(c) Verbal orders for drugs and treatments shall be received only by licensed nurses, psychiatric technicians, pharmacists, physicians, physicians' assistants from their supervising physicians only, and certified respiratory therapists when the orders relate specifically to respiratory care. Such orders shall be recorded immediately in the client's health record by the person receiving the order and shall include the date and time of the order. The order shall be signed by the prescriber within five days.

(d) The signing of orders shall be by signature or a personal computer key. Signature stamps shall not be used.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.25. Pharmaceutical Service—Drug Order Processing.

Signed orders for drugs shall be transmitted to the issuing pharmacy within 48 hours, either by written prescription of the prescriber or by an order form which produces a direct copy of the order, or by an electronically reproduced facsimile.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.26. Pharmaceutical Service—Personal Medications.

(a) Facilities shall maintain a record which includes, for each drug ordered by prescription, the name of the client, the drug name, and strength, the date ordered, the date and amount received and the name of the issuing pharmacy. The records shall be kept at least one year.

(b) Medications brought by or with the client on admission to the mental health rehabilitation center shall not be used unless the contents of the containers have been examined and positively identified after admission by the client's physician or a pharmacist retained by the mental health rehabilitation center.

(c) The mental health rehabilitation center may use drugs transferred from other licensed facilities or those drugs dispensed or obtained after admission from any licensed or governmental pharmacy and may accept the delivery of those drugs by any agency of the client or pharmacy without the necessity of identification by a physician or pharmacist.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.27. Pharmaceutical Service—Controlled Drugs.

(a) Drugs listed in Schedules II, III, and IV of the Federal Comprehensive Drug Abuse Prevention and Control Action of 1970 shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the licensee. Drugs listed in Schedule II of the above Act shall be stored in a locked cabinet or a locked drawer, separate from noncontrolled drugs, unless they are supplied on a scheduled basis as part of a unit dose medication system.

(b) Separate records of use shall be maintained on all Schedule II drugs. Such records shall be maintained accurately and shall include the name of the client, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug. Such records shall be reconciled at least daily and shall be retained at least one year. If such drugs are supplied on a scheduled basis as part of a unit dose medication system, such records need not be maintained separately.

(c) Drug records shall be maintained for drugs listed in Schedules III and IV of the above Act in such a way that the receipt and disposition of each dose of any such drug may be readily traced. Such records need not be separate from other medication records.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.28. Pharmaceutical Service—Disposition of Drugs.

(a) Drugs which have been dispensed for individual client use and are labeled in conformance with state and federal law for outpatient use shall be furnished to clients on discharge on the orders of the discharging physician. If the physician's discharge orders do not include provisions for drug disposition, drugs shall be furnished to clients unless:

(1) The discharging physician specifies otherwise, or

(2) The client leaves or is discharged without a physician's order, or approval, or

(3) The client is discharged to a general acute care hospital, acute psychiatric hospital, or acute care rehabilitation hospital, or

(4) The drug was discontinued prior to discharge, or

(5) The labeled directions for use are not substantially the same as most current orders for the drug in the client's health record.

(b) A record of the drugs sent with the client shall be made in the client's health record.

(c) Client's drugs supplied by prescription which have been discontinued and those which remain in the mental health rehabilitation center after discharge of the client shall be destroyed by the mental health rehabilitation center in the following manner:

(1) Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the facility in the presence of a pharmacist and a registered nurse employed by the mental health rehabilitation center. The name of the client, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the client's health record or in a separate log. Such log shall be retained for at least three (3) years.

(2) Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the mental health rehabilitation center in the presence of a pharmacist or licensed nurse. The name of client, the name and strength of the drug, the prescription number if applicable, the amount destroyed, the date of destruction and the signatures of the person named above and one other person shall be recorded in the client's health record or in a separate log. Such log shall be retained for at least three (3) years.

(d) Unless otherwise prohibited under applicable federal or state laws, individual client drugs supplied in sealed containers may be returned if unopened, to the issuing pharmacy for disposition provided that:

(1) No drugs covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 are returned.

(2) All such drugs are identified as to lot or control number.

(3) The signatures of the receiving pharmacist and a registered nurse employed by the mental health rehabilitation center are recorded in a separate log which lists the name of the client, the name, strength, prescription number (if applicable), the amount of the drug returned and the date of return. The log must be retained for at least three (3) years.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.29. Pharmaceutical Service—Unit Dose Medication System.

In facilities utilizing a unit dose medication system, there shall be at least a 24–hour supply of client medications on hand at all times, except those drugs that are to be discontinued within the 24–hour period. Drugs that are part of a unit dose medication system shall not exceed a 30 day supply.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.30. Pharmaceutical Service—Staff.

(a) Mental health rehabilitation centers shall retain a consulting pharmacist who devotes a sufficient number of hours during a regularly scheduled visit, for the purpose of coordinating, supervising and reviewing the pharmaceutical service committee, or its equivalent, at least quarterly. The report shall include a log or record of time spent in the mental health rehabilitation center. There shall be a written agreement between the pharmacist and the mental health rehabilitation center which includes duties and responsibilities of both.

(b) A pharmacist shall review the drug regimen of each client at least monthly and prepare appropriate reports. The review of the drug regimen of each client shall include all drugs currently ordered, information concerning the client's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes, and laboratory test results. The pharmacists shall be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the mental health rehabilitation center director and director of the nursing service.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.31. Pharmaceutical Service—Equipment and Supplies.

(a) There shall be adequate equipment and supplies necessary for the provision of pharmaceutical services within the mental health rehabilitation center including at least the following:

(1) Refrigerator with an accurate thermometer.

(2) Lockable drug cabinets, drawers, closets or rooms.

(3) Drug service trays and/or carts.

(4) Drug preparation counter area and convenient water source.

(5) Reference materials containing drug monographs on all drugs in use in the facility. Such monographs shall include information concerning generic and brand names, if applicable, available strengths and dosage forms and pharmacological data including indications and side effects.

(b) Emergency supplies shall be readily available to each nursing station. Emergency drug supplies shall meet the following requirements:

(1) Legend drugs shall not be stored in the emergency supply, except under the following conditions:

(A) Injectable supplies of legend drugs shall be limited to a maximum of three single doses in ampules or vials or one container of the smallest available multi–dose vial and shall be in sealed, unused containers.

(B) Sublingual or inhalation emergency drugs shall be limited to single sealed containers of the smallest available size.

(C) Not more than 24 emergency drugs in solid, oral dosage form or suppository dosage form may be stored, if in sealed containers. Not more than four doses of any one drug may be so stored.

(2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper–proof seal must be broken to gain access to the drugs. The director of nursing service or charge nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist.

(3) The contents of the supply shall be listed on the outside of the container.

(4) The supply shall be checked at least monthly by the pharmacist.

(5) Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the client, the date and time of administration and the signature of the person administering the dose.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.32. Pharmaceutical Service—Unit Dose Medication System.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.33. Pharmaceutical Service—Staff.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 785.34. Pharmaceutical Service—Equipment and Supplies.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 6. Required Programs

§ 786.00. Program Requirements—General.

(a) Mental health rehabilitation centers shall have the capability of providing, at a minimum, a rehabilitation and activity program as specified in these regulations.

(b) The objective shall be to provide a rehabilitation and activity program aimed at improving the adaptive functioning of persons with mental disabilities to enable clients to move into a less restrictive environment while preventing regression to a lower level of functioning.

(c) Orientation and in–service training of staff members to assist them in the recognition and understanding of the emotional problems, social needs of clients, and the means for taking appropriate action. Utilization of available community resources and services, including the purpose and value of the participation of consumers and family members, should be included in the orientation.

(d) The mental health rehabilitation center shall comply with all requirements of its approved Plan of Operation and any approved, specific alternate requirement which shall govern the operation of the program notwithstanding the provisions of any other regulations contained in this subchapter.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.10. Rehabilitation Program—Services.

(a) The program shall include services designed to assist persons considered seriously disabled due to a mental illness to develop skills to become self–sufficient and capable of increasing levels of independent functioning in the community. The services in this program shall include, but not be limited to, clinical treatment which includes psychiatric and psychological services, learning disability assessment and educational services, prevocational and vocational counseling, development of independent living skills, self–help and social skills, and community outreach to develop linkages with other support and service systems, including family members.

(b) All services shall be client centered, in recognition of varying

individual goals, diverse needs, concerns, strengths, motivations, and disabilities.

(c) The program shall emphasize the participation of clients in all aspects of the program including, but not limited to, individual treatment/service planning, program design and evaluation.

(d) Structured day and evening services shall consist of, at a minimum, an average of fourteen (14) specific rehabilitation service hours and seven (7) activity program hours per week for each client, and shall be available seven (7) days a week. Services shall include, but not be limited to:

(1) Individual and group counseling or therapy.

(2) Crisis intervention.

(3) Pre–vocational or vocational counseling.

(4) Provision of educational services and remediation.

(5) Client advocacy, including assisting clients to develop their own advocacy skills.

(6) Independent living skills.

(7) Money management.

(8) Self–control and symptom management.

(9) Sex education.

(10) Self–medication education.

(11) Personal grooming and hygiene.

(12) An activity program that encourages socialization within the program and general community, and that assists linking the client to resources which are available after leaving the program

(e) Consultative resources shall be used, including consumer and family members, in the planning and organization of rehabilitation services for persons with mental disabilities, incorporating discharge planning intended to enable the client to function and gain independence.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.11. Rehabilitation Program—Admission Requirements.

(a) The mental health rehabilitation center shall have an admission agreement, signed by the client or authorized representative, describing the services to be provided and the expectations and rights of the client regarding program rules, client empowerment and involvement in the program, and fees. The client shall receive a copy of the signed admission agreement.

(b) There shall be an initial written assessment of each client within fifteen (15) days of admission, unless a similar assessment has been done by the referring agency within thirty (30) days prior to admissions to the mental health rehabilitation center. The assessment shall include, at a minimum:

(1) Health and psychiatric histories.

(2) Psychosocial skills.

(3) Social support skills.

(4) Current psychological, education, vocational and other functional needs and/or limitations.

(5) Medical needs, as reported.

(6) Self control and symptom management.

(7) The signature of a licensed mental health professional.

(c) Each client admitted shall have a comprehensive individual mental health evaluation within 30 days of admission, signed by a licensed mental health professional upon completion.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.12. Rehabilitation Program—Staff.

(a) Licensees are required to provide additional mental health professional, administrative or supportive personnel whenever the Department determines, through a written evaluation, that additional personnel are needed to provide for the health, safety and rehabilitation needs of clients.

(b) Interdisciplinary Professional Staff: The mental health rehabilitation center shall provide either through direct employment or by contractual arrangement, an interdisciplinary professional staff to develop and implement a specialized rehabilitation program and services, and to provide specific expertise to the program staff, and to provide direct client services.

(1) The interdisciplinary professional staff shall be composed of at least two of the following disciplines:

(A) Psychologist.

(B) Social Worker.

(C) Marriage, Family and Child Counselor.

(D) Occupational Therapist.

(E) Mental Health Rehabilitation Specialist.

(F) Program Director as specified in Section 786.13(d).

(G) Licensed Nursing Staff.

(H) Any other related discipline approved by the Department

(2) Each member of the professional staff shall have a minimum of one (1) year of experience or training in a mental health setting.

(3) In addition to other staffing requirements, a licensed mental health rehabilitation facility which provides a rehabilitation services program shall provide interdisciplinary professional staff as required in (b) above, in accordance with the following schedule:

(A) For facilities having an average of 41 or fewer clients per week, a minimum of 24 hours per week of interdisciplinary professional staff time.

(B) For facilities having an average of 42 or more clients per week, a minimum of 48 hours per week of interdisciplinary professional staff time.

(c) Program staff shall include only those full or part time employees of the mental health rehabilitation center whose duties and responsibilities include the treatment, counseling or supervision of the mental health rehabilitation center's program population.

(1) At a minimum, all program staff shall have graduated from high school or possess a General Equivalency Diploma (GED) and have a minimum of two (2) years of full–time experience, or its part–time equivalent, working in a mental health program serving persons with severe and persistent mental disabilities. Such experience shall be in the direct provision of services to a program's identified clients or residents. A bachelors degree with a major in psychology, social work or behavioral sciences may be substituted for the two (2) years of full–time work experience or its part–time equivalent.

(A) Persons who have been consumers of mental health services may be utilized in the program when consistent with program design and services provided, and (c)(1) above.

(B) Program staff shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the required rehabilitation services.

(2) The mental health rehabilitation center shall provide at least one (1) hour of program staff time for each five (5) hours of rehabilitation services provided for each client.

(d) Program staff time shall not include the program director, interdisciplinary professional staff, director of nursing service or nursing staff.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.13. Rehabilitation Program—Program Director.

(a) The mental health rehabilitation center shall have a program director who meets the requirements of Section 782.40. The program director shall not be the director of nursing service or a charge nurse.

(b) The program director shall also have at least two years experience or training in a mental or training setting, one year of which shall include experience or training in program development for persons with severe and persistent mental disabilities.

(c) The program director shall ensure that an in–service education program is provided.

(d) The program director may be included and counted as a

member of interdisciplinary professional staff in mental rehabilitation centers with 41 or fewer beds.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.14. Rehabilitation Program—In–Service Education.

(a) The mental health rehabilitation center shall provide to all rehabilitation and activity staff an average of fifty two (52) hours per year of ongoing, planned academic and on–the–job in–service education. The education shall include, but not be limited to, the following:

(1) Client–centered approach as to addressing the needs and goals of persons with mental disabilities.

(2) Principles and practices of psychosocial rehabilitation and community support, including self–help, peer support and family involvement.

(3) Cultural competence.

(4) Interpersonal relationships and communication skills.

(5) Confidentiality of client information.

(6) Preservation of client dignity, including provision of privacy.

(7) Client rights and civil rights.

(8) Conflict resolution.

(9) Prevention and control of infections.

(10) Fire prevention and safety.

(11) Accident prevention and safety measures.

(12) Choking prevention and intervention.

(13) Sex education.

(14) Use of unlicensed staff.

(b) In addition to (a) above, all direct service staff shall have training in cardiopulmonary resuscitation.

(c) The mental health rehabilitation center shall maintain a record of the in–service education. This record shall include the signature of staff in attendance, the number of hours, the date and the subjects covered.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.15. Rehabilitation Program—Individual Service Plan and Documentation Requirements.

(a) The written individual service plan shall be prepared within 30 days following admission by the program director or a staff member that is a licensed mental health professional, and shall include, but not be limited to, the following:

(1) Specific goals and measurable objectives, the staff and client's responsibilities for their achievement.

(A) Statement of specific treatment/rehabilitation needs and goals.

(B) The individual service plan shall indicate the services to be provided, the objectives to be accomplished, and the staff responsible for the provision of each service.

(C) The objectives shall be measurable, with time frames, and shall be reviewed and updated at least monthly.

(b) There shall be weekly progress notes in the record for each client which shall include notes written by members of the program staff or interdisciplinary professional staff providing rehabilitation services to the client. The notes shall be a general review of weekly progress.

(c) Documentation of reviews by staff and clients of the individual service plan on at least a monthly basis.

(1) Clients shall be involved in an on–going review of progress towards goal attainment and in the planning and evaluation of their treatment/rehabilitation goals.

(2) Anticipated length of stay for the client in the mental health rehabilitation center needed to accomplish identified goals, and methods to evaluate the achievement of these goals.

(d) There shall be a review and updating of the individual service plan as necessary but at least quarterly, and more often if there is a change in the client's condition.

(1) The quarterly review shall include a reevaluation which shall be a summary of the progress of the client in the rehabilitation program, the appropriateness of identified needs, client goals and objectives and the success of the plan.

(2) The client should be present at the quarterly review and if agreed to by the client, family members may be notified and attend the quarterly review.

(e) The service plan shall be approved by the program director or a licensed mental health professional, and signed by the client.

(f) Prior to discharge, there shall be a written discharge summary prepared by the staff which shall include an outline of services provided, goals accomplished, reason and plan for discharge, and referral follow–up plans.

(g) At least every four (4) months, the mental health rehabilitation center in conjunction with the local mental health director or designee, shall reassess each client to determine the need for continued placement of the client in the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.16. Rehabilitation Program—Equipment.

There shall be sufficient equipment, assistive devices and supplies available to implement the treatment/rehabilitation program ordered or indicated for meeting the mental and emotional needs of clients.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.17. Activity Program—General.

An activity program shall be staffed and equipped to encourage the participation of each client and to meet the activity needs and interests of each client.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.18. Activity Program—Requirements.

(a) Clients shall be encouraged to participate in activities planned to meet their individual assessed needs. An activity program shall have a written, planned schedule of social and other purposeful independent or group activities. The program shall be designed to stimulate and support physical and mental capabilities to the fullest extent, and to enable the client to maintain the highest attainable social, physical and mental functioning.

(b) The activity program shall consist of individual activities, and small and large group activities to which family members shall be invited, if agreed to by the client, which are designed to meet the needs and interests of each client and which shall include, but are not limited to:

(1) Social activities.

(2) Indoor and outdoor activities.

(3) Supervised activities away from the facility.

(4) Opportunity for client involvement for planning and implementation of the activity program.

(5) Creative activities.

(6) Educational activities.

(7) Exercise activities.

(8) Opportunity for client involvement in religious programs.

(9) Client government.

(c) Activities shall be available on a daily basis.

(d) There shall be an activity coordinator, who meets the requirements of Section 782.11 and shall:

(1) Develop and implement the activity program under the supervision of the program director.

(2) Coordinate the activity schedule with other client services.

(3) Post the activity schedule conspicuously, in large visible print, for the information of clients and staff.

(4) Maintain age appropriate equipment and supplies in sufficient quantity.

(5) Develop and maintain contacts with community agencies and organizations.

(6) Maintain progress notes specific to the leisure and activity needs of the clients, at least quarterly, and more frequently if needed, in the client record.

(7) Maintain a current record of the type of frequency of activities provided and the names of clients participating in each activity.

(e) Where appropriate, the activity coordinator may recruit, train and supervise a volunteer program to assist with, and augment, services of the activity program.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.19. Activity Program—Staff.

(a) Activity staff with appropriate training and experience shall be available to meet the needs and interest of clients.

(1) At a minimum, all activity staff shall have graduated from high school or possess a General Equivalency Diploma (GED) and have a minimum of two (2) years of full–time experience, or its part–time equivalent, working in a mental health program serving persons with mental disabilities. Such experience shall be in the direct provision of services to a program's identified clients or residents. A bachelors degree with a major in psychology, social work or behavioral sciences may be substituted for the two (2) years of full–time work experience or its part–time equivalent.

(A) Persons who have been consumers of mental health services may be utilized in the activity program when consistent with program design and services provided, and (a)(1) above.

(2) The mental health rehabilitation center shall provide at least one (1) hour of activity program staff time for each seven (7) hours of activity programs provided to each client.

(b) An activity director shall be designated by and be responsible to the program director.

(1) Be an occupational therapist, art therapist, music therapist, dance therapist, or recreation therapist.

(2) Have two (2) years of experience in a social or recreational program within the past five (5) years, one (1) year of which was full–time in client activities and programs in a mental health setting.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.20. Activity Program—Equipment and Supplies.

Each mental health rehabilitation center shall provide equipment and supplies for both independent and group activities and for clients having special interests.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.21. Activity Program—Staff.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.22. Activity Program—Equipment and Supplies.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 786.23. Activity Program—Space.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 7. Physical Plant

§ 787.00. Fire Safety.

(a) The licensee shall be responsible for maintaining the mental health rehabilitation center in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic. The licensee shall also secure and maintain a clearance relative to health safety from the State Fire Marshal in order to comply with the requirements for participation in the Federal Medicare and California's Medi–Cal programs.

(b) Clients shall not be permitted to smoke in the mental health rehabilitation center.

(1) The mental health rehabilitation center shall provide designated outside areas for smoking.

(A) Clients shall be permitted to smoke only in the designated areas.

(B) The designated area shall be under the periodic observation of mental health rehabilitation center personnel.

(2) "No Smoking" signs shall be posted in prominent locations within the mental health rehabilitation center.

(c) Smoking or open flames shall not be permitted in any space where oxygen cylinders are stored or where oxygen is in use. Such space shall be identified by prominently posted "No Smoking" or "No Open Flame" signs.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.10. Alterations to Existing Buildings or New Construction.

(a) Alterations to existing buildings or new construction shall be in conformance with the California Building Standards Code, Title 24, California Code of Regulations and requirements of the State Fire Marshal.

(b) Mental health rehabilitation centers licensed and in operation prior to the effective date of changes to applicable law or regulations shall not be required to institute corrective alterations or construction in order to comply with such new requirements. Any mental health rehabilitation center for which preliminary or working drawings and specifications have been approved by the Department prior to the effective date of changes to construction regulations shall not be required to comply with such new requirements provided substantial actual construction is commenced within one year of the effective date of such new requirements.

(c) All mental health rehabilitation centers shall maintain in operating condition all buildings, fixtures and spaces in the numbers and types as specified in the construction requirements under which the facility or unit was first licensed.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.11. Space Conversion.

Space approved for specific use at the time of licensure shall not be converted to other use without the approval of the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.12. Notice to Department.

The Department shall be notified in writing, by the owner or licensee of the mental health rehabilitation center, within five (5) days of the commencement of any construction, remodeling or alterations to the mental health rehabilitation center.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.13. Housekeeping.

(a) Each mental health rehabilitation center shall routinely clean articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures.

(b) Schedules and procedures shall be posted which indicate the areas of the facility which shall be cleaned daily, weekly or monthly. The cleaning schedules and procedures shall be implemented.

(c) Cleaning supplies and equipment shall be available to housekeeping staff. Such cleaning supplies and equipment shall meet the following requirements:

(1) Cleaning supplies and equipment shall be stored in rooms for housekeeping use only.

(2) A commercial detergent germicide shall be used for all cleaning.

(3) Mop heads shall be removable and changed at least daily.

(d) Housekeeping personnel shall be employed to maintain the interior of the mental health rehabilitation center in a safe, clean, orderly and attractive manner free from offensive odors.

(e) Janitor closets, service sinks and storage areas shall be clean and maintained to meet the needs of the facility.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.14. Laundry.

(a) When a mental health rehabilitation center operates its own laundry, the laundry areas shall be:

(1) Located in relationship to other areas so that steam, odors, lint and objectionable noises do not reach client or personnel areas.

(2) Adequate in size, well–lighted, ventilated to meet the needs of the mental health rehabilitation center, and be kept clean and sanitary.

(3) Laundry equipment shall be kept in good condition, maintained in a sanitary condition, and have a suitable capacity.

(b) Laundry areas shall have, at a minimum, the following:

(1) Separate rooms for the storage of clean linen and soiled linen.

(2) Handwashing and toilet facilities maintained at locations convenient for laundry personnel.

(3) Separate linen carts labeled "soiled" or "clean" linen and constructed of washable materials which shall be laundered or suitably cleaned as needed to maintain sanitation.

(c) Written procedures for handling, storage, transportation and processing of linens shall be posted in the laundry and shall be implemented.

(d) If the mental health rehabilitation center does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this section.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.15. General Maintenance.

(a) The mental health rehabilitation center, including the grounds, shall be maintained in a clean and sanitary condition and in good condition at all times to ensure safety and well–being of clients, staff and visitors.

(b) Buildings and grounds shall be free of environmental pollutants and such nuisances as may adversely affect the health or welfare of clients to the extent that such conditions are within the reasonable control of the mental health rehabilitation center.

(c) All buildings, fixtures, equipment and spaces shall be maintained in operable condition.

(d) Personnel shall be employed to provide preventive maintenance and to carry out the required maintenance program.

(e) Equipment provided shall meet all applicable California Occupational Safety and Health Act requirements in effect at the time of purchase. All portable electrical medical equipment designed for 110–120 volts, 60 hertz current, shall be equipped with a 3 wire–grounded power cord with a hospital–grade 3 prong plug. The cord shall be an integral part of the plug.

(f) The mental health rehabilitation center shall be maintained free from vermin and rodents through operation of a pest control program. The pest control program shall be conducted in the main client buildings, all outbuildings on the property and all grounds.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.16. Air Filters.

(a) The licensee shall be responsible for regular inspection, cleaning or replacement of all filters installed in heating, air conditioning and ventilating systems, as necessary to maintain the systems in normal operating condition.

(b) A written record of inspection, cleaning or replacement, including static pressure drop, shall be maintained and available for inspection. The record shall include a description of the filters originally installed, the American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE) efficiency rating and the criteria established by the manufacturer or supplier to determine when replacement or cleaning is necessary.

(c) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and by–pass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and by–pass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department.

(d) Where a filter maintenance is performed by an equipment service company, a certification shall be provided to the licensee that the requirements listed in this section have been accommodated.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.17. Water Supply and Plumbing.

(a) Where water for human consumption is from an independent source, it shall be subjected to bacteriological analysis by the local health Department or a licensed commercial laboratory at least every three months. A copy of the most recent laboratory report shall be available for inspection.

(b) Plumbing, drainage facilities, and drinking water supplies shall be maintained in compliance with Part 5, Title 24, California Code of Regulations, Basic Plumbing Requirements.

(c) Vacuum breakers shall be maintained in operating condition where required by Part 5, Title 24, California Code of Regulations.

(d) Hot water temperature controls shall be maintained to automatically regulate temperature of hot water delivered to plumbing fixtures used by clients to attain a hot water temperature in compliance with Part 5, Title 24, California Code of Regulations.

(e) Minimum hot water temperature shall be maintained at the final rinse section of dishwashing facilities as required by Part 5, Title 24, California Code of Regulations, unless alternate methods are approved by the Department.

(f) Taps delivering water at or above the state temperatures shall be in compliance with requirements specified in Part 5, Title 24, California Code of Regulations. Special precautions shall be taken to prevent the scalding of clients.

(g) Grab bars, readily accessible to clients, shall be maintained at each toilet, bathtub and shower used by clients.

(h) Toilet, handwashing and bathing facilities shall be maintained in operating condition and in the number and types specified in construction requirements in effect at the time the building or unit was constructed. Those handwashing facilities listed in Part 5, Title 24, California Code of Regulations, shall not be equipped with aerators.

(i) If the mental health rehabilitation center accepts physically handicapped clients, the water closets, bathing and toileting appliances shall be equipped for use by the physically handicapped.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.18. Lighting and Power System.

(a) All rooms, attics, basements, passageways, and other spaces shall be provided with artificial illumination, as set forth in Part 3, Title 24, California Code of Regulations.

(b) All client rooms shall have a minimum of 30 foot candles of light delivered to reading or working surfaces and not less than 20 foot candles of light in the rest of the room.

(c) All accessible areas of corridors, storerooms, stairways, ramps, exits and entrances shall have a minimum of 20 foot candles of light.

(d) Auxiliary lighting and power facilities shall be provided as required by Part 3, Title 24, California Code of Regulations. Flashlights shall be in readiness for use at all times. Open–flame type of light shall not be used.

(e) The licensee shall provide and maintain an emergency electrical system in safe operating condition and in compliance with subsections (d), (e) and (f). The system shall serve all lighting, signals, alarms and equipment required to permit continued operation of all necessary functions of the mental health rehabilitation center for a minimum of six hours.

(f) If the Department determines that an evaluation of the emergency electrical system of a mental health rehabilitation center or portion thereof is necessary, the Department may require the licensee to submit a report by a registered electrical engineer which shall establish a bias for alteration of the system to provide reasonable compliance with Part 3, Title 24, California Code of Regulations. Essential engineering data, including load calculations, assumptions and tests, and, where necessary, plans and specifications, acceptable to the Department, shall be submitted in substantiation of the report. When corrective action is determined to be necessary, the work shall be initiated and completed within an acceptable time limit.

(g) The emergency lighting and power system shall be maintained in operating condition to provide automatic restoration of power for emergency circuits within ten seconds after normal power failure.

(h) Emergency generators shall be tested at least every 14 days under full load condition for a minimum of 30 minutes.

(i) A written record of inspection, performance, exercising period, and repair of the emergency electrical system shall be maintained on the premises and available for inspection by the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.19. Mechanical Systems.

Heating, air conditioning and ventilating systems shall be maintained in normal operating conditions to provide a comfortable temperature and shall meet the requirements of Part 4, Title 24, California Code of Regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.20. Maintenance Manual.

(a) A written manual on maintenance of heating, air conditioning and ventilation systems shall be adopted by each mental health rehabilitation center.

(b) A log shall be utilized to document maintenance work performed.

(c) When maintenance is performed by an equipment service company, a certification shall be provided to the licensee that the required work has been performed in accordance with acceptable standards. This certification shall be retained on file in the mental health rehabilitation center for review by the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.21. Space.

Space located in the mental health rehabilitation center or internally connected to a licensed mental health rehabilitation center shall be considered a part of the mental health rehabilitation center and shall be subject to licensing regulations.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.22. Rehabilitation Program—Space.

(a) The rehabilitation program shall have identified program or service areas in order to provide at least the required program services.

(b) Indoor and outdoor areas shall be designated for rehabilitation program services.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.23. Nursing Service—Space.

(a) A nursing station shall be maintained in each nursing unit or building.

(b) Each nursing station shall have a cabinet, a desk, space for records, a bulletin board, a telephone and a specifically designated and well illuminated medication storage compartment with a lockable door. If a separate medication room is maintained, it shall have a lockable door and a sink with water connections for care of equipment and for handwashing.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.24. Activity Program—Space.

(a) Each mental health rehabilitation center shall provide a designated activity area which meets the independent and group activity needs of clients. Such areas shall be of sufficient size to accommodate necessary equipment and permit unobstructed movement of wheelchair and ambulatory clients or personnel responsible for instruction and supervision.

(b) Storage space for equipment and supplies shall be provided and shall be maintained in a clean and orderly manner.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.25. Client Rooms.

(a) Each client's room shall be labeled with a number, letter or combination of the two for identification.

(b) Clients' rooms shall not be locked except for rooms approved by the Department for seclusion of clients.

(c) Only upon the written approval of the Department shall an exit door, corridor door, yard enclosure or perimeter fences be locked to egress.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.26. Client's Property Storage and Room Furnishings.

(a) Each client room shall be provided with a closet or locker space for clothing, toilet articles and other personal belongings.

(b) For each licensed bed there shall be provided:

(1) A clean comfortable bed with an adequate mattress, sheets, pillow, pillow case and blankets, all of which shall be in good condition, and consistent with individual client needs.

(2) A night stand, chair, and reading light, all of which shall be in good condition.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 787.27. Client Capacity.

(a) A mental health rehabilitation center shall not have more clients or beds set up for use than the number for which it is licensed except in case of emergency when temporary permission may be granted by the Director or designee.

(b) Clients shall not be housed in areas which have not been approved by the Department for client housing and which have not been given a fire clearance by the State Fire Marshal except as provided in (a) above.

(c) The number of licensed beds shown on a license shall not exceed the number of beds for which the mental health rehabilitation center meets applicable construction and operational requirements.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Article 8. Citations and License Revocation

§ 788.00. Definitions.

(a) The following definitions shall apply to this article:

(1) Substantial probability means that the likelihood of an event is real, actual and not imaginary, insignificant or remote.

(2) Physical harm means that type of dangerous bodily injury, illness or condition in which:

(A) A part of the body would be permanently removed, rendered functionally useless or substantially reduced in capacity, either temporarily or permanently and/or;

(B) A part of an internal function of the body would be inhibited in its normal performance to such a degree as to temporarily or permanently cause a reduction in physical or mental capacity or shorten life.

(3) Direct relationship means one in which a significant risk or effect is created and does not include a remote or minimal risk or effect.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 788.10. Filing of Names and Addresses.

(a) The licensee of each mental health rehabilitation center shall file with the Department the address of the licensee to whom all license citations and revocations shall be mailed by the Department.

(b) Each licensee shall also designate one or more persons who is authorized to accept, on the licensee's behalf, any license citations and revocations to be served by any representative of the Department.

(c) Each licensee shall file with the Department the names or titles of those persons who are such designees of the licensee.

(d) Each licensee shall also file with the Department a written notice of any change in address or of any change of designee. The Department shall mail all license citations and revocations to the latest address on file with the Department.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 788.11. Issuance of Revocation and License Citations.

(a) Each citation shall be in writing and shall include at least the following:

(1) The earliest feasible time for the elimination of the condition constituting the noncompliance with regulations of this chapter. Such time shall be the shortest possible time within which the licensee reasonably can be expected to comply with the regulations. In prescribing such time, the Department shall consider the following factors:

(A) The risk of physical harm to clients or staff because of the alleged noncompliance.

(B) The number of clients affected.

(C) The availability of required equipment or personnel.

(D) The estimated time required for delivery, and any installation of required equipment.

(E) Any other relevant circumstances.

(2) The Department shall require a plan describing the corrective measures that the licensee will take to remedy the conditions that caused the issuance of the citation(s).

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 788.12. Conditions of Revocation of License.

(a) The Department may revoke a license for noncompliance with the provisions of this chapter. In establishing the conditions for imposing revocation, the Department shall consider:

(1) the gravity of the noncompliance which shall include:

(A) The degree of substantial probability that death or physical harm to the client would result and, if applicable, did result from the noncompliance.

(B) The severity of serious physical harm to a client or guest which was likely to result and, if applicable, that did result, from the noncompliance.

(C) The extent of noncompliance with the provisions of the applicable statutes or regulations.

(2) Mitigating circumstances, which shall include awareness of the applicable statutes and regulations and reasonable diligence in complying with such requirements, prior accomplishments manifesting the licensee's desire to comply with such requirements, and any other mitigating factors in favor of the licensee.

(3) Any previous license citations and revocations committed by the licensee.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 788.13. Appeal of Revocation.

The licensee may appeal any license citations or revocations imposed by submitting a written appeal to the Director within 30 calendar days of the issuance of a citation. The Director shall respond to the appeal within 60 calendar days. If an appeal is denied, the licensee may request a citation review conference.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

§ 788.14. License Revocation and Citation Review Conference.

(a) At a citation review conference:

(1) The licensee shall have the right to be represented by legal counsel, or a person of the licensee's choosing, to prevent oral or written information on the licensee's behalf, and to explain any mitigating circumstances.

(2) The representatives of the Department who issued the citation should attend the conference and present information, oral or written, in substantiation of the alleged noncompliance.

(3) The conference shall be an informal proceeding, and shall not be conducted in the manner of a judicial hearing or as a hearing under the Administrative Procedure Action (Chapter 5 [commencing with Section 11500] of Part 1 of Division 3 of Title 2 of the Government Code), and need not be conducted according to technical rules relating to evidence and witnesses.

(4) Neither the licensee nor the Department shall have the right to subpoena any witness to attend the conference, to record testimony at the conference, nor to formally cross–examine any person testifying at the conference. However, the licensee and the Department may present any witness on its behalf at the conference.

NOTE: Authority cited: Sections 5675 and 5768, Welfare and Institutions Code; Section 3 of Chapter 678 of the Statutes of 1994. Reference: Sections 5675 and 5768, Welfare and Institutions Code.

Chapter 4. Community Mental Health Services Under the Lanterman–Petris–Short Act

Article 1. Application

§ 800. Application of Subchapter.

Subchapter 4 shall apply to community mental health services as provided for in the Lanterman–Petris–Short Act of part 1 of division 5 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 5400, Welfare and Institutions Code. Reference: Sections 5000 through 5401, Welfare and Institutions Code. Additional authority cited: Section 5750, Welfare and Institutions Code.

§ 801. Section Headings.

Article 2. Definitions and General Provisions

§ 810. Act.

''Act'' means the Lanterman–Petris–Short Act, Division 5, Part 1 (commencing with Section 5000 of the Welfare and Institutions Code).

NOTE: Authority cited: Section 5400, Welfare and Institutions Code. Reference: Section 5000, Welfare and Institutions Code.

§ 811. Department.

''Department'' means the State Department of Mental Health.

NOTE: Authority cited: Sections 4012 and 5400, Welfare and Institutions Code. Reference: Chapter 1252, Statutes of 1977.

§ 812. Shall and May.

As used in this subchapter, ''shall'' is mandatory and ''may'' is permissive.

§ 813. Mental Disorder.

NOTE: Authority cited: Section 5400, Welfare and Institutions Code. Reference: Sections 5150, 5200 and 5250, Welfare and Institutions Code.

Article 3. Facilities

§ 820. Designation by Board of Supervisors.

§ 821. Approval of Facilities.

Any facility designated by the board of supervisors of a county for evaluation and treatment pursuant to Articles 1 and 2 of Chapter 2, Part 1, Division 5 of the Welfare and Institutions Code, is subject to approval of the Department. Such a facility shall be approved by the Department if it meets the requirements of Chapter 3 of this title for inpatient services.

NOTE: Authority cited: Sections 5400 and 5404, Welfare and Institutions Code. Reference: Sections 5150, 5202, 5366.1, 5400 and 5404, Welfare and Institutions Code.

§ 821.1. Approval of Persons or Agencies for Prepetition Screening.

Any person or agency designated by the board of supervisors of a county under Section 5202 of the Act to provide prepetition screening is subject to the approval of the Department. Such person or agency shall be approved by the Department only if the person or agency is working under the direction of the Director of Local Mental Health Services or a physician designated by the Director of Local Mental Health Services or social worker as defined in Section 624 or 625 designated by the Director of Local Mental Health Services.

NOTE: Authority cited: Sections 5202 and 5400, Welfare and Institutions Code. Reference: Section 5202, Welfare and Institutions Code.

§ 822. Professional Person in Charge of a Facility.

As used in the Act, ''professional person in charge of a facility'' means a person as defined in Section 623, 624, 625, 626, or 627 of this Chapter who is designated by the governing board of the facility or other agency or person having control of the facility as the professional person clinically in charge of the facility for purposes of the Act. The designation shall be in writing.

NOTE: Authority cited: Sections 5600.5, 5750 and 5751, Welfare and Institutions Code. Reference: Sections 5150, 5152.1, 5154, 5208, 5251, 5254, 5254.1, 5257, 5258, 5264, 5267, 5268, 5275, 5301, 5326, 5328(k), 5328.3, 5328.4, 5328.6, 5328.8, 5352, 5352.3, 5352.5 and 5366.1, Welfare and Institutions Code.

§ 823. Attending Staff.

''Attending staff'' under section 5150 of the Act means any person having responsibility for the care and treatment of the patient, as designated by the Local Mental Health Director, on the staff of an evaluation facility designated by the county.

§ 824. Facilities for Inebriates and Alcoholics.

§ 825. Calculation of Evaluation and Treatment Period.

As of January 1, 1979, all facilities that are designated as 72–hour evaluation and treatment facilities pursuant to Section 5150 of the Welfare and Institutions Code must count Saturdays, Sundays, and holidays as part of the 72–hour period unless exempted by the Department.

NOTE: Authority cited: Section 5151, Welfare and Institutions Code. Reference: Section 5151, Welfare and Institutions Code.

§ 825.1. Exemption Requests.

Facilities wishing to be exempted from this requirement must apply through the Local Mental Health Director who shall submit a written request to the Department requesting such exemption.

NOTE: Authority cite: Section 5151, Welfare and Institutions Code. Reference: Section 5151, Welfare and Institutions Code.

§ 825.2. Exemption Request Requirements.

The request shall include the following information:

(a) The identity of the facility for which the exemption is requested;

(b) The reason(s) that evaluation and treatment services cannot be made available on Saturdays, Sundays, and holidays. If the reason relates to staffing, there shall be included a statement explaining normal staffing standards pursuant to Article 10 of Subchapter 3 on days when evaluation and treatment services are provided and why such staffing is not available on Saturdays, Sundays, and holidays.

(c) A description of the efforts the facility has made and will make to provide evaluation and treatment services on Saturdays, Sundays, and holidays.

NOTE: Authority cited: Section 5151, Welfare and Institutions Code. Reference: Section 5151, Welfare and Institutions Code.

§ 825.3. Certification of Exemptions.

The Department will either certify that the facility cannot reasonably provide evaluation and treatment services on Saturdays, Sundays, and holidays or deny such certification. If granted, the certification shall be effective for two years unless revoked in accordance with Section 825.4.

NOTE: Authority cited: Section 5151, Welfare and Institutions Code. Reference: Section 5151, Welfare and Institutions Code.

§ 825.4. Reapplication for or Revocation of Certification.

If certification is denied a facility, the Local Mental Health Director may reapply for certification at any time. In addition, prior certifications exempting facilities may be revoked by the Department upon a finding that the facility can reasonably be expected to provide such services and after written notice and opportunity for the facility to respond has been given.

NOTE: Authority cited: Section 5151, Welfare and Institutions Code. Reference: Section 5151, Welfare and Institutions Code.

§ 829. Mental Health Treatment Facility.

NOTE: Authority cited: Sections 1500 and 1851, Probate Code. References: Sections 1500 and 1851, Probate Code and division 5, part 1, chapter 2 and chapter 3, Welfare and Institutions Code.

Article 4. Conservatorship

§ 830. Conservatorship.

Article 5. Patients' Rights: Convulsive Treatment and Psychosurgery

§ 835. General Provision.

Any person, without regard to where that person is treated, shall have the right to refuse convulsive treatment, insulin coma treatment, prefrontal sonic treatment, and psychosurgery, except as otherwise provided by statute or regulation. In addition, any administration of these treatments or performance of psychosurgery, wherever administered or performed, shall be performed only by a physician licensed to practice in the State of California, and shall be subject to the regulations contained in this Article.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5325(f), 5325.1(i), 5326.6, 5326.7, 5326.75 and 5326.85, Welfare and Institutions Code.

§ 836. Types of Treatment: Definitions.

(a) ''Convulsive treatment'' is the planned induction of a seizure through electrical or chemical means for therapeutic purposes. When more than one seizure is induced in a single treatment session, each seizure shall be considered a separate treatment for records–keeping and reporting purposes.

(b) ''Insulin Coma Treatment'' consists of the production of a coma for therapeutic purposes, with or without convulsions, through the intramuscular administration of insulin.

(c) ''Psychosurgery'' is defined as any of those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of any of the following:

(1) Modification, alteration, or control of thoughts, feelings, actions, or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(2) Modification or alteration of normal brain function, brain tissue or brain cells in order to modify, alter, or control thoughts, feelings, actions, or behavior; or

(3) Treatment of abnormal brain function, brain tissue or brain cells in order to modify, alter, or control thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior.

Psychosurgery shall not include surgery for relief of pain caused by physical disease elsewhere in the body.

(d) "Prefrontal sonic treatment" is the direct stimulation and/or destruction of brain cells or brain tissue by ultrasound for therapeutic purposes, as discussed in Section 837.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5325, 5326.6, 5326.7, 5326.75, 5326.8 and 5326.85, Welfare and Institutions Code.

§ 836.1. Voluntary and Involuntary Patients: Definitions.

(a) "Involuntary patients," for purposes of this Article, include:

(1) Persons involuntarily detained for 72–hour evaluation and treatment under Section 5150 of the Welfare and Institutions Code;

(2) Persons certified for intensive treatment under Section 5250 of the Welfare and Institutions Code;

(3) Persons certified for additional intensive treatment as suicidal under Section 5260 of the Welfare and Institutions Code;

(4) Persons postcertified as a demonstrated danger of substantial physical harm to others under Section 5300 of the Welfare and Institutions Code;

(5) Persons under temporary or permanent conservatorship or guardianship;

(6) Persons who have been judicially committed, as defined under Section 5008.1 of the Welfare and Institutions Code. In the event that this Article conflicts with regulations dealing with the developmentally disabled promulgated under Chapter 1 (commencing with Section 4500) of the Welfare and Institutions Code, the latter statute and regulations shall control.

(b) "Voluntary patients," for the purposes of this Article, include all other patients not included in subdivision (a) above.

NOTE: Authority cited: Sections 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.7, 5326.15 and 5326.75, Welfare and Institutions Code.

§ 836.2. Facility: Definition.

"Facility" includes any health facility, including but not limited to, any health facility as defined in Section 1250 of the Health and Safety Code, in which convulsive treatment, insulin coma treatment, prefrontal sonic treatment or psychosurgery is administered or performed.

NOTE: Authority cited: Sections 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5325, 5326.6, 5326.7, 5326.15 and 5326.75, Welfare and Institutions Code.

§ 837. Procedures for Insulin Coma and Prefrontal Sonic Treatment.

(a) Unless otherwise indicated, all the requirements set forth in statute or regulation for the administration of convulsive treatment shall be followed when insulin coma treatment is administered, or when prefrontal sonic treatment is administered which involves only direct stimulation of brain cells or brain tissue.

(b) Unless otherwise indicated, all the requirements of statute or regulation described for psychosurgery shall be followed when prefrontal sonic treatment is administered and there exists any possibility there will be destruction of brain cells or brain tissue.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.6, 5326.7 and 5326.75, Welfare and Institutions Code.

§ 838. Quarterly Reports on Convulsive, Insulin Coma, and Prefrontal Sonic Treatment—Application and Requirement.

(a) The reporting requirements of Welfare and Institutions Code Section 5326.15 shall be applicable to all facilities which administer or perform convulsive treatment, insulin coma treatment, or prefrontal sonic treatment involving only direct stimulation of cells or tissue, and to all physicians who provide these treatments outside health facilities.

(b) Quarterly, any such facility which has performed these treatments during the prior quarter, or which considers such treatment methods a part of the facility's program, shall report to the local mental health director. These reports shall be made regardless of whether or not any of these treatment methods were used during the quarter. Likewise, any physician who considers any of these methods a service that he or she provides, and whose use of the above–mentioned treatment methods is not included in any facility's report, must submit a quarterly report to the local mental health director even if such treatments were not administered during that particular quarter.

(c) Quarterly reports shall be made on a form which shall be issued by the Director of the State Department of Mental Health which shall include all necessary instructions and definitions.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.1 and 5326.15, Welfare and Institutions Code.

§ 838.1. Quarterly Reports on Psychosurgery.

Each facility which performs psychosurgery, or prefrontal sonic treatment involving destruction of cells or tissue, or each physician who performs these treatments outside a facility, shall submit to the local mental health director a quarterly report of all such procedures actually performed during the preceding quarter. The report shall contain, in addition to the data listed in Welfare and Institutions Code Section 5326.15, the following information:

(a) Psychiatric diagnosis;

(b) Type of psychosurgery performed;

(c) Date surgery performed;

(d) Complications that arose during or after completing psychosurgery.

NOTE: Authority cited: Sections 5326.95 and 5400, Welfare and Institutions Code. Reference: Section 5326.15, Welfare and Institutions Code.

§ 838.2. Failure to Submit Quarterly Reports.

A facility, clinic, or physician who fails to submit the reports as provided in Section 838 or 838.1, by the 15th of the month following completion of the quarter, shall be notified by the local mental health director of the legal obligation to submit these reports. Failure to comply within 15 days after such notification shall be reported to the Director of the State Department of Mental Health who may take any or all of the actions specified in Section 5326.9 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Section 5326.15, Welfare and Institutions Code.

§ 838.3. Quarterly Reports to State.

The local mental health director shall transmit copies of all quarterly reports received to the Director of the State Department of Mental Health, or to the office designated by the Director, by the last day of the month following the end of the quarter.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.1 and 5326.15, Welfare and Institutions Code.

§ 839. Informed Consent for Electroconvulsive Treatment.

(a) For purposes of obtaining written informed consent to electroconvulsive treatment, the treating physician shall use the consent form developed by the department. The form entitled "Informed Consent for Electroconvulsive Treatment (ECT) MH 300 (11/90)" is the standard written consent form prescribed in section 5326.3 of the Welfare and Institutions Code.

(b) The oral explanation required by section 5326.4 of the Welfare and Institutions Code regarding the information contained on the consent form shall be in a language or modality understood by the person giving consent.

NOTE: Authority cited: Section 5326.95, Welfare and Institutions Code. Reference: Sections 5325, 5326.2, 5326.3, 5326.4, 5326.5, 5326.6, 5326.7, 5326.75 and 5326.8, Welfare and Institutions.

§ 840. Capacity to Consent or Refuse Consent to Recommended Treatment or Surgery.

(a) A person shall be deemed to have the capacity to consent or to refuse to consent if it is determined that such person has actually understood and can knowingly and intelligently act upon the information specified in Welfare and Institutions Code Section 5326.2. Understanding of the potential benefits and risks of the proposed treatment or surgery is the primary factor in determining such capacity to consent or to refuse consent.

(b) A person shall not be deemed to lack capacity to consent or refuse consent solely by virtue of any psychiatric or medical diagnosis.

(c) When Section 5326.7(e) of the Welfare and Institutions Code requires that a person's attorney make a determination as to the person's capacity or incapacity to give written informed consent, the attorney shall make an independent judgment of capacity.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.5, 5326.7 and 5326.75, Welfare and Institutions Code.

§ 841. Refusal to Consent to Recommended Treatment or Surgery.

If a patient is deemed by the physician to have the capacity to give informed consent, but refuses to do so, the physician shall indicate in the clinical record that the treatment was refused despite the physician's advice, and that he or she has explained to the patient the patient's responsibility for any untoward consequence of the refusal. However, such explanation shall in no case be made in a manner so as to constitute duress or coercion. Transfer of the patient to another facility, loss of hospital privileges or placement in a more restrictive setting may subsequently be justified for medical or psychiatric reasons, but shall not be a direct consequence of the patient's refusal to consent to the proposed treatment.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.5 and 5326.85, Welfare and Institutions Code.

§ 845. Minors.

(a) Under no circumstances shall psychosurgery or prefrontal sonic treatment be performed on a person under 18 years of age.

(b) The following minors shall be subject to the provisions of Section 5326.7 of the Welfare and Institutions Code: (1) persons aged 16 or 17 who are involuntary patients, or who lack verification of capacity to give written informed consent as required by Section 5326.75 of the Welfare and Institutions Code; and (2) all persons aged 12, 13, 14, or 15.

(c) For persons listed in subdivision (b), except where such persons have been emancipated, the custodial parent or parents, or the individual or agency with legal custody, shall be considered the guardian for purposes of granting or withholding substituted consent.

(d) Persons aged 16 and 17 who are voluntary patients may themselves grant or withhold consent for convulsive treatment to the same extent as adults who are voluntary patients.

NOTE: Authority cited: Sections 5325(g), 5326.95 and 5400, Welfare and Institutions Code. Reference: Sections 5326.6 and 5326.8, Welfare and Institutions Code.

§ 847. Post–Treatment Review Committees.

(a) Any facility in which convulsive treatment is performed, whether on a voluntary or an involuntary patient, shall designate a qualified committee of three psychiatrists and/or neurologists knowledgeable about the treatment and its effect to verify the appropriateness and need for such treatment. This committee shall review all convulsive treatments given in that facility on a quarterly basis. If treatments are initiated in a facility, and then continued outside that facility, the physician who continues treatments shall report the total number to the facility. Any such treatments shall be reviewed by the facility's review committee.

(b) For convulsive treatments and insulin coma treatments not included under Subdivision (a), the local mental health director shall establish the post–treatment review committee. This committee shall consist of three psychiatrists and/or neurologists, and shall meet on a quarterly basis to verify the appropriateness and need for such treatment. Records submitted to these committees shall have data identifying the patient deleted, except where disclosure is otherwise authorized by Welfare and Institutions Code Sections 5328, et seq.

(c) Refusal by any facility or physician to submit convulsive treatment and insulin coma treatment cases for review shall be reported by the review committees to the Director of the State Department of Mental Health who may take any or all of the actions specified in Section 5326.9 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 5326.91, 5326.95 and 5400, Welfare and Institutions Code. Reference: Section 5326.91, Welfare and Institutions Code.

§ 849. Excessive Use of Convulsive Treatment.

(a) Convulsive treatments shall be considered excessive if more than 15 treatments are given to a patient within a 30–day period, or a total or more than 30 treatments are given to a patient within a one–year period.

(b) If, in the judgment of the attending physician, more than the above limits are indicated, prior approval must first be obtained from the review committee of the facility or county, whichever is appropriate. (Sections 847 and 848.) Requests for approval shall

include documentation of the diagnosis, the clinical findings leading to the recommendation for the additional treatments, the consideration of other reasonable treatment modalities and the opinion that additional treatments pose less risk than other potentially effective alternatives available for the particular patient at the present time. A maximum number of additional treatments shall be specified. The review committee shall act upon any such request within seven days of its receipt and shall document the maximum number of additional treatments approved. All applicable informed consent procedures shall also be followed.

NOTE: Authority cited: Sections 5326.95 and 5400, Welfare and Institutions Code. Reference: Section 5326.95, Welfare and Institutions Code.

Article 5.5. Voluntary Patients' Right to Refuse Antipsychotic Medications

§ 850. Refusal of Antipsychotic Medications.

Every person admitted as a voluntary patient for psychiatric evaluation or treatment in any facility as listed in Section 860 of this subchapter has the right to refuse the administration of antipsychotic medications.

A voluntary patient for purposes of this article does not include:

(a) voluntary minor patients unless such minor is otherwise authorized by law to seek and consent to treatment for mental illness, nor

(b) conservatees (as defined by Section 5350 et seq. of the Welfare and Institutions Code, i.e., "L–P–S conservatees") whose conservators have been given the right to require their conservatees to receive treatment related specifically to remedying or preventing the recurrence of the conservatees' being gravely disabled.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325, 5325.1, 5358, 6000, 6002 and 6004, Welfare and Institutions Code.

§ 851. Informed Consent to Antipsychotic Medications.

A voluntary patient shall be treated with antipsychotic medications only after such person has been informed of his or her right to accept or refuse such medications and has consented to the administration of such medications. In order to make an informed decision, the patient must be provided with sufficient information by the physician prescribing such medications (in the patient's native language, if possible) which shall include the following:

(a) The nature of the patient's mental condition,

(b) The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff,

(c) The reasonable alternative treatments available, if any,

(d) The type, range of frequency and amount (including use of PRN orders), method (oral or injection), and duration of taking the medications,

(e) The probable side effects of these drugs known to commonly occur, and any particular side effects likely to occur with the particular patient,

(f) The possible additional side effects which may occur to patients taking such medication beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might at times include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code; *Cobbs v. Grant* (1972) 8 Cal. 3d 229.

§ 852. Maintenance of Records.

For each patient receiving antipsychotic medications, the facility shall maintain a written record of the patient's decision to consent to such medications.

That written record shall be a written consent form signed by the patient indicating that items (a) through (f) of Section 851 have been discussed with the patient by the prescribing physician.

In the event that the patient has been shown but does not wish to sign the written consent form, it shall be sufficient for the physician to place the unsigned form in the patient's records maintained by the facility together with the notation that while the patient understands the nature and effect of antipsychotic medications and consents to the administration of such medications, the patient does not desire to sign a written consent form.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code.

§ 853. Emergency.

Nothing in this article is intended to prohibit the physician from taking appropriate action in an emergency. An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent. If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient.

NOTE: Authority cited: Sections 5325, 5326 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code; *Cobbs v. Grant* (1972) 8 Cal. 3d 229.

§ 854. Withdrawal of Consent.

A voluntary patient may withdraw consent to the administration of antipsychotic medications at any time by stating such intention to any member of the treatment staff.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325, 5325.1, 6000, 6002 and 6004, Welfare and Institutions Code.

§ 855. Consequence of Refusal.

The refusal to consent to the administration of antipsychotic medications shall not in itself constitute grounds for initiating an involuntary commitment.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5150, 5250, 5325 and 5325.1, Welfare and Institutions Code.

§ 856. Definition of Antipsychotic Medication.

For purposes of this article, ''antipsychotic medication'' means any drug customarily used for the treatment of symptoms of psychoses and other severe mental and emotional disorders.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Title 9, California Administrative Code, Sections 850–855.

§ 857. Reports of Violations.

Any alleged or suspected violation of the rights of patients as set out in this article shall be reported to the county patients' rights advocate, or for state hospital patients, to the state hospital patients' rights advocate, who shall report all complaints to the Director of the State Department of Mental Health. The Director shall take appropriate action which, depending on the nature of the complaint, could include:

(a) Referral for disciplinary action to the facility governing body for review and monitoring,

(b) Referral to the Board of Medical Quality Assurance regarding a review of the individual practitioner's license,

(c) Referral for review of the facility license,

(d) Compelling negotiations to ensure compliance with these regulations, withholding part or all of state mental health funds, or taking appropriate court action.

The remedies provided by these regulations shall not preclude any other remedies which the individual patient may have under the law.

NOTE: Authority cited: Sections 5325 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325, 5325.1, 5326.9 and 5655, Welfare and Institutions Code.

Article 6. Patient Rights: Denial for Good Cause

§ 860. Application of Article.

NOTE: Authority cited: Section 5326, Welfare and Institutions Code. Reference: Section 5326, Welfare and Institutions Code.

§ 861. List of Rights.

§ 862. Notification of Rights.

(a) A list of the rights set forth in Section 5325 of the Welfare and Institutions Code and in Section 861, as well as the complaint procedure, prescribed in Section 864, shall remain posted, in English and Spanish, in all wards and common living areas of facilities specified in Section 860.

(b) Each person admitted to a facility specified in Section 860 shall be personally notified of his rights in writing, in language he can understand, or shall have his rights brought to his attention by other means if he is unable to read or understand the information provided him.

(c) A notation to the effect that notification, or an attempt to provide notification, has occurred, shall be entered in the patient's/resident's record within 24 hours of admission.

§ 863. Definitions.

(a) The ''Patients' Rights Specialist'' means the person in the Headquarters Office of the Department of Health delegated the responsibility for ensuring that mentally and developmentally disabled persons in facilities providing mental health services or residential care are afforded their statutory and constitutional rights.

(b) The ''Patients' Advocate'' means the person in a local mental health program delegated the responsibility for ensuring that mentally disabled persons in facilities specified in Section 860 are afforded their statutory and constitutional rights.

(c) The ''Residents' Advocate'' means the person in a regional center program delegated the responsibility for ensuring that developmentally disabled residents in facilities specified in Section 860 are afforded their statutory and constitutional rights.

§ 863.1. Assignment of Patients'/Residents' Advocate.

(a) Each county mental health director shall assign a Patients' Advocate to handle complaints of mentally disabled patients and residents regarding the abuse, unreasonable denial, or punitive withholding of a right guaranteed under Section 861 of this article. Each regional center director shall assign a Residents' Advocate to handle similar complaints from developmentally disabled residents. If the person assigned to handle complaints is a member of the staff of a particular facility, he shall not be involved in the direct supervision of patients or residents of that facility.

(b) The appointment of a Patients'/Residents' Advocate in a state hospital, as well as the complaint procedure to be observed there, shall be in accordance with Department of Health directives on the patients' rights program for state hospitals.

§ 863.2. Duties of Patients'/Residents' Advocate.

(a) The Patients'/Residents' Advocate shall:

(1) Ensure that the rights listed in Section 5325 of the Welfare and Institutions Code and in Section 861 remain posted in all facilities where posting is required pursuant to Section 860.

(2) Ensure that all incoming patients/residents are notified of these rights.

(3) Assist in training staff of facilities specified in Section 860 regarding patients'/residents' rights.

(4) Investigate complaints of patients/residents or their responsible relatives, and, if necessary, act as advocate for patients/residents.

(5) Act as advocate in behalf of patients/residents who are unable to register a complaint because of their mental or physical condition.

(6) Act as local consultant in the area of patients'/residents' rights.

(7) Act as liaison to the Patient Rights Specialist, Department of Health.

§ 864. Complaint Procedure.

(a) The list of rights that shall be posted, provided, or explained to the patient/resident pursuant to Section 862 shall contain:

(1) Notification that any patient/resident who believes a right of his/hers has been abused, punitively withheld, or unreasonably denied may file a complaint with the Patients'/Residents' Advocate.

(2) The name of the Patients'/Residents' Advocate who has been assigned to handle such complaints, his telephone number, and the times during which he may be contacted.

(b) When a complaint is received by the Patients'/Residents' Advocate he shall, within two working days, take action to investigate and resolve it.

(c) If the complainant expresses dissatisfaction with the action taken, the matter shall be referred, within five working days, to the local mental health director if the complaint originated in the mental disabilities program or to the regional center director if the complaint originated in the developmental disabilities program.

(d) If the complaint cannot be satisfactorily resolved by the local mental health director or by the regional center director within ten working days, it shall be referred to the Patients' Rights Specialist, Department of Health, whose responsibility it shall be to make a decision in the case. Appeal from the decision of the Patients' Rights Specialist may be made to the Director of State Department of Health, or his designee.

§ 865. Authority for Denial of Rights.

(a) (Reserved)

(b) ''Professional person in charge of the facility'' is defined in Section 822 of this subchapter, Title 9, California Administrative Code; in community care facilities it is the administrator of the facility. Prior to denying the rights, as listed in Section 861, of a resident for good cause, the administrator of a community care facility shall first obtain concurrence from the resident's physician or social worker that good cause for denial exists.

(c) Notwithstanding the provisions of this article, good cause denial of that right listed under subdivision (f) of Section 5325 shall be in accordance with the provisions set forth in Article 7 (commencing with Section 5325) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code, as interpreted by court decision.

(d) Any person who has the lawful right on his own choice to discharge himself from a facility shall be informed of said right at the time of admission to the facility. If the person elects to discharge himself from the facility rather than voluntarily accepting any denial of his rights, such election shall be documented in his treatment record, and the person shall be permitted to leave the facility.

§ 865.1. Denial of Rights in Community Care Facilities.

(a) A right listed in Section 861 of this article may be denied a resident of a licensed community care facility only upon the failure of all other means taken to resolve the behavior necessitating denial.

(b) Agreements and negotiations between the resident, administrator, and social worker shall be the primary means of resolving problems regarding the rights of the resident.

(c) If the community care facility, after compliance with subsections (a) and (b) of this section, wishes to deny one or more Section 861(a) through (e) rights, the procedure of Section 865 must be followed.

§ 865.2. Good Cause for Denial of Rights.

(a) Rights listed in Section 861, except for that right listed in subdivision (g), may be denied only for good cause, and the rights under subdivision (f) may be denied only under the conditions

specified in Article 7 (commencing with Section 5325) of Chapter 2 of Part 1 of Division 5 of the Welfare and Institutions Code. Good cause for denying a patient/resident the exercise of a right exists when the professional person in charge of a facility or his designee has good reason to believe:

(1) That the exercise of the specific right would be injurious to the patient/resident; or

(2) That there is evidence that the specific right, if exercised would seriously infringe on the rights of others; or

(3) That the institution or facility would suffer serious damage if the specific right is not denied; and

(4) That there is no less restrictive way of protecting the interests specified in (1), (2), or (3).

(b) The reason used to justify the denial of a right to a patient/resident must be related to the specific right denied. A right shall not be withheld or denied as a punitive measure, nor shall a right be considered a privilege to be earned.

(c) Treatment modalities shall not include denial of any right specified in Section 861 of this article. Waivers signed by the patient/resident or by the responsible relative/guardian/conservator shall not be used as a basis for denying Section 861 rights in any treatment modality.

§ 865.3. Documentation of Denial of Rights.

(a) Each denial of a patient's/resident's right shall be noted in his treatment record. Documentation shall take place immediately whenever a right has been denied. The notation shall include:

(1) Date and time the right was denied.

(2) Specific right denied.

(3) Good cause for denial of right.

(4) Date of review if denial was extended beyond 30 days.

(5) Signature of the professional person in charge of the facility or his designee authorizing denial of right.

(b) The patient/resident shall be told of the content of the notation.

(c) Each denial of a right shall be documented regardless of the gravity of the reason for the denial or the frequency with which a specific right is denied in a partiular facility or to a particular individual.

§ 865.4. Seclusion and Restraints.

(a) Seclusion is the involuntary isolation of a patient in a locked room. Seclusion and/or restraints shall never be used as punishment or as a substitute for a less restrictive alternative form of treatment.

(b) Each instance of seclusion and/or restraints shall be noted in the patient's record in accordance with Section 865.3.

(c) Documentation of the Section 861 rights actually denied a person in seclusion or restraints shall be entered in the patient's record.

(d) In addition to the foregoing, all of the provisions contained in Sections 70577(j) (General Acute Care Hospitals), 71545 (Acute Psychiatric Hospitals), 72407, 72409, 72411, 72413 (SNF), and 73403, 73405, 73407, 73409 (ICF) of Title 22 of the California Administrative Code shall prevail as applicable rules for the respective health care facilities.

(e) The authority for the use of seclusion and/or restraints on any resident of a community care facility shall be in accordance with provisions of Title 22, California Administrative Code, Section 80403(f).

§ 865.5. Restoration of Rights.

A right shall not continue to be denied a patient/resident when the good cause for its denial no longer exists. When a right has been denied, staff shall employ the least restrictive means of managing the behavior problem which led to the denial. The date a specific right is restored shall be documented in the patient's/resident's treatment record.

§ 866. Quarterly Reports to the Director of Health.

(a) Each local mental health director shall, by the last day of January, April, July, and October, report on the appropriate form to the Patients' Rights Specialist, Department of Health, the number of persons, by facility, whose rights were denied and the specific right or rights denied. Denials of rights in the following types of local facilities must be reported to the local mental health director for inclusion in each quarterly report:

(1) Facilities that treat persons involuntarily detained under the Lanterman–Petris–Short Act;

(2) Local mental health facilities operated directly by or under contract with local mental health services or designated in the county plan to provide such services;

(3) Private mental institutions;

(4) Psychiatric units of general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities.

(b) The content of the quarterly reports shall enable the State Director of Health and the Patients' Rights Specialist to identify individual treatment records, if necessary, for further analysis and investigation.

(c) Each facility shall note in its report to the local mental health directors that the treatment record of a person denied a specific right is identifiable and can be located for purposes of analysis and investigation by the Department.

(d) State hospitals shall submit quarterly reports on denials of rights directly to the Patients' Rights Specialist, Department of Health, in accordance with Department directive on the patients' rights program in state hospitals, as revised 1975.

§ 867. Access to Denial of Rights Information.

Information in a patient's/resident's treatment record pertaining to a denial of a right shall be available on request to the patient/resident, his attorney/conservator/guardian, the Department of Health, a member of the State Legislature, or a member of a county board of supervisors.

§ 868. Annual Review.

(a) The Patients' Rights Specialist shall, with the assistance of the Patients'/Residents' Advocate, conduct an annual review of the patients' rights program in each local mental health program and regional center.

(b) The Patients' Rights Specialist shall submit a report of the annual review to the local mental health director or the regional center director, as appropriate, with a copy to the Mental Disabilities Services Branch Chief, or the Developmental Disabilities Branch Chief, as appropriate.

Chapter 4.5. Patients' Rights and Related Procedures for Non–Lanterman–Petris–Short Act Patients in Department of Mental Health Facilities

Article 1. General Provisions

§ 880. Application of Chapter.

Chapter 4.5 applies to patients' rights and related procedures for all non–Lanterman–Petris–Short Act (LPS) patients placed in or committed to a treatment program in a Department of Mental Health facility, except when transferred to or placed in a federally certified program.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 4027, Welfare and Institutions Code.

§ 881. Definitions, Abbreviations and Program Terms.

(a) "Abuse" means physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering. The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

(b) "Administrative isolation" means the temporary separation of a patient from other patients and the normal living environment for the purpose of protecting possible evidence or maintaining safety and security during a criminal investigation.

(c) "Confidential mail" means letters or documents sent to or received from attorneys, courts or government officials through the mail.

(d) "Confidential telephone calls" means telephone calls that are not monitored or recorded by hospital staff.

(e) "Contraband" means materials, articles, or goods that patients are prohibited from having in their possession because such materials, articles or goods present a risk to safety and security in the facility.

(f) "Department " means the State Department of Mental Health.

(g) "Facility" means a state hospital or other locked inpatient facility operated by the Department, either directly or by contract, for the care and treatment of non–LPS patients.

(h) "Facility director" means the Executive Director or designee in overall charge of the facility.

(i) "Facility monetary replacement system" means the alternate methods used to allow patients to purchase personal items within the facility without using United States currency.

(j) "Interdisciplinary team" means the group of persons from each of the disciplines or service areas that works directly with the patient.

(k) "Medical care" means procedures determined to be medically necessary, and that are not merely cosmetic in nature.

(*l*) "Medical isolation" means the confinement of a patient alone in a room for the purpose of preventing the spread of infectious or contagious diseases that may be a public health concern.

(m) "Mental disorder" means a diagnosed mental disorder listed in the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, DSM–IV–TR, 2000.

(n) "Neglect" means the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

(o) "Non–LPS" means that the placement in or commitment to the facility is pursuant to legal authority other than the Lanterman–Petris–Short (LPS) Act, commencing with Section 5000, of Part 1, Division 5 of the Welfare and Institutions Code).

(p) "Office of Patients' Rights" means the contractor designated in accordance with Section 5510 of the Welfare and Institutions Code. The contractor is delegated the responsibility for providing direct advocacy and investigative services in the state hospitals and technical assistance, training and advice regarding patients' rights to advocates, mental health programs and/or patients.

(q) "Package" means a wrapped or boxed object, a parcel, or a container in which something is packed for storage, mailing, or transporting.

(r) "Patient" means a person placed in or committed to a facility under authority of law for care and treatment.

(s) "Patients' Rights Advocate" means the person in the facility delegated the responsibility for reviewing and attempting to resolve patients' rights complaints and for ensuring that patients' rights of mentally disordered persons in the facility are observed and protected. This individual shall have no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

(t) "Physical restraint" means the direct application of physical force and/or approved restraining devices and methods to an individual, to restrict and/or limit freedom of movement.

(u) "Privacy" means being free from observation by individuals of the opposite sex during medical examinations, personal care, bathing and restroom use, except during emergencies and necessary supervision by staff.

(v) "Protective isolation" means the separation of a patient from other patients and the normal living environment to protect that individual from harm by others.

(w) "Safety" means protection of persons and property from potential danger, risk, injury, harm or damage.

(x) "Security" means the measures necessary to achieve the management and accountability of patients of the facility, staff, and visitors, as well as property of the facility.

(y) "Seclusion" means the involuntary confinement of a person in a locked room or any area where the person is physically prevented from leaving.

(z) "Treatment" means clinical intervention and action that is devised and implemented based on comprehensive assessment of the patient by the interdisciplinary team and that is designed to improve or stabilize a diagnosed mental and/or physical condition.

(aa) "Treatment Plan" means the method developed by the interdisciplinary team to implement treatment for the patient on an ongoing basis. The treatment plan is documented in writing in the patient's medical record, includes specific goals and objectives, identifies a continuum of care, and is reviewed and modified at frequent intervals by the interdisciplinary team.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 4005.1 and 4027, Welfare and Institutions Code.

Article 2. Non–LPS Patients' Rights

§ 882. Notification of Rights.

(a) Upon admission to the facility, each non–LPS patient shall be informed of the rights specified in Sections 883 and 884 and given a copy of their rights in the language or modality understood by the patient.

(b) These patients' rights shall also be prominently posted in the predominant languages of the patients in patients' living areas.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 4027 and 5600.2(a), Welfare and Institutions Code.

§ 883. Non–LPS Patients' Rights — Non–Deniable.

(a) The patient's parent, guardian, or conservator may not waive the rights listed in this Section unless authority to waive these rights is specifically granted by court order.

(b) Non–LPS Patients have the following rights:

(1) A right to privacy, dignity, respect and humane care.

(2) A right to receive treatment for a diagnosed mental disorder that is provided in a method least restrictive of individual liberty and promotes personal independence.

(3) A right to medical care and treatment for physical ailments and conditions according to accepted clinical standards and practices.

(4) A right to refuse psychosurgery, electroconvulsive therapy, experimental and other hazardous procedures.

(5) A right to be free from harm including abuse or neglect, and unnecessary or excessive medication, restraint, seclusion, or protective or administrative isolation. Medication, restraint, seclusion, or protective or administrative isolation shall not be used as punishment, as retaliation for filing complaints, for the convenience of staff, as a substitute for a treatment program or in quantities that interfere with the patient's treatment.

(6) A right to confidential case discussions, consultation, examination, and patient records. Confidential information shall only be provided to those people providing evaluation and/or treatment or as authorized by law.

(7) A right to be informed of the procedures for filing complaints and the process for appeals when complaints are not resolved to the patient's satisfaction.

(8) A right to access the services of a Patients' Rights Advocate.

(9) A right to confidential communications with an attorney, either through correspondence or through private consultation, during regularly scheduled visiting days and hours.

(10) A right to religious freedom and practice, within the context of the environment of a secure treatment facility.

(11) A right to opportunities for physical exercise and recreational activities.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 4027, Welfare and Institutions Code.

§ 884. Patients' Rights Subject to Denial for Good Cause.

(a) The patient's parent, guardian, or conservator may not waive the rights listed in this Section unless authority to waive these rights is specifically granted by court order. These rights shall only be denied for good cause in accordance with Subsection (b) of this Section.

(b) Non–LPS Patients have the following rights, subject to denial for good cause:

(1) A right to keep and use personal possessions as space permits, except items and materials that are listed as contraband by the facility. Each facility shall make a copy of the contraband listing available on all treatment units and public areas within the facility. Each patient shall receive a copy of the contraband listing upon admission.

(2) A right to have access to individual secured storage space for personal possessions in accordance with the formal policies and procedures of the facility. Title 19, Section 314 and Title 22, Sections 71543 and 73507 require hospitals and licensees to comply with State Fire Marshall regulations.

(3) A right to keep and spend a sum of the patient's own money via the facility monetary replacement system.

(4) A right to personal visits during regularly scheduled visiting days and hours. The right to have visits shall not be denied except as is necessary for reasonable security of the facility and the safety of persons. The length and frequency of visits and the number of persons permitted to visit a patient at the same time may be limited consistent with safety, security, and to ensure that all patients have a fair opportunity to have visitors.

(5) A right to access telephones to make and receive confidential telephone calls, or to have such calls made for them. Telephone hours, frequency and duration of telephone calls, and method of payment may be limited to ensure access by all patients.

(6) A right to have access to letter writing materials and to mail and receive correspondence. Designated facility employees shall open and inspect all incoming and outgoing mail addressed to and from patients for contraband. Confidential mail, as defined in Section 881(c), shall not be read. Limitations on size, weight and volume of mail shall be specified by formal facility policy.

(7) A right to receive packages. Designated facility employees shall open and inspect all incoming and outgoing packages addressed to and from patients for contraband. Limitations on the size, weight and volume, and frequency/number of packages allowed shall be specified by formal facility policy.

(8) A right to have access to legal reference material. Limitations on the time, duration, frequency, and method of access shall be specified by formal facility policy to ensure opportunity for access by all patients.

(9) A right to participate in appropriate programs of publicly supported education that are consistent with the patient's treatment plan and with the secure treatment facility environment.

(10) A right to social interaction. The formation of supervised patient leisure time activity groups that promote educational, social, cultural and recreational interests of participating patients shall be permitted, except for activities that pose a threat to safety and security.

(c) The rights specified in Subsection (b) of this Section shall be denied only for good cause. Good cause for denying a patient the exercise of a right exists when the facility director determines that:

(1) The exercise of the specific right would be injurious to the patient; or

(2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others; or

(3) The facility would suffer serious damage if the specific right is not denied, or;

(4) The exercise of the right would compromise the safety and security of the facility and/or the safety of others; and

(5) That there is no less restrictive way of protecting the interests specified in Subsections (c)(1) through (4) of this Section.

(d) The reason for denial of a right under this Section must be related to the specific right denied. A right specified in this Section shall not be withheld or denied as a punitive measure, nor shall a right specified in this Section be considered a privilege to be earned. A denial of a right shall not exceed thirty days without additional staff review. Treatment plans shall not include denial of any right specified in Subsection (b) of this Section.

(e) Each denial of a right specified in this Section shall be noted in the patient's treatment record. Documentation shall take place immediately whenever a right is denied. The notation shall include:

(1) Date and time the right was denied.

(2) Specific right denied.

(3) Good cause for denial of right.

(4) Date of review if denial was extended beyond 30 days.

(5) The facility director's signature authorizing the denial.

(f) The patient shall be told of the content of the notation and the process for restoration at the time of the denial.

(g) Each denial of a right specified in this Section shall be documented regardless of the reason for the denial, or the frequency with which a specific right is denied in a particular facility, or to a particular patient.

(h) A patient's right under this Section shall be restored when the good cause for its denial no longer exists. When a right has been denied, staff shall employ the least restrictive means of managing the behavior that led to the denial. The date that a specific right is restored shall be documented in the patient's treatment record.

(i) Information in the patients' treatment record pertaining to a denial of rights shall be available on request to the patient, their attorney/conservator/guardian, the Department, or excluding the patient identity, a member of the State Legislature.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 4027, Welfare and Institution Code.

§ 885. Complaint and Appeal Procedure.

Non–LPS patients shall be informed of and provided with a written procedure for filing complaints or appeals alleging violations of any right(s) contained in Sections 883 and 884. The written procedure shall contain the following information:

(a) Notification that any patient who believes a patients' right listed in this Article has been abused, punitively withheld, or unreasonably denied may file a complaint with the Patients' Rights Advocate.

(b) The contact name of the Patients' Rights Advocate assigned to address patients' rights complaints, their telephone number and contact times.

(c) A statement that the Patients' Rights Advocate shall take action to investigate and address patients' rights complaints within two working days.

(d) A statement that if the complainant is not satisfied with the response and/or action taken pursuant to Subsection (c) of this Section, the complainant may, within ten working days, request that the complaint be referred to the facility director for review and response.

(e) A statement that the facility director shall take action to review the patients' rights complaint and issue a response within fifteen working days.

(f) A statement that if the complainant is not satisfied with the response of the facility director, the complainant may, within thirty working days, request that the complaint be referred to the Office of Patients' Rights for review and response.

(g) A statement that if the complainant is not satisfied with the response of the Office of Patients Rights, the complainant may

request, within thirty working days, that the complaint be referred to the Director of the Department.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 4027, Welfare and Institutions Code.

§ 886. Quarterly Reports to the Office of Patients' Rights.

(a) Each facility director shall file quarterly reports with the Office of Patients' Rights, by the last day of January, April, July, and October. These reports shall list the number of patients whose right or rights were denied and the specific right or rights that were denied.

(b) The quarterly reports shall enable the Director of the Department and the Office of Patients' Rights to identify individual treatment records, if necessary, for further analysis and investigation.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Section 4027, Welfare and Institutions Code.

Article 3. General Limitations Applicable to Non–LPS Patients.

§ 890. Clothing.

The facility director shall specify the types of clothing that are authorized to be worn by non–LPS patients in the facility.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 4027 and 7232, Welfare and Institutions Code.

§ 891. Internet Usage.

Non–LPS patients shall not have access to the Internet.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 4005.1 and 4027, Welfare and Institutions Code.

§ 892. Operating Businesses from Within the Facility.

Non–LPS patients shall not operate a business from within the facility. If there is any business activity of a patient or disposition of property owned by a patient that needs to be attended to or to be administered, the patient shall designate a person outside the facility to be responsible for doing so. If necessary, the patient shall execute a power of attorney or other legally authorizing instrument that allows the patient's designee the legal authority to take care of the patient's business or property while the patient is in the facility.

NOTE: Authority cited: Sections 4005.1 and 4027, Welfare and Institutions Code. Reference: Sections 4005.1 and 4027, Welfare and Institutions Code.

Chapter 5. Conduct of Research and Patient Data Information Requirements in Facilities Providing Service Under Divisions 5, 6, or 7 of the Welfare and Institutions Code

Article 1. Application

§ 900. Application of Chapter.

Chapter 5 shall apply to mental health services as provided for in Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), and Division 7 (commencing with Section 7000) of the Welfare and Institutions Code, to either voluntary or involuntary patients.

NOTE: Authority cited for Subchapter 5: Sections 4101, 5750, 7003, 7201, Welfare and Institutions Code. Reference: Section 5328(e), Welfare and Institutions Code.

§ 901. Section Headings.

Article 2. Definitions and General Provisions

§ 910. Department.

''Department'' means the State Department of Mental Health.

NOTE: Authority cited: Sections 4012 and 5400, Welfare and Institutions Code. Chapter 1252, Statutes of 1977.

§ 911. Shall and May.

As used in this subchapter, ''shall'' is mandatory and ''may'' is permissive.

§ 912. Facilities.

As used in this subchapter ''facilities'' include every State Hospital, Neuropsychiatric Institute, Local Mental Health Service, private or public establishment and institution providing services under Divisions 5, 6 or 7 of the Welfare and Institutions Code.

Article 3. Research

Article 4. Patient Data Information

NOTE: Authority cited for Article 4: Sections 4011, 5750, 6002, 7003 and 7201, Welfare and Institutions Code.

Chapter 6. Joint Regulations for Handicapped Children—Interagency Responsibilities for Providing Services to Handicapped Children

§ 1000. Joint Regulations for Handicapped Children

CROSS–REFERENCE: See Title 2, Division 9, Articles 1–9, Sections 60000–60610, not consecutive.

Chapter 7. Acute and Nonacute Levels of 24–Hour Mental Health Care Provided by County Mental Health Agencies in Correctional Treatment Centers

§ 1101. Application of Chapter.

This Chapter shall apply to acute and nonacute levels of 24– hour mental health care provided by county mental health agencies in correctional treatment centers in local detention facilities.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a). Health and Safety Code. Reference: Sections 1250(i) and 1254, Health and Safety Code.

§ 1102. Definitions.

The following definitions contained in Article 1 (commencing with Section 79501) of Chapter 12 of Division 5 of Title 22 as adopted by the Department of Health Services shall apply to terms used in this chapter; Sections 79509; 79511; 79513; 79516; 79531; 79535; 79537; 79539; 79541; 79543; 79547; 79551; 79559; 79561; 79564; 79565; 79567; 79569; 79571; 79575 and 79577.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1103. Mental Health Treatment Program.

A mental health treatment program shall be organized, staffed, and equipped to provide mental health treatment services for inmate–patients who require 24–hour inpatient care and treatment for acute or nonacute mental health disorders. A mental health treatment program is an optional program within a licensed correctional treatment center and therefore shall be subject to all pertinent rules contained in 22 CCR Sections 79501 through 79861.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1104. Mental Health Treatment Program—General Requirements.

(a) The mental health treatment program shall be only for inmate–patients with a diagnosable mental disorder who require 24–hour mental health care.

(b) Each mental health treatment program shall have a clinical director who shall direct the clinical program, provide general direction to professional and nonprofessional staff and be responsible for the quality of clinical services performed in the facility.

(c) The clinical director of the mental health treatment program in

consultation with other mental health staff, shall develop and implement written policies and procedures for the mental health treatment program.

(d) There shall be preadmission patient screening for each inmate–patient completed by the clinical director or his or her designee.

(e) Release of medical records or mental health treatment information concerning any inmate–patient shall be only as authorized under Section 5328 of the Welfare and Institutions Code.

(f) Involuntary mental health treatment, including involuntary medication, shall be provided only as authorized in accordance with Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code, unless involuntary treatment is otherwise authorized by law.

NOTE: Authority cited: Sections 1250.1(a)(12) and 2367.10(a), Health and Safety Code. Reference: Sections 1250(i) and 1254, Health and Safety Code.

§ 1105. Mental Health Treatment Program—Admission and Discharge Policies.

(a) Each mental health treatment program shall develop and implement written admission and discharge policies approved by the Governing Body encompassing which staff members authorized by law to diagnose and treat may admit or discharge inmate–patients, the types of diagnoses for which inmate–patients may be admitted, limitations imposed by law or licensure, staffing limitations, preadmission inmate–patient screening, rules governing emergency admission, limitation of services, termination of services, discharge of inmate–patients and other relevant functions.

(b) No inmate–patient may be placed in a mental health treatment program who is not admitted as an inmate–patient by a member of the mental health treatment program staff.

(c) The inmate–patient's condition, provisional diagnosis and a plan for initial treatment shall be determined by admitting staff within 24 hours of admission.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1106. Mental Health Treatment Program—Multidisciplinary Treatment Team.

(a) The multidisciplinary treatment team shall be comprised of those persons who work directly with the inmate–patient in each of the disciplines or service areas that provide service to the inmate–patient, including the clinical director or designee, a psychiatrist, a clinical psychologist, a licensed clinical social worker, a member of the nursing staff and any other staff person who is involved in the treatment and care of the inmate–patient.

(b) The multidisciplinary treatment team shall provide assessment, and any reassessment, of an inmate–patient's individual treatment plan.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(i) and 1254, Health and Safety Code.

§ 1107. Mental Health Treatment Program—Individual Treatment Plan.

(a) The individual treatment plan shall:

(1) Be developed in writing by the multidisciplinary treatment team and, where possible, in collaboration with the inmate–patient. The treatment plan shall be developed as soon as possible, but no later than 72 hours following the inmate–patient's admission.

(2) Be based on a comprehensive assessment of the inmate–patient's physical, mental, emotional and social needs.

(3) Be reviewed and updated as often as indicated, but no less often than every seven (7) days, weekends and holidays excepted, for acute mental health inmate–patients and every thirty (30) days for nonacute mental health inmate–patients.

(4) Include, but not be limited to:

(A) A statement of the inmate–patient's physical and mental condition, including all mental health diagnoses.

(B) Prescribed medication, dosage and frequency of administration.

(C) Specific goals of treatment with intervention and actions that identify steps toward improvement or recovery and observable, measurable objectives.

(D) Identification of methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(E) Documentation of the success or failure in achieving stated objectives.

(F) Evaluation of the factors contributing to the inmate–patient's progress or lack of progress toward recovery and a statement of the multidisciplinary treatment team decision for follow–up action.

(G) An activity plan.

(H) A plan for other services needed by the inmate–patient which are not provided by the mental health treatment program.

(I) Goals for aftercare and a plan for post–discharge follow–up.

(b) The individual treatment plan shall be in writing and be approved by a clinical psychologist, psychiatrist, licensed clinical social worker, licensed marriage, family and child counselor, or a psychiatric mental health nurse designated by the clinical director.

(c) The staff shall observe and note any chances in the inmate–patient's condition and the treatment plan shall be modified in response to the observed changes.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1108. Mental Health Treatment Program—Services.

(a) Psychiatric and psychological services.

(1) Psychiatrists or clinical psychologists, within the scope of their licensure and subject to the rules of the facility, shall be responsible for the initial diagnosis of each inmate–patient.

(2) An inmate–patient shall be evaluated by a psychiatrist as soon as possible but not later than seventy–two (72) hours from the time staff determines that the inmate–patient requires or may require psychotropic medication.

(b) Social work services shall be organized, directed and supervised by a licensed clinical social worker.

(c) Mental health rehabilitation therapy services.

(1) Mental health treatment programs shall provide and conduct organized therapeutic social, recreational and vocational activities in accordance with the interests, abilities and needs of the inmate–patient, and will include the opportunity for exercise.

(2) Mental health rehabilitation therapy services shall be designed by and provided under the direction of a recreational therapist, an occupational therapist, a psychiatrist, a clinical psychologist, a licensed clinical social worker, a licensed marriage, family, and child counselor, or a psychiatric mental health nurse.

(d) Aftercare plan.

(1) A written aftercare plan shall describe those services that should be provided to an inmate–patient following discharge, transfer or release from the mental health program for the purpose of enabling the inmate–patient to maintain stabilization and/or achieve an optimum level of functioning.

(2) Prior to or at the time of discharge, transfer or release from the mental health treatment program, each inmate–patient shall be evaluated concerning the inmate–patient's need for aftercare services. This evaluation shall consider the inmate's potential in–custody housing, proximity to release from incarceration, probable need for community treatment and social services, and need for continued mental health care.

(3) Aftercare plans shall include, but not be limited to, the following:

(A) Arrangement for medication supervision and follow–up care.

(B) Referral to social, vocational or education services, if available and appropriate.

(4) A member of the multidisciplinary treatment team designated by the clinical director shall be responsible for ensuring that the referral of the inmate–patient to the appropriate aftercare service has been completed and documented in the inmate–patient's health record.

(5) Arrangements for necessary community referral, placement, conservatorship or post–discharge care shall be made prior to release from custody.

(6) A copy of the aftercare plan conforming to the requirements of Section 5622 of the Welfare and Institutions Code shall be transmitted to the local director of mental health services or a designee in the county of residence for any inmatepatient referred to community service funded by the Bronzan–McCorquodale Act [Part 2 (commencing with Section 5600) of Division 5 of the Welfare and Institutions Code].

(7) The inmate–patient shall receive a copy of the aftercare plan when referred to community services.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1109. Acute Mental Health Care.

Acute mental health care means that level of voluntary or involuntary 24 hour care that is required to provide ongoing intensive evaluation and treatment by mental health staff to inmate–patients suffering from severe mental disorder. Acute levels of care include, but are not limited to: (1) treatment of acute levels of severe mental disorder or (2) clinical restraint and seclusion. Such inmate–patients are those, who if in the community, would require the services of a licensed health facility providing 24–hour acute mental health care. Such facilities include but are not limited to psychiatric health facilities or acute psychiatric hospitals.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Section 1250(j) and 1254, Health and Safety Code.

§ 1110. Nonacute 24–Hour Mental Health Care.

Nonacute 24–hour mental health care means that level of voluntary or involuntary care that is required to provide mental health services to mentally disordered inmate–patients who are not in need of acute mental health care, but who require general mental health evaluation, diagnostic assessment, treatment, nursing and/or related services, on a 24–hour per day basis in order to achieve stabilization and/or an optimal level of functioning. Such inmate–patients are those who, if in the community, would require the services of a licensed health facility providing 24–hour subacute mental health care. Such facilities include, but are not limited to, skilled nursing facilities with special treatment programs. Subacute has the same meaning as nonacute as defined in this section.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1111. Mental Health Treatment Program Staffing—Basic Requirements.

(a) Each mental health treatment program shall have a clinical director who shall be a psychiatrist, clinical psychologist, licensed clinical social worker, licensed marriage, family and child counselor, or a psychiatric mental health nurse operating within his or her scope of licensure. The clinical director shall have at least three years of direct clinical experience with the severely mentally disordered (after the completion of his or her last year of graduate education).

(b) Only that portion of correctional treatment center staff or contracted employee hours spent on the care of patients in the mental health treatment program may be counted as part of the required staffing pattern.

(c) The required minimum staffing ratios shall be calculated based upon the actual census of inmate–patients receiving 24–hour mental health care.

(d) Mental health treatment program nursing services shall be provided under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Two years of experience in psychiatric nursing; or

(3) Two years of experience in nursing administration or supervision and one year of experience in psychiatric nursing.

(e) A registered nurse with experience in psychiatric nursing shall be employed forty (40) hours per week.

(f) There shall be a registered nurse, a licensed vocational nurse or a psychiatric technician in the mental health treatment area at all times.

(g) In addition to the minimum staffing required above, the mental health treatment program shall employ professional and other staff on all shifts in the number and with the qualifications to provide all necessary services for those inmate–patients admitted for care.

(h) Clinical psychologists, licensed clinical social workers, and licensed marriage, family and child counselors shall be employed pursuant to the provisions of Section 5751.2 of the Welfare and Institutions Code.

(i) Psychiatric postgraduate trainees, interns, residents, postdoctoral fellows or instructors may practice psychiatric medicine under the provisions of Section 2065 of the Business and Professions Code.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code; and Section 5751.2, Welfare and Institutions Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1112. Mental Health Treatment Program Staffing—Acute Care Requirements.

Mental health treatment programs that provide acute 24–hour mental health care shall meet the following dedicated full–time equivalent staff to census ratios for only acute inmate–patients in any 24–hour period. These are minimum requirements of the total numbers of persons to staff all shifts in any 24–hour period. Staff required by earlier sections of this chapter for the disciplines listed in this section may be counted toward meeting the staffing pattern required in this section for that portion of their time that is spent in caring for acute patients. The above staffing requirements in this section for registered nurse, licensed vocational nurse, or psychiatric technician are to be followed instead of the requirement of 2.5 nursing hours per patient day required for other correctional treatment center inmate–patients. That portion of the time of a psychiatric mental health nurse that is counted toward one category of the staffing requirements shall not be counted towards another category of the staffing requirements. Unlicensed custody staff, to the degree they do work that would otherwise be done by mental health workers and who meet the qualifications of mental health workers, as defined in Title 22, Section 79547, may be counted toward the mental health worker requirement. The following chart specifies acute care staffing requirements in relation to the acute mental health care inmate–patient census.

Acute Mental Health Care Census:	1–5	6–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–90	91–100
Staff: Psychiatrist or Clinical Psychologist or Licensed Clinical Social Worker or Licensed Marriage, Family and Child Counselor, or Psychiatric Mental Health Nurse	.5	1	2	3	4	5	6	7	8	9	10
Registered Nurse or Licensed Vocational Nurse or Psychiatric Technician	3	4	5	6	8	10	12	14	16	18	20
Mental Health Worker	1.5	3	5	8	10	13	15	18	20	23	25
TOTALS	5	8	12	17	22	28	33	39	44	50	55

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1113. Mental Health Treatment Program Staffing—Nonacute Care Requirements.

Nonacute 24–hour mental health care may be provided by any correctional treatment center meeting the basic staffing requirements specified in 22 CCR Section 79631, Nursing Service– Staff Required Services, including the requirements for 2.5 nursing hours per patient day, and by the Mental Health Treatment Program Staffing—Basic Requirements, set forth in Section 791.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1114. Mental Health Treatment Program—Space.

Space shall be provided for the conduct of the mental health treatment program and shall include:

(1) A consultation room for interviewing.

(2) An observation room for acutely disturbed inmate–patients.

(3) Indoor or outdoor facilities for therapeutic activities.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 1115. Clinical Restraint, Treatment Restraint, and Clinical Seclusion.

(a) Written policies and procedures concerning the use of clinical restraint, treatment restraint, and clinical seclusion shall be developed and approved by the correctional treatment center administration.

(b) Clinical restraint and clinical seclusion shall be based on a written or verbal order of a psychiatrist or clinical psychologist. Clinical restraint shall additionally require a physician's or physician's assistant's, or nurse practitioner's written or verbal approval operating under the supervision of a physician. The order shall include the reason for restraint or seclusion and the types of restraints. Under emergency circumstances, clinical restraint or clinical seclusion may be applied and then an approval and/or an order shall be obtained as soon as possible, but at least within one hour of application. Emergency circumstances exist when there is a sudden marked change in the inmate–patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate–patient or others, and it is impractical to first obtain an order and approval. Telephone orders and approvals for clinical restraint and clinical seclusion shall be received only by licensed medical and mental health care staff, shall be recorded immediately in the inmate–patient's health record, and shall be signed within twenty–four (24) hours.

(c) A physician shall complete a medical assessment of an inmate–patient at the earliest opportunity but not later than twenty four (24) hours after the inmate–patient has been placed in a clinical restraint or clinical seclusion.

(d) Clinical restraint, treatment restraint and clinical seclusion shall only be used as a measure to prevent injury to self or others. Clinical restraint, treatment restraint and clinical seclusion shall only be used when less restrictive alternative methods are not sufficient to protect the inmate–patient or others from injury, and shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff. Removing an inmate–patient from an activity or area to another unlocked area for a period of time as a way to use separation as a behavioral modification technique shall not be considered clinical seclusion.

(e) Each order for clinical restraint and clinical seclusion shall be in force no longer than twenty–four (24) hours.

(f) There shall be no PRN orders (as needed orders) for clinical restraint and clinical seclusion.

(g) An inmate–patient placed in a clinical restraint shall be physically checked at least every fifteen (15) minutes by nursing staff to assure that the restraints remain properly applied, that circulation is not impaired, that the inmate–patient is not in danger of harming himself or herself, and that other medical problems are not present. Fluids and nourishment shall be provided every two (2) hours, except during sleep. An opportunity to use a toilet or, when necessary, an alternative shall be provided every two hours, except during sleep. An inmate–patient placed in clinical seclusion shall be checked by nursing staff at least every fifteen (15) minutes. Routine range of motion exercises shall be done with clinically restrained inmate–patients for at least ten (10) minutes every two hours. A written record shall be kept of these checks and exercises, and maintained in the individual inmate–patient health record.

(h) The inmate–patient's health record shall include written justification for the application of clinical restraints, note the times of application and removal of clinical restraints and document the inmate–patient's status, the judgment of a physician or clinical psychologist on the necessity of continuing the order, and the approval of a physician on the medical safety of the continuation of restraints at a minimum of once every twenty–four (24) hours.

(i) Clinical and treatment restraints shall be used in such a way as to minimize the risk of physical injury to the inmate–patient and to ensure the least possible discomfort. The minimum necessary force shall be used. Belts and cuffs shall be well padded.

(j) Clinical restraints shall be placed on inmate–patients only in an

area that is under direct observation of staff. Such inmate–patients shall be afforded protection from other inmate–patients who may also be in the area.

NOTE: Authority cited: Sections 1250.1(a)(12) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 5325, Welfare and Institutions Code.

Chapter 8. Recovery Houses

NOTE: Authority cited: Sections 11217, Health and Safety Code and Sections 4351–4355 and 4360, Welfare and Institutions Code. Reference: Section 11217, Health and Safety Code, and Sections 4350–4370.5, Welfare and Institutions Code.

Chapter 9. Audit Appeals of Community Mental Health Services Under the Short–Doyle Act

Article 1. Definitions

§ 1550. Policy.

Upon conclusion of any audit or examination by or on behalf of the Department of Mental Health or its predecessors, of records or reports of a Local Mental Health Service as defined in subchapter 3, efforts will be made to resolve and reconcile all differences with the Local Mental Health Service. When such differences cannot be resolved, the audit or examination findings shall not be final except as set forth in this article.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1551. Definitions.

The following definitions shall govern the construction of sections 1550 through 1590.

(a) Act. ''Act'' means part 2 of division 5 of the Welfare and Institutions Code, known as the Short–Doyle Act.

(b) Director. ''Director'' means the Director of the Department of Mental Health unless otherwise specified.

(c) Local Director. ''Local Director'' means the administrator or director of the Local Mental Health Service appointed by the governing body.

(d) Department. ''Department'' means the State Department of Mental Health.

(e) May, Shall, and Should. ''May'' is permissive. ''Shall'' is mandatory. ''Should'' means suggested or recommended.

(f) Date of Receipt. The ''Date of Receipt'' shall be the date of signed certified mail receipt. A mailing by the Department shall be properly addressed if addressed to the last address of record with the Department.

(g) Location. The ''location'' of informal conferences and hearings shall be:

The County of San Francisco for Local Mental Health Service in the 1st Appellate District which includes the following counties:

Alameda	Lake	Napa	Santa Clara
Contra Costa	Marin	San Benito	Santa Cruz
Del Norte	Mendocino	San Francisco	Solano
Humboldt	Monterey	San Mateo	Sonoma

The County of Los Angeles for Local Mental Health Service in the 2nd or 4th Appellate District which includes the following counties:

2nd Appellate District

Los Angeles	San Luis Obispo	Santa Barbara	Ventura

4th Appellate District

Orange	Inyo	San Bernardino	San Diego
	Riverside	Imperial	

The County of Sacramento for Local Mental Health Service in the 3rd or 5th Appellate District which includes the following counties:

3rd Appellate District

Alpine	Glenn	Plumas	Sutter
Amador	Lassen	Sacramento	Tehama
Butte	Modoc	San Joaquin	Trinity
Calaveras	Mono	Shasta	Yolo
Colusa	Nevada	Sierra	Yuba
El Dorado	Placer	Siskiyou	

5th Appellate District

Fresno	Kings	Mariposa	Stanislaus
Kern	Madera	Merced	Tulare
			Tuolumne

Notwithstanding the above, the parties by mutual agreement may select any place within the State.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Article 2. Informal Conference

§ 1555. Time for Filing Request.

If a Local Mental Health Service disputes any audit or examination findings, the Local Mental Health Service may file a request within sixty (60) days of the date of receipt of the written notice of the audit or examination findings that the Department of Mental Health conduct an informal conference. This request may be amended at any time during this sixty (60)–day period. A request shall be deemed filed on the date it is delivered or mailed to the Director. If no such request is made, the audit or examination findings shall then be final.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1556. Contents of Request.

The request shall be in writing and shall be known as the ''Statement of Disputed Issues''. It need not be formal, but it shall be specific as to the issues which are in dispute, and it shall set forth the Local Mental Health Service's contentions as to those issues.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1557. Informal Conference.

The Department shall schedule an informal conference within thirty (30) calendar days and shall conduct the informal conference within two–hundred ten (210) calendar days following receipt of the request therefor. The informal conference shall be held at the locations defined in section

1551. Notice of the time and place of the informal conference shall be given in writing by the Department to the Local Mental Health Service at least fifteen (15) calendar days in advance of the conference. The results of the informal conference shall, within forty–five (45) calendar days from the close of the conference, be mailed to the Local Mental Health Service in the form of a written letter of findings. The time limits in this section may be extended by mutual agreement of the Local Mental Health Service and the Department.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Article 3. Filing of Appeal

§ 1560. Audit Appeal Hearing.

If upon receipt of the written letter of findings the Local Mental Health Service continues to dispute any matter which was in issue at the informal conference, the Local Mental Health Service may appeal to the Director for a hearing conducted by a hearing officer designated by the Director.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1561. Time for Filing Appeal.

The Local Mental Health Service shall have thirty (30) calendar

days following the date of receipt of the letter of findings within which to file an appeal with the Director. An appeal shall be deemed filed on the date it is delivered or mailed to the Director. The time limits in this section may be extended by mutual agreement of the Local Mental Health Director and the Department.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1562. Denial of Late Appeal.

If an appeal under section 1561 is filed after the time permitted herein, a decision shall be issued denying the appeal unless the Local Mental Health Service shows good cause for the late filing. The determination of what constitutes good cause is solely within the discretion of the Director.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Section 5700.1 and 5712, Welfare and Institutions Code.

§ 1563. Form of Appeal.

An appeal shall be in writing, signed by the Local Director or his or her authorized agent, and shall state the address of the Local Mental Health Service and of the agent, if any. An original and a copy of the appeal shall be submitted. The designation of an agent must be in writing by the Local Mental Health Director.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1564. Contents of Appeal.

An appeal need not be formal, but it shall be specific as to the issues which continue to be in dispute and shall set forth the Local Mental Health Service's contentions as to those issues. If an appeal fails to state the specific grounds upon which it is based, the Local Mental Health Director or authorized agent shall be notified that it does not comply with the requirement of this section. Within fifteen (15) calendar days after the date that such notice is received, an amended appeal may be filed. If, within the time permitted, the Local Mental Health Director or the authorized agent fails to amend the appeal, the appeal shall be dismissed.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Article 4. Formal Appeal Hearing

§ 1565. Disqualification of Hearing Officer.

A hearing officer shall voluntarily disqualify himself or herself and withdraw from any proceedings in which he or she has an interest. A party may request the disqualification of a hearing officer by filing an affidavit stating in detail the grounds upon which it is claimed that a fair and impartial hearing cannot be given, or that the hearing officer has an interest in the proceedings. The hearing officer shall immediately present the affidavit to the Director who will initiate an investigation into the allegations and shall advise the complaining party, in writing, of his or her decision. A copy of this decision shall be mailed to the other parties.

If the Director is able to conveniently reassign the case to another hearing officer, no investigation shall be required.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1566. Joinder of Successive Appeals.

If, at the time any appeal is filed, one or more prior appeals by the same Local Mental Health Service involving the same or similar issues have not been heard by a hearing officer, such prior appeals may be combined with the last appeals filed and the hearing officer may issue a single decision.

If this procedure is undertaken, notice must first be given to the other party or parties involved and agreement must be mutual and in writing.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1567. Scheduling of Hearings.

(a) Hearings shall be scheduled within thirty (30) calendar days from receipt of the appeal request under section 1561 and shall be set for a reasonable time thereafter, at such locations defined in section 1551.

(b) Written notice of the time and place of the hearing on an appeal shall be mailed to each party by the hearing officer at least fifteen (15) calendar days before the date of the hearing. The notice period may be shortened with the consent of all parties.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1568. Witnesses and Subpoenas.

(a) A party shall arrange for his or her witnesses to be present at the hearing.

(b) A subpoena may be issued by a hearing officer on his or her own motion.

(c) A subpoena to compel the attendance of a witness may be issued by a hearing officer upon written request made by a party and a showing of the need therefor.

(d) An application for a subpoena duces tecum ordering a witness to produce books, papers, correspondence, memoranda, or other records shall be made by affidavit to a hearing officer. The application should contain:

(1) the name and address of the person or entity upon whom the subpoena is to be served,

(2) a description of the documents, paper, books, accounts, letters, photographs, objects, or other tangible things which are not privileged and which should be produced,

(3) a showing of the materiality of these items to the issue(s) involved in the proceedings, and

(4) a statement indicating that, to the best of applicant's knowledge, the witness has such items in his or her possession or under his or her control.

(e) Each party shall arrange for the service of all subpoenas issued to him or her. A copy of the affidavit for the subpoena duces tecum shall be served with the subpoena.

(f) With the exception of employees of the Department, witnesses who are subpoenaed for any hearing are entitled to the fees and mileage reimbursements set forth in section 68093 of the Government Code. A written request must be filed with the hearing officer not later than ten (10) calendar days after the date on which the witness appeared at the hearing. If a request is not filed within ten (10) calendar days, no fees or mileage reimbursement shall be allowed.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1569. Consolidation of Proceedings.

Any number of proceedings may be consolidated for hearing or decision when the facts and circumstances are similar and no substantial right of any party will be prejudiced.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1570. Severance of Issues.

The hearing officer may, upon the motion of any party, or upon his or her own motion, proceed to the hearing of any issue or issues where it is found that the decision of that issue or issues could abate further proceedings on the appeal.

(a) An interlocutory decision on that separately heard issue may be prepared by the hearing officer and adopted by the Director as his or her final decision on the specified issue.

(b) The hearing on any remaining issues presented by the Local Mental Health Service's appeal may be postponed until this interlocutory decision has been issued.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1571. Preparation for Hearing.

A party appearing at a hearing before a hearing officer shall have his or her evidence prepared and witnesses present and be ready to proceed. The hearing officer, if he or she deems it necessary for a party's preparation or hearing may, on reasonable notice, require either or both parties to submit a written statement of their contentions and the reasons therefor. A copy of such written statement shall be provided to all parties.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1572. Conduct of Hearing.

(a) Testimony shall be taken only by oath or affirmation and under penalty of perjury.

(b) Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party first called that witness to testify, and to rebut evidence.

(c) Any relevant evidence shall be admitted if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of such evidence improper, over objection, in civil or criminal actions.

(d) A hearing officer may order the taking of interrogatories and depositions, and assess the expense to the requesting party when the hearing officer deems it proper.

(e) A hearing officer may question any party or witness and may admit any relevant and material evidence.

(f) The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

(g) A party has the burden of proving whatever facts it must establish to sustain its position.

(h) The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1573. Official and Judicial Notice.

(a) The hearing officer shall take official notice of those matters which must be judicially noticed by a court under section 451 of the Evidence Code. The hearing officer may take official notice of those matters set forth in section 452 of the Evidence Code.

(b) Each party shall be given reasonable opportunity to present information relevant to the propriety of taking official notice, and the matters to be noticed.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1574. Department Records.

(a) A hearing officer may order the production or inspection of any records in the possession of the Department when necessary to decide the issues in any proceeding before a hearing officer or to assist a party in preparing for the proceedings.

(b) A request by a party for an order to produce or inspect Department records shall be in writing and shall state clearly the information desired, the records desired to be produced or inspected, and the reason(s) therefor.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1575. Continuance of Hearings; Further Hearing.

A hearing officer may continue a hearing to another time or place on his or her own motion or, upon a showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as provided in this section, shall be in accordance with requirements set forth in other parts of this subchapter. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party present at the hearing. Notice thereof shall be given in accordance with this subchapter.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1576. Continuance for Additional Evidence.

If, after a hearing has begun, the hearing officer determines that additional evidence is necessary to decide the case, the hearing officer may:

(a) Continue the hearing to a later date and order either party to produce additional evidence, or

(b) Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any material submitted after the close of the hearing shall be made available to both parties and each party shall have the opportunity for rebuttal. The hearing officer may order a further hearing if the nature of the additional evidence or the refutation thereof makes a further hearing desirable.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1577. Representation at a Hearing.

A hearing officer may refuse to allow any person to represent a party in any hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with the proper instructions or orders of the hearing officer or the provisions of this subchapter.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1578. Oral Argument and Briefs.

At the request of any party made prior to the close of the hearings, the hearing officer may grant oral argument. If written argument is requested, it may be granted and parties shall be advised as to the time and manner within which such argument is to be filed. The hearing officer may, at his or her own discretion, require any party to submit written memoranda pertaining to any or all issues raised in the hearing.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1579. Decision.

(a) At the conclusion of the hearing or rehearing pursuant to this section, the hearing officer shall take the matter under submission and within forty–five (45) calendar days thereafter submit to the Director a proposed decision that may be adopted as the final decision of the Director provided, however, that the proposed decision in any dispute involving services provided under part 2 of division 5 of the Welfare and Institutions Code shall be first submitted to the Director of Health Services, who, no later than ten (10) days after receipt, shall forward

the proposed decision with his or her written comments, if any, to the Director. The proposed decision shall be in writing and shall contain findings of fact, a determination of the issues presented, and an order. The Director may adopt the proposed decision without reading or hearing the record, or he or she may reject the proposed decision and have a decision prepared based upon the record, or he or she may remand the matter to the hearing officer for a rehearing to take additional evidence.

(b) The Director shall, within twenty (20) calendar days of the receipt of the proposed decision, take action as set forth in subsection (a) of this section. The decision shall be final upon adoption by the Director. Copies of the decision of the Director shall be mailed to the Local Mental Health Service and any representative thereof.

(c) A decision shall be issued dismissing the appeal if a Local Mental Health Director or the authorized agent fails to appear at a hearing. A copy of the decision shall be mailed to each party together with a statement of the Local Mental Health Service's right to reopen the appeal.

(d) Any decision dismissing an appeal may be rescinded if the Local Mental Health Director makes an application in writing within ten (10) calendar days after personal service, or the date of receipt of such decision, showing good cause for the failure to appear at the hearing. Lack of good cause will be presumed when a continuance of the hearing was not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(e) The parties shall be notified in writing of an order granting or denying any application to rescind a dismissal.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Article 5. Recovery of Overpayments

§ 1585. Recovery of Overpayments to Local Mental Health Service.

(a) Any overpayment to a Local Mental Health Service determined by audit or examination to be due and payable shall be liquidated by the Department by offset against current payments due to the Local Mental Health Service.

(b) Notwithstanding subsection (a) the Department and the Local Mental Health Service may execute an agreement which provides an alternate repayment schedule.

(c) This section shall not be construed to preclude the Department from utilizing any other method of recovery available by law, as deemed appropriate by the Director.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

§ 1586. Time of Recovery.

The Department shall begin recovery of an overpayment, as set forth in section 1585, sixty–one (61) calendar days after notice of the audit findings, unless:

(1) The Local Mental Health Service files a timely request for an informal conference, in which case recovery will take place thirty–six (36) calendar days from the date of mailing of a letter of findings, or

(2) The Local Mental Health Service files a timely appeal, in which case recovery will take place fifteen (15) calendar days from the date of mailing of the decision of the Director.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Article 6. Payments

§ 1590. Underpayments.

In the event of an underpayment to a Local Mental Health Service due to a denied appeal which is subsequently overturned, the Department shall be responsible for the prompt filing of all required claims with the State Board of Control to obtain the necessary appropriation and approval to make payment.

NOTE: Authority cited: Sections 5400 and 5750, Welfare and Institutions Code. Reference: Sections 5700.1 and 5712, Welfare and Institutions Code.

Chapter 10. Medi–Cal Psychiatric Inpatient Hospital Services

Article 1. Definitions, Abbreviations and Program Terms

§ 1700. Acute Psychiatric Inpatient Hospital Services.

"Acute Psychiatric Inpatient Hospital Services" means medically necessary services received in a psychiatric inpatient hospital by a beneficiary while not on administrative day services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1701. Administrative Day Service.

"Administrative Day Services" means services authorized by a Mental Health Plan's Point of Authorization or a Short–Doyle/Medi–Cal provider's Utilization Review Committee that is acting as a Point of Authorization, for a beneficiary residing in a psychiatric inpatient hospital when, due to a lack of residential placement options at appropriate, non–acute treatment facilities as identified by the Mental Health Plan, the beneficiary's stay at the psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1702. Beneficiary.

"Beneficiary" means any person certified as eligible under the Medi–Cal Program according to Section 51001, Title 22, California Code of Regulations.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1703. Contract Hospital.

"Contract Hospital" means a provider of psychiatric inpatient hospital services which is certified by the Department of Health Services to provide Medi–Cal services, and which has a contract with a specific Mental Health Plan to provide psychiatric inpatient hospital services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1704. Culturally Competent Services.

"Culturally Competent Services" means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross–cultural settings. These behaviors, attitudes and policies shall be designed to foster a climate that will provide services which recognize and are sensitive to cultural diversity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1705. Department.

"Department" means the State Department of Mental Health.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778, 14680 and 14684, Welfare and Institutions Code.

§ 1706. Disproportionate Share Hospital (DSH).

"Disproportionate Share Hospital (DSH)" means a provider as defined in Section 1923(b)(1) of the Social Security Act, 42 USC 1396 r–4.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14680, Welfare and Institutions Code.

§ 1707. Fee–for–Service/Medi–Cal Provider.

"Fee–for–Service/Medi–Cal Provider" means a provider who submits reimbursement claims for Medi–Cal psychiatric inpatient hospital services through the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14680 and 14684, Welfare and Institutions Code.

§ 1708. Fiscal Intermediary.

"Fiscal Intermediary" means the entity which has contracted with the Department of Health Services to perform services for the Medi–Cal Program pursuant to Section 14104.3 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778, 14104.3 and 14684, Welfare and Institutions Code.

§ 1709. Hospital.

"Hospital" means an institution, including a psychiatric health facility, that meets the requirements of Section 51207, Title 22, California Code of Regulations.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1710. Hospital–Based Ancillary Services.

"Hospital–Based Ancillary Services" means services, which include but are not limited to electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a psychiatric inpatient hospital, other than routine services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1711. Implementation Plan for Psychiatric Inpatient Hospital Services.

Implementation Plan for Psychiatric Inpatient Hospital Services" means a written description submitted to the Department by the Mental Health Plan and approved by the Department which specifies the procedures which will be used by a prospective Mental Health Plan to provide psychiatric hospital services as described in this chapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5779 and 14684, Welfare and Institutions Code.

§ 1712. Medi–Cal Managed Care Plan.

"Medi–Cal Managed Care Plan" means an entity contracting with the Department of Health Services to provide services to beneficiaries under Chapter 7, commencing with Section 14000 or Chapter 8, commencing with Section 14200 of Division 9, Part 3 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1713. Mental Health Plan.

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the Department to contract, arrange and/or provide psychiatric inpatient hospital services for beneficiaries. An MHP may be a county, counties acting jointly or another governmental or nongovernmental entity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1714. Mental Health Plan (MHP) of Beneficiary.

"MHP of beneficiary" means the MHP responsible for authorizing and paying the required matching funds for psychiatric inpatient hospital services for beneficiaries. The responsible MHP shall be determined by the beneficiary's county of residence code as listed in the Medi–Cal Eligibility Data System (MEDS) file.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1715. MHP Payment Authorization.

"MHP Payment Authorization" means the initial process in which reimbursement for services provided by a psychiatric inpatient hospital to a beneficiary is authorized in writing by the MHP. In addition to the MHP payment authorization, the claim must meet all other Medi–Cal requirements prior to payment.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1716. Non–contract Hospital.

"Non–contract Hospital" means a provider of psychiatric inpatient hospital services which is certified by the Department of Health Services to provide Medi–Cal services but which does not have a contract with a specific MHP to provide psychiatric inpatient hospital services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 14684, Welfare and Institutions Code.

§ 1717. Point of Authorization.

"Point of Authorization" means the function within the MHP that is required to receive provider communications twenty–four hours a day, seven days a week regarding requests for MHP payment authorization of psychiatric inpatient hospital services for beneficiaries and authorizes payment for those services. This function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization functions.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1718. Provider.

"Provider" means a hospital, certified by the Department of Health Services to be a Medi–Cal provider, whether a Fee–for–Service/Medi–Cal or a Short–Doyle/Medi–Cal provider, which provides psychiatric inpatient hospital services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1719. Psychiatric Inpatient Hospital Services.

"Psychiatric Inpatient Hospital Services" means both acute psychiatric inpatient hospital services and administrative day services provided in a general acute psychiatric inpatient hospital, or a free–standing psychiatric hospital which are certified by Department of Health Services to be Medi–Cal providers or a psychiatric health facility that is licensed by the Department and certified by the Department of Health Services as a Medi–Cal provider of hospital services. A free–standing psychiatric hospital or psychiatric health facility that is larger than sixteen (16) beds may only be reimbursed for beneficiaries 65 years of age and over and for persons under 21 years of age, except if the patient was receiving such services prior to his/her twenty–first birthday. If he/she continues without interruption to require and receive such services, the eligibility for services continues to the date he/she no longer requires such services, or if earlier, his/her twenty–second birthday. These restrictions regarding services in free standing psychiatric hospitals and psychiatric health facilities shall cease to have effect if federal law changes and reimbursement are subsequently approved.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 14680 and 14684, Welfare and Institutions Code.

§ 1720. Receipt or Date of Receipt.

"Receipt" means the receipt or date of receipt of a Treatment Authorization Request or other document. The date of receipt shall be as indicated by a time stamp or fax time and date recorded on that document. In the absence of a date/time stamp made by the receiver, the postmark date shall be used as the date of receipt.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1721. Routine Services.

"Routine Services" means bed, board and all medical, nursing and other support services usually provided to an inpatient by a psychiatric inpatient hospital. Routine services do not include hospital–based ancillary services or physician or psychologist services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1722. Short–Doyle/Medi–Cal Provider.

"Short–Doyle/Medi–Cal Provider" means a provider that submits claims for Medi–Cal psychiatric inpatient hospital services through the Department to the Department of Health Services and not to the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1723. Submit or Date of Submission.

"Submit" or "date of submission" means to transmit a document by mail, fax, or hand delivery. The date of submission shall be as indicated by the postmark date, fax date, or the date of hand delivery as shown by a time stamp on the document. In the absence of a date/time stamp by the receiver, the postmark date shall be used as the date of submission.

§ 1724. Traditional Hospital Provider.

"Traditional Hospital Provider" means a provider that, according to the latest historical Medi–Cal payment data collected by the Department of Health Services, provides services to beneficiaries of an MHP that account for five (5) percent or twenty thousand dollars ($20,000), whichever is more, of the total fiscal year Medi–Cal psychiatric inpatient hospital service payments made for beneficiaries of an MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778, 14680 and 14684, Welfare and Institutions Code.

Article 2. Administration

§ 1725. Applicability of Laws and Regulations.

(a) Each MHP shall comply with all applicable Federal regulations and guidelines and all applicable State Medi–Cal regulations in Title 22 of the California Code of Regulations, except as provided in Section 5776 of the Welfare and Institutions Code, for MHP payment authorization and funding of psychiatric inpatient hospital services.

(b) Except for Short–Doyle/Medi–Cal hospital services, this chapter shall not apply to a beneficiary enrolled in a Medi–Cal Managed Care Plan which includes the provision of Fee–for–Service/Medi–Cal (FFS/MC) psychiatric inpatient hospital services to beneficiaries.

(c) Unless specifically allowed by this chapter, provisions of the contract between the MHP and the Provider shall not be in conflict with this chapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5776, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1726. Designation of MHPs.

(a) A county that wishes to be designated as the MHP for the beneficiaries of that county shall communicate its intent in a resolution from the county board of supervisors which shall be transmitted to the Department. The resolution shall state:

(1) The county assumes responsibility for Medi–Cal authorization and payment for all psychiatric inpatient hospital services for beneficiaries of that MHP.

(2) The county recognizes and agrees that the allocation of State funds pursuant to Section 5778 Welfare and Institutions Code is payment in full from the State for the services specified in (a)(1) except as described in Section 1750 of this chapter.

(3) The county shall utilize a public planning process that involves various constituency groups to assist in formulating policies and procedures for the operation of the MHP insofar as these policies and procedures are not specifically prescribed in law and regulation.

(4) The county shall submit to the Department an Implementation Plan for Psychiatric Inpatient Hospital Services pursuant to Section 1727 of this chapter.

(b) If a county declines to be the MHP for the beneficiaries of that county, other qualifying entities including other counties acting jointly, or governmental, and non–governmental entities, may be selected as the MHP by the Department pursuant to Section 5775 Welfare and Institutions Code. The entity selected shall meet the same duties and obligations required of a county in (a)(1)–(4).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1727. Implementation Plan for Psychiatric Inpatient Hospital Services.

(a) An entity applying to become the MHP for beneficiaries who are residents of a specific county, including counties which have submitted a resolution, shall submit within sixty (60) calendar days prior to implementation an Implementation Plan for Psychiatric Inpatient Hospital Services to the Department that includes:

(1) Procedures for MHP payment authorization of psychiatric inpatient hospital services by the MHP including the point of authorization.

(2) A process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, educational, health, housing and vocational rehabilitation services.

(B) Outreach efforts for the purpose of providing information regarding access under the MHP to beneficiaries and providers.

(3) The processes for problem resolution as required in Article 5 of this chapter.

(4) A description of the provider selection process, including provider selection criteria consistent with Section 1729. The MHP shall include a Request for Exemption from Contracting in accordance with Section 1730(c) of this chapter if the MHP decides not to contract with a Traditional Hospital Provider or DSH.

(5) A description of the provision, to the extent feasible, of culturally competent and age–appropriate services to beneficiaries.

(6) A description of a process for planned admissions in non–contract hospitals if such an admission is determined to be necessary by the MHP.

(b) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan for Psychiatric Inpatient Hospital Services. Notices of approval, disapproval and requests for additional information shall be forwarded to applicant MHP entities within sixty (60) calendar days of the receipt of the Implementation Plan. Upon approval by the Department, the Implementation Plan becomes a binding contract between the Department and the MHP. The contract term shall be one year with automatic renewal for an additional one year period, provided the MHP continues to meet its obligations under this chapter.

(c) An MHP shall notify the Department in writing prior to implementing changes in the policies, processes or procedures that modify its current Implementation Plan. If the changes meet the minimum standards in this chapter, the changes shall be approved by the Department. The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within thirty (30) days after the receipt of the notice from the MHP. The MHP may implement the proposed changes thirty (30) calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778, 14683 and 14684, Welfare and Institutions Code.

§ 1728. Scope of Reimbursable Services.

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in (b) and (c).

(b) Psychiatric Inpatient Hospital Services for a Fee–for–Service/Medi–Cal provider shall include:

(1) Routine services, and

(2) All hospital–based ancillary services.

(c) Psychiatric Inpatient Hospital Services for a Short–Doyle/Medi–Cal provider shall include:

(1) Routine services,

(2) All hospital–based ancillary services, and

(3) Services of a physician or a psychologist provided in the hospital to inpatients.

(d) An MHP shall not be responsible for the payment authorization for the following services:

(1) Out–of–state psychiatric inpatient hospital services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

(2) Psychiatric inpatient hospital services provided by a hospital operated by the Department or the State Department of Developmental Services.

(3) Psychiatric inpatient hospital services, except administrative day services which follow any approved acute inpatient psychiatric hospital service day, provided to a beneficiary eligible for Medicare (Part A) except as specified in (4) below, prior to the exhaustion of the beneficiary's Medicare (Part A) benefits.

(4) Psychiatric inpatient hospital services, including administrative day services, provided to beneficiaries who are also eligible for Medi–Care (Part A), in hospitals reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), prior to the exhaustion of the beneficiary's Medicare (Part A) benefits when the DRG reimbursement covers administrative day services according to Medicare (Part A).

(5) Psychiatric inpatient hospital services provided to persons enrolled in a Medi–Cal Managed Care Plan that includes the provision of Fee–for–Service/Medi–Cal psychiatric inpatient hospital services.

(6) Acute psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code.

(e) An MHP shall authorize payment for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part A) if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day, and there is compliance with Section 1777(j)(5).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1729. Provider Selection Criteria.

An MHP shall establish a provider selection process which meets the following criteria:

(a) The MHP shall require that each provider:

(1) Comply with all applicable Federal Medicaid laws, regulations and guidelines and all applicable State statutes and regulations.

(2) Sign a provider agreement with the Department of Health Services.

(3) Provide psychiatric inpatient hospital services, within its scope of licensure, to all beneficiaries who are referred by the MHP, unless compelling clinical circumstances exist that contraindicate admission, or the MHP negotiates a different arrangement with the provider.

(4) Refer beneficiaries for other services when necessary.

(5) Not refuse an admission solely on the basis of age, sex, race, religion, physical or mental disability, or national origin.

(b) In addition to the specified conditions in (a), an MHP may consider but is not limited to any or all of the following in selecting providers:

(1) History of Medi–Cal certification, licensure and accreditation.

(2) Circumstances and outcomes of any current or previous litigation against the provider.

(3) The geographical location(s) that would maximize beneficiary participation.

(4) Ability of the provider to:

(A) Offer services at competitive rates.

(B) Demonstrate positive outcomes and cost effectiveness.

(C) Address the needs of beneficiaries based on factors including age, language, culture, physical disability, and specified clinical interventions.

(D) Serve beneficiaries with severe mental illness and serious emotional disturbances.

(E) Meet the quality improvement, authorization, clinical and administrative requirements of the MHP.

(F) Work with beneficiaries, their families and other providers in a collaborative and supportive manner.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1730. Contracting for Service Availability.

(a) An MHP shall contract with DSH and Traditional Hospital Providers when:

(1) The DSH or Traditional Provider meets the provider selection criteria described in the MHP's Implementation Plan as required by Section 1727(a)(4).

(2) The DSH is located:

(A) In the same county as the MHP, or

(B) In a different county than the MHP and according to the latest historical Medi–Cal paid claims data, the DSH provides services to beneficiaries of the MHP that account for five (5) percent or twenty thousand dollars ($20,000), whichever is more, of the total fiscal year Fee–For–Service/Medi–Cal psychiatric inpatient hospital service payments for beneficiaries of the MHP.

(b) Prior to the beginning of each state fiscal year, the Department shall notify all MHPs of the DSH and Traditional Hospital Providers for that fiscal year.

(c) If an MHP determines not to contract with a DSH or Traditional Hospital Provider, it shall submit a Request for Exemption from Contracting to the Department with its Implementation Plan for Psychiatric Inpatient Hospital Services. The MHP shall submit Requests for Exemption initiated after the submission of the Implementation Plan to the Department as a separate submission. The Request for Exemption from Contracting shall address the projected effect on beneficiaries. At a minimum, the Request for Exemption from Contracting shall include:

(1) The name of the hospital for which the Request for Exemption from Contracting is requested.

(2) An analysis of the most recently available data from the Office of Statewide Health Planning and Development (OSHPD) on the availability, within an accessible geographic area, of hospital beds for psychiatric inpatient hospital services with and without a contract. Other data may be substituted if OSHPD data is not available or if equally reliable data is more comprehensive.

(3) The estimated impact on maximum and average travel time and distances for beneficiaries to obtain psychiatric inpatient hospital services, from providers either with or without a contract.

(4) An MHP shall notify the DSH or Traditional Hospital Provider of the Request for Exemption from Contracting at the same time that the Request for Exemption is sent to the Department.

(5) The Department shall approve or deny in writing the MHP's Request for Exemption from Contracting within thirty (30) calendar days of its receipt and shall notify both the MHP and the DSH or Traditional Hospital Provider of its decision. The Department shall deny any Request for Exemption from Contracting when failure to contract is likely to result in hardship to beneficiaries as measured by local community standards.

(d) At a minimum, a contract between an MHP and a provider of psychiatric inpatient hospital services shall meet federal contracting requirements as provided in 42 CFR, Section 434.6 and shall include the following provisions:

(1) Treatment requirements as a condition for reimbursement for psychiatric inpatient hospital services assure which ensure beneficiaries will receive the same level of services as provided to all other patients served.

(2) Assurances that beneficiaries will not be discriminated against in any manner, including admission practices, placement in special wings or rooms, or provisions of special or separate meals.

(3) Specifics of how the provider shall make records available for authorized review for fiscal audits, program compliance and beneficiary complaints.

(4) Language specifying that the per diem rate included in the contract is considered to be payment in full, subject to third party liability and patient share of costs, for psychiatric inpatient hospital services to a beneficiary.

(5) Language specifying that the rate structure in the contract includes all services defined as psychiatric inpatient hospital services in this chapter and that the rate structure does not include non–hospital based physician or psychologist services rendered to a beneficiary covered under the contract unless the provider is a Short–Doyle/Medi–Cal Provider.

(6) Requirements that a provider adhere to Title XIX of the Social Security Act, 42 USC and conform to all applicable Federal and State statutes and regulations.

(e) No provision of a contract shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code Section 5520.

(f) A formal contract between an MHP and a psychiatric inpatient hospital is not required when the MHP owns or operates the hospital.

(g) By October 1 of each year, an MHP shall submit to the Department a list of all hospitals with which an MHP has current contracts.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1731. State Oversight.

(a) The Department shall provide ongoing oversight to an MHP through site visits and monitoring of data reports from MHPs and claims processing. In addition, the Department shall:

(1) Perform reviews of program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with this chapter and the provisions of the Department's Federal Waiver Request for Medi–Cal Psychiatric Inpatient Hospital Services.

(2) Perform immediate on–site reviews of MHP program operations whenever there is a threat to the health or safety of beneficiaries.

(3) Monitor compliance with problem resolution process requirements contained in Article 5 of this chapter and the MHP's Implementation Plan for Psychiatric Inpatient Hospital Services.

(4) Monitor provider contracts to ensure that the MHP enters into necessary contracts with DSH and Traditional Hospital Providers.

(5) Monitor denials of MHP authorizations for payment.

(b) If the Department activities in (a) result in a determination that an MHP is out of compliance with State or Federal laws and regulations, the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation.

(2) A description of any corrective action required by the Department and time limits for compliance.

(c) In the event that the agreement with an MHP is terminated for any cause, the remaining balance of State funds which were transferred to the MHP for psychiatric inpatient hospital services shall be returned to the Department. The State has a right to examine all records of an MHP to determine the balance of funds to be returned to the Department.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Article 3. Fiscal Provisions

§ 1739. Allowable Psychiatric Accommodation Code.

"Allowable Psychiatric Accommodation Code" means a reimbursable hospital billing code that may be used by Fee–For–Service/Medi–Cal providers to claim payment for psychiatric inpatient hospital services provided to beneficiaries. The allowable codes are:

097 Psychiatric Acute (Adolescent and Child)
098 Administrative Days
114 Room and Board, Private, Psychiatric
124 Room and Board, Semi–Private 2 Bed, Psychiatric
134 Room and Board, Semi–Private 3 or 4 Bed, Psychiatric
154 Room and Board – Ward (Medical or General), Psychiatric
204 Intensive Care, Psychiatric

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1740. Border Communities.

"Border Communities" mean those communities located outside the State of California which are included in California's rate regions because of their proximity and utilization by Medi–Cal beneficiaries. Specific border communities are set forth in Section 1752(i).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1741. Located.

"Located" means the actual physical location of a psychiatric inpatient hospital, and unless otherwise specified, refers to the specific county within the geographical boundaries of which the hospital exists.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1742. Per Diem Rate.

"Per Diem Rate" means a daily rate paid for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1743. Rate Region.

"Rate Region" means regions, by county in California and border communities outside California, as specified in this chapter, for the purpose of establishing and determining reimbursement rates for non–contract Fee–For–Service/Medi–Cal providers.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1744. Risk Reinsurance.

"Risk Reinsurance" means an insurance policy purchased for an MHP that provides coverage for costs of providing services exceeding specified limits.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1745. Small County.

"Small County" means a county in California with a population of less than 200,000 by 1990 census data.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1746. Small County Reserve.

"Small County Reserve" means that portion of the State General Fund appropriation for consolidation of psychiatric inpatient hospital services that is allocated for use by MHPs in small counties as self–insurance to provide a mechanism to reduce financial risk.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1747. Third Party Liability.

"Third Party Liability" means an amount owed for psychiatric inpatient hospital services on behalf of a beneficiary by any payor other than Medi–Cal or the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1748. Usual and Customary Charges.

"Usual and Customary Charges" means those uniform charges which are listed in a provider's established charge schedule which are in effect and applied consistently to most patients.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1749. Utilization Control and Operations Committee.

"Utilization Control and Operations Committee" means a group of individuals designated by the MHPs in the small counties to provide oversight for the Small County Reserve.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1750. Small County Reserve.

(a) Small counties shall establish the Small County Reserve with funds allocated by the Department for that purpose.

(b) The Small County Reserve shall be used for:

(1) Reimbursement of MHPs in small counties for the cost of psychiatric inpatient hospital services in excess of their allocation.

(2) Purchase of risk reinsurance for MHPs in small counties.

(3) Costs associated with the administration of the Reserve.

(c) Any interest earned from funds held in the Small County Reserve shall accrue to the Small County Reserve.

(d) The Department shall not be liable for payments that exceed the balance in the Small County Reserve. When costs do not exceed the balance in the Small County Reserve during any given State fiscal year, the amount of unexpended funds shall be reported to the Department by November 30 of the following State fiscal year. The unexpended funds may be retained in the Small County Reserve and used as specified in (b).

(e) The administrative procedures for, and the process of, appointing members to the Utilization Control and Operations Committee of the Small County Reserve shall be determined by the small counties, through an organization representing the counties, in consultation with the Department.

(f) The Utilization Control and Operations Committee shall:

(1) Develop procedures and provide policy direction for the operation of the Small County Reserve.

(2) Determine circumstances under which a small county MHP shall be eligible to receive Small County Reserve funds.

(3) Provide guidance for the day–to–day operation of the Small County Reserve.

(4) Monitor utilization of psychiatric inpatient hospital services by member MHPs.

(5) Recommend corrective actions and arrange for technical assistance to MHPs that have been denied access to the Small County Reserve funds.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1751. Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, Fee–for–Service/Medi–Cal Providers.

(a) Reimbursement for acute psychiatric inpatient hospital services for each Fee–for–Service/Medi–Cal provider with a contract with any MHP, shall be based on a per diem rate established through negotiations between the provider and the MHP in the county in which the provider is located except when:

(1) The MHP from the county in which the provider is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.

(2) The provider is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department to be designated as the negotiator.

(3) For a provider owned or operated by the same organizational entity as the MHP, the per diem rate must be approved by the Department. The Department shall approve a per diem rate submitted by the MHP, if the rate is not greater than the highest per diem rate within the State negotiated by a different MHP for a different hospital.

(b) The per diem rate shall include routine services and all hospital–based ancillary services.

(c) Only one rate for each allowable psychiatric accommodation code for each negotiated rate Fee–for–Service/Medi–Cal provider may be established and shall be used by all MHPs with that provider. The negotiated rate shall not be subject to retrospective adjustment to cost.

(d) Reimbursement for administrative day services shall be the rate established in accordance with Section 51542, Title 22, California Code of Regulations except for facility–specific reimbursements determined by the Department of Health Services in accordance with Section 51511(a)(2)(B), Title 22, California Code of Regulations plus an allowance for hospital–based ancillary services equal to twenty–five (25) percent of the maximum rate established under Section 51542.

(e) For both acute psychiatric inpatient hospital services and administrative day services, reimbursement to the provider shall be based on the per diem rate, less third party liability and patient share of cost.

(f) The provider shall bill its usual and customary charges.

(g) At the end of each fiscal year, the Department shall compare, in aggregate, usual and customary charges to per diem rate for each provider. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) The per diem rate included in the contract shall be considered to be payment in full, less third party liability and patient share of costs, for psychiatric inpatient hospital services to a beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1752. Rate Setting for Psychiatric Inpatient Hospital Services for Non–negotiated Rate, Fee–for–Service/Medi–Cal Providers.

(a) Reimbursement rates for acute psychiatric inpatient hospital services for each Fee–for–Service/Medi–Cal provider with no contract with any MHP, shall be determined by the Department.

(1) The reimbursement rates in (a) shall be calculated by the Department prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among contract providers or the addition of new contract providers.

(2) One rate per allowable psychiatric accommodation code per non–negotiated rate, Fee–for–Service/Medi–Cal provider per Rate Region listed in (i) shall be established and shall be used by all MHPs.

(3) The rates shall not be subject to retrospective adjustment to cost.

(b) The per diem rate includes routine services and all hospital–based ancillary services.

(c) The per diem rate shall equal the weighted average diem rates negotiated for all Fee–for–Service/Medi–Cal providers within the Rate Region where the non–negotiated rate provider is located and shall be based on the following information from each Fee–for–Service/Medi–Cal hospital with a contract in the Rate Region where the non–negotiated rate provider is located:

(1) The latest available fiscal year Medi–Cal paid claims data for Fee–for–Service/Medi–Cal acute psychiatric inpatient hospital services patient days.

(2) The negotiated per diem rates for the subsequent fiscal year.

(d) Reimbursement for administrative day services shall be based on a rate established in accordance with Section 51542, Title 22, California Code of Regulations, except for facility–specific reimbursements determined by the Department of Health Services in accordance with Section 51511(a)(2)(B), Title 22, California Code of Regulations, plus an allowance for hospital–based ancillary services equal to twenty–five (25) percent of the maximum rate established under Section 51542.

(e) For both acute psychiatric inpatient services and administrative day services, interim reimbursement to the non–negotiated rate, Fee–for–Service/Medi–Cal provider shall be based on the calculated per diem rate less third party liability and patient share of cost.

(f) The provider shall bill its usual and customary charges.

(g) At the end of each fiscal year, the Department shall compare, in aggregate, the usual and customary charges to the per diem rate for each provider. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) The Medi–Cal payment constitutes payment in full for acute psychiatric inpatient hospital services less third party liability and patient share of costs, for psychiatric inpatient hospital services to a beneficiary.

(i) The Rate Regions are:

(1) Superior – Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Grants Pass, Klamath Falls, Lakeview, and Medford, Oregon.

(2) Central Valley – Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, Yuba, and Carson City, Incline Village, Reno, and Sparks, Nevada.

(3) Bay Area – Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma.

(4) Southern California – Imperial, Inyo, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Ventura, Las Vegas, and Yerington, Nevada and Kingman and Yuma, Arizona.

(5) Los Angeles

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1753. Rate Setting for Psychiatric Inpatient Hospital Services for Short–Doyle/Medi–Cal Providers.

(a) Reimbursement for acute psychiatric inpatient hospital services for Short–Doyle/Medi–Cal providers shall be established in accordance with Section 51516, Title 22, California Code of Regulations.

(b) Reimbursement for administrative day services for Short–Doyle/Medi–Cal providers shall be established in accordance with Section 51542, Title 22, California Code of Regulations.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5720 and 5724, Welfare and Institutions Code.

§ 1754. Rate Reporting.

An MHP shall provide to the Department, within thirty (30) calendar days prior to the beginning of each State fiscal year, a listing of rates negotiated with negotiated rate, Fee–For–Service/Medi–Cal providers of psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1755. Reporting Unexpended Balances.

An MHP shall report to the Department by November 30 of the year following the close of the State fiscal year, the amount of any unexpended balance still remaining from the allocation made pursuant to Section 5778 Welfare and Institutions Code. This reporting requirement shall also apply to the organizational entity administering the small county reserve defined in Section 1746.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5777, Welfare and Institutions Code.

Article 4. Provision of Services

§ 1765. Adverse Decision.

"Adverse Decision" means denial or termination of an MHP payment authorization y the MHP's Point of Authorization or by a Short–Doyle/Medi–Cal provider's Utilization Review Committee which determines the MHP's authorization for payment.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1766. Continued Stay Services.

"Continued Stay Services" means psychiatric inpatient hospital services for beneficiaries which occur after admission.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1767. County Medical Services Program.

"County Medical Services Program" means the service delivery and payment system for health care for low income persons who are not eligible for Medi–Cal and which is administered by the Department of Health Services for counties.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1768. Emergency Admission.

"Emergency Admission" means an admission to a psychiatric inpatient hospital of a beneficiary due to an emergency psychiatric condition.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1769. Emergency Psychiatric Condition.

"Emergency Psychiatric Condition" means that a beneficiary has a condition that meets admission reimbursement criteria for medical necessity in Section 1774 of this chapter and, due to a mental disorder, is:

(a) A danger to self or others, or

(b) Immediately unable to provide for, or utilize, food, shelter or clothing.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5777, Welfare and Institutions Code.

§ 1770. Licensed Mental Health Professional.

"Licensed mental health professional" means, for the purposes of this chapter, a licensed physician, a licensed clinical psychologist, a licensed clinical social worker, a licensed marriage, family and child counselor, a registered nurse, a licensed vocational nurse, and a licensed psychiatric technician. Individuals who have a waiver of licensure to obtain supervised clinical hours for one of the above categories may perform the functions of a licensed mental health professional specified in this chapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1771. Planned Admission.

"Planned Admission" means an admission of a beneficiary to a psychiatric inpatient hospital with a contract with an MHP for the purpose of providing medically necessary treatment that cannot be provided in another setting or a lower level of care and is not an emergency admission. Planned admissions may occur in a non–contract psychiatric inpatient hospital pursuant to Section 1727(a)(6) of this chapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1772. Prior Authorization.

"Prior authorization" means that a provider obtains the written MHP payment authorization by the MHP's Point of Authorization or the Short–Doyle/Medi–Cal provider's Utilization Review Committee, if acting as a Point of Authorization, prior to the admission of a beneficiary or the provision of continued stay services to a beneficiary in a psychiatric inpatient hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1773. Utilization Review Committee.

"Utilization Review Committee" means a committee that reviews services provided to determine appropriateness for psychiatric inpatient hospital services, identifies problems with quality of care, and meets the requirements of Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5777, Welfare and Institutions Code.

§ 1774. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi–Cal reimbursement for an admission to a acute psychiatric inpatient hospital, the beneficiary shall meet medical necessity criteria set forth in (1) and (2) below:

(1) One of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

(F) Other Disorders of Infancy, Childhood, or Adolescence

(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)

(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

(2) A beneficiary must have both (A) and (B):

(A) Cannot be safely treated at another level of care; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represents a current danger to self or others, or significant property destruction.

b. Prevents the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Presents a severe risk to the beneficiary's physical health.

d. Represents a recent, significant deterioration in ability to function.

2. Requires admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a psychiatric inpatient hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications which meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications which meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a psychiatric inpatient hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1775. Provider Utilization Control.

All providers shall comply with Federal requirements for utilization control pursuant to Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Each provider shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 5778, Welfare and Institutions Code.

§ 1776. MHP Payment Authorization – General Provisions.

(a) The MHP payment authorization shall be determined for:

(1) Fee–for–Service/Medi–Cal providers by an MHP's Point of Authorization.

(2) For Short–Doyle/Medi–Cal providers by either:

(A) An MHP's Point of Authorization, or

(B) The provider's Utilization Review Committee.

(b) An MHP that authorizes payment to a provider of psychiatric inpatient hospital services, shall be responsible for payment of the Medi–Cal matching funds, with the following exceptions:

(1) Psychiatric inpatient hospital services for individuals eligible for the County Medical Services Program. These services shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

(2) Psychiatric inpatient hospital services for a beneficiary from San Mateo, Santa Barbara or Solano County who is not a member of the County Organized Health System in those counties. These services shall be authorized by the MHP for the beneficiary's county but the MHP shall not be responsible for payment of those services.

(c) An MHP shall authorize payment for psychiatric inpatient hospital services that meet the requirements of this chapter and any additional contract requirements. When all other authorization criteria are met, MHP payment authorization requests presented for authorization beyond the timelines specified in this chapter shall be granted when an MHP determines that the provider was prevented from submitting a timely request because of circumstances beyond the provider's control.

(1) The provider shall submit any additional and relevant documentation, if required by the MHP, within sixty (60) calendar days of submission of the late request. The documentation shall verify that the lateness was due to:

(A) A natural disaster which has:

1. Destroyed or damaged the provider's business office or records, or

2. Substantially interfered with the processing of provider's request for MHP payment authorization; or

(B) Delays caused by other circumstances beyond the provider's control which have been reported to an appropriate law enforcement or fire agency when applicable.

(2) Circumstances which shall not be considered beyond the control of the provider include but are not limited to:

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

(C) Illness or absence of any employee trained to prepare MHP payment authorizations.

(D) Delays caused by the United States Postal Service or any private delivery service.

(d) The MHP authorizing payment for services shall be the MHP for the county of residence as specified on the Medi–Cal Eligibility Data System (MEDS) file.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1777. MHP Payment Authorization by a Point of Authorization.

(a) A provider shall submit a separate written request for MHP payment authorization of psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP for each of the following:

(1) The planned admission of a beneficiary.

(2) Ninety–nine (99) calendar days of continuous service to a beneficiary, if the hospital stay exceeds that period of time.

(3) Discharge.

(4) Services that qualify for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(5) Administrative day services that are requested for a beneficiary.

(b) A provider shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission.

(2) Within fourteen (14) calendar days after:

(A) Ninety–nine (99) calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

(B) Discharge.

(C) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(c) A written request for MHP payment authorization to the Point of Authorization shall be in the form of:

(1) A Treatment Authorization Request (TAR) for Fee–for–Service/Medi–Cal providers or;

(2) As specified by the MHP Short–Doyle/Medi–Cal providers.

(d) The Point of Authorization staff that approve or deny payment shall be licensed mental health professionals of the beneficiary's MHP.

(e) Approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing:

(1) On the same TAR on which the Fee–for–Service/Medi–Cal provider requested MHP payment authorization or,

(2) In an MHP payment authorization log maintained by the MHP for Short–Doyle/Medi–Cal providers.

(f) The MHP shall document that all adverse decisions regarding provider requests for MHP payment authorization based on medical necessity criteria or emergency medical condition were reviewed and approved:

(1) by a physician, or

(2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under his/her scope of practice.

(g) A request for an MHP payment authorization may be denied by a Point of Authorization if the request is not submitted in accordance with timelines in this chapter [except as specified in Section 1776(c)], the notification requirements, the medical necessity reimbursement criteria, emergency psychiatric condition criteria on an emergency admission or if the provider has failed to meet any other mandatory requirements of the contract negotiated between the provider and the MHP.

(h) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 days of the receipt of the request.

(i) Point of Authorization staff may authorize payments for up to seven (7) calendar days in advance of service provision.

(j) Approval of the MHP payment authorization by a Point of Authorization requires that:

(1) Planned admission requests for an MHP's payment authorization shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services, as specified in Section 1774. The request shall be submitted and approved prior to admission.

(2) Emergency admissions shall not be subject to prior MHP payment authorization.

(3) A request for MHP payment authorization for continued stay services shall be submitted to the Point of Authorization as follows:

(A) A contract provider's request shall be submitted within the timelines specified in the contract. If the contract does not specify timelines, the contract provider shall be subject to the same timeline requirements as the non–contract providers.

(B) A non–contract provider's request shall be submitted to the Point of Authorization not later than:

1. Within fourteen (14) calendar days after the beneficiary is discharged from the hospital, or

2. Within fourteen (14) calendar days after a beneficiary has

received ninety–nine (99) continuous calendar days of psychiatric inpatient hospital services.

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service as well as the other requirements for timeliness of notification and any other contractual requirements except as specified in Section 1776.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non–acute treatment facility in a reasonable geographic area and a provider documents contacts with a minimum of five (5) appropriate, non–acute treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five (5) contacts per week if there are less than five (5) appropriate, non–acute treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.

2. The lack of appropriate, non–acute treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

(C) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which are not covered by Medi–Cal, providers shall notify the Point of Authorization within twenty–four (24) hours or as specified in the contract, prior to beginning administrative day services meeting the requirements in Section 1728.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a provider shall be approved by an MHP when necessary documentation, as specified in Title 22, California Code of Regulations, is submitted.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1778. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) A provider shall not be required to obtain prior authorization for payment for an emergency admission, whether voluntary or involuntary.

(b) The provider of emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1774 of this chapter, and due to a mental disorder, is:

(1) A danger to self or others, or

(2) Immediately unable to provide for, or utilize, food, shelter or clothing.

(c) The provider of emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within twenty–four (24) hours of the time of the admission of the beneficiary to the hospital, or within the timelines specified in the contract, if applicable.

(1) If the provider cannot determine the MHP of the beneficiary, the provider shall notify the MHP of the county where the provider is located, within twenty–four (24) hours of admission.

(2) The MHP for the county where the provider is located shall assist the provider to determine the MHP of the beneficiary. The provider shall notify the MHP of the beneficiary within twenty–four (24) hours of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A provider notified the Point of Authorization within twenty–four (24) hours of admission of a beneficiary to the hospital or within the time required by contract, if applicable.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in (b) for the day of admission.

(4) A non–contract provider includes documentation that the beneficiary could not be safely transferred to a contract hospital of the MHP of the beneficiary if the transfer was requested by an MHP.

(e) After an emergency admission, a beneficiary's MHP may:

(1) Transfer the beneficiary from a non–contract to a contract provider as soon as it is safe to do so, based on reasonable clinical judgement.

(2) Choose to authorize continued stay with a non–contract provider.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1779. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short–Doyle/Medi–Cal provider, if not made by an MHP's Point of Authorization pursuant to Section 1777 of this chapter, shall be made by the provider's Utilization Review Committee.

(1) The Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, CFR, Chapter IV, Subchapter C, Part 456, Subpart D.

(2) The decision regarding MHP payment authorization shall be documented in writing by the Utilization Review Committee.

(b) The Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a Utilization Review Committee requires that:

(1) When provider documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non–acute treatment facility within a reasonable geographic area and the provider documents contacts with a minimum of five (5) appropriate, non–acute treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirements of five (5) contacts per week if there are fewer than five (5) appropriate, non–acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one (1) contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Article 5. Problem Resolution Processes

§ 1790. Complaint Resolution Process.

"Complaint Resolution Process" means an informal process for the resolution of beneficiary concerns or complaints regarding psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1791. Denial.

"Denial" means that the MHP does not approve a request for MHP payment authorization of an admission for psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1792. Fair Hearing.

"Fair Hearing" means a formal hearing, as required by Federal regulations and State statutes and regulations, which is conducted when requested by a beneficiary within specified timelines, because his/her services or extension of services are denied or terminated.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1793. Grievance Process.

"Grievance Process" means the MHP's formal process for the purpose of hearing and attempting to resolve beneficiary concerns or complaints regarding psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1794. Terminated.

"Terminated" means that the MHP does not approve a request for continued stay services after an MHP payment authorization for an admission.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1795. Beneficiary Problem Resolution Processes.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a complaint or grievance about any psychiatric inpatient hospital service–related issue.

(b) The MHP's beneficiary problem resolution processes shall include both:

(1) A Complaint Resolution Proces; and,

(2) A Grievance Process (Two Levels)

(c) An MHP shall ensure that each beneficiary has adequate information about and access to the resolution processes in (b).

(d) The Complaint Resolution Process shall, at a minimum:

(1) Focus upon resolution of a beneficiary's concerns as quickly and simply as possible.

(2) Emphasize simple, informal and easily understood procedures.

(3) Inform a beneficiary of his or her right to use the Grievance Process at any time before, during or after the Complaint Resolution Process has begun.

(4) Identify a procedure by which issues identified as a result of the Complaint Resolution Process are transmitted to the MHP's Quality Improvement Committee, to the MHP's administration or to another appropriate body within the MHP to implement needed action.

(5) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(e) The Grievance Process shall, at a minimum:

(1) Be a formal written procedure that provides for two levels of review within the MHP.

(2) Allow for the resolution of each level of a grievance within thirty (30) calendar days of receipt of the grievance by that level of the MHP.

(3) Identify a procedure by which issues identified as a result of the Grievance Process are transmitted to the MHP's Quality Improvement Committee, to the MHP's administration or to another appropriate body within the MHP to implement needed action.

(4) Identify the roles and responsibilities of the MHP, the provider and the beneficiary.

(5) Provide for:

(A) Recording the grievance in a Grievance Log(s) within one (1) working day of the date of receipt of the grievance.

(B) The Log entry shall include but not be limited to:

1. The name of the beneficiary.

2. The date of receipt of the grievance.

3. The nature of the problem.

4. The time period allowed for resolution.

5. The party responsible for addressing the grievance.

(C) Recording the resolution of a grievance within the required time period or document the reason(s) the problem has not been resolved.

(D) Documenting the notification of a beneficiary of the resolution of the grievance or documenting efforts to notify the beneficiary if he or she could not be contacted.

(E) If a provider was included in the grievance, notifying any provider involved with the resolution of the beneficiary grievance.

(F) Notifying the beneficiary of his or her right to appeal the grievance decision to a second level of review within the MHP.

(f) The MHP shall ensure that for the Complaint Resolution Process or the Grievance Process:

(1) A beneficiary may authorize another person to act on his or her behalf.

(2) Specific MHP staff are identified as having responsibility for assisting a beneficiary with these processes at the beneficiary's request.

(3) A beneficiary shall not be subject to discrimination or any other penalty for filing a complaint or grievance.

(4) Procedures used shall maintain the confidentiality of a beneficiary.

(g) An MHP's Grievance Log(s) shall be open to review by the Department, the Department of Health Services and the Federal oversight agency.

(h) A provider may have its own complaint resolution and grievance processes. A beneficiary shall have access to the provider's processes as well as those provided by the MHP.

(i) No provision of an MHP Beneficiary Problem Resolution Process shall be construed to replace or conflict with the duties of county patients' rights advocates designated in Welfare and Institutions Code Section 5500.

(j) Each MHP shall report to the Department by October 1 of each year, a summary of beneficiary grievances, as well as their status and resolution.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1796. Fair Hearing and Notice of Action.

(a) An MHP shall provide a written Notice of Action to the beneficiary that informs him or her of the right to a fair hearing when:

(1) An MHP payment authorization for a planned admission is denied.

(2) An MHP payment authorization for continued stay services is terminated for a beneficiary by the MHP while the beneficiary remains in the hospital.

(b) Fair hearing shall be administered by the Department of Health Services.

(c) An MHP shall be governed by the conditions set forth in Section 51014.1, Title 22, California Code of Regulations, and court rulings that have interpreted or modified existing regulations.

(d) For the purpose of this chapter, each reference to Department in Section 51014.1, Title 22, California Code of Regulations, shall mean the MHP.

(e) For the purpose of this section, "medical service" as cited in Section 51014.1, Title 22, California Code of Regulations shall mean those psychiatric inpatient hospital services that are subject to prior authorization by an MHP pursuant to Article 4 of this chapter.

(f) An MHP shall submit to the Department within ten (10) working days, copies of all Notices of Action delivered to beneficiaries.

NOTE: Authority cited: Section 14684, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1797. Medical Assistance for Beneficiary Pending Fair Hearing Decision.

A beneficiary receiving psychiatric inpatient hospital services pursuant to this chapter shall have the same rights to file for medical assistance pending fair hearing as prescribed in Section 51014.2, Title 22, California Code of Regulations, or required by court decisions.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1798. Provider Appeal Process—Services.

(a) A provider may appeal a denied, terminated or reduced request for MHP payment authorization of psychiatric inpatient hospital services which is based on this chapter to the beneficiary's MHP. Any additional MHP contractual requirements which are beyond the requirements of this chapter cannot be appealed to the Department. The written appeal shall be submitted to the MHP within ninety (90) calendar days of the date of receipt date of notification of the non–approval of payment.

(b) The MHP shall have sixty (60) calendar days from its receipt of the appeal to inform the provider in writing of the decision and its basis.

(1) If no basis is found for altering the decision the provider shall be notified of its right to submit an appeal to the Department when applicable.

(2) If the MHP grants the request, the MHP shall have fourteen (14) calendar days from the date of receipt of the provider's revised request for MHP payment authorization to approve the document.

(3) If an MHP does not respond within sixty (60) calendar days, the appeal is denied and the provider retains the right to appeal directly to the Department.

(c) If a provider chooses to appeal to the Department an MHP's denial of MHP payment authorization, the appeal shall be submitted in writing, along with supporting documentation, within thirty (30) calendar days from the date of the MHP's written decision of denial. The provider may appeal to the Department within thirty (30) calendar days after sixty (60) calendar days from submission to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(1) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(2) Clinical records supporting the existence of medical necessity if at issue.

(3) A summary of reasons why the MHP should have approved the MHP payment authorization.

(4) A contact person(s) name, address and phone number.

(d) The Department shall notify the MHP and the provider of its receipt of a request for appeal within seven (7) calendar days, along with a request for specific documentation supporting the denial of the MHP payment authorization.

(e) The MHP shall submit the required documentation within twenty–one (21) calendar days or the Department shall find in favor of the provider.

(f) The Department shall have sixty (60) calendar days from the receipt of the MHP's documentation to notify, in writing, the provider and the MHP of its decision and its basis.

(1) The Department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the department.

(2) If the Department upholds a provider's appeal, the MHP has fourteen (14) calendar days from the receipt of the provider's revised request for payment to approve the MHP payment authorization document or submit documentation to the Medi–Cal fiscal intermediary required to process the MHP payment authorization.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1799. Provider Appeal Process—Claims Processing.

(a) A Fee–for–Service/Medi–Cal provider may file an appeal concerning the processing or payment of its claims for psychiatric inpatient hospital services directly to the fiscal intermediary. The fiscal intermediary shall have sixty (60) calendar days from the receipt of the appeal to make a determination in writing to the provider.

(b) A Short–Doyle/Medi–Cal provider may file an appeal concerning the processing or payment of its claims for psychiatric inpatient hospital services directly to the Department. The Department shall have sixty (60) calendar days from the receipt of the appeal to make a determination in writing to the provider.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

Chapter 11. Medi–Cal Specialty Mental Health Services

Subchapter 1. General Provisions

Article 1. General

§ 1810.100. General Program Description.

Specialty mental health services, as defined in Section 1810.247 and in accordance with this Chapter, shall be provided to Medi–Cal beneficiaries of each county through a mental health plan which contracts with the Department to provide specialty mental health services to those Medi–Cal beneficiaries and to share in the financial risk of providing specialty mental health services as provided in this Chapter. When a mental health plan contracts with the Department pursuant to this Chapter, all beneficiaries of that county shall be eligible to receive Medi–Cal funded specialty mental health services as described in this Chapter only through the mental health plan. Medi–Cal funded services that are not the responsibility of the mental health plan may be obtained by beneficiaries under the provisions of Title 22, Division 3, Subdivision 1, beginning with Section 50000.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5776, 5777, 5778, 5780, 14640, 14681, 14682, 14683, 14684 and 14685, Welfare and Institutions Code.

§ 1810.110. Applicability of Laws and Regulations and Program Flexibility.

(a) Each mental health plan contracting with the Department pursuant to this Chapter shall comply with this Chapter, all applicable federal laws, regulations and guidelines, and all applicable State laws and regulations, including Medi–Cal regulations in Division 3, Subdivision 1, of Title 22, beginning with Section 50000.

(b) Nothing in this Chapter supersedes federal or state laws or regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(c) Provisions of contracts between mental health plans and providers shall not be in conflict with this Chapter.

(d) The Department may waive specific requirements of the regulations in Subchapters 1, 2, 3, and 4 at the request of a mental health plan pursuant to Section 5719.5 of the Welfare and Institutions

Code for the purpose of testing elements of the specialty mental health services delivery system as authorized by Section 5778(c) of the Welfare and Institutions Code, provided the mental health plan remains in compliance with all other applicable laws and regulations. A written request and substantiating evidence supporting the request shall be submitted by the mental health plan to the Department. If the request is consistent with this Subsection the Department, in consultation with the State Department of Health Services, pursuant to Section 5719.5 of the Welfare and Institutions Code, shall approve the request. The approval shall provide for the terms and conditions under which the exception is granted, and shall be effected by an amendment to the contract between the mental health plan and the Department under this Chapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5719.5, 5775, 5776, 5777, 5778 and 14684, Welfare and Institutions Code.

Article 2. Definitions, Abbreviations and Program Terms

§ 1810.200. Action.

"Action", in the case of a mental health plan (MHP), means:

(a) A denial, modification, reduction or termination of a provider's request for MHP payment authorization of a specialty mental health service covered by the MHP.

(b) A determination by the MHP or its providers that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a) have not been met and the beneficiary is not entitled to any specialty mental health services from the MHP.

(c) A failure by the MHP to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP; or

(d) A failure by the MHP to act within the timeframes for resolution of grievances, appeals, or the expedited appeals established in Subchapter 5, Article 1.

NOTE: Authority: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1810.201. Acute Psychiatric Inpatient Hospital Services.

"Acute Psychiatric Inpatient Hospital Services" means those services provided by a hospital to beneficiaries for whom the facilities, services and equipment described in Section 1810.350 are medically necessary for diagnosis or treatment of a mental disorder in accordance with Section 1820.205.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code.

§ 1810.202. Administrative Day Service.

"Administrative Day Services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non–acute residential treatment facilities that meet the needs of the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code.

§ 1810.203. Adult Residential Treatment Service.

"Adult Residential Treatment Service" means rehabilitative services, provided in a non–institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.203.5. Appeal.

"Appeal" means:

(a) A request by a beneficiary or a beneficiary's representative for review of an action as defined in Section 1810.200;

(b) A request by a beneficiary or a beneficiary's representative for review of a provider's determination to deny or modify a beneficiary's request for a covered specialty mental health service;

(c) A request by a beneficiary or a beneficiary's representative for review of the timeliness of the delivery of a specialty mental health service when the beneficiary believes that services are not being delivered in time to meet the beneficiary's needs, whether or not the mental health plan has established a timeliness standard for the delivery of the service.

NOTE: Authority: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1810.204. Assessment.

"Assessment" means a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following: mental status determination, analysis of the beneficiary's clinical history; analysis of relevant cultural issues and history; diagnosis; and the use of testing procedures.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.205. Beneficiary.

"Beneficiary" means any person certified as eligible under the Medi–Cal Program according to Title 22, Section 51000.2.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14000, 14005 and 14684, Welfare and Institutions Code.

§ 1810.205.1. Border Community.

"Border Community" means a community located outside the State of California that is not considered to be out of state for the purpose of excluding coverage by the MHPs because of its proximity to California and historical usage of providers in the community by Medi–Cal beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.205.2. Client Plan.

"Client Plan" means a plan for the provision of specialty mental health services to an individual beneficiary who meets the medical necessity criteria in Sections 1830.205 or 1830.210.

NOTE: Authority: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.206. Collateral.

"Collateral" means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.207. Contract Hospital.

"Contract Hospital" means a hospital that has a contract with a specific Mental Health Plan to provide psychiatric inpatient hospital services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.208. Crisis Residential Treatment Service.

"Crisis Residential Treatment Service" means therapeutic or rehabilitative services provided in a non–institutional residential setting which provides a structured program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.209. Crisis Intervention.

"Crisis Intervention" means a service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who do not meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.210. Crisis Stabilization.

"Crisis Stabilization" means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral and therapy. Crisis stabilization is distinguished from crisis intervention by being delivered by providers who do meet the crisis stabilization contact, site, and staffing requirements described in Sections 1840.338 and 1840.348.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.211. Cultural Competence.

"Cultural Competence" means a set of congruent practice skills, behaviors, attitudes and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.212. Day Rehabilitation.

"Day Rehabilitation" means a structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning, consistent with requirements for learning and development, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.213. Day Treatment Intensive.

"Day Treatment Intensive" means a structured, multi–disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the individual in a community setting, which provides services to a distinct group of individuals. Services are available at least three hours and less than 24 hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.214. Department.

"Department" means the State Department of Mental Health.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778, 14680 and 14684, Welfare and Institutions Code.

§ 1810.214.1. Disproportionate Share Hospital (DSH).

"Disproportionate Share Hospital (DSH)" means a hospital that serves a disproportionate share of low–income people as determined annually by the State Department of Health Services in accordance with Section 14105.98 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14105.98, Welfare and Institutions Code; and Title 42, United States Code, Section 1396r–4.

§ 1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental specialty mental health services" means mental health related diagnostic services and treatment, other than physical health care, available under the Medi–Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by the State Department of Health Services to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered by this Chapter as specialty mental health services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code; and Title 42, United States Code, Section 1396d(r).

§ 1810.216. Emergency Psychiatric Condition.

"Emergency Psychiatric Condition" means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.216.1. Fair Hearing.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 10950–10965 and 14684, Welfare and Institutions Code.

§ 1810.216.2. Expedited Appeal.

"Expedited Appeal" means an appeal as defined in Section 1810.203.5 to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that following

the timeframe for an appeal as established in Section 1850.207 would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

NOTE: Authority: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1810.216.4. Expedited Fair Hearing.

"Expedited Fair Hearing" means a fair hearing as defined in Section 1810.216.6 to be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that that following the timeframe for a fair hearing as established in Title 42, Code of Federal Regulations, Section 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

NOTE: Authority: Section 14680, Welfare and Institutions Code. Reference: Sections 10950–10965 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Sections 438.410(a), 431.244 and Part 438, Subpart F.

§ 1810.216.6. Fair Hearing.

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, Sections 50951 and 50953.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 10950–10965 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 431.244 and Part 438, Subpart F.

§ 1810.216.8. Federal Financial Participation (FFP).

"Federal Financial Participation (FFP)" means the federal matching funds available for services provided to Medi–Cal beneficiaries under the Medi–Cal program.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.217. Fee–for–Service/Medi–Cal Hospital.

"Fee–for–Service/Medi–Cal Hospital" means a hospital that submits reimbursement claims for Medi–Cal psychiatric inpatient hospital services through the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14680 and 14684, Welfare and Institutions Code.

§ 1810.218. Fiscal Intermediary.

"Fiscal Intermediary" means the entity, which has contracted with the State Department of Health Services to perform services for the Medi–Cal Program pursuant to Section 14104.3 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778, 14104.3 and 14684, Welfare and Institutions Code.

§ 1810.218.1. Grievance.

"Grievance" means a beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an appeal as defined in Section 1810.203.5 filed through the MHP's grievance process as described in Sections 1850.205 and 1850.206 or a provider's grievance process if the MHP has delegated the process to a provider in accordance with Section 1850.209.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1810.218.2. Group Provider.

"Group Provider" means an organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.219. Hospital.

"Hospital" means an institution that meets the requirements of Title 22, Section 51207, and has been certified by the State Department of Health Services as a Medi–Cal provider of inpatient hospital services. Hospital includes general acute care hospitals as defined in Section 1250(a) of the Health and Safety Code, acute psychiatric hospitals as defined in Section 1250(b) of the Health and Safety Code, and psychiatric health facilities certified by the State Department of Health Services as Medi–Cal providers of inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.220. Hospital–Based Ancillary Services.

"Hospital–Based Ancillary Services" means services, which include but are not limited to prescription drugs, laboratory services, x–ray, electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), that are received by a beneficiary admitted to a hospital, other than routine hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.221. Implementation Plan.

"Implementation Plan" means a written description submitted to the Department by a prospective Mental Health Plan and approved by the Department that specifies the procedures that will be used by the Mental Health Plan to provide specialty mental health services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778 and 14684, Welfare and Institutions Code.

§ 1810.222. Individual Provider.

"Individual Provider" means licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.222.1. Institution for Mental Diseases.

"Institution for Mental Diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disorders, including medical attention, nursing care, and related services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Title 42, United States Code, Section 1396d(a) and (i).

§ 1810.223. Licensed Mental Health Professional.

"Licensed mental health professional" means licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.223.5. Medi–Cal Eligibility Data System (MEDS).

"Medi–Cal Eligibility Data System (MEDS)" means the data system maintained by the State Department of Health Services that contains information on Medi–Cal eligibility including a beneficiary's county of responsibility.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.224. Medi–Cal Managed Care Plan.

"Medi–Cal Managed Care Plan" means an entity contracting with the State Department of Health Services to provide services to enrolled beneficiaries under Chapter 7, commencing with Section 14000, or Chapter 8, commencing with Section 14200, of Division 9, Part 3 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.225. Medication Support Services.

"Medication Support Services" means those services that include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. Service activities may include but are not limited to evaluation of the need for medication; evaluation of clinical effectiveness and side effects; the obtaining of informed consent; instruction in the use, risks and benefits of and alternatives for medication; and collateral and plan development related to the delivery of the service and/or assessment of the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.225.1. Memorandum of Understanding (MOU).

"Memorandum of Understanding (MOU)" means a written agreement between mental health plans and Medi–Cal managed care plans describing their responsibilities in the delivery of specialty mental health services to beneficiaries who are served by both parties.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 14681 and 14683, Welfare and Institutions Code.

§ 1810.226. Mental Health Plan (MHP).

"Mental Health Plan" (MHP) means an entity that enters into a contract with the Department to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in this Chapter. An MHP may be a county, counties acting jointly or another governmental or non–governmental entity.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.227. Mental Health Services.

"Mental Health Services" means individual or group therapies and interventions that are designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self–sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.228. MHP of Beneficiary.

"MHP of beneficiary" means the MHP responsible for providing or arranging and paying for specialty mental health services for a beneficiary under the provisions of this Chapter. The responsible MHP is the MHP serving the county that corresponds to the beneficiary's county of responsibility code as listed in the Medi–Cal Eligibility Data System (MEDS), unless another MHP is determined responsible pursuant to Section 1850.405.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.229. MHP Payment Authorization.

"MHP Payment Authorization" means the written, electronic or verbal authorization given by an MHP to a provider for reimbursement of specialty mental health services provided to a beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.230. Non–Contract Hospital.

"Non–contract Hospital" means a hospital which is certified by the State Department of Health Services to provide Medi–Cal services, but which does not have a contract with a specific MHP to provide psychiatric inpatient hospital services to beneficiaries.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 14684, Welfare and Institutions Code.

§ 1810.230.5. Notice of Action.

"Notice of Action" means a written notice from the MHP to a beneficiary when an MHP takes an action as defined in Section 1810.200(a), (c) or (d) or when an MHP or its providers take an action as defined in Section 1810.200(b).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1810.231. Organizational Provider.

"Organizational provider" means a provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.231.1. Physical Health Care or Physical Health Care Based Treatment.

"Physical Health Care" and "Physical Health Care Based Treatment" mean health care services provided by health professionals, including physicians, whose practice is predominately general medicine, family practice, internal medicine, pediatrics, obstetrics or gynecology, or whose practice is predominately a health care specialty area other than psychiatry or psychology. Physical health care does not include:

(a) A physician service as described in Title 22, Section 51305, delivered by a psychiatrist. A psychiatrist for the purpose of this definition is a physician who has not indicated a psychiatrist specialty as part of the provider enrollment process for the Medi–Cal program.

(b) A psychologist service as described in Title 22, Section 51309.

(c) An EPSDT supplemental service as described in Title 22, Sections 51340 or 51340.1, delivered by a licensed clinical social worker, a licensed marriage and family therapist to treat a mental illness or condition.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.232. Plan Development.

"Plan Development" means a service activity that consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary's progress.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.233. Point of Authorization.

"Point of Authorization" means the function within the MHP that is required to receive provider communications 24 hours a day, seven days a week regarding requests for MHP payment authorization of psychiatric inpatient hospital, psychiatric health facility, and psychiatric nursing facility services and authorizes payment for those services. This function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization functions.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.234. Prior Authorization.

"Prior authorization" means the issuance of an MHP payment authorization to a provider before the requested service has been provided.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.235. Provider.

"Provider" means person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi–Cal program as described in this Chapter and in Division 3, Subdivision 1 of Title 22, beginning with Section 50000. Provider includes but is not limited to licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, general acute care hospitals, and acute psychiatric hospitals. The MHP is a provider when direct services are provided to beneficiaries by employees of the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.236. Psychiatric Health Facility.

"Psychiatric Health Facility" means a facility licensed by the Department under the provisions of Chapter 9, Division 5 of Title 22, beginning with Section 77001. For the purposes of this Chapter, psychiatric health facilities that have been certified by the State Department of Health Services as Medi–Cal providers of inpatient hospital services will be governed by the provisions applicable to hospitals and psychiatric inpatient hospital services, except when specifically indicated in context.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.237. Psychiatric Health Facility Services.

"Psychiatric Health Facility Services" means therapeutic and/or rehabilitative services provided in a psychiatric health facility, other than a psychiatric health facility that has been certified by the State Department of Health Services as a Medi–Cal provider of inpatient hospital services, on an inpatient basis to beneficiaries who need acute care, which is care that meets the criteria of Section 1820.205, and whose physical health needs can be met in an affiliated general acute care hospital or in outpatient settings.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.237.1. Psychiatric Inpatient Hospital Professional Services.

"Psychiatric Inpatient Hospital Professional Services" means specialty mental health services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all specialty mental health services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital–based ancillary services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.238. Psychiatric Inpatient Hospital Services.

"Psychiatric Inpatient Hospital Services" means both acute psychiatric inpatient hospital services and administrative day services provided in a hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 14132 and 14684, Welfare and Institutions Code.

§ 1810.239. Psychiatric Nursing Facility Services.

"Psychiatric Nursing Facility Services" means skilled nursing facility services as defined in Title 22, Section 51123, that include special treatment program services for mentally disordered persons as defined in Title 22, Section 72443, provided by an entity that is licensed as a skilled nursing facility by the State Department of Health Services and is certified by the Department to provide special treatment program services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code.

§ 1810.240. Psychiatrist Services.

"Psychiatrist Services" means services provided by licensed physicians, within their scope of practice, who have contracted with the MHP to provide specialty mental health services, who have indicated a psychiatrist specialty as part of the provider enrollment process for the Medi–Cal program, to diagnose or treat a mental illness or condition. For the purposes of this Chapter, psychiatrist services may only be provided by physicians who are individual or group providers.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code.

§ 1810.241. Psychologist Services.

"Psychologist Services" means services provided by licensed psychologists, within their scope of practice, to diagnose or treat a mental illness or condition. For the purposes of this Chapter, psychologist services may only be provided by licensed psychologists who are individual or group providers.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code.

§ 1810.242. Receipt or Date of Receipt.

"Receipt" means the receipt of a Treatment Authorization Request or other document. The "date of receipt" means the date the document was received as indicated by a date stamp made by the receiver or the fax date recorded on the document. For documents submitted by mail, the postmark date shall be used as the date of receipt in the absence of a date/time stamp made by the receiver.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778 and 14684, Welfare and Institutions Code.

§ 1810.243. Rehabilitation.

"Rehabilitation" means a service activity which includes, but is not limited to assistance in improving, maintaining, or restoring a beneficiary's or group of beneficiaries' functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.243.1. Rehabilitative Mental Health Services.

"Rehabilitative Mental Health Services" means those services included in Section 1810.247(a) and separately defined in this Article.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.243.5. Risk Reinsurance.

"Risk Reinsurance" means an insurance policy purchased for an MHP that provides coverage for costs of providing services exceeding specified limits.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.244. Routine Hospital Services.

"Routine Hospital Services" means bed, board and all medical, nursing and other support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital–based ancillary services, psychiatrist or other physician services, or psychologist services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.245. Service Activities.

"Service Activities" means activities conducted to provide specialty mental health services when the definition of the service includes these activities. Service activities include, but are not limited to, assessment, collateral, therapy, rehabilitation, and plan development.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.246. Short–Doyle/Medi–Cal Hospital.

"Short–Doyle/Medi–Cal Hospital" means a hospital that submits claims for Medi–Cal psychiatric inpatient hospital services through the Department to the State Department of Health Services and not to the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.246.1. Significant Support Person.

"Significant support person" means persons, in the opinion of the beneficiary or the person providing services, who have or could have a significant role in the successful outcome of treatment, including but not limited to the parents or legal guardian of a beneficiary who is a minor, the legal representative of a beneficiary who is not a minor, a person living in the same household as the beneficiary, the beneficiary's spouse, and relatives of the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.246.2. Small County.

"Small County" means a county in California with a population of less than 200,000 as determined by 1990 census data.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.246.3. Small County Reserve.

"Small County Reserve" means that portion of the State General Fund appropriation for consolidation of psychiatric inpatient hospital services that is allocated for use by MHPs in small counties as self–insurance to provide a mechanism to reduce financial risk.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.247. Specialty Mental Health Services.

"Specialty Mental Health Services" means:

(a) Rehabilitative Mental Health Services, including:

(1) Mental health services;

(2) Medication support services;

(3) Day treatment intensive;

(4) Day rehabilitation;

(5) Crisis intervention;

(6) Crisis stabilization;

(7) Adult residential treatment services;

(8) Crisis residential treatment services;

(9) Psychiatric health facility services;

(b) Psychiatric Inpatient Hospital Services;

(c) Targeted Case Management;

(d) Psychiatrist Services;

(e) Psychologist Services;

(f) EPSDT Supplemental Specialty Mental Health Services; and

(g) Psychiatric Nursing Facility Services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.3, 14021.4, 14132 and 14684, Welfare and Institutions Code.

§ 1810.248. Submit or Date of Submission.

"Submit" means to transmit a document by mail, fax, or hand delivery. The "date of submission" means the date the document was submitted as indicated by the postmark date, the fax date, or the date of hand delivery as shown by a date stamp made by the receiver. For documents submitted by mail, the postmark date shall be used as the date of submission.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5775, Welfare and Institutions Code.

§ 1810.249. Targeted Case Management.

"Targeted Case Management" means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.3 and 14684, Welfare and Institutions Code.

§ 1810.250. Therapy.

"Therapy" means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered to an individual or group of beneficiaries and may include family therapy at which the beneficiary is present.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14021.4 and 14684, Welfare and Institutions Code.

§ 1810.251. Third Party Liability.

"Third Party Liability" means an amount owed for specialty mental

health services on behalf of a beneficiary by any payer other than the MHP, the Medi–Cal program or the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.252. Traditional Hospital.

"Traditional Hospital" means a Fee–for–Service/Medi–Cal hospital that, according to historical Medi–Cal payment data collected by the State Department of Health Services for the most recent fiscal year, provides services to beneficiaries of an MHP that account for five percent or twenty thousand dollars, whichever is more, of the total fiscal year Medi–Cal psychiatric inpatient hospital service payments made to Fee–for–Service/Medi–Cal hospitals for beneficiaries of an MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.253. Urgent Condition.

"Urgent Condition" means a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.253.1. Usual and Customary Charges.

"Usual and Customary Charges" means those uniform charges that are listed in a provider's established charge schedule which are in effect and applied consistently to most patients.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.254. Waivered/Registered Professional.

"Waivered/Registered Professional" means an individual who has a waiver of psychologist licensure issued by the Department or has registered with the corresponding state licensing authority for psychologists, marriage and family therapists or clinical social workers to obtain supervised clinical hours for psychologist, marriage and family therapist or clinical social worker licensure.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

Article 3. Administration

§ 1810.305. Designation of MHPs.

(a) A county that wishes to be designated by the Department as the MHP for the beneficiaries of that county shall communicate its intent in a resolution from the county board of supervisors, which shall be transmitted, to the Department. The resolution shall state that:

(1) The county is willing to assume responsibility for Medi–Cal authorization and payment for all covered specialty mental health services for beneficiaries of that MHP and assures that access to services through the MHP will be no less than access provided to beneficiaries prior to operation of the MHP.

(2) The county recognizes and agrees that the allocation of State funds pursuant to Section 5778 of the Welfare and Institutions Code, will be the full payment from the State for the services specified in Subsection (a)(1), except as specifically provided in this Chapter or in the contract between the county and the Department under this Chapter.

(3) The county will utilize a public planning process that involves various constituency groups, including, but not limited to beneficiaries, providers, and beneficiaries' significant support persons as self identified, to assist in formulating policies and procedures for the operation of the MHP insofar as these policies and procedures are not specifically prescribed in law and regulation.

(4) The county will submit to the Department an Implementation Plan pursuant to Section 1810.310.

(b) The Department may designate other qualifying entities including another county, other counties acting jointly, or other governmental and non–governmental entities, to be the MHP pursuant to Section 5775 of the Welfare and Institutions Code under any of the following conditions:

(1) A county declines to be the MHP for the beneficiaries of that county.

(2) The county or the Department terminates or fails to renew the contract between the Department and a county originally designated to be the MHP.

(3) The county fails to utilize a public planning process pursuant to Subsection (a)(3).

(4) The county fails to submit an Implementation Plan to the Department pursuant to Section 1810.310.

(5) The Implementation Plan submitted by the county pursuant to Section 1810.310 is disapproved by the Department.

(c) The entity selected under Subsection (b) shall meet the same duties and obligations required of a county in Subsections (a)(1)–(4).

(d) The Department may designate an entity to be an MHP pursuant to Subsection (b) through a competitive procurement process. If the Department elects to do so, the Department may integrate the requirements of Subsections (a)(1)–(4) and the requirements of Section 1810.310 into the procurement process.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.310. Implementation Plan.

(a) An entity designated to be an MHP shall submit an Implementation Plan to the Department, within the time frame established by the Department. The time frame shall be no more than 180 days and no less than 90 calendar days prior to the date on which the entity proposes to begin operations. The Implementation Plan shall include:

(1) Procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization.

(2) A description of the process for:

(A) Screening, referral and coordination with other necessary services, including, but not limited to, substance abuse, educational, health, housing and vocational rehabilitation services.

(B) Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.

(C) Assuring continuity of care for beneficiaries receiving specialty mental health services prior to the date the entity begins operation as the MHP.

(D) Providing clinical consultation and training to beneficiaries' primary care physicians and other physical health care providers.

(3) A description of the processes for problem resolution as required in Subchapter 5.

(4) A description of the provider selection process, including provider selection criteria consistent with Sections 1810.425 and 1810.435. The entity designated to be the MHP shall include a Request for Exemption from Contracting in accordance with Section 1810.430(c) if the entity decides not to contract with a Traditional Hospital or DSH.

(5) Documentation that demonstrates that the entity:

(A) Offers an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries that will be served by the MHP, and

(B) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP.

(6) A description of how the MHP will deliver age–appropriate services to beneficiaries.

(7) The proposed Cultural Competence Plan as described in Section 1810.410, unless the Department has determined that the Cultural Competence Plan will be submitted in accordance with the terms of the contract between the MHP and the Department pursuant to Section 1810.410(c).

(8) A description of a process for planned admissions in non–contract hospitals if such an admission is determined to be necessary by the MHP.

(9) A description of the MHP's Quality Improvement and Utilization Management Programs.

(10) A description of policies and procedures that assure beneficiary confidentiality in compliance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(11) Other policies and procedures identified by the Department as relevant to determining readiness to provide specialty mental health services to beneficiaries as described in this Chapter.

(b) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan. Notices of Approval, Notices of Disapproval and requests for additional information shall be forwarded to applicant MHP entities within 60 calendar days of the receipt of the Implementation Plan.

(c) An MHP shall submit proposed changes to its approved Implementation Plan in writing to the Department for review.

(1) An MHP shall submit proposed changes in the policies, processes or procedures that would modify the MHP's current Implementation Plan prior to implementing the proposed changes.

(2) An MHP shall submit documentation establishing its continued capacity to meet the Implementation Plan requirements of Subsection (a)(5) whenever there is a change in the MHP's operation that would require a change in services or providers by 25 percent or more of the beneficiaries who are receiving services from the MHP or a reduction of an average of 25 percent or more in provider rates for providers of outpatient mental health services that paid on a fee–for–service basis.

(3) If the changes are consistent with this Chapter, the changes shall be approved by the Department.

(4) The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for disapproval, to the MHP within 30 calendar days after the receipt of the notice from the MHP.

(5) The MHP may implement the proposed changes 30 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778, 14683 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.207.

§ 1810.315. Contracts Between the Department and the MHP.

Upon approval of an Implementation Plan pursuant to Section 1810.310, the entity designated pursuant to Section 1810.305 shall enter into a contract with the Department. There is no obligation to pay by the Department absent an executed contract with the MHP, incorporating these regulations as terms of the contract.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 5778, Welfare and Institutions Code.

§ 1810.317. Contract Term.

The term of the contract between an MHP and the Department shall be for a term agreed to by the parties. Regardless of the effective date of the contract, the expiration date of the contract shall be June 30, the end of the State fiscal year.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 5778, Welfare and Institutions Code.

§ 1810.319. Contract Amendment.

The contract may be amended by mutual written agreement of the MHP and the Department.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 5778, Welfare and Institutions Code.

§ 1810.320. Contract Renewal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 5778, Welfare and Institutions Code.

§ 1810.321. Contract Renewal.

(a) The Department may, in its sole discretion renew an MHP contract.

(b) If the MHP chooses non–renewal of the contract, then the MHP shall give the Department at least 180 calendar days prior notice of non–renewal.

(c) If the Department chooses non–renewal of the contract, the Department shall give the MHP at least 180 calendar days prior notice of non–renewal, unless the Department determines that the MHP has not complied with the requirements of law or regulation or terms of the contract, in which case the Department must give at least 90 days prior notice of non–renewal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 5778, Welfare and Institutions Code.

§ 1810.323. Contract Termination.

(a) The MHP may terminate its contract with the Department in accordance with the terms of its contract with the Department by delivering written notice of termination to the Department at least 180 calendar days prior to the effective date of termination.

(b) The Department shall immediately terminate its contract with an MHP if the Department finds that there is an immediate and significant threat to the health and safety of Medi–Cal beneficiaries as a result of action or inaction by the MHP.

(c) The Department shall terminate its contract with an MHP that the Secretary, Health and Human Services has determined does not meet the requirements for participation in the Medicaid program as provided in Title XIX of the Social Security Act. The Department shall deliver written notice of termination to the MHP at least 60 calendar days prior to the effective date of termination.

(d) The Department may terminate the MHP contract for noncompliance with the requirements of law or regulations or terms of the contract. The Department shall deliver written notice of termination to the MHP at least 90 calendar days prior to the effective date of termination.

(e) The Department may terminate its contract with an MHP for any reason not specified in Subsections (b), (c), or (d) by delivering written notice of termination to the MHP at least 180 calendar days prior to the effective date of termination.

(f) The Department may terminate its contract with an MHP if the Department determines that the contract is no longer in the best interests of the State.

(g) The written notice of termination shall be provided to the MHP and to other persons and organizations as the Department may deem necessary.

(h) The written notice of termination shall include the reason for the termination and the effective date of termination.

(i) In the event that the contract with an MHP is terminated for any cause, the remaining balance of State funds that were transferred to the MHP for specialty mental health services pursuant to Section 1810.330 shall be returned to the Department on a timeline specified by the Department in the notice of termination. The Department has a right to examine all records of an MHP to determine the balance of funds to be returned to the Department.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5776, 5777, 5778 and 5780, Welfare and Institutions Code.

§ 1810.325. Appeal of Contract Termination.

(a) The MHP may appeal, in writing, a contract termination to the Department within 15 working days after the date of receipt of the notice of termination, setting forth relevant facts and arguments. The Department shall grant or deny the appeal within 30 calendar days after receipt of the appeal. In granting an appeal, the Department may take another action available under Section 1810.380(b). The Department's election to take another action shall not be appealed to the Department. Except for terminations pursuant to Section 1810.323(b), the Department shall suspend the termination date until the Department has acted on the MHP's appeal.

(b) The MHP may request that a public hearing be held by the Office of Administrative Hearings to allow the Department to show cause for the termination. The public hearing shall be held no later than 30 calendar days after receipt by the MHP of the notice to terminate the contract. In order to give the Office of Administrative Hearings sufficient time to arrange for a hearing, the MHP request for a hearing shall be submitted no later than five working days after receipt of the notice to terminate, by making its request to the Office of Administrative Hearings directly. The MHP shall have no right to a hearing before the Office of Administrative Hearings, unless the request has been submitted no later than five working days after receipt of the notice to terminate.

(c) The Office of Administrative Hearings shall provide written recommendations concerning the termination of the contract to the Department and to the MHP within 30 calendar days after conclusion of the hearing. The Department shall act to grant or deny the appeal within 30 calendar days after receipt of the recommendations of the Office of Administrative Hearings. In granting an appeal, the Department may take another action available under Section 1810.380(b). The Department's election to take another action shall not be appealable to the Department or to the Office of Administrative Hearings. Except for terminations pursuant to Section 1810.323(b), the Department shall suspend the termination date until the Department has acted on the MHP's appeal.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5776, 5777, 5778 and 5780, Welfare and Institutions Code.

§ 1810.330. Allocation of State Funds to MHPs.

In consultation with a statewide organization representing counties, the Department shall determine the methodology for allocating state funds to the MHPs annually. The methodology shall include a determination of the level for the Small County Reserve allocation as provided in Section 5778(j)(2)(A) and (k) of the Welfare and Institutions Code. The allocation shall include state funds for specialty mental health services covered by the MHP pursuant to Section 1810.345 that are not eligible for federal financial participation pursuant to Subchapter 4, subject to the appropriation of such funds by the legislature. State funds based on the allocation process shall be provided to each MHP annually in accordance with the terms of its contract with the Department and to the Small County Reserve as provided in Section 5778(j)(2)(A) and (k) of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 5778, Welfare and Institutions Code.

§ 1810.335. Renegotiation of the Allocation of State Funds to an MHP.

Either the Department or an MHP may request renegotiation of the amount of state funds paid to the MHP for the fiscal year, if it determines that there have been changes in the obligations of the MHP as a result of changes in federal or state law or regulation or the interpretation or implementation of federal or state law or regulation that increases or decreases the cost of providing services under the contract between the Department and the MHP after the annual allocation of state funds has been determined in accordance with Section 1810.330. Any change in the amount of state funds to be paid to the MHP agreed to by the parties shall be effected as an amendment to the contract between the Department and the MHP and shall be effective as of the date the obligations changed or a date agreed to by the parties, whichever is later. Any changes in state funding shall be subject to appropriation by the legislature.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 5778, Welfare and Institutions Code.

§ 1810.341. Small County Reserve Allocation.

(a) MHPs in small counties shall establish the Small County Reserve with funds allocated by the Department pursuant to Section 1810.330.

(b) The Small County Reserve may only be used for:

(1) Reimbursement of MHPs in small counties for the cost of psychiatric inpatient hospital services in excess of their allocation.

(2) Purchase of risk reinsurance for MHPs in small counties.

(3) Alternatives to hospitalization as determined by the MHPs in small counties.

(4) Costs associated with the administration of the Reserve.

(c) Any interest earned from funds held in the Small County Reserve shall accrue to the Small County Reserve.

(d) The Department shall not be liable for obligations of the MHPs in small counties that exceed the balance in the Small County Reserve. When costs do not exceed the balance in the Small County Reserve during any given State fiscal year, the amount of unexpended funds shall be reported to the Department by November 30 of the following State fiscal year. The unexpended funds may be retained in the Small County Reserve and used as specified in Subsection (b).

(e) The MHPs in the small counties shall establish a Utilization Control and Operations Committee. The administrative procedures for, and the process of, appointing members to the Utilization Control and Operations Committee of the Small County Reserve shall be determined by the MHPs in small counties, through an organization representing the MHPs, in consultation with the Department. The Department shall not be liable for any action of the MHPs in small counties or the Utilization Control and Operations Committee related to the administration of the Small County Reserve.

(f) The Utilization Control and Operations Committee shall:

(1) Develop procedures and provide policy direction for the operation of the Small County Reserve.

(2) Determine circumstances under which a small county MHP shall be eligible to receive Small County Reserve funds.

(3) Provide guidance for the day–to–day operation of the Small County Reserve.

(4) Monitor utilization of psychiatric inpatient hospital services and other specialty mental health services by member MHPs.

(5) Recommend corrective actions and arrange for technical assistance to MHPs that have been denied access to the Small County Reserve funds.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.345. Scope of Covered Specialty Mental Health Services.

(a) The MHP of a beneficiary shall provide or arrange and pay for specialty mental health services to the beneficiary when the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210 are met and when specialty mental health services are required to assess whether the medical necessity criteria are met. The MHP of a beneficiary shall be required to provide specialty mental health services only to beneficiaries who:

(1) Are eligible to receive Medi–Cal funded services in a Medi–Cal

program under Title 22, Division 3, Subdivision 1, Chapter 2, Article 5, Section 50201 et seq., or Article 7, Section 50301 et seq., which includes the provision of specialty mental health services, and only to the extent the specific specialty mental health services are included in that Medi–Cal program, and

(2) Have met their share of cost obligations under Title 22, Sections 50651–50659.

(b) Except as provided elsewhere in this Chapter, the MHP shall not be required to establish a formal arrangement within the MHP's organization or through contracts with providers for any specific specialty mental health service, but shall ensure that the type or types of specialty mental health services provided to each individual beneficiary are adequate to meet the needs of the beneficiary as described in the medical necessity criteria in Sections 1820.205, 1830.205, or 1830.210.

(c) When appropriate based on the mental health condition of the beneficiary, the MHP of a beneficiary shall ensure that covered specialty mental health services described in Section 1810.247(a) are directed toward the maximum reduction of the mental disability and restoration of the beneficiary to the best possible functional level to the extent required by the Medi–Cal State Plan under rehabilitative mental health services. The Medi–Cal State Plan is California's State plan for medical assistance as described in Title 42, Section 1396 and 1396a, United States Code.

(d) The Department may exclude psychiatric nursing facility services from the specialty mental health services covered by the MHP until the Department determines that all necessary systems are in place at the State level to ensure proper payment of the providers of psychiatric nursing facility services and proper claiming of federal funds pursuant to Subchapter 4, beginning with Section 1840.100. The Department shall insure that the contract between the MHP and the Department and the allocation to the MHP pursuant to Section 1810.330 reflect the exclusion or inclusion of these services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 14007.5, 14011, 14142, 14145 and 14682, Welfare and Institutions Code; and Title 42, United States Code, Section 1396 and 1396a.

§ 1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

(a) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services as described in Subsections (b) and (c) and Section 1810.345.

(b) Psychiatric Inpatient Hospital Services for a Fee–for–Service/Medi–Cal hospital shall include:

(1) Routine hospital services and

(2) All hospital–based ancillary services.

(c) Psychiatric Inpatient Hospital Services for a Short–Doyle/Medi–Cal hospital shall include:

(1) Routine hospital services,

(2) All hospital–based ancillary services, and

(3) Psychiatric inpatient hospital professional services.

(d) An MHP shall be responsible for the MHP payment authorization for psychiatric inpatient hospital services provided to a beneficiary eligible for Medicare (Part A) if the payment being authorized is for administrative day services following any approved acute psychiatric inpatient hospital services day and there is compliance with Section 1820.220(j)(5).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.355. Excluded Services.

MHPs shall not be responsible to provide or arrange and pay for the following services:

(a) Medi–Cal services, which are those services described in Title 22, Division 3, Subdivision 1, Chapter 3, Section 51001 et seq., that are not specialty mental health services for which the MHP is responsible pursuant to Section 1810.345.

(1) Prescribed drugs as described in Title 22, Section 51313, and laboratory, radiological, and radioisotope services as described in Title 22, Section 51311, are not the responsibility of the MHPs, except when provided as hospital–based ancillary services. Medi–Cal beneficiaries may obtain Medi–Cal covered prescription drugs and laboratory, radiological, and radioisotope services prescribed by licensed mental health professionals acting within their scope of practice and employed by or contracting with the MHP under provisions of Title 22, Division 3, Subdivision 1, beginning with Section 50000.

(2) Medical transportation services as described in Title 22, Section 51323, are not the responsibility of the MHP, except when the purpose of the medical transportation service is to transport a beneficiary receiving psychiatric inpatient hospital services from a hospital to another hospital or another type of 24 hour care facility because the services in the facility to which the beneficiary is being transported will result in lower costs to the MHP.

(3) Physician services as described in Title 22, Section 51305, that are not psychiatric services as defined in Section 1810.240, even if the services are provided to treat a diagnosis included in Sections 1820.205 or 1830.205, are not the responsibility of the MHP.

(4) Personal care services as defined in Title 22, Section 51183, and as defined by the State Department of Health Services as EPSDT supplemental services pursuant to Title 22, Section 51340(e)(3) are not the responsibility of the MHP.

(b) Out–of–state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State.

(c) Specialty mental health services provided by a hospital operated by the Department or the State Department of Developmental Services.

(d) Specialty mental health services provided to a beneficiary eligible for Medicare prior to the exhaustion of beneficiary's Medicare mental health benefits, unless the services have been denied by Medicare. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), when the DRG reimbursement covers administrative day services according to Medicare (Part A).

(e) Specialty mental health services provided to a beneficiary enrolled in a Medi–Cal Managed Care Plan to the extent specialty mental health services are covered by the Medi–Cal Managed Care Plan.

(f) Psychiatric inpatient hospital services received by a beneficiary when services are not billed to an allowable psychiatric accommodation code as defined in Section 1820.100(a).

(g) Medi–Cal services that may include specialty mental health services as a component of a larger service package as follows:

(1) Psychiatrist and psychologist services provided by adult day health centers pursuant to Title 22, Section 54325.

(2) Home and community based waiver services as defined in Title 22, Section 51176.

(3) Psychiatrist services, psychologist services, and EPSDT supplemental specialty mental health services payable by the Medi–Cal fiscal intermediary that are authorized by the California Children's Services (CCS) Program to treat CCS eligible beneficiaries or the Genetically Handicapped Persons Program (GHPP) to treat GHPP eligible beneficiaries.

(4) Local Education Agency (LEA) services as defined in Title 22, Section 51190.4.

(5) Specialty mental health services provided by Federally Qualified Health Centers, Indian Health Centers, and Rural Health Clinics.

(6) Home health agency services as described in Title 22, Section 51337.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5776, 5777, 5778, 5780, 14681, 14682, 14683, 14684 and 14685, Welfare and Institutions Code.

§ 1810.360. Notification of Beneficiaries.

(a) Prior to the date the MHP begins operation, the Department shall mail a notice to all beneficiaries in a county containing the following information:

(1) The date the MHP will begin operation.

(2) The name and statewide, toll–free telephone number of the MHP.

(3) The availability of a booklet and provider list that contain the information required by Title 42, Code of Federal Regulations, Section 438.10(f)(6) and (g).

(4) The availability of problem resolution processes, including fair hearings.

(b) The Department shall provide beneficiaries who become eligible for Medi–Cal after the notice described in Subsection (a) is mailed with a notice containing the information listed in Subsections (a)(2)–(4) either through the mail or through the Medi–Cal eligibility determination process.

(c) The Department shall provide an annual written notice to all Medi–Cal beneficiaries informing them of their right to request and obtain a booklet and provider list from the MHP that contain the information required by Title 42, Code of Federal Regulations, Section 438.10(f)(6) and (g).

(d) The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers. This responsibility applies to the beneficiary's receipt of any specialty mental health service, including but not limited to an assessment to determine whether medical necessity criteria pursuant to Section 1830.205 are met.

(e) The booklet and provider list shall be updated as required by the contract between the Department and the MHP. Pursuant to Title 42, Code of Federal Regulations, Section 438.10(f)(4), when there is a change in the scope of specialty mental health services covered by the MHP, an update in the form of a booklet insert shall be provided to beneficiaries at least 30 days prior to the change.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14683, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.10.

§ 1810.365. Beneficiary Billing.

(a) The MHP of a beneficiary, or an affiliate, vendor, contractor, or sub–subcontractor of the MHP shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health services provided under this Chapter or related administrative services such as billing for missed appointments or making copies of client records, except to collect:

(1) Other health care coverage pursuant to Title 22, Section 51005.

(2) Share of cost as provided in Title 22, Sections 50657 through 50659.

(3) Copayments in accordance with Section 14134 of the Welfare and Institutions Code and Title 22, Section 51004.

(b) In the event that a beneficiary willfully refuses to provide other current health insurance coverage billing information, as described in Title 22, Section 50763(a)(5), to a provider, including the MHP, upon giving the beneficiary written notice of intent, the provider may bill the beneficiary as a private pay patient.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14005.9, 14024 and 14134, Welfare and Institutions Code.

§ 1810.370. MOUs with Medi–Cal Managed Care Plans.

(a) The MHP shall enter into an MOU with any Medi–Cal Managed Care Plan that enrolls beneficiaries covered by the MHP. The MOU shall, at a minimum, address the following:

(1) Referral protocols between plans, including:

(A) How the MHP will provide a referral to the Medi–Cal managed care plan when the MHP determines that the beneficiary's mental illness would be responsive to physical health care based treatment and

(B) How the Medi–Cal managed care plan will provide a referral when the Medi–Cal managed care plan determines specialty mental health services covered by the MHP may be required.

(2) The availability of clinical consultation, including consultation on medications, to the Medi–Cal managed care plan for beneficiaries whose mental illness is being treated by the Medi–Cal managed care plan.

(3) Management of a beneficiary's care, including procedures for the exchange of medical information. The procedures shall ensure that the confidentiality of medical records is maintained in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(4) Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the Medi–Cal managed care plan. The procedures shall address, but are not limited to:

(A) Prescription drugs and laboratory services covered by the Medi–Cal managed care plan and prescribed through the MHP. Prescription drug and laboratory service procedures shall include:

1. The MHP's obligation to provide the names and qualifications of the MHP's prescribing physicians to the Medi–Cal managed care plan, if the Medi–Cal managed care plan covers prescription drugs.

2. The Medi–Cal managed care plan's obligation to provide the Medi–Cal managed care plan's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to the MHP, if the Medi–Cal managed care plan covers these services.

3. The MHP's obligation to designate a process or entity to receive notices of actions, denials, or deferrals from the Medi–Cal managed care plan and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination by the Medi–Cal managed care plan.

4. The MHP's obligation to respond by the close of the business day following the day the deferral notice is received by the MHP.

(B) Emergency room facility and related services other than specialty mental health services, home health agency services as described in Title 22, Section 51337, non–emergency medical transportation, and services to treat the physical health care needs of beneficiaries who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

(C) Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary' mental health or medical condition.

(5) A process for resolving disputes between the MHP and the Medi–Cal managed care plan that includes a means for beneficiaries to receive medically necessary services, including specialty mental health services and prescription drugs, while the dispute is being resolved. When the dispute involves the Medi–Cal managed care plan continuing to provide services to a beneficiary the Medi–Cal managed care plan believes requires specialty mental health services from the MHP, the MHP shall identify and provide the Medi–Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi–Cal managed care plan provider responsible for the beneficiary's care.

(b) If the MHP does not enter into an MOU with the Medi–Cal managed care plan, the MHP shall not be out of compliance with this Section provided the MHP establishes to the satisfaction of the Department that it has made good faith efforts to enter into an MOU.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777.5 and 14681, Welfare and Institutions Code.

§ 1810.375. MHP Reporting.

Each MHP shall submit reports to the Department as specified below.

(a) A report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.

(b) A list of all hospitals with which the MHP has current contracts, submitted by October 1 of each year.

(c) Fee–for–Service/Medi–Cal contract hospital rates negotiated by the MHP for each State fiscal year, submitted June 1 prior to the beginning of each State fiscal year.

(d) By December 31 of the year following the close of each State fiscal year, the amount of any unexpended balance still remaining from the allocation made pursuant to Sections 1810.330 or 1810.335 for that State fiscal year. This reporting requirement shall also apply to the organizational entity administering the small county reserve pursuant to Section 1810.341(e).

(e) Any reports required in the contract between the Department and the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777 and 14684, Welfare and Institutions Code.

§ 1810.380. State Oversight.

(a) The MHPs shall be subject to state oversight, including the following:

(1) Site visits and monitoring of data reports from MHPs and claims processing.

(2) Reviews of program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with this Chapter and the contract between the Department and the MHP.

(3) Immediate on–site reviews of MHP program operations whenever the Department obtains information indicating that there is a threat to the health or safety of beneficiaries.

(4) Monitoring compliance with problem resolution process requirements contained in Subchapter 5 and the MHP's Implementation Plan.

(5) Monitoring provider contracts to ensure that the MHP enters into necessary contracts with DSH and Traditional Hospitals.

(6) Monitoring denials of MHP payment authorizations.

(7) Annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, the services covered by the MHPs as required by Title 42, Code of Federal Regulations, Section 438.204.

(b) If the Department determines that an MHP is out of compliance with State or Federal laws and regulations or the terms of the contract between the MHP and the Department, the Department may take any or all of the following actions:

(1) Require that the MHP develop a plan of correction.

(2) Withhold all or a portion of payments due to the MHP from the Department.

(3) Impose civil penalties pursuant to Section 1810.385.

(4) Terminate the contract with the MHP pursuant to Section 1810.323.

(5) Take other actions deemed necessary to encourage and ensure contract and regulatory compliance.

(c) If the Department determines that an action should be taken pursuant to Subsection (b), the Department shall provide the MHP with a written Notice of Noncompliance. The Notice of Noncompliance shall include:

(1) A description of the violation

(2) A description of any corrective action required by the Department and time limits for compliance.

(3) A description of any and all proposed actions by the Department under this Section or Sections 1810.385 or 1810.323, and any related appeal rights.

(d) Except as provided in Section 1810.325, the MHP may appeal the Notice of Noncompliance to the Department, in writing, within 15 working days after the receipt of the notice, setting forth relevant facts and arguments. The Department shall grant or deny the appeal in whole or in part within 30 calendar days after receipt of the appeal. Except as provided in Section 1810.325, the Department shall suspend any proposed action pursuant to Subsection (c)(3) until the Department has acted on the MHP's appeal.

(e) In consultation with representatives from beneficiaries, their family members, MHPs, and selected other stakeholders, the Department shall develop, and update as appropriate, a comprehensive oversight program. The Department may effect this oversight program through administrative actions; incorporation into regulation as changes to this Section, to Implementation Plan requirements in Section 1810.310 or to other standards in this Chapter; and amendments to the contract between the Department and each MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5775, 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.204.

§ 1810.385. Civil Penalties.

(a) The Department may impose one or more of the civil penalties specified in Subsection (b) upon an MHP that fails to comply with the provisions of Sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, the provisions of this Chapter, or the terms of the MHP's contract with the Department.

(b) Civil penalties imposed by the Department shall be in the amounts specified below with respect to violation of:

(1) The provisions of Sections 1810.360, 1850.205, 1850.210, and 1850.215.

(A) First violation: $1,000.

(B) Second and each subsequent violation: $5,000.

(2) The provisions of Section 1810.375 and any other regulation or contract provision establishing a time frame for action.

(A) First violation: $500, plus $25 per day for each day that the item to be submitted is late.

(B) Second and each subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

(3) Any provision of this Chapter that is not specifically addressed in this Section.

(A) First violation: $500.

(B) Second violation: $1,000.

(C) Third and each subsequent violation: $5,000.

(4) Any provision of the contract between the MHP and the Department that is not specifically governed by this Chapter.

(A) First violation: $500.

(B) Second and subsequent violations: $1,000.

(5) Any provision of Sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, which is not specifically addressed in this Chapter.

(A) First violation: $1,000.

(B) Second and subsequent violations: $1,000.

(c) When the Department issues a notice of noncompliance as described in Section 1810.380 to an MHP found by the Department to be in violation of any provision of law, regulation or the contract, failure to comply with corrective actions in the notice within the time limits given shall be deemed to be a subsequent violation under this Section.

NOTE: Authority cited: Sections 5775(e)(1) and 14680, Welfare and Institutions Code. Reference: Sections 5775(e)(1) and 5777, Welfare and Institutions Code.

Article 4. Standards

§ 1810.405. Access Standards for Specialty Mental Health Services.

(a) The MHP of the beneficiary shall be responsible for assuring that the beneficiary has access to specialty mental health services as provided in Section 1810.345 and Section 1810.350.

(b) Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self–referral or through referral by another person or organization, including but not limited to:

(1) Physical health care providers

(2) Schools

(3) County welfare departments

(4) Other MHPs

(5) Conservators, guardians, or family members

(6) Law enforcement agencies.

(c) To treat a beneficiary's urgent condition, each MHP shall make specialty mental health services available 24 hours a day, seven days a week. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP shall have a statewide, toll–free telephone number available 24 hours a day, seven days per week, to act on MHP payment authorization requests for specialty mental health services to treat a beneficiary's urgent condition. Under these circumstances, the MHP shall act on the MHP payment authorization request within one hour of the request.

(d) Each MHP shall provide a statewide, toll–free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

(e) At the request of a beneficiary, the MHP of the beneficiary shall provide for a second opinion by a licensed mental health professional, other than a psychiatric technician or a licensed vocational nurse, employed by, contracting with or otherwise made available by the MHP when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2) or (b)(3)(C) or Section 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. The MHP shall determine whether the second opinion requires a face–to–face encounter with the beneficiary.

(f) The MHP shall maintain a written log of the initial requests for specialty mental health services from beneficiaries of the MHP. The requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain the name of the beneficiary, the date of the request, and the initial disposition of the request. An MHP may submit requests to the Department for approval of alternative mechanisms that will track initial requests for specialty mental health services. The alternative mechanism shall include the information required of the written log. The data in the alternative mechanism shall be accessible to review by the Department. Requests for approval for alternative mechanisms shall be submitted as components of or changes to the MHP's Implementation Plan pursuant to Section 1810.310.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1810.410. Cultural and Linguistic Requirements.

(a) Definitions:

(1) "Key points of contact" means common points of access to specialty mental health services from the MHP, including but not limited to the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP.

(2) "Primary language" means that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

(3) "Threshold Language" means a language that has been identified as the primary language, as indicated on the MEDS, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

(b) Each MHP shall comply with the cultural competence and linguistic requirements included in this Section, the terms of the contract between the MHP and the Department, and the MHP's Cultural Competence Plan established pursuant to Subsection (c). The terms of the contract between the MHP and the Department may provide additional requirements for the Cultural Competence Plan, including a description of the acceptable data sources and requirements for arraying data for the components of the Cultural Competence Plan.

(c) Each MHP shall develop and implement a Cultural Competence Plan that includes the following components:

(1) Objectives and strategies for improving the MHP's cultural competence based on the assessments required in Subsection (c)(2) and the MHP's performance on the standards in Subsection (d).

(2) A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability.

(3) A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by location of the services, pursuant to Section 1810.360 (f)(1).

(4) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

(d) The Department shall establish timelines for the submission and review of the Cultural Competence Plan described in Subsection (b) either as a component of the Implementation Plan process described in Section 1810.310 or as a term of the contract between the MHP and the Department. The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually.

(e) Each MHP shall have:

(1) A statewide, toll–free telephone number as required by Section 1810.405(d).

(2) Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the specialty mental health services or related services available through that key point of contact. The threshold languages shall be determined on a countywide basis. MHPs may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

(A) The MHP has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

(B) The MHP provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

(3) Policies and procedures to assist beneficiaries who need oral

interpreter services in languages other than threshold languages to access the specialty mental health services or related services available through that key point of contact.

(4) General program literature used by the MHP to assist beneficiaries in accessing services including, but not limited to, the beneficiary brochure required by Section 1810.360(c), materials explaining the beneficiary problem resolution and fair hearing processes required by Section 1850.205(c)(1), and mental health education materials used by the MHP, in threshold languages, based on the threshold languages in the county as a whole.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.415. Coordination of Physical and Mental Health Care.

(a) The MHP shall make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving specialty mental health services from the MHP.

(b) The MHP shall arrange appropriate management of a beneficiary's care, including the exchange of medical information, with a beneficiary's other health care providers or providers of specialty mental health services. The MHP shall maintain the confidentiality of medical records in accordance with State and federal laws and regulations governing the confidentiality of personal or medical information, including mental health information, relating to beneficiaries.

(c) The MHP shall coordinate with pharmacies and Medi–Cal managed care plans as appropriate to assist beneficiaries to receive prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures.

(d) When the MHP determines that the beneficiary's diagnosis is not included in Section 1830.205(b)(1) or is included but would be responsive to physical health care based treatment, the MHP of the beneficiary shall refer the beneficiary to:

(1) A provider outside the MHP, which may include:

(A) Whenever possible, a provider with whom the beneficiary already has a patient–provider relationship;

(B) The Medi–Cal managed care plan in which the beneficiary is enrolled;

(C) A provider in the area who has indicated to the MHP a willingness to accept MHP referrals, including federally qualified health centers, rural health clinics, and Indian health clinics; or

(2) An entity that provides assistance in identifying providers willing to accept Medi–Cal beneficiaries, which may include, where appropriate:

(A) The health care options program described in Section 14016.5 of the Welfare and Institutions Code;

(B) The local Child Health and Disability Prevention program as described in Title 17, Section 6800 et seq.;

(C) Provider organizations;

(D) Other community resources available in the county of the MHP.

The MHP of the beneficiary shall not be required to ensure the beneficiary's access to physical health care based treatment or to ensure the beneficiary's access to treatment from licensed mental health professionals for diagnoses not covered in Section 1830.205(b)(1). When the situation generating a referral under this Subsection meets the criteria established in Section 1850.210(i), a notice of action will be provided in accordance with that Section.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1810.425. Hospital Selection Criteria.

An MHP shall establish a hospital selection process that meets the following criteria:

(a) The MHP shall require that each hospital:

(1) Comply with federal Medicaid laws, regulations and guidelines and State statutes and regulations.

(2) Sign a provider agreement with the State Department of Health Services.

(3) Provide psychiatric inpatient hospital services, within its scope of licensure, to all beneficiaries who are referred by the MHP, unless compelling clinical circumstances exist that contraindicate admission, or the MHP negotiates a different arrangement with the hospital.

(4) Refer beneficiaries for other services when necessary.

(5) Not refuse an admission solely on the basis of age, sex, race, religion, physical or mental disability, or national origin.

(b) In addition to the specified conditions in Subsection (a), an MHP may consider but is not limited to any or all of the following in selecting hospitals:

(1) History of Medi–Cal certification, licensure and accreditation.

(2) Circumstances and outcomes of any current or previous litigation against the hospital.

(3) The geographic location(s) that would maximize beneficiary participation.

(4) Ability of the hospital to:

(A) Offer services at competitive rates.

(B) Demonstrate positive outcomes and cost effectiveness.

(C) Address the needs of beneficiaries based on factors including age, language, culture, physical disability, and specified clinical interventions.

(D) Serve beneficiaries with severe mental illness and serious emotional disturbances.

(E) Meet the quality improvement, authorization, clinical and administrative requirements of the MHP.

(F) Work with beneficiaries, their families and other providers in a collaborative and supportive manner.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.430. Contracting for Psychiatric Inpatient Hospital Service Availability.

(a) An MHP shall contract with DSH and Traditional Hospitals when:

(1) The DSH or Traditional Hospital meets the hospital selection criteria described in the MHP's Implementation Plan as required by Section 1810.310(a)(4).

(2) The DSH is located:

(A) In the same county as the MHP, or

(B) In a different county than the MHP and according to the latest historical Medi–Cal paid claims data, the DSH provides services to beneficiaries of the MHP that account for five percent or twenty thousand dollars, whichever is more, of the total fiscal year Fee–For–Service/Medi–Cal psychiatric inpatient hospital service payments for beneficiaries of the MHP.

(b) Prior to the beginning of each State fiscal year, the Department shall notify all MHPs of the DSH and Traditional Hospitals for that fiscal year.

(c)(1) If an MHP determines not to contract with a DSH or Traditional Hospital, it shall submit a Request for Exemption from Contracting to the Department with its Implementation Plan. The MHP shall submit Requests for Exemption initiated after the submission of the Implementation Plan to the Department as a separate submission. The Request for Exemption from Contracting

shall address the projected effect on beneficiaries. At a minimum, the Request for Exemption from Contracting shall include:

(A) The name of the hospital for which the Request for Exemption from Contracting is requested.

(B) An analysis of the most recently available data from the Office of Statewide Health Planning and Development (OSHPD) on the availability, within an accessible geographic area, of hospital beds for psychiatric inpatient hospital services with and without a contract. Other data may be substituted if OSHPD data are not available or if equally reliable data are more comprehensive.

(C) The estimated impact on maximum and average travel time and distances for beneficiaries to obtain psychiatric inpatient hospital services, from hospitals either with or without a contract.

(2) An MHP shall notify the DSH or Traditional Hospital of the Request for Exemption from Contracting at the same time that the Request for Exemption is sent to the Department.

(3) The Department shall approve or deny in writing the MHP's Request for Exemption from Contracting within 30 calendar days of its receipt and shall notify both the MHP and the DSH or Traditional Hospital of its decision. The Department shall deny any Request for Exemption from Contracting when failure to contract is likely to result in hardship to beneficiaries as measured by local community standards.

(d) At a minimum, a contract between an MHP and a provider of psychiatric inpatient hospital services shall meet federal contracting requirements as provided in Title 42, Code of Federal Regulations, Section 438.6(*l*), and shall include the following provisions:

(1) Treatment requirements, as a condition for reimbursement for psychiatric inpatient hospital services, that ensure beneficiaries will receive the same level of services as provided to all other patients served.

(2) Assurances that beneficiaries will not be discriminated against in any manner, including admission practices, placement in special wings or rooms, or provision of special or separate meals.

(3) Specifics of how the hospital shall make records available for authorized review for fiscal audits, program compliance and beneficiary complaints.

(4) Language specifying that the per diem rate included in the contract is considered to be payment in full, subject to third party liability and patient share of costs, for psychiatric inpatient hospital services to a beneficiary.

(5) Language specifying that the rate structure in the contract includes all services defined as psychiatric inpatient hospital services in this Chapter and that the rate structure does not include psychiatric inpatient hospital professional services rendered to a beneficiary covered under the contract unless the hospital is a Short–Doyle/Medi–Cal Hospital.

(6) Requirements that a hospital adheres to Title XIX of the Social Security Act and conforms to federal and State statutes and regulations.

(e) No provision of a contract shall be construed to replace or conflict with the duties of county patients' rights advocates described in Section 5520 of the Welfare and Institutions Code.

(f) A formal contract between an MHP and a hospital is not required when the MHP owns or operates the hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.6.

§ 1810.435. MHP Individual, Group and Organizational Provider Selection Criteria.

(a) Each MHP shall establish individual, group, and organizational provider selection criteria that comply with the requirements of this Section, the terms of the contract between the MHP and the Department, and the MHP's Implementation Plan pursuant to Section 1810.310.

(b) In selecting individual or group providers with which to contract, the MHP shall require that each individual or group provider:

(1) Possess the necessary license or certification to practice psychotherapy independently. Each individual practicing as part of a group provider shall possess the necessary license or certification.

(2) Maintain a safe facility.

(3) Store and dispense medications in compliance with State and federal laws and regulations.

(4) Maintain client records in a manner that meets state and federal standards.

(5) Meet the MHP's Quality Management Program standards.

(6) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(c) In selecting organizational providers with which to contract, the MHP shall require that each provider:

(1) Possess the necessary license to operate.

(2) Provide for appropriate supervision of staff.

(3) Have as head of service a licensed mental health professional or mental health rehabilitation specialist as described in Sections 622 through 630.

(4) Possess appropriate liability insurance.

(5) Maintain a safe facility.

(6) Store and dispense medications in compliance with all pertinent State and federal standards.

(7) Maintain client records in a manner that meets State and federal standards.

(8) Meet the MHP's Quality Management Program standards and requirements.

(9) Have accounting and fiscal practices that are sufficient to comply with its obligations pursuant to Section 1840.105.

(10) Meet any additional requirements established by the MHP as part of a credentialing or other evaluation process.

(d) The MHP shall certify that a provider other than the MHP meets the criteria in Subsections (b) or (c) prior to the provision of specialty mental health services under this Chapter, unless another time frame is provided in the contract between the Department and the MHP. For organizational providers, the MHP's certification process shall include an on site review in addition to a review of relevant documentation.

(e) When an organizational provider is the MHP, the Department shall certify that each specific office or facility owned or operated by the MHP meets the criteria in Subsections (b) and (c), of the contract between the Department and the MHP. Unless another time frame is provided in the contract between the Department and the MHP, the Department's certification shall be obtained by the MHP prior to use of the provider for the provision of specialty mental health services under this Chapter. The Department's certification process shall include an on–site review of the office or facility in addition to a review of relevant documentation.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1810.436. MHP Individual, Group and Organizational Provider Contracting Requirements.

(a) At a minimum, a contract between an MHP and a provider shall meet federal contracting requirements as provided in Title 42, Code of Federal Regulations, Section 438.6(*l*), and shall include the following provisions:

(1) Treatment requirements, as a condition for reimbursement, that ensure beneficiaries will receive the same level of services as provided to all other patients served.

(2) Assurances that beneficiaries will not be discriminated against in any manner.

(3) Specifics of how the provider shall make records available for authorized review for fiscal audits, program compliance and beneficiary complaints.

(4) Language specifying that the rate included in the contract is considered to be payment in full, subject to third party liability and beneficiary share of cost, for the specialty mental health services provided to a beneficiary.

(5) Requirements that the provider adhere to Title XIX of the Social Security Act and conform to other federal and State statutes and regulations.

(b) No provision of a contract shall be construed to replace or conflict with the duties of county patients' rights advocates described in Section 5520 of the Welfare and Institutions Code.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.6.

§ 1810.438. Alternative Contracts and Payment Arrangements Between MHPs and Providers.

(a) Except as provided in Subsection (d), the MHP shall request approval from the Department to establish a contract with a provider for specialty mental health services where that provider is held financially responsible for specialty mental health services provided to beneficiaries by one or more other providers or to establish a payment arrangement with contract or non–contract providers that would not be allowed under this Chapter absent approval under this Section.

(b) The MHP may request approval from the Department under this Section by submitting a written request to the Department containing a description of:

(1) The proposed contract terms concerning reimbursement or the proposed payment arrangement,

(2) A complete description of the administrative system of the provider and the MHP that will ensure proper payment to the provider, claiming of the FFP available for services provided to Medi–Cal beneficiaries under the Medi–Cal program, and MHP and provider cost reporting.

(c) The MHP shall not implement the proposed contract terms or payment arrangement until written approval by the Department is received. The Department shall review the proposal and approve the request only if the following conditions are met:

(1) The proposed contract or payment arrangement complies with federal and state requirements for reimbursement for specialty mental health services.

(2) The MHP has established appropriate systems to prevent duplicate claiming of FFP.

(3) The MHP has established appropriate procedures to assure that services provided under the contract or payment arrangement are reported by only one provider in cost and data reporting to the Department.

(d) Contracts between the MHP and a Fee–for–Service/Medi–Cal hospital that include psychiatric inpatient hospital professional services pursuant to Section 5781 of the Welfare and Institutions Code shall not require approval from the Department.

(e) Nothing in this Section shall exclude or exempt a provider from compliance with licensing requirements for health care service plans and specialized health care service plans under Section 1340 et seq. of the Health and Safety Code.

(f) A negotiated case rate or capitation rate of payment between an MHP and a provider pursuant to this Section shall not be the basis for finding a violation of the requirements of Title 22, Sections 51501(a) or 51480 and shall not be the basis for otherwise reducing the provider's reimbursement pursuant to Title 22, Division 3, Subdivision 1, Chapter 3, Article 7. A case rate is a payment method that reimburses the provider a set rate per time period per patient who receives at least one service during the time period, regardless of the actual number of services provided. A capitation rate is a payment method that reimburses the provider a set rate per time period, usually per month, per identified patient for all services needed by the patient, whether or not any services are received.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 1340 et seq., Health and Safety Code; and Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1810.440. MHP Quality Management Programs.

The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the Department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:

(1) Is accountable to the director of the MHP.

(2) Has active involvement in planning, design and execution from:

(A) Providers;

(B) Beneficiaries who have accessed specialty mental health services through the MHP; and

(C) Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.

(3) Ensures that the persons participating in the Quality Improvement Program under Subsection (a)(2) shall not be subject to discrimination or any other penalty in their other relationships with the MHP as a result of their role in representing themselves and their constituencies in the Quality Improvement Program.

(4) Includes substantial involvement of a licensed mental health professional.

(5) Conducts monitoring activities including but not limited to review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

(6) Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:

(1) Assures that the access and authorization criteria established in this Chapter are met.

(2) Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.

(3) Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical records system that meets the requirements of the contract between the MHP and the Department and requirements of State and federal law and regulation governing beneficiary documentation and medical records systems, including the following:

(1) Client plans signed (or electronic equivalent) by:

(A) The person providing the service(s), or

(B) A person representing a team or program providing services, or

(C) A person representing the MHP providing services.

(2) Documentation of the beneficiaries' participation in and agreement with their client plans. Documentation of participation in and agreement with the client plan may include, but is not limited to reference in the client plan to the beneficiary's participation in and agreement with the client plan, the beneficiary's signature on the client plan, or a description in the medical record of the beneficiary's participation and agreement with the client plan, except as follows:

(A) The MHP shall obtain the beneficiary's signature or the signature of the beneficiary's legal representative on the client plan when:

1. The beneficiary is expected to be in long term treatment as determined by the MHP and

2. The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service.

(B) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan under Subsection (d)(1) and the beneficiary refuses to sign the client plan or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14683 and 14684, Welfare and Institutions Code.

Subchapter 2. Medi–Cal Psychiatric Inpatient Hospital Services

Article 1. Fiscal Provisions

§ 1820.100. Definitions.

(a) "Allowable Psychiatric Accommodation Code" means a code that may be used by Fee–For–Service/Medi–Cal hospitals and MHPs to establish negotiated rates for psychiatric inpatient hospital services provided to beneficiaries. The allowable codes are:

097 Psychiatric Acute (Adolescent and Child)
114 Room and Board, Private, Psychiatric
124 Room and Board, Semi–Private 2 Bed, Psychiatric
134 Room and Board, Semi–Private 3 or 4 Bed, Psychiatric
154 Room and Board — Ward (Medical or General), Psychiatric
169 Administrative Days
204 Intensive Care, Psychiatric

(b) "Located" means the actual physical location of a hospital, and unless otherwise specified, refers to the specific county within the geographic boundaries of which the hospital exists.

(c) "Per Diem Rate" means a daily rate paid for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1820.110. Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, Fee–for–Service/Medi–Cal Hospitals.

(a) Except as approved by the Department pursuant to Section 1810.438, reimbursement for acute psychiatric inpatient hospital services for each Fee–for–Service/Medi–Cal hospital with a contract with any MHP, shall be based on a per diem rate established through negotiations between the hospital and the MHP in the county in which the hospital is located except when:

(1) The MHP from the county in which the hospital is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.

(2) The MHP from the county in which the hospital is located declines to contract with the hospital or is otherwise exempt from contracting under this Subchapter and another MHP wants to negotiate rates. The MHP shall request approval from the Department to be designated as the negotiator. The Department shall approve the request unless approval has already been given to another MHP.

(3) The hospital is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department to be designated as the negotiator.

(4) A hospital is owned or operated by the same organizational entity as the MHP. The per diem rate must be submitted by the MHP and approved by the Department. The Department shall approve a per diem rate submitted by the MHP if it is not greater than the highest per diem rate within the State, negotiated by a different MHP for a different hospital.

(b) Except as approved by the Department pursuant to Section 1810.438, the per diem rate shall include routine hospital services and all hospital–based ancillary services.

(c) Except as approved by the Department pursuant to Section 1810.438, only one rate for each allowable psychiatric accommodation code for each negotiated rate Fee–for–Service/Medi–Cal hospital may be established and shall be used by all MHPs with that hospital. The negotiated rate shall not be subject to retrospective adjustment to cost.

(d) Except as approved by the Department pursuant to Section 1810.438, reimbursement for administrative day services shall be the rate established in accordance with Title 22, Section 51542 except for facility–specific reimbursements determined by the State Department of Health Services in accordance with Title 22, Section 51511(a)(2)(B) plus an allowance for hospital–based ancillary services equal to 25 percent of the maximum rate established under Title 22, Section 51542(a)(3).

(e) For both acute psychiatric inpatient hospital services and administrative day services, reimbursement to the hospital shall be based on the per diem rate, less third party liability and patient share of cost.

(f) Except as approved by the Department pursuant to Section 1810.438, the hospital shall submit reimbursement claims for Medi–Cal psychiatric inpatient hospital services to the fiscal intermediary based on its usual and customary charges.

(g) Except as approved by the Department pursuant to Section 1810.438, at the end of each fiscal year, the Department shall compare, in aggregate, usual and customary charges to per diem rate for each hospital. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) Except as approved by the Department pursuant to Section 1810.438, the per diem rate included in the contract less third party liability and patient share of costs shall be considered to be payment in full for acute psychiatric inpatient hospital services to a beneficiary. The per diem rate established pursuant to Subsection (d) less third party liability and patient share of costs shall be considered to be payment in full for administrative day services to a beneficiary.

(i) The MHP shall not be responsible to reimburse Fee–for–Service/Medi–Cal hospitals that deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi–Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, United States Code, Section 1396a(a)(n).

§ 1820.115. Rate Setting for Psychiatric Inpatient Hospital Services for Non–Negotiated Rate, Fee–for–Service/Medi–Cal Hospitals.

(a) Reimbursement rates for acute psychiatric inpatient hospital services for each Fee–for–Service/Medi–Cal hospital with no contract with any MHP shall be determined by the Department.

(1) The reimbursement rates in Subsection (a) shall be calculated by the Department prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among Fee–for–Service/Medi–Cal contract hospitals or the addition of new Fee–for Service/Medi–Cal contract hospitals.

(2) One rate per allowable psychiatric accommodation code per non–negotiated rate, Fee–for–Service/Medi–Cal hospital per Rate Region listed in Subsection (i) shall be established and shall be used by all MHPs.

(3) The rates shall not be subject to retrospective adjustment to cost.

(b) The per diem rate includes routine hospital services and all hospital–based ancillary services.

(c) The per diem rate by accommodation code shall equal the

weighted average per diem rates by accommodation code negotiated for all Fee–for–Service/Medi–Cal hospitals within the Rate Region listed in Subsection (i) where the non–negotiated rate Fee–for–Service/Medi–Cal hospital is located or, if there are no Fee–for–Service/Medi–Cal hospitals with a negotiated rate by accommodation code within the Rate Region, the weighted average per diem rates by accommodation code negotiated for all Fee–for–Service/Medi–Cal hospitals statewide. The per diem rate shall be based on the following information from each Fee–for–Service/Medi–Cal hospital with a contract in the Rate Region where the non–negotiated rate Fee–for–Service/Medi–Cal hospital is located or statewide, if there are no Fee–for–Service/Medi–Cal hospitals with a negotiated rate by accommodation code within the Rate Region:

(1) The latest available fiscal year Medi–Cal paid claims data for Fee–for–Service/Medi–Cal acute psychiatric inpatient hospital services patient days.

(2) The negotiated per diem rates by accommodation code for Fee–for–Service/Medi–Cal hospitals for the subsequent fiscal year.

(d) Reimbursement for administrative day services shall be the rate established in accordance with Title 22, Section 51542, except for facility–specific reimbursements determined by the State Department of Health Services in accordance with Title 22, Section 51511(a)(2)(B), plus an allowance for hospital–based ancillary services equal to 25 percent of the maximum rate established under Title 22, Section 51542(a)(3).

(e) For both acute psychiatric inpatient hospital services and administrative day services, interim reimbursement to the non–negotiated rate Fee–for–Service/Medi–Cal hospital shall be based on the calculated per diem rate less third party liability and patient share of cost.

(f) The hospital shall bill its usual and customary charges.

(g) At the end of each fiscal year, the Department shall compare, in aggregate, the usual and customary charges to the per diem rate for each hospital. Future claims shall be offset by the amount that the per diem rate exceeds the usual and customary charges for that fiscal year.

(h) The per diem rates established by this Section less third party liability and patient share of costs shall be considered to be payment in full for psychiatric inpatient hospital services to a beneficiary.

(i) The Rate Regions, including specified border communities, are:

(1) Superior — Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity Counties, and Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, and Merrill, Oregon.

(2) Central Valley — Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba Counties, and Carson City, Incline Village, Minden, Reno, Sparks, and Zephyr Cove, Nevada.

(3) Bay Area — Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma Counties.

(4) Southern California — Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura Counties, and Las Vegas and Henderson, Nevada; and Bullhead City, Kingman, Lake Havasu City, Parker and Yuma, Arizona.

(5) Los Angeles County.

(j) The MHP shall not be responsible to reimburse Fee–for–Service/Medi–Cal hospitals that deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi–Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n).

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, United States Code, Section 1396a(a)(n).

§ 1820.120. Rate Setting for Psychiatric Inpatient Hospital Services for Short–Doyle/Medi–Cal Hospitals.

(a) Except as approved by the Department pursuant to Section 1810.438, reimbursement for acute psychiatric inpatient hospital services for Short–Doyle/Medi–Cal hospitals shall be established in accordance with Section 1840.105.

(b) Except as approved by the Department pursuant to Section 1810.438, reimbursement for administrative day services for Short–Doyle/Medi–Cal hospitals shall be established in accordance with Title 22, Section 51542.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5720 and 5724, Welfare and Institutions Code.

Article 2. Provision of Services

§ 1820.200. Definitions.

(a) "Adverse Decision" means denial or termination of an MHP payment authorization by the MHP's Point of Authorization or by a Short–Doyle/Medi–Cal hospital's Utilization Review Committee that determines the MHP's authorization for payment.

(b) "Continued Stay Services" means psychiatric inpatient hospital services for beneficiaries that occur after admission.

(c) "County Medical Services Program" means the service delivery and payment system for health care for low–income persons who are not eligible for Medi–Cal and which is administered by the State Department of Health Services for counties.

(d) "Emergency Admission" means an admission of a beneficiary to a hospital due to an emergency psychiatric condition for psychiatric inpatient hospital services.

(e) "Planned Admission" means an admission of a beneficiary to a hospital with a contract with an MHP for the purpose of providing medically necessary treatment that cannot be provided in another setting or a lower level of care and is not an emergency admission. Planned admissions may occur in a non–contract hospital pursuant to the MHP's Implementation Plan, as provided in Section 1810.310(a)(7) of this Chapter.

(f) "Utilization Review Committee" means a committee that reviews services provided to determine appropriateness for psychiatric inpatient hospital services, identifies problems with quality of care, and meets the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5777, Welfare and Institutions Code.

§ 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

(a) For Medi–Cal reimbursement for an admission to a hospital for psychiatric inpatient hospital services, the beneficiary shall meet medical necessity criteria set forth in Subsections (a)(1)–(2) below:

(1) One of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM–IV™ (1994)*, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy or Early Childhood

(D) Tic Disorders

(E) Elimination Disorders

(F) Other Disorders of Infancy, Childhood, or Adolescence

(G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)

(H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder

(I) Schizophrenia and Other Psychotic Disorders

(J) Mood Disorders

(K) Anxiety Disorders

(L) Somatoform Disorders

(M) Dissociative Disorders

(N) Eating Disorders

(O) Intermittent Explosive Disorder

(P) Pyromania

(Q) Adjustment Disorders

(R) Personality Disorders

(2) Both the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either Subsection (a)(2)(B)1. or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

(b) Continued stay services in a hospital shall only be reimbursed when a beneficiary experiences one of the following:

(1) Continued presence of indications that meet the medical necessity criteria as specified in (a).

(2) Serious adverse reaction to medications, procedures or therapies requiring continued hospitalization.

(3) Presence of new indications that meet medical necessity criteria specified in (a).

(4) Need for continued medical evaluation or treatment that can only be provided if the beneficiary remains in a hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1820.210. Hospital Utilization Control.

All hospitals shall comply with Federal requirements for utilization control pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D. These requirements include certification of need for care, evaluation and medical review, plans of care and utilization review plan. Each hospital shall establish a Utilization Review Committee to determine whether admission and length of stay are appropriate to level of care and to identify problems with quality of care. Composition of the committee shall meet the requirements of Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 5778, Welfare and Institutions Code.

§ 1820.215. MHP Payment Authorization—General Provisions.

(a) The MHP payment authorization shall be determined for:

(1) Fee–for–Service/Medi–Cal hospitals, by an MHP's Point of Authorization.

(2) Short–Doyle/Medi–Cal hospitals contracting with the MHP, by either:

(A) An MHP's Point of Authorization, or

(B) The hospital's Utilization Review Committee, as agreed to in the contract.

(3) Short–Doyle/Medi–Cal hospitals that do not have a contract with the MHP, by an MHP's Point of Authorization.

(b) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this Chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505 or unless the services are provided to individuals eligible for the County Medical Services Program (CMSP). Services provided to individuals eligible for the CMSP shall be authorized by the MHP for that county, but the MHP will not be responsible for payment of those services.

(c) MHP payment authorization requests presented for authorization beyond the timelines specified in this Subchapter shall be accepted for consideration by the MHP when the MHP determines that the hospital was prevented from submitting a timely request because of a reason that meets one of the criteria specified below. The MHP may accept MHP payment authorization requests presented beyond the timelines specified in the Subchapter for other acceptable reasons as determined by the MHP. The hospital shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(1) A natural disaster that has:

(A) Destroyed or damaged the hospital's business office or records; or

(B) Substantially interfered with the hospital's agent's processing of requests for MHP payment authorization; or

(2) Delays caused by other circumstances beyond the hospital's control. Documentation shall include evidence that the circumstance causing the delay was reported to a law enforcement or fire agency, if the circumstance is required to be reported. Circumstances not considered beyond the control of the hospital include but are not limited to:

(A) Negligence by employees.

(B) Misunderstanding of program requirements.

(C) Illness or absence of any employee trained to prepare MHP payment authorizations.

(D) Delays caused by the United States Postal Service or any private delivery service.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1820.220. MHP Payment Authorization by a Point of Authorization.

(a) A hospital shall submit a separate written request for MHP payment authorization of psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP for each of the following:

(1) The planned admission of a beneficiary.

(2) Ninety–nine calendar days of continuous service to a beneficiary, if the hospital stay exceeds that period of time.

(3) Upon discharge.

(4) Services that qualify for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(5) Administrative day services that are requested for a beneficiary.

(b) A hospital shall submit the request for MHP payment authorization for psychiatric inpatient hospital services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission.

(2) Within 14 calendar days after:

(A) Ninety–nine calendar days of continuous service to a beneficiary if the hospital stay exceeds that period of time.

(B) Discharge.

(C) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing (Aid Paid Pending).

(c) Except as approved by the Department pursuant to Section 1810.438, a written request for MHP payment authorization to the Point of Authorization shall be in the form of:

(1) A Treatment Authorization Request (TAR) for Fee–for–Service/Medi–Cal hospitals; or

(2) As specified by the MHP for Short–Doyle/Medi–Cal hospitals.

(d) The Point of Authorization staff that approve or deny payment shall be licensed mental health or waivered/registered professionals of the beneficiary's MHP.

(e) Except as approved by the Department pursuant to Section 1810.438, approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing:

(1) On the same TAR on which the Fee–for–Service/ Medi–Cal hospital requested MHP payment authorization or

(2) In an MHP payment authorization log maintained by the MHP for Short–Doyle/Medi–Cal hospitals.

(f) The MHP shall document that all adverse decisions regarding hospital requests for MHP payment authorization based on medical necessity criteria or the criteria for emergency admission were reviewed and approved:

(1) by a physician, or

(2) at the discretion of the MHP, by a psychologist for patients admitted by a psychologist and who received services under the psychologist's scope of practice.

(g) A request for an MHP payment authorization may be denied by a Point of Authorization if the request is not submitted in accordance with timelines in this Subchapter or does not meet medical necessity reimbursement criteria in Section 1820.205 or emergency psychiatric condition criteria in Section 1820.225(b) on an emergency admission or if the hospital has failed to meet any other mandatory requirements of the contract negotiated between the hospital and the MHP.

(h) A Point of Authorization shall approve or deny the request for MHP payment authorization within 14 calendar days of the receipt of the request and, for a request from a Fee–for–Service Medi–Cal hospital, shall submit the TAR to the fiscal intermediary within 14 calendar days of approval or denial. The Point of Authorization shall provide for an expedited review of an MHP payment authorization request for a planned admission in accordance with the timelines in Title 42, Code of Federal Regulations, Section 438.210(d)(2), when the MHP determines or the hospital certifies that following the 14 calendar day time frame would seriously jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function.

(i) Point of Authorization staff may authorize payments for up to seven calendar days in advance of service provision.

(j) Approval of the MHP payment authorization by a Point of Authorization requires that:

(1) Planned admission requests for an MHP's payment authorization shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric inpatient hospital services, as specified in Section 1820.205, any other requirements of this Subchapter that apply to the admission, and any mandatory requirements of the contract negotiated between the hospital and the MHP. The request shall be submitted and approved prior to admission.

(2) Emergency admissions shall not be subject to prior MHP payment authorization.

(3) A request for MHP payment authorization for continued stay services shall be submitted to the Point of Authorization as follows:

(A) A contract hospital's request shall be submitted within the timelines specified in the contract. If the contract does not specify timelines, the contract hospital shall be subject to the same timeline requirements as the non–contract hospitals.

(B) A non–contract hospital's request shall be submitted to the Point of Authorization not later than:

1. Within 14 calendar days after the beneficiary is discharged from the hospital, or

2. Within 14 calendar days after a beneficiary has received 99 continuous calendar days of psychiatric inpatient hospital services.

(4) Requests for MHP payment authorization for continued stay services shall be approved if written documentation has been provided to the MHP indicating that the beneficiary met the medical necessity reimbursement criteria for acute psychiatric inpatient hospital services for each day of service in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP.

(5) Requests for MHP payment authorization for administrative day services shall be approved by an MHP when the following conditions are met in addition to requirements for timeliness of notification and any mandatory requirements of the contract negotiated between the hospital and the MHP:

(A) During the hospital stay, a beneficiary previously has met medical necessity criteria for reimbursement of acute psychiatric inpatient hospital services.

(B) There is no appropriate, non–acute residential treatment facility in a reasonable geographic area and a hospital documents contacts with a minimum of five appropriate, non–acute residential treatment facilities per week subject to the following requirements:

1. Point of Authorization staff may waive the requirements of five contacts per week if there are fewer than five appropriate, non–acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, non–acute residential treatment facilities and the contacts made at appropriate facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

(C) An MHP may submit a request to the Department for approval to use an alternative to the procedures described in Subsection (j)(5)(B). The Department shall approve the request if the MHP establishes to the satisfaction of the Department that the alternative ensures that placement options for beneficiaries who are receiving administrative days are being considered in a timely manner.

(D) For beneficiaries also eligible under Medicare (Part A) who have received acute psychiatric inpatient hospital services which were approved for Medicare (Part A) coverage, the hospital has notified the Point of Authorization within 24 hours or as specified in the contract, prior to beginning administrative day services.

(6) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a hospital shall be approved by an MHP when necessary documentation, as specified in Section 1850.215, is submitted.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.210.

§ 1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

(a) The MHP shall not require a hospital to obtain prior MHP payment authorization for an emergency admission, whether voluntary or involuntary.

(b) The hospital providing emergency psychiatric inpatient hospital services shall assure that the beneficiary meets the criteria for medical necessity in Section 1820.205, and due to a mental disorder, is:

(1) A current danger to self or others, or

(2) Immediately unable to provide for, or utilize, food, shelter or clothing.

(c) The hospital providing emergency psychiatric inpatient hospital services shall notify the MHP of the county of the beneficiary within ten calendar days of the time of presentation for emergency services, or within the timelines specified in the contract, if a time

requirement is included as a term of the contract between the hospital and MHP.

(1) If the hospital cannot determine the MHP of the beneficiary, the hospital shall notify the MHP of the county where the hospital is located, within ten calendar days of the date of presentation for emergency services.

(2) The MHP for the county where the hospital is located shall assist the hospital to determine the MHP of the beneficiary. The hospital shall notify the MHP of the beneficiary within ten calendar days of the date of presentation for emergency services of determination of the appropriate MHP.

(d) Requests for MHP payment authorization for an emergency admission shall be approved by an MHP when:

(1) A hospital notified the Point of Authorization within ten calendar days of the date of presentation for emergency services or within the time required by contract, if a time requirement is included as a term of the contract between the hospital and MHP.

(2) Written documentation has been provided to the MHP that certifies that a beneficiary met the criteria in Subsection (b) at the time of admission.

(3) Written documentation has been provided to the MHP that certifies a beneficiary met the criteria in Subsection (b) for the day of admission.

(4) A non–contract hospital includes documentation that the beneficiary could not be safely transferred to a contract hospital or a hospital owned or operated by the MHP of the beneficiary, if the transfer was requested by the MHP.

(5) Any mandatory requirements of the contract negotiated between the hospital and the MHP are met.

(e) After an emergency admission, the MHP of the beneficiary may:

(1) Transfer the beneficiary from a non–contract to a contract hospital or a hospital owned or operated by the MHP of the beneficiary as soon the patient is stable. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.

(2) Choose to authorize continued stay with a non–contract hospital.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.114(d)(ii).

§ 1820.230. MHP Payment Authorization by a Utilization Review Committee.

(a) MHP payment authorization for psychiatric inpatient hospital services provided by a Short–Doyle/Medi–Cal hospital, if not made by an MHP's Point of Authorization pursuant to Section 1820.220, shall be made by the hospital's Utilization Review Committee.

(1) The hospital's Utilization Review Committee shall meet the Federal requirements for participants pursuant to Title 42, Code of Federal Regulations, Chapter IV, Subchapter C, Part 456, Subpart D.

(2) The decision regarding MHP payment authorization shall be documented in writing by the hospital's Utilization Review Committee.

(b) The hospital's Utilization Review Committee or its designee shall approve or deny the initial MHP payment authorization no later than the third working day from the day of admission.

(c) At the time of the initial MHP payment authorization, the hospital's Utilization Review Committee or its designee shall specify the date for the subsequent MHP payment authorization determination.

(d) Approval of MHP payment authorization by a hospital's Utilization Review Committee requires that:

(1) When documentation in the clinical record substantiates that the beneficiary met the medical necessity criteria, the hospital's Utilization Review Committee shall authorize payment for each day that services are provided.

(2) Requests for MHP payment authorization for administrative day services shall be approved by the hospital's Utilization Review Committee when both of the following conditions are met:

(A) During the hospital stay, a beneficiary previously had met medical necessity criteria for acute psychiatric inpatient hospital services.

(B) There is no appropriate, non–acute residential treatment facility within a reasonable geographic area and the hospital documents contacts with a minimum of five appropriate, non–acute residential treatment facilities per week for placement of the beneficiary subject to the following requirements.

1. The MHP or its designee can waive the requirement of five contacts per week if there are fewer than five appropriate, non–acute residential treatment facilities available as placement options for the beneficiary. In no case shall there be less than one contact per week.

2. The lack of placement options at appropriate, residential treatment facilities and the contacts made at appropriate treatment facilities shall be documented to include but not be limited to:

a. The status of the placement option.

b. Date of the contact.

c. Signature of the person making the contact.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Subchapter 3. Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services

§ 1830.100. General Provisions.

This Subchapter applies to specialty mental health services other than psychiatric inpatient hospital services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

Article 1. Fiscal Provisions

§ 1830.105. Provider Rate Setting Standards and Requirements.

(a) Except as approved by the Department pursuant to Section 1810.438, the MHP shall reimburse organizational providers that provide services to beneficiaries of the MHP in accordance with Section 1840.105.

(b) The MHP shall reimburse individual and group providers that contract with the MHP in accordance with the terms of the contract.

(c) The MHP shall reimburse individual or group providers that provide services to beneficiaries of the MHP and that do not have a contract with the MHP at the rates established by the Medi–Cal program in Title 22, Division 3, Subdivision 1, Chapter 3, Article 7, unless a different rate is agreed to between the MHP and the provider, except as provided in Subsection (d).

(d) The MHP shall reimburse individual or group providers that provide psychiatric inpatient hospital professional services to a beneficiary of the MHP with an emergency medical condition and that do not have a contract with the MHP at the rates established by the Medi–Cal program in Title 22, Division 3, Subdivision 1, Chapter 3, Article 7.

(e) Individual and group providers shall bill the MHP the provider's usual and customary charges for the specialty mental health service rendered to the beneficiary. The rate paid by the MHP to individual and group providers less third party liability and beneficiary share of cost shall be considered payment in full for the specialty mental health services provided to the beneficiary.

(f) Organizational providers shall bill the MHP in accordance with the cost settlement requirements described in Section 1840.105 that apply to the provider.

(g) The MHP shall not be responsible to reimburse providers who

deliver Medicare covered services to a beneficiary for any Medicare coinsurance and deductible payments due to the provider from the Medi–Cal program pursuant to Title 42, United States Code, Section 1396a(a)(n), unless the provider is an organizational provider contracting with or otherwise authorized by the MHP of the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, United States Code, Section 1396a(a)(n).

§ 1830.115. Psychiatric Nursing Facility Services Rates.

Except as approved by the Department pursuant to Section 1810.438, the rate for psychiatric nursing facility services shall be the rate established by the State Department of Health Services in accordance with Title 22, Sections 51510, 51511, 51511.1, 51535, and 51535.1. The nursing facility shall bill its usual and customary charges. The rate established by this Section less third party liability and beneficiary share of cost shall be considered payment in full for the scope of services described in those Sections provided to the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Article 2. Provision of Services

§ 1830.205. Medical Necessity Criteria for MHP Reimbursement of Speciality Mental Health Services.

(a) The following medical necessity criteria determine Medi–Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in Subsections (1)–(3) below to be eligible for services:

(1) Have one of the following diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, DSM–IV™, Fourth Edition (1994)*, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition

(G) Mood Disorders, except Mood Disorders due to a General Medical Condition

(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication–Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:

(A) A significant impairment in an important area of life functioning.

(B) A reasonable probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)–(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

(1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi–Cal program for providing such services to the beneficiary is greater than the total cost to the Medi–Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in *T.L. v. Belshé*.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14132 and 14684, Welfare and Institutions Code; Title 42, Section 1396d(r), United States Code; and *T.L. v. Belshé*, United States District Court, Eastern District of California, Case No. CV–S–93–1782 LKK PAN.

§ 1830.215. MHP Payment Authorization.

(a) The MHP may require that providers obtain MHP payment authorization of any or all specialty mental health services covered by this Subchapter as a condition of reimbursement for the service in accordance with the provisions of this Section. MHP payment authorization under this Section shall be provided in compliance with Title 42, Code of Federal Regulations, Section 438.210, which is hereby incorporated by reference.

(b) The MHP's authorization function may be assigned to a person, an identified staffing unit, a committee, or an organizational executive who may delegate the authorization function; including any such persons or entities affiliated with a contracting provider to which the MHP has delegated the authorization function.

(c) The individuals who review and approve or deny requests from providers for MHP payment authorization shall be licensed mental health professionals or waivered/registered professionals of the MHP of the beneficiary. Licensed psychiatric technicians and licensed vocational nurses may approve or deny such requests only when the provider indicates that the beneficiary to whom the specialty mental health services will be delivered has an urgent condition as defined in Section 1810.253.

(d) The MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service covered by this Subchapter as a condition of reimbursement for the service, except for those services provided to beneficiaries with emergency psychiatric conditions as provided in Sections 1830.230 and 1830.245.

(e) Notwithstanding the provisions of Subsections (a) and (d), the MHP shall require that providers obtain MHP payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services as required in the MHP contract with the Department.

(f) Notwithstanding the discretion given to MHPs in Subsections (a) and the requirements of Subsection (c), the MHP shall comply with the specific MHP payment authorization requirements of Sections 1830.230, 1830.245, and 1830.250.

(g) Whether or not the MHP payment authorization of a specialty mental health service is required pursuant to this Section, the MHP may require that providers notify the MHP of their intent to provide the service prior to the delivery of the service.

(1) If the MHP does not require notice or has not informed providers of the notice requirement, MHP payment authorization requests presented for authorization beyond the timelines established by the MHP shall be accepted for consideration by the MHP when the MHP determines that the provider was prevented from submitting a timely request because of a reason that meets one of the criteria specified in Subsections (g)(1)(A)–(B). The MHP may accept MHP payment authorizations requests presented beyond the timelines specified in the Subchapter for other acceptable reasons as determined by the MHP. The provider shall submit factual documentation deemed necessary by the MHP with the MHP payment authorization request. Any additional documentation requested by the MHP shall be submitted within 60 calendar days of the MHP's request. The documentation shall verify that the late submission was due to:

(A) A natural disaster that has:

1. Destroyed or damaged the provider's business office or records, or

2. Substantially interfered with the provider's agent's processing of requests for MHP payment authorization; or

(B) Delays caused by other circumstances beyond the provider's control. Documentation shall include evidence that the circumstance causing the delay was reported to a law enforcement or fire agency, if the circumstance is required to be reported. Circumstances that shall not be considered beyond the control of the provider include but are not limited to:

1. Negligence by employees.

2. Misunderstanding of program requirements.

3. Illness or absence of any employee trained to prepare MHP payment authorizations.

4. Delays caused by the United States Postal Service or any private delivery service.

(2) If the MHP does require such notice, the MHP shall inform providers of this requirement by including the MHP requirement in a publication commonly available to all providers serving beneficiaries. If notice is required and given by the provider, the MHP shall consider requests for MHP payment authorization submitted beyond the timelines for submission established by the MHP in accordance with the provisions of Subsection (g)(1). If notice is required and not given by the provider, the MHP may deny requests for MHP payment authorization submitted beyond the timelines for submission established by the MHP, regardless of the reason for the late submission.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and 42 Code of Federal Regulations, Section 438.210.

§ 1830.220. Authorization of Out–of–Plan Services.

(a) "Out–of–Plan Services" means specialty mental health services covered by this Subchapter, other than psychiatric nursing facility services, provided to a beneficiary by providers other than the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary.

(b) The MHP shall be required to provide out–of–plan services, when the services are also available through the MHP of the beneficiary or a provider contracting with the MHP of the beneficiary, only under the following circumstances:

(1) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric inpatient hospital services as described in Section 1820.225 to the extent provided in Section 1830.230.

(2) When a beneficiary with an emergency psychiatric condition is admitted for psychiatric health facility services under the conditions described in Section 1830.245.

(3) When a beneficiary is out of county and develops an urgent condition and there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

(4) When there are no providers contracting with the MHP reasonably available to the beneficiary based on the MHP's evaluation of the needs of the beneficiary, the geographic availability of providers, and community standards for availability of providers in the county in which the beneficiary is placed and the beneficiary is placed out of county by:

(A) The Foster Care Program as described in Article 5 (commencing with Section 11400), Chapter 2, Part 3, Division 9 of the Welfare and Institutions Code, the Adoption Assistance Program as described in Chapter 2.1 (commencing with Section 16115), Part 4, Division 9 of the Welfare and Institutions Code, or other foster care arrangement,

(B) A Lanterman–Petris–Short or Probate Conservator or other legal involuntary placement.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 11400, 14684 and 16115, Welfare and Institutions Code.

§ 1830.225. Initial Selection and Change of Person Providing Services.

(a) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide a beneficiary who has been

determined by the MHP to meet the medical necessity criteria for outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative or targeted case management services an initial choice of the person who will provide the service to the beneficiary. At the election of the MHP, the MHP may limit the beneficiary's choice to either a choice between two of the individual providers contracting with the MHP, or a choice between two of the persons providing services who are employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

(b) Whenever feasible, the MHP of the beneficiary, at the request of the beneficiary, shall provide beneficiaries an opportunity to change persons providing outpatient psychiatrist, psychologist, EPSDT supplemental specialty mental health, rehabilitative, or targeted case management services. At the election of the MHP, the MHP may limit the beneficiary's choice of another person to provide services, to either an individual provider contracting with the MHP, or to another person providing services who is employed by, contracting with or otherwise made available by the group or organizational provider to whom the MHP has assigned the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1830.230. Psychiatric Inpatient Hospital Professional Services.

(a) Notwithstanding any other provisions of this Chapter, the medical necessity criteria that apply to psychiatric inpatient hospital professional services are the medical necessity criteria in Section 1820.205.

(b) When the beneficiary is admitted to a Fee–for–Service/Medi–Cal hospital, the MHP shall not require prior authorization of psychiatric inpatient hospital professional services that do not exceed one service per day of acute psychiatric inpatient hospital services. On the day of admission, the MHP shall not require prior authorization of a psychiatrist service or a mental health or medication support service by a physician in addition to a service by an admitting licensed mental health professional who is not a physician.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1830.245. Psychiatric Health Facility Services.

(a) Notwithstanding any other provision of this Chapter, the medical necessity criteria that apply to psychiatric health facility services are the medical necessity criteria of Section 1820.205.

(b) The MHP may not require a psychiatric health facility to obtain prior authorization for an admission when the beneficiary has an emergency psychiatric condition.

(c) If the MHP requires MHP payment authorization for psychiatric health facility services, MHP payment authorization for the admission of a beneficiary with an emergency psychiatric condition shall be made in accordance with the terms of the contract between the MHP and the psychiatric health facility or with the terms of the contract between another MHP and the psychiatric health facility, if the MHP does not have a contract with the psychiatric health facility and the contract between another MHP and the psychiatric health facility covers the admission. Where there is no contract between an MHP and the psychiatric health facility that covers the admission, the MHP payment authorization shall be approved by the MHP when:

(1) The psychiatric health facility notified the MHP's Point of Authorization within 24 hours of admission of a beneficiary to the facility.

(2) Written documentation that certifies that a beneficiary met the criteria in Section 1820.225(b) at the time of admission, for the day of admission, and for any additional days prior to discharge during which the beneficiary received psychiatric health facility services, has been provided to the MHP within 14 calendar days of discharge or after the beneficiary has received 99 continuous calendar days of psychiatric health facility services, whichever is sooner.

(3) If, after the emergency admission, the MHP of the beneficiary requests transfer of the beneficiary to a psychiatric health facility contracting with the MHP, a contract hospital, or a psychiatric health facility or hospital owned or operated by the MHP of the beneficiary and the psychiatric health facility does not transfer the beneficiary, documentation shall include evidence that the beneficiary could not be safely transferred. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the psychiatric health facility.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777 and 14684, Welfare and Institutions Code.

§ 1830.250. MHP Payment Authorization for Psychiatric Nursing Facility Services.

(a) The following conditions apply to the provisions of psychiatric nursing facility services by the MHP:

(1) The MHP of the beneficiary shall not exclude any nursing facility that is licensed and certified to provide psychiatric nursing facility services and is in good standing with the Medi–Cal program from providing services to the beneficiary on the grounds that the facility would be providing out–of–plan services pursuant to Section 1830.220.

(2) Psychiatric nursing facility services shall be billed by the psychiatric nursing facility to the fiscal intermediary, rather than the MHP.

(b) A psychiatric nursing facility shall submit a separate written request for MHP payment authorization of psychiatric nursing facility services to the Point of Authorization of the MHP of the beneficiary for each of the following:

(1) The planned admission of a beneficiary.

(2) Services the psychiatric nursing facility believes are medically necessary that exceed the days previously authorized by the MHP.

(3) Services that qualify for Medical Assistance Pending Fair Hearing pursuant to Section 1850.215.

(c) Unless there is a contract between the psychiatric nursing facility and the MHP that provides for different time frames, a psychiatric nursing facility shall submit the request for MHP payment authorization for psychiatric nursing facility services to the Point of Authorization of the beneficiary's MHP not later than:

(1) Prior to a planned admission;

(2) Ten working days prior to the expiration date of a previous MHP payment authorization; or

(3) The date that a beneficiary qualifies for Medical Assistance Pending Fair Hearing pursuant to Section 1850.215.

(d) A written request for MHP payment authorization to the Point of Authorization shall be in the form of a Treatment Authorization Request (TAR).

(e) Approval or disapproval for each MHP payment authorization shall be documented by the Point of Authorization in writing on the same TAR on which the psychiatric nursing facility requested MHP payment authorization.

(f) A Point of Authorization shall approve, deny or defer the request for MHP payment authorization within three working days of the receipt of the request. If the request is deferred, the MHP shall advise the psychiatric nursing facility of the additional documentation required by the MHP. The Point of Authorization shall send an approved or denied TAR to the fiscal intermediary within 14 calendar days of the approval or denial.

(g) MHP payment authorizations shall be approved by the MHP's Point of Authorization as follows:

(1) Requests for MHP payment authorization for planned admissions and continued stays shall be approved when written documentation provided indicates that the beneficiary meets medical necessity criteria for reimbursement of psychiatric nursing facility services, as specified in Section 1830.205, in addition to any other requirements of this Chapter that apply to the admission.

(2) An MHP payment authorization approved by the MHP for a specific time period shall not be terminated or reduced because the beneficiary receiving the psychiatric nursing facility services:

(A) Is on leave of absence from the facility, subject to the limitations described in Title 22, Section 51535, or

(B) Has exercised the bed hold option provided by Title 22, Sections 72520, 73504, 76506, and 76709.1, subject to the limitations of Title 22, Section 51535.1.

(3) Medical Assistance Pending Fair Hearing Decision requests for MHP payment authorization by a psychiatric nursing facility shall be approved by the MHP when necessary documentation, as specified in Section 1850.215, is submitted.

(h) The MHP that approves the MHP payment authorization shall have financial responsibility as described in this Chapter for the services authorized, unless financial responsibility is assigned to another entity pursuant to Sections 1850.405 and 1850.505.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 438.210.

Subchapter 4. Federal Financial Participation

Article 1. General

§ 1840.100. Definitions.

(a) "Claiming" means the process by which MHPs may obtain FFP for the expenditures they have made for specialty mental health services to Medi–Cal beneficiaries.

(b) "Health Care Procedure Coding System (HCPCS)" means a coded listing and description of health care services and items as defined in Title 22, Section 51050, which is prepared and updated annually by the Centers for Medicare and Medicaid Services. HCPCS consists of the *Current Procedural Terminology (CPT) Standard Edition, American Medical Association, Fourth Edition, 2001*, and each of its subsequent revisions, and other codes and descriptions authorized by the Centers for Medicare and Medicaid Services to describe services and items not contained in the CPT. Unless a different definition is adopted by the State Department of Health Services in Title 22, Division 3, Subdivision 1, Chapter 3, beginning with Section 51000, the definitions of individual HCPCS codes used in this Subchapter are the definitions provided in HCPCS in accordance with Title 22, Section 51050.

(c) "Legal entity" means each MHP and each of the corporations, partnerships, agencies, or individuals providing specialty mental health services under contract with the MHP, except that legal entity does not include individual or group providers, Fee–For–Service/Medi–Cal hospitals or psychiatric nursing facilities.

(d) "Lockout" means a situation or circumstance under which FFP is not available for a specific specialty mental health service. Lockout as used in this Subchapter does not address whether or not the provider of a specific specialty mental health service is entitled to payment for that service from the MHP.

(e) "Reimbursement" means a payment of FFP.

(f) "Service functions" mean mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, psychiatric health facility services, and targeted case management in the context of claiming FFP.

(g) "Short–Doyle/Medi–Cal system" means the system operated by the State Department of Health Services for the purpose of claiming FFP for specialty mental health services covered by the MHP other than psychiatric inpatient hospital services in a Fee–For–Service/Medi–Cal hospital or psychiatric nursing facility services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.105. General.

(a) Except as provided in this Subchapter, FFP for specialty mental health services shall be based on the lowest of the following:

(1) The provider's usual and customary charge to the general public for the same or similar services, unless the provider is a nominal charge provider pursuant to Medicare rules at Title 42, Code of Federal Regulations, Section 413.13.

(2) The provider's reasonable and allowable cost of rendering the services, based on year–end cost reports and Medicare principles of reimbursement pursuant to Title 42, Code of Federal Regulations, Part 413 and as described in HCFA Publication 15–1, for providers not contracting on a negotiated rate basis.

(3) The negotiated rates for providers, including the MHP, contracting on a negotiated rate basis pursuant to Subchapter 2, Article 1, beginning with Section 1820.100; Subchapter 3, Article 1, beginning with Section 1830.100; or Sections 5705 or 5716 of the Welfare and Institutions Code.

(4) The maximum allowances established by Title 22, Section 51516, except that the definitions of individual specialty mental health services shall be the definitions in this Chapter. When crisis stabilization is claimed under this Subchapter, the maximum allowance provided in Title 22, Section 51516, for "crisis stabilization–emergency room" shall apply when the service is provided in a 24–hour facility, including a hospital outpatient department. The maximum allowance for "crisis stabilization–urgent care" shall apply when the service is provided in any other appropriate site.

(b) Reimbursement to the MHP, Short–Doyle/Medi–Cal hospitals, or organizational providers based on negotiated rates shall be subject to retrospective cost settlement that shares equally between the federal government and the legal entity the portion of the federal reimbursement that exceeds actual cost in the aggregate by the legal entity. In no case will payments exceed the established maximum allowances.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5705, 5716, 5718, 5720, 5724 and 5778, Welfare and Institutions Code.

§ 1840.110. Claims Submission.

(a) Except as otherwise provided in this Subchapter, the MHP shall submit all claims for specialty mental health services provided to Medi–Cal beneficiaries by the MHP through the Short–Doyle/Medi–Cal system.

(b) Except for good cause, as specified in Title 22, Section 51008.5, and approved by the State Department of Health Services, claims for specialty mental health services shall be presented to the Department no later than six months after the month of service. The Department shall present such claims to the State Department of Health Services no later than seven months after the date of service.

(c) The Department shall resubmit a claim, which has been returned by the State Department of Health Services for correction or additional information, no later than three months after the month in which the claim was returned by the State Department of Health Services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778 and 14021.5, Welfare and Institutions Code.

§ 1840.112. MHP Claims Certification and Program Integrity.

(a) Each MHP shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations Sections 438.604, 438.606, and Section 438.608, which are hereby incorporated by reference.

(b) Each MHP shall certify to the Department, in writing, each monthly claim prior to submission to the State for reimbursement. The certification shall attest to the following for each beneficiary with services included in the claim:

(1) An assessment of the beneficiary was conducted in compliance with the requirements established in the MHP contract with the Department.

(2) The beneficiary was eligible to receive Medi–Cal services at the time the services were provided to the beneficiary.

(3) The services included in the claim were actually provided to the beneficiary.

(4) Medical necessity was established for the beneficiary as defined under this chapter for the service or services provided, for the timeframe in which the services were provided.

(5) A client plan was developed and maintained for the beneficiary that met all client plan requirements established in the MHP contract with the Department

(6) For each beneficiary with day rehabilitation, day treatment intensive or EPSDT supplemental specialty mental health services included in the claim, all requirements for MHP payment authorization in the MHP contract for day rehabilitation, day treatment intensive and EPSDT supplemental specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re–authorization periods as established in the MHP contract with the Department.

NOTE: Authority cited: Sections 5775, 14043.75 and 14680, Welfare and Institutions Code. Reference: Sections 5718, 5719, 5724, 5767, 5776, 5777, 5778 and 14684, Welfare and Institutions Code; and 42 CFR Part 433, Section 433.51, Part 438, Sections 438.604, 438.606 and 438.608 and Part 455, Section 455.18.

§ 1840.115. Alternative Contract Provider Rates.

FFP for payments to providers by the MHP based on Section 1810.438 shall be claimed on the basis of actual services provided in accordance with articles 2 and 3 of this Subchapter.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

Article 2. Psychiatric Inpatient Hospital Services

§ 1840.205. General.

(a) FFP for Short–Doyle/Medi–Cal hospitals shall be claimed through the Short–Doyle/Medi–Cal system in accordance with Section 1840.110.

(b) FFP for Fee–For–Service/Medi–Cal hospitals shall be claimed by the State Department of Health Services in the same manner as FFP is claimed for other Medi–Cal services billed to the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.210. Non–Reimbursable Psychiatric Inpatient Hospital Services.

(a) The MHP may claim FFP for psychiatric inpatient hospital services in a psychiatric health facility that is larger than 16 beds and is certified by the State Department of Health Services as a Medi–Cal provider of inpatient hospital services or an acute psychiatric hospital that is larger than 16 beds only under the following conditions:

(1) The beneficiary is 65 years of age or older, or

(2) The beneficiary is under 21 years of age, or

(3) The beneficiary was receiving such services prior to his/her twenty–first birthday and the services are rendered without interruption until no longer required or his/her twenty–second birthday, whichever is earlier.

(b) The restrictions in Subsection (a) regarding claiming FFP for services in acute psychiatric hospitals and psychiatric health facilities shall cease to have effect if federal law changes or a federal waiver is obtained and reimbursement is subsequently approved.

(c) The MHP may not claim FFP for psychiatric inpatient hospital services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.215. Lockouts for Psychiatric Inpatient Hospital Services.

(a) The following services are not reimbursable on days when psychiatric inpatient hospital services are reimbursed, except for the day of admission to psychiatric inpatient hospital services:

(1) Adult Residential Treatment Services,

(2) Crisis Residential Treatment Services,

(3) Crisis Intervention,

(4) Day Treatment Intensive,

(5) Day Rehabilitation,

(6) Psychiatric Nursing Facility Services, except as provided in Subsection (b),

(7) Crisis Stabilization, and

(8) Psychiatric Health Facility Services.

(b) Psychiatric Nursing Facility Services may be claimed for the same day as a psychiatric inpatient hospital services, if the beneficiary has exercised the bed hold option provided by Title 22, Sections 72520, 73504, 76506, and 76709.1, subject to the limitations of Title 22, Section 51535.1.

(c) When psychiatric inpatient hospital services are provided in a Short–Doyle/Medi–Cal hospital, in addition to the services listed in (a), psychiatrist services, psychologist services, mental health services, and medication support services are included in the per diem rate and not separately reimbursable, except for the day of admission.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

Article 3. Specialty Mental Health Services Other Than Psychiatric Inpatient Hospital Services

§ 1840.302. Psychiatric Nursing Facility Services.

FFP for psychiatric nursing facility services shall be claimed by the State Department of Health Services in the same manner as FFP is claimed for other Medi–Cal services billed to the fiscal intermediary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.304. Crosswalk Between Service Functions and HCPCS Codes.

(a) When an individual or group provider bills and is paid by the MHP for psychiatrist, psychologist, or EPSDT supplemental specialty mental health services using CPT or other HCPCS codes, the MHP shall claim FFP by service function based on a crosswalk between allowable CPT and other HCPCS codes and service functions established by the Department pursuant to the contract between the MHP and the Department. The dollar amount claimed shall be in accordance with Section 1840.105.

(b) When a provider that is a hospital outpatient department bills and is paid by the MHP for facility room use using the HCPCS codes Z7500 or Z7502 in addition to the CPT or other HCPCS code for the specialty mental health service provided to the beneficiary, the MHP shall claim FFP for the combined codes under the CPT or other HCPCS codes for the specialty mental health service provided to the beneficiary that are listed on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a). When a provider bills the MHP using a CPT or other HCPCS code that is not included on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) other than Z7500 or Z7502, the MHP shall determine the appropriate service function for the service provided and shall claim FFP in accordance with Section 1840.308.

(c) The HCPCS codes listed on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) may be billed by any individual or group providers acting within the scope of their practice.

(d) The lockouts described in Section 1840.215 and Sections 1840.360 through 1840.374 shall apply to claiming of FFP for services claimed under this Section. For the purpose of determining lockouts the service shall be considered to be the service function identified on the crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a).

(e) The crosswalk established pursuant to the contract between the MHP and the Department as specified in Subsection (a) shall not be used to claim FFP for services provided by organizational providers.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.306. Psychiatrist, Psychologist, and EPSDT Supplemental Specialty Mental Health Services.

FFP for psychiatrist, psychologist, and EPSDT supplemental specialty mental health services shall be claimed through the Short–Doyle/Medi–Cal system in accordance with Section 1840.110, based on the provisions of Section 1840.304, including the crosswalk identified in Section 1840.304(a), unless the terms of the contract between provider and the MHP require the provider to provide and bill for services in accordance with Section 1840.308. The dollar amount claimed shall be in accordance with Section 1840.105.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.308. Service Functions.

FFP for service functions shall be claimed through the Short–Doyle/Medi–Cal system in accordance with Section 1840.110. To be eligible for reimbursement, each service function shall have been provided in accordance with Sections 1840.314 through 1840.372. The services may be delivered either by individual, group, or organizational providers. The dollar amount claimed shall be in accordance with Section 1840.105.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.312. Non–Reimbursable Services—General.

The following services are not eligible for FFP:

(a) Academic educational services.

(b) Vocational services that have as a purpose actual work or work training.

(c) Recreation.

(d) Socialization is not reimbursable if it consists of generalized group activities that do not provide systematic individualized feedback to the specific targeted behaviors of the beneficiaries involved.

(e) Board and care costs for Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services.

(f) Medi–Cal program benefits that are excluded from coverage by the MHP as described in Section 1810.355.

(g) Specialty mental health services covered by this Article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental diseases, unless:

(1) The beneficiary was receiving, prior to his/her twenty–first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required or his/her twenty–second birthday, whichever is earlier; and

(2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include but are not limited to acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi–Cal provider of inpatient hospital services.

(h) Specialty mental health services covered by this Article provided during the time a beneficiary under 21 years of age resides in an institution for mental disease other than an institution for mental disease that has been accredited in accordance with Title 42, Code of Federal Regulations, Sections 440.160 and 441.150 through 441.156. Facilities at which FFP may be available include acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as Medi–Cal providers of inpatient hospital services.

(i) The restrictions in Subsections (g) and (h) regarding claiming FFP for services to beneficiaries residing in institutions for mental disease shall cease to have effect if federal law changes or a federal waiver is obtained and claiming FFP is subsequently approved.

(j) Specialty mental health services that are minor consent services as defined in Title 22, Section 50063.5 to the extent that they are provided to beneficiaries whose Medi–Cal eligibility pursuant to Title 22, Section 50147.1 is determined to be limited to minor consent services.

(k) The MHP may not claim FFP for specialty mental health services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.314. Claiming for Service Functions—General.

In order to receive FFP for provider payments made by the MHP or for services delivered directly by the MHP, the MPH must assure that the following requirements are met for all service functions:

(a) The provider must meet the standards for participation in the Medi–Cal program as established under Titles XVIII and XIX of the Social Security Act.

(b) Contacts with significant support persons in the beneficiary's life are directed exclusively to the mental health needs of the beneficiary.

(c) When services are being provided to or on behalf of a beneficiary by two or more persons at one point in time, each person's involvement shall be documented in the context of the mental health needs of the beneficiary.

(d) Services shall be provided within the scope of practice of the person delivering service, if professional licensure is required for the service.

(e) Services shall be provided:

(1) Under the direction of one or more of the following:

(A) Physician

(B) Psychologist

(C) Licensed Clinical Social Worker

(D) Marriage and Family Therapist

(E) Registered Nurse

(F) Waivered/Registered Professional when supervised by a licensed mental health professional in accordance with laws and regulations governing the registration or waiver.

(2) Direction may include, but is not limited to being the person directly providing the service, acting as a clinical team leader, direct or functional supervision of service delivery, or approval of client plans. Individuals are not required to be physically present at the service site to exercise direction.

(f) Hospital outpatient departments as defined in Title 22, Section 51112, operating under the license of a hospital may only provide service functions in compliance with licensing requirements.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.316. Claiming for Service Functions Based on Minutes of Time.

(a) For the following services the billing unit is the time of the person delivering the service in minutes of time:

(1) Mental Health Services

(2) Medication Support Services

(3) Crisis Intervention

(4) Targeted Case Management

(b) The following requirements apply for claiming of services based on minutes of time:

(1) The exact number of minutes used by persons providing a reimbursable service shall be reported and billed. In no case shall more than 60 units of time be reported or claimed for any one person during a one–hour period. In no case shall the units of time reported or claimed for any one person exceed the hours worked.

(2) When a person provides service to or on behalf of more than one beneficiary at the same time, the person's time must be prorated to each beneficiary. When more than one person provides a service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.

(3) The time required for documentation and travel is reimbursable when the documentation or travel is a component of a reimbursable service activity, whether or not the time is on the same day as the reimbursable service activity.

(4) Plan development for Mental Health Services and Medication Support Services is reimbursable. Units of time may be billed regardless of whether there is a face–to–face or phone contact with the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.318. Claiming for Service Functions on Half Days or Full Days of Time.

(a) Day treatment intensive and day rehabilitation shall be billed as half days or full days of service.

(b) The following requirements apply for claiming of services based on half days or full days of time:

(1) A half–day shall be billed for each day in which the beneficiary receives face–to–face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

(2) A full day shall be billed for each day in which the beneficiary receives face–to–face services in a program with services available more than four hours per day.

(3) Although the beneficiary must receive face–to–face services on any full day or half–day claimed, all service activities during that day are not required to be face–to–face with the beneficiary.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.320. Claiming for Service Functions Based on Calendar Days.

(a) The following services are reimbursed based on calendar days:

(1) Adult Residential Treatment Services

(2) Crisis Residential Treatment Services

(3) Psychiatric Health Facility Services.

(b) The following requirements apply for claiming of services based on calendar days:

(1) A day shall be billed for each calendar day in which the beneficiary receives face–to face services and the beneficiary has been admitted to the program. Services may not be billed for days the beneficiary is not present.

(2) Board and care costs are not included in the claiming rate.

(3) The day of admission may be billed but not the day of discharge.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.322. Claiming for Service Functions Based on Hours of Time.

(a) Crisis Stabilization shall be reimbursed based on hours of time:

(b) The following requirements apply for claiming of services based on time:

(1) Each one–hour block that the beneficiary receives crisis stabilization services shall be claimed.

(2) Partial blocks of time shall be rounded up or down to the nearest one–hour increment except that services provided during the first hour shall always be rounded up.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.324. Mental Health Services Contact and Site Requirements.

Mental Health Services may be either face–to–face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.326. Medication Support Services Contact and Site Requirements.

(a) Medication Support Services may be either face–to–face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

(b) Medication Support Services that are provided within a residential or day program shall be billed as Medication Support Services separately from the residential or day program service.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Day Treatment Intensive Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.330. Day Rehabilitation Services Contact and Site Requirements.

Day Rehabilitation Services shall have a clearly established site for services, although all services need not be delivered at that site.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.332. Adult Residential Treatment Services Contact and Site Requirements.

(a) Adult Residential Treatment Services shall have a clearly established certified site for services, although all services need not be delivered at that site. Services shall not be claimable unless there is face–to–face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs that provide Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the Department as either a Transitional Residential Treatment Program or a Long Term Residential Treatment Program in accordance with Chapter 3, Division 1, of Title 9. Facility capacity must be limited to a maximum of 16 beds.

(c) In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.334. Crisis Residential Treatment Services Contact and Site Requirements.

(a) Crisis Residential Treatment Services shall have a clearly established certified site for services although all services need not be delivered at that site. Services shall not be claimable unless there is face–to–face contact between the beneficiary and a treatment staff

person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs shall have written procedures for accessing emergency psychiatric and health services on a 24–hour basis.

(c) Programs providing Crisis Residential Treatment Services shall be certified as a Social Rehabilitation Program (Short–term Crisis Residential Treatment Program) by the Department in accordance with Chapter 3, Division 1, of Title 9. Facility capacity shall be limited to a maximum of 16 beds.

(d) In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services shall be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services in accordance with Chapters 1 and 2, Division 6, of Title 22 or authorized to operate as a Mental Health Rehabilitation Center by the Department in accordance with Chapter 3.5, Division 1, of Title 9, beginning with Section 51000.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.336. Crisis Intervention Contact and Site Requirements.

Crisis Intervention may either be face–to–face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.338. Crisis Stabilization Contact and Site Requirements.

(a) Crisis Stabilization shall be provided on site at a licensed 24–hour health care facility or hospital based outpatient program or a provider site certified by the Department or an MHP to perform crisis stabilization.

(b) Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Immediate access and reasonable proximity shall be defined by the Mental Health Plan. Medications must be available on an as needed basis and the staffing pattern must reflect this availability.

(c) All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the beneficiary's need shall be made, to the extent resources are available.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.340. Psychiatric Health Facility Services Contact and Site Requirements.

(a) Psychiatric Health Facility Services shall have a clearly established certified site for services. Services shall not be claimable unless there is face–to–face contact between the beneficiary and a treatment staff person of the facility on the day of service and the beneficiary has been admitted to the program.

(b) Programs providing Psychiatric Health Facility Services must be licensed as a Psychiatric Health Facility by the Department.

(c) Programs shall have written procedures for accessing emergency health services on a 24–hour basis.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.342. Targeted Case Management Contact and Site Requirements.

Targeted Case Management may be either face–to–face or by telephone with the beneficiary or significant support persons and may be provided anywhere in the community.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.344. Service Function Staffing Requirements—General.

Mental Health Services, Day Rehabilitation Services, Day Treatment Intensive Services, Crisis Intervention Services, Targeted Case Management, and Adult Residential Treatment Services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with state law.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.346. Medication Support Services Staffing Requirements.

Medication Support Services shall be provided within the scope of practice by any of the following:

(a) Physician

(b) Registered Nurse

(c) Licensed Vocational Nurse

(d) Psychiatric Technician

(e) Pharmacist

(f) Physician Assistant

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.348. Crisis Stabilization Staffing Requirements.

(a) A physician shall be on call at all times for the provision of those Crisis Stabilization Services that may only be provided by a physician.

(b) There shall be a minimum of one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times beneficiaries are present.

(c) At a minimum there shall be a ratio of at least one licensed mental health or waivered/registered professional on site for each four beneficiaries or other patients receiving Crisis Stabilization at any given time.

(d) If the beneficiary is evaluated as needing service activities that can only be provided by a specific type of licensed professional, such persons shall be available.

(e) Other persons may be utilized by the program, according to need.

(f) If Crisis Stabilization services are co–located with other specialty mental health services, persons providing Crisis Stabilization must be separate and distinct from persons providing other services.

(g) Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.350. Day Treatment Intensive Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Treatment Intensive services to eight beneficiaries or other clients in attendance during the period the program is open:

(1) Physicians

(2) Psychologists or related waivered/registered professionals

(3) Licensed Clinical Social Workers or related waivered/registered professionals

(4) Marriage and Family Therapists or related waivered/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons providing Day Treatment Intensive services who do not participate in the entire Day Treatment Intensive session, whether full–day or half–day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Treatment Intensive services and function in other capacities.

(c) Persons providing services in Day Treatment Intensive programs serving more than 12 clients shall include at least one person from two of the following groups:

(1) Physicians

(2) Psychologists or related waivered/registered professionals

(3) Licensed Clinical Social Workers or related waivered/registered professionals

(4) Marriage and Family Therapists or related waivered/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.352. Day Rehabilitation Staffing Requirements.

(a) At a minimum there must be an average ratio of at least one person from the following list providing Day Rehabilitation services to ten beneficiaries or other clients in attendance during the period the program is open:

(1) Physicians

(2) Psychologists or related waivered/registered professionals

(3) Licensed Clinical Social Workers or related waivered/registered professionals

(4) Marriage and Family Therapists or related waivered/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

(b) Persons providing Day Rehabilitation who do not participate in the entire Day Rehabilitation session, whether full–day or half–day, may be utilized according to program need, but shall only be included as part of the above ratio formula on a pro rata basis based on the percentage of time in which they participated in the session. The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Day Rehabilitation services and function in other capacities.

(c) Persons providing services in Day Rehabilitation programs serving more than 12 clients shall include at least two of the following:

(1) Physicians

(2) Psychologists or related waivered/registered professionals

(3) Licensed Clinical Social Workers or related waivered/registered professionals

(4) Marriage and Family Therapists or related waivered/registered professionals

(5) Registered Nurses

(6) Licensed Vocational Nurses

(7) Psychiatric Technicians

(8) Occupational Therapists

(9) Mental Health Rehabilitation Specialists as defined in Section 630.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.354. Adult Residential Treatment Services Staffing Requirements.

(a) Staffing ratios and qualifications in Adult Residential Treatment Services shall be consistent with Section 531(b), (c).

(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Adult Residential Treatment Services and function in other capacities.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.356. Crisis Residential Treatment Services Staffing Requirements.

(a) Staffing ratios and qualifications in Crisis Residential Treatment Services shall be consistent with Section 531(a).

(b) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Crisis Residential Treatment Services and function in other capacities.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.358. Psychiatric Health Facility Staffing Requirements.

(a) Staffing ratios in Psychiatric Health Facility Services shall be consistent with Title 22, Section 77061.

(b) Staffing qualifications shall be consistent with Title 22, Sections 77004, 77011.2, 77012, 77012.1, 77012.2, 77017, 77023, and 77079.12.

(c) The MHP shall ensure that there is a clear audit trail of the number and identity of the persons who provide Psychiatric Health Facility Services and function in other capacities.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.360. Lockouts for Day Rehabilitation and Day Treatment Intensive.

Day Rehabilitation and Day Treatment Intensive are not reimbursable under the following circumstances:

(a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission to those services.

(b) Mental Health Services are not reimbursable when provided by Day Rehabilitation or Day Treatment Intensive staff during the same time period that Day Rehabilitation or Day Treatment Intensive is provided.

(c) Two full–day or one full–day and one half–day or two half–day programs may not be provided to the same beneficiary on the same day.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.362. Lockouts for Adult Residential Treatment Services.

Adult Residential Treatment Services are not reimbursable under the following circumstances:

(a) When Crisis Residential Treatment Services, Psychiatric Inpatient Hospital Services, Psychiatric Health Facility, or Psychiatric Nursing Facility Services are reimbursed, except for the day of admission.

(b) When an organizational provider of both Mental Health Services and Adult Residential Treatment Services allocates the same staff's time under the two cost centers of Mental Health Services and Adult Residential Treatment Services for the same period of time.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.364. Lockouts for Crisis Residential Treatment Services.

Crisis Residential Treatment Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Crisis Residential Treatment Services:

(a) Mental Health Services
(b) Day Treatment Intensive
(c) Day Rehabilitation
(d) Psychiatric Inpatient Hospital Services
(e) Psychiatric Health Facility Services
(f) Psychiatric Nursing Facility Services
(g) Adult Residential Treatment Services
(h) Crisis Intervention
(i) Crisis Stabilization

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.366. Lockouts for Crisis Intervention.

(a) Crisis Intervention is not reimbursable on days when Crisis Residential Treatment Services, Psychiatric Health Facility Services, Psychiatric Nursing Facility Services, or Psychiatric Inpatient Hospital Services are reimbursed, except for the day of admission to those services.

(b) The maximum amount claimable for Crisis Intervention in a 24–hour period is 8 hours.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.368. Lockouts for Crisis Stabilization.

(a) Crisis Stabilization is not reimbursable on days when Psychiatric Inpatient Hospital Services, Psychiatric Health Facility Services, or Psychiatric Nursing Facility Services are reimbursed, except on the day of admission to those services.

(b) Crisis Stabilization is a package program and no other specialty mental health services are reimbursable during the same time period this service is reimbursed, except for Targeted Case Management.

(c) The maximum number of hours claimable for Crisis Stabilization in a 24–hour period is 20 hours.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.370. Lockouts for Psychiatric Health Facility Services.

Psychiatric Health Facility Services are not reimbursable on days when the following services are reimbursed, except for day of admission to Psychiatric Health Facility Services:

(a) Adult Residential Treatment Services
(b) Crisis Residential Treatment Services
(c) Crisis Intervention
(d) Day Treatment Intensive
(e) Day Rehabilitation
(f) Psychiatric Inpatient Hospital Services
(g) Medication Support Services
(h) Mental Health Services
(i) Crisis Stabilization
(j) Psychiatric Nursing Facility Services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.372. Lockouts for Medication Support Services.

The maximum amount claimable for Medication Support Services in a 24–hour period is 4 hours.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

§ 1840.374. Lockouts for Targeted Case Management Services.

(a) Targeted Case Management Services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided in Subsection (b):

(1) Psychiatric Inpatient Hospital Services
(2) Psychiatric Health Facility Services
(3) Psychiatric Nursing Facility Services

(b) Targeted Case Management Services, solely for the purpose of coordinating placement of the beneficiary on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 5778, Welfare and Institutions Code.

Subchapter 5. Problem Resolution Processes

Article 1. Beneficiary Problem Resolution Processes

§ 1850.205. General Provisions.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a problem or concern about any issue related to the MHP's performance of its duties under this Chapter, including the delivery of specialty mental health services.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A grievance process;
(2) An appeal process; and
(3) An expedited appeal process.

(c) For the grievance, appeal, and expedited appeal processes, found in Sections 1850.206, 1850.207 and 1850.208 respectively, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Section 1850.210. For the purposes of this Section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making forms that may be used to file grievances, appeals, and expedited appeals, and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process.

(3) That a beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified by the MHP as having responsibility for assisting a beneficiary, at the beneficiary's request, with these processes, including assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing specialty mental health services to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for consideration in the MHP's Quality Improvement Program as required by Section 1810.440(a)(5).

(8) That the individuals making the decision on the grievance,

appeal, or expedited appeal were not involved in any previous review or decision–making on the issue presented in the respective problem resolution process.

(9) That the individual making the decision on the grievance, appeal, or expedited appeal has the appropriate clinical expertise as determined by the MHP to treat the beneficiary's condition, if the grievance is regarding the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal is about clinical issues.

(d) For the grievance, appeal, and expedited appeal processes found in Sections 1850.206, 1850.207, and 1850.208, the MHP shall:

(1) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem.

(2) Record in the grievance and appeal log or another central location determined by the MHP the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary, or document the reason(s) that there has not been final disposition of the grievance, appeal, or expedited appeal.

(3) Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal.

(4) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing.

(5) Identify the roles and responsibilities of the MHP, the provider, and the beneficiary.

(6) Notify those providers cited by the beneficiary or otherwise involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

(e) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5520 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1850.206. The Grievance Process.

In addition to meeting the requirements of Section 1850.205, the grievance process shall, at a minimum:

(a) Allow beneficiaries to present their grievance orally or in writing.

(b) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension or if the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(c) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1850.207. The Appeal Process.

In addition to meeting the requirements of Section 1850.205, the appeal process shall, at a minimum:

(a) Allow a beneficiary to file an appeal orally or in writing.

(b) Require a beneficiary to follow an oral appeal with a written appeal. The date the MHP receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes in Subsection (c).

(c) Provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the MHP determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(d) Inform the beneficiary of his or her right to request a fair hearing after the appeal process of the MHP has been exhausted.

(e) Allow the beneficiary to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.

(f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process.

(g) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal.

(h) Notify the beneficiary and/or his or her representative of the resolution of the appeal in writing. The notice shall contain:

(1) The results of the appeal resolution process.

(2) The date that the appeal decision was made.

(3) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal.

(i) Promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1850.208. The Expedited Appeal Process.

In addition to meeting the requirements of Section 1850.205 and 1850.207(a), (d), (e), (f), (g), and (i), the expedited appeal process shall, at a minimum:

(a) Be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

(b) Allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

(c) Ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

(d) Resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the MHP receives the appeal. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the MHP determines that there is need for additional information and that the delay is in the beneficiary's interest. If the MHP extends the timeframes, the MHP shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in Section 1810.230.5.

(e) Provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice

to the beneficiary and/or his or her representative. The written notice shall meet the requirements of Section 1850.207(h).

(f) If the MHP denies a request for expedited appeal resolution, the MHP shall:

(1) Transfer the expedited appeal request to the timeframe for appeal resolution as required by Section 1850.207(c).

(2) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in Section 1810.230.5.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

§ 1850.209. Beneficiary Problem Resolution Processes Established by Providers.

(a) Nothing in this Section and Sections 1850.205, 1850.206, 1850.207, and 1850.208 precludes a provider other than the MHP from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the MHP to use or exhaust the provider's processes prior to using the MHP's beneficiary problem resolution process, unless the following conditions have been met:

(1) The MHP delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation.

(2) The provider's beneficiary problem resolution process fully complies with this Section, Section 1850.205, and, depending on processes delegated, Sections 1850.206, 1850.207, and/or 1850.208.

(3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the MHP or the provider.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5520 and 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Part 438, Subpart F.

Article 2. Fair Hearing and Notice of Action

§ 1850.210. Provision of Notice of Action.

(a) The MHP shall provide a beneficiary of the MHP with a Notice of Action when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service to the beneficiary.

(1) Except as provided in Subsection (c), when the denial or modification involves a request from a provider for continued MHP payment authorization of a specialty mental health service or when the MHP reduces or terminates a previously approved MHP payment authorization, notice shall be provided in accordance with Title 22, Section 51014.1.

(2) Notice is not required when a denial is a non–binding verbal description to a provider of the specialty mental health services that may be approved by the MHP.

(3) Notice is not required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request MHP payment authorization of additional specialty mental health services before the end of the approved duration of services.

(4) Except as provided in Subsection (b), notice is not required when the denial or modification is a denial or modification of a request for MHP payment authorization for a specialty mental health service that has already been provided to the beneficiary.

(b) A Notice of Action is required when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post–service, prepayment determination by the MHP that the service was not medically necessary or otherwise was not a service covered by the MHP.

(c) The MHP shall deny the MHP payment authorization request and provide the beneficiary of the MHP with a Notice of Action when the MHP does not have sufficient information to approve or modify, or deny on the merits, an MHP payment authorization request from a provider within the timeframes required by Sections 1820.220 or 1830.215.

(d) The MHP shall provide the beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of a grievance decision within 60 calendar days, an appeal decision within 45 days, or an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to Sections 1850.206, 1850.207 or 1850.208 respectively, the MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to notify the affected parties of the grievance, appeal or expedited appeal decision within the extension period.

(e) The MHP shall provide a beneficiary of the MHP with a Notice of Action if the MHP fails to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP.

(f) The MHP shall comply with the requirements of Section 1850.212 regarding the content of Notices of Action and with the following timeframes for mailing of Notices of Action:

(1) The written Notice of Action issued pursuant to Subsections (a) or (b) shall be deposited with the United States postal service in time for pick–up no later than the third working day after the action, except that a Notice of Action issued pursuant to Subsection (a)(1) shall be provided in accordance with the applicable timelines of Title 22, Section 51014.1.

(2) The written Notice of Action issued pursuant to Subsections (c) or (d) shall be deposited with the United States Postal Service in time for pick–up on the date that the applicable timeframe expires.

(3) The written Notice of Action issued pursuant to Subsection (e) shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the MHP expires.

(g) When a Notice of Action would not be required under Subsections (a), (b), or (c), the MHP shall provide a beneficiary of the MHP with Notice of Action under this Subsection when the MHP or its providers determine that the medical necessity criteria in Section 1830.205(b)(1), (b)(2), (b)(3)(C) or 1830.210(a) have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services from the MHP. A Notice of Action pursuant to this Subsection is not required when a provider, including the MHP acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the MHP, including but not limited to crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any specialty mental health service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other specialty mental health service covered by the MHP. The Notice of Action under this Subsection, shall, at the election of the MHP, be hand delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with Subsection (f)(1) and shall specify the information contained in Section 1850.212(b).

(h) For the purpose of this Section, each reference to a Medi–Cal managed care plan in Title 22, Section 51014.1, shall mean the MHP.

(i) For the purposes of this Section, "medical service" as cited in Title 22, Section 51014.1, shall mean specialty mental health services that are subject to prior authorization by an MHP pursuant to Subchapters 2 and 3, beginning with Sections 1820.100 and 1830.100, respectively.

(j) The MHP shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department, the Department of Health Services and other appropriate oversight entities as specified in the contract between the Department and the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and 42 CFR Part 438, Sections 438.210 and 438.404.

§ 1850.212. Contents of a Notice of Action.

(a) The Notice of Action, issued pursuant to Section 1850.210(a)–(e) shall contain the following information:

(1) The action taken by the MHP.

(2) The reason for the action taken.

(3) A citation of the specific regulations or MHP payment authorization procedures supporting the action.

(4) The beneficiary's right to file an appeal or expedited appeal with the MHP.

(5) The beneficiary's right to a fair hearing or to request an expedited fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self–represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) An explanation of the circumstances under which a specialty mental health service will be continued if a fair hearing is requested.

(D) The time limits for requesting a fair hearing or an expedited fair hearing.

(b) A Notice of Action, issued pursuant to Section 1850.210(g), shall specify the following:

(1) The reason that the medical necessity criteria were not met, including a citation of the applicable regulation.

(2) The beneficiary's options for obtaining care outside the MHP, if applicable.

(3) The beneficiary's right to request a second opinion on the determination.

(4) The beneficiary's right to file an appeal or expedited appeal with the MHP.

(5) The beneficiary's right to a fair hearing or to request an expedited fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the beneficiary may be either:

1. Self–represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limits for requesting a fair hearing or an expedited fair hearing.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code; and Title 42, Code of Federal Regulations, Section 431.244 and Part 438, Subpart F.

§ 1850.213. Fair Hearings.

The fair hearings under this Article shall be administered by the State Department of Health Services, in accordance with Title 22, Sections 50951 and 50953.

NOTE: Authority cited: Section 14684, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1850.215. Continuation of Services Pending Fair Hearing Decision.

(a) A beneficiary receiving specialty mental health services pursuant to this Chapter shall have a right to file for continuation of specialty mental health services pending fair hearing pursuant to Title 22, Section 51014.2. The time limits for filing for a continuation of services pursuant to Title 22, Section 51014.2 shall not be extended by a beneficiary's decision to pursue an MHP's beneficiary problem resolution process as described in Section 1850.205.

(b) The MHP shall provide continuation of specialty mental health services pending a fair hearing in accordance with Title 22, Section 51014.2. If an MHP allows providers to deliver specialty mental health services for a set number of visits or a set duration of time without prior authorization, the MHP shall provide continuation of specialty mental health services pending a fair hearing when the MHP denies an MHP payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing pursuant to Subsection (a).

(c) For the purpose of this Section, each reference to Medi–Cal managed care plan in Title 22, Section 51014.2, shall mean the MHP.

(d) Before requesting a state fair hearing, the beneficiary must exhaust the MHP's problem resolution processes as described in Section 1850.205.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

Article 3. Provider Problem Resolution and Appeal Processes

§ 1850.305. General Provisions.

(a) An MHP shall develop provider problem resolution and appeal processes that enable providers to resolve MHP payment authorization issues or other complaints and concerns. The MHP shall not subject a provider to discrimination or any other penalty for using the provider problem resolution and appeal processes.

(b) The MHP shall ensure that participating providers are provided written information regarding the provider problem resolution and appeal processes.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1850.310. Provider Problem Resolution Process.

The Provider Problem Resolution Process shall, at a minimum:

(a) Include a means to accept written or verbal concerns or complaints from providers and address these concerns or complaints quickly and easily.

(b) Utilize simple, informal, and easily understood procedures.

(c) Inform providers of their right to access the Provider Appeal Process at any time before, during, or after the Provider Problem Resolution Process has begun when the complaint concerns a denied or modified request for MHP payment authorization or the processing or payment of a provider's claim to the MHP and whether accessing the Provider Problem Resolution Process will affect the provider's timelines for accessing the Provider Appeal Process.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1850.315. Provider Appeal Process.

The Provider Appeal Process shall include the following:

(a) A provider may appeal a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP. The written appeal shall be submitted to the MHP within 90 calendar days of the date of receipt of the non–approval of payment or within 90 calendar days of the MHP's failure to act on the request in accordance with the time frames required by Sections 1820.220 or 1830.250, or established by the MHP pursuant to Section 1830.215.

(b) The MHP shall have 60 calendar days from its receipt of the appeal to inform the provider in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.

(1) If the appeal concerns the denial or modification of an MHP payment authorization request, the MHP shall utilize personnel not involved in the initial denial or modification decision to determine the appeal decision.

(2) If the appeal is not granted in full, the provider shall be notified

of any right to submit an appeal to the Department pursuant to Section 1850.320.

(3) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the MHP's decision to approve the MHP payment authorization request.

(4) If applicable, the MHP shall have 14 calendar days from the date of receipt of the provider's revised request for MHP payment authorization to submit the documentation to the Medi–Cal fiscal intermediary that is required to process the MHP payment authorization.

(c) If an MHP does not respond within 60 calendar days to the appeal, the appeal shall be considered denied in full by the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1850.320. Provider Appeals to the Department.

When an appeal concerning the denial or modification of an MHP payment authorization request for the specialty mental health services provided in an emergency as described in Sections 1820.225, 1830.230, and 1830.245 is denied in full or in part by the MHP's Provider Appeal Process on the basis that the provider did not comply with the required timelines for notification or submission of the MHP payment request, that the medical necessity criteria were not met, or that the requirements of Section 1820.220(j)(5) for approval of administrative days were not met, the provider may appeal the denial or modification to the Department. A hospital may not appeal the denial or modification of MHP payment authorization to the Department when the denial or modification is based on the MHP's determination that a hospital has failed to comply with mandatory provisions of the contract between the provider and the MHP as allowed by Sections 1820.220(g), (j) and 1820.225(d)(5).

(a) Hospitals and the individual, group or organizational providers who have provided specialty mental health services under Sections 1820.225, 1830.230, and 1830.245 to a beneficiary during the psychiatric inpatient hospital stay that is the subject of the appeal may appeal separately to the Department unless they have agreed to another arrangement as a term of their contract with the MHP.

(b) If a provider chooses to appeal an MHP's denial or modification of MHP payment authorization, the provider shall submit an appeal to the Department in writing, along with supporting documentation, within 30 calendar days from the date the MHP's written decision of denial or modification is submitted to the provider. The provider may appeal to the Department within 30 calendar days after 60 calendar days from submission of the appeal under Section 1850.315(a) to the MHP, if the MHP fails to respond. Supporting documentation shall include, but not be limited to:

(1) Any documentation supporting allegations of timeliness, if at issue, including fax records, phone records or memos.

(2) Clinical records supporting the existence of medical necessity if at issue.

(3) A summary of reasons why the MHP should have approved the MHP payment authorization.

(4) A contact person(s) name, address and phone number.

(c) The Department shall notify the MHP and the provider of its receipt of a request for appeal pursuant to this Section within seven calendar days from the date of receipt of the request. The notice to the MHP shall include a request to the MHP for specific documentation supporting denial of the MHP payment authorization and a request for documentation establishing any agreements with the appealing provider or other providers who may be affected by the appeal pursuant to Subsection (a).

(d) The MHP shall submit the requested documentation within 21 calendar days of the date the notice to the MHP from the Department pursuant to Subsection (c) was received by the MHP or the Department shall decide the appeal based solely on the documentation filed by the provider.

(e) The Department shall have 60 calendar days from the receipt of the MHP's documentation or from the 21st calendar day after the request for documentation was received by the MHP, whichever is earlier, to notify the provider and the MHP, in writing, of its decision, including a statement of the reasons for the decision that addresses each issue raised by the provider and the MHP, and any actions required by the MHP or the provider to implement the decision. At the election of the provider, if the Department fails to act within the 60 calendar days, the appeal may be considered to have been denied by the Department.

(1) The Department may allow both a provider representative(s) and the MHP representative(s) an opportunity to present oral argument to the Department.

(2) If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from receipt of the Department's decision to uphold the appeal.

(3) If applicable, the MHP shall have 14 calendar days from the receipt of the provider's revised MHP payment authorization request to approve the MHP payment authorization or submit documentation to the Medi–Cal fiscal intermediary required to process the MHP payment authorization.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

§ 1850.325. Provider Appeal Process — Claims Processing.

Notwithstanding Sections 1850.305–1850.320:

(a) A Fee–for–Service/Medi–Cal hospital or a psychiatric nursing facility may file an appeal concerning the processing or payment of its claims for payment for services directly to the fiscal intermediary postmarked or FAXED within 90 calendar days of the date the payment was due. The fiscal intermediary shall have 60 calendar days from the receipt of the appeal to make a determination in writing to the provider.

(b) An MHP may file an appeal concerning the processing or payment of its claim for services paid through the Short–Doyle/Medi–Cal system to the Department postmarked or FAXED within 90 calendar days of the date the payment was due. The Department shall have 60 calendar days from the receipt of the appeal to make a determination in writing to the MHP.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Section 14684, Welfare and Institutions Code.

Article 4. Resolution of Disputes Between MHPs regarding MHP of Beneficiary

§ 1850.405. Arbitration Between MHPs.

(a) Under the following arbitration processes the MHP of the beneficiary may be determined to be different than that specified in the MEDS file.

(b) Any two or more MHPs may develop an arbitration agreement to provide for determining final responsibility for MHP payment authorization as described in Subchapters 2 and 3, beginning with Sections 1820.100 and 1830.100, respectively, when there is a dispute between the participating MHPs. Each arbitration agreement must:

(1) Provide for the selection of an arbitrator.

(2) Include timelines for filing and resolution.

(3) Include criteria that will serve as a basis for a decision.

(4) Specify that decisions reached under the arbitration process will be final.

(5) Be signed by all participating MHPs or their designees.

(6) Require that all decisions of the arbitrator shall be in writing.

(7) Provide that a copy of each decision shall be forwarded to the affected MHPs within 14 calendar days of the decision.

(c) In cases where there is a disagreement between MHPs that are not participating in an arbitration process, the arbitration process shall be as follows:

(1) Each MHP shall provide the Department with at least one individual available to serve as an arbitrator. The MHP shall confirm

or update the available individuals annually. The Department shall provide a listing of the available individuals to the MHPs annually by October 1. The parties to the dispute may agree to a single arbitrator. If the parties to the dispute cannot agree on a single arbitrator, the parties shall each select an arbitrator from the list of available individuals, except that an individual identified by either involved MHP may not be selected. The selected arbitrators shall select a third arbitrator who is not an individual identified by either involved MHP from the listing.

(2) The arbitrators' services shall be reimbursed at the hourly rate charge of $150.00, not to exceed a total of ten hours. The parties shall share equally in paying for the arbitrators' services. Payment shall be made directly to the arbitrators unless the arbitrator is an employee of the MHP, in which case payment shall be made to that MHP.

(3) The arbitrators' decision as to the MHP of the beneficiary shall be based on a review of the facts in relation to the following criteria:

(A) If a beneficiary has moved to a county or acts to establish residency in a county and has a clear intent to reside in the county, the MHP for that county shall be considered the MHP of the beneficiary.

(B) If a beneficiary is a Lanterman–Petris–Short or Probate Conservatee, the MHP for the county in which the beneficiary is conserved shall be considered the MHP of the beneficiary.

(C) If a beneficiary has been placed in legal custody by a county, the MHP for the county that initiated the legal proceeding shall be considered the MHP of the beneficiary. If a beneficiary is on parole or in a conditional release program and is restricted to a particular area, the MHP for the county that includes the area to which the beneficiary is restricted shall be the MHP of the beneficiary.

(D) If a beneficiary has adopted a transient, nomadic lifestyle and has a clear intent to continue this lifestyle, the MHP for the county in which the beneficiary presents for services shall be considered the MHP of the beneficiary.

(E) If a beneficiary, because of the beneficiary's mental status, is unable to form or express a clear intent to reside anywhere, the following may be considered evidence that the MHP for the county involved would be the MHP of the beneficiary:

1. The county that originated residential, medical, or psychiatric placement.

2. The county in which the beneficiary has current housing.

3. The county that has paid general assistance to the beneficiary.

4. The county in which the beneficiary has received ongoing community mental health clinical care during the last six months.

(F) Where the facts do not clearly meet the criteria, the arbitrators' decision shall be reasonable in light of the facts presented using the criteria in Subsections (a)(3)(A)–(E) as general guidelines.

(4) The affected MHPs shall provide relevant documentation to arbitrators no later than 21 calendar days after the arbitrators have been selected.

(5) The arbitrators shall decide on the issue no later than 60 calendar days:

(A) From the date documentation is received from the affected MHPs, or

(B) From 21 calendar days after the arbitrator has been selected, whichever is sooner.

(6) The arbitrators shall issue the decision in writing to the affected MHPs within 14 calendar days of the decision.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

§ 1850.415. Implementation of the Arbitrators' Decision.

When the arbitrators acting under Section 1850.405 determine that an MHP is responsible for payment for specialty mental health services previously authorized by another MHP, the MHP found responsible for payment of services shall perform, within 14 calendar days from the date of the arbitrator's decision, any action required of the MHP to implement the decision of the arbitration process. The Department reserves the right to take action necessary to implement the decision of the arbitration process if the MHP found to be responsible fails to comply with the decision.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code

§ 1850.420. Provision of Medically Necessary Services Pending Resolution of Dispute.

A dispute regarding the MHP of the beneficiary shall not delay medically necessary services to beneficiaries. The MHP of the beneficiary as identified on the MEDS file shall be responsible for providing or authorizing and paying for the service until the dispute is resolved.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5777, 5778 and 14684, Welfare and Institutions Code.

Article 5. Resolution of Disputes Between MHPs and Medi–Cal Managed Care Plans

§ 1850.505. Requests for Resolution.

(a) Except as provided in Subsection (c), when an MHP has a dispute with a Medi–Cal Managed Care Plan that cannot be resolved to the satisfaction of the MHP concerning the obligations of the MHP or the Medi–Cal Managed Care Plan under their respective contracts with the State, State Medi–Cal laws and regulations, or an MOU as described in Section 1810.370, the MHP may submit a request for resolution to the Department.

(b) Except as provided in Subsection (c), when a Medi–Cal Managed Care plan has a dispute with an MHP that cannot be resolved to the satisfaction of the Medi–Cal Managed Care Plan concerning the obligations of the MHP or the Medi–Cal Managed Care Plan under their respective contracts with the State, State Medi–Cal laws and regulations, or an MOU as described in Section 1810.370, the Medi–Cal Managed Care Plan may submit a request for resolution to the State Department of Health Services.

(c) If the MHP and the Medi–Cal managed care plan have agreed in the MOU entered into pursuant to Section 1810.370 to binding arbitration as the means for resolving disputes, the MHP and the Medi–Cal managed care plan may not request resolution of the dispute under this Section.

(d) If the MHP and the Medi–Cal Managed Care Plan have an MOU pursuant to Section 1810.370, a request for resolution by either department shall be submitted to the respective department within 15 calendar days of the completion of the dispute resolution process between the parties as provided in the MOU. If there is no MOU, a request for resolution shall be submitted to the respective department within 30 calendar days after the event giving rise to the dispute. The request for resolution shall contain the following information:

(1) A summary of the issue and a statement of the desired remedy, including any disputed services that have been or are expected to be delivered to the beneficiary and the expected rate of payment for each type of service.

(2) History of attempts to resolve the issue.

(3) Justification for the desired remedy.

(4) Documentation regarding the issue.

(e) Upon receipt of a request for resolution, the department receiving the request shall notify the other department and the other party within seven calendar days. The notice to the other party shall include a copy of the request and will ask for a statement of the party's position on the dispute, any relevant documentation supporting its position, and any dispute of the rate of payment for services included by the other party in its request.

(f) The other party shall submit the requested documentation within 21 calendar days from notification of the party from whom documentation is being requested by the party that received the initial request for resolution or the departments shall decide the dispute based solely on the documentation filed by the initiating party.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1850.515. Departments' Responsibility for Review of Disputes.

(a) The two departments shall each designate at least one and no more than two individuals to review the dispute and make a joint recommendation to directors of the departments or their designees.

(b) The recommendation shall be based on a review of the submitted documentation in relation to the statutory, regulatory and contractual obligations of the MHP and the Medi–Cal Managed Care Plan.

(c) The individuals reviewing the dispute may, at their discretion, allow representatives of both the MHP and the Medi–Cal Managed Care Plan an opportunity to present oral argument.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1850.520. Departments' Decision.

(a) The Directors of the departments or their designees shall jointly issue a written decision to the MHP and the Medi–Cal Managed Care Plan within 30 calendar days:

(1) From the receipt of the documentation requested from the other party, or

(2) From the twenty–first calendar day after the request for documentation, whichever is earlier.

(b) The written decision of the departments shall include a statement of the reasons for the decision, the determination of rates of payment if the rates of payment were disputed, and any decision and any actions required by the MHP and the Medi–Cal Managed Care Plan to implement the decision.

(c) The departments shall take any necessary steps to enforce the decision, including the withholding of funds to meet any financial liability established pursuant to Section 1850.530.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1850.525. Provision of Medically Necessary Services Pending Resolution of Dispute.

A dispute between an MHP and a Medi–Cal Managed Care Plan shall not delay medically necessary specialty mental health services, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries. Until the dispute is resolved, the following shall apply:

(a) The parties may agree to an arrangement satisfactory to both parties regarding how the services under dispute will be provided; or

(b) When the dispute concerns the Medi–Cal Managed Care Plan's contention that the MHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, the Medi–Cal Managed Care Plan shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved. The MHP shall identify and provide the Medi–Cal managed care plan with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the Medi–Cal managed care plan provider responsible for the beneficiary's care.

(c) When the dispute concerns the MHP's contention that the Medi–Cal Managed Care Plan is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1850.530. Financial Liability.

(a) When the resolution of a dispute under this Article includes a determination that the unsuccessful party in the dispute has a financial liability to the other party for services rendered by the successful party, financial liability and the liquidation of that liability shall follow the criteria of Subsections (b)–(d).

(b) Unless determined otherwise as provided in Subsection (c), financial liability shall not exceed the lower of the following rates, in effect at the time the services were rendered:

(1) The usual and customary charges made to the general public by the provider who rendered the service.

(2) The fee–for–service rates for similar services under the Medi–Cal program. Upon determination of the financial liability, if no final rate has been established for the providers who rendered the services for the period and type of services in question, then the applicable interim rate shall be used for the final determination of financial liability.

(c) The rate of payment included in the request pursuant to Section 1850.505(d)(1) shall be presumed correct, and the successful party shall be entitled to the full rate requested in its request should it prevail, unless the other party disputed the rate of payment in its response under Section 1850.505(e), which places the rates in issue.

(d) A plan determined to be financially liable shall within 30 calendar days of the effective date of the decision:

(1) Reimburse the successful party for the full amount of the determined liability.

(2) Provide proof of reimbursement in such form as the written decision of the departments requires.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

§ 1850.535. Additional Conditions of the Dispute Resolution Process.

(a) Nothing in this Article shall preclude the departments from taking oversight/corrective actions against their respective plans.

(b) Nothing in this Article shall preclude a beneficiary from utilizing the MHP's beneficiary problem resolution process or any similar process offered by the Medi–Cal managed care plan or to request a fair hearing. When there is a conflict between a fair hearing decision and a decision by the departments under this Article, the fair hearing decision shall take precedence.

NOTE: Authority cited: Section 14680, Welfare and Institutions Code. Reference: Sections 5778, 5780, 14681, 14683 and 14684, Welfare and Institutions Code.

Chapter 12. Mental Health Program Standards for the Community Treatment Facility

Article 1. General Provisions

§ 1900. Application of Chapter.

(a) This Chapter shall apply to mental health programs of a Community Treatment Facility, hereinafter referred to as a CTF, as defined in Section 1502(a)(8) of the Health and Safety Code. Pursuant to Section 4094 of the Welfare and Institutions Code, the State Department of Mental Health, hereinafter referred to as the Department, certifies the mental health program while the California Department of Social Services licenses a facility as a CTF following issuance of a certificate of compliance by the Department.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1901. Definitions and Terms.

(a) Meaning of words. A word or phrase shall have its usual meaning unless the context or a definition clearly indicates a different

meaning. Words and phrases used in their present tense include the future tense. Words and phrases in the singular form include the plural form. Use of the word "shall" denotes mandatory conduct, "may" denotes permissive conduct.

(b) "Advocate" means the person or persons authorized to provide advocacy services pursuant to Section 5520 et seq. of the Welfare and Institutions Code.

(c) "Applicant" means any adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity that has made application for an initial CTF mental health program certification.

(d) "Certificate holder" means the adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity that has an approved mental health program documented by a certificate issued to them by the Department.

(e) "Child" means an individual under 18 years of age who is seriously emotionally disturbed as defined in Section 5600.3 of the Welfare and Institutions Code, including those individuals 18 through 21 years of age specified in Section 1924(b).

(f) "Child care staff" means a direct service employee, as defined by the Division of Community Care Licensing, of a CTF whose duties include but are not limited to the care and supervision of the children residing in the facility.

(g) "Child's facility record" means the documents supporting the child's admission and treatment at the CTF.

(h) "Clinical psychologist" means a psychologist licensed by this State who possesses a doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code, and who has not less than two years clinical experience in a multi–disciplinary facility licensed or operated by this or another State or by the United States to provide health care, or who is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology and as provided in Section 1316.5 of the Health and Safety Code.

(i) "Conservator" means a person appointed pursuant to Section 5350 of the Welfare and Institutions Code.

(j) "Department" means the California State Department of Mental Health.

(k) "Emergency" means an unforseen situation that calls for immediate action without time for full deliberation to prevent the physical injury of a child or others or extreme property damage which could result in such injury.

(*l*) "Interagency placement committee" means a committee established by the county in accordance with Section 4096(c) of the Welfare and Institutions Code with a membership that includes at least a representative from the county placing agency and a licensed mental health professional from the county department of mental health.

(m) "Least restrictive setting" means the treatment setting which affords the maximum amount of personal freedom consistent with the effective delivery of services for the child being treated that can fulfill the objectives of the child's treatment plan.

(n) "Licensed clinical social worker" means a person who is licensed as a clinical social worker by the Board of Behavioral Science Examiners.

(o) "Licensed marriage, family, and child counselor" means a marriage, family, and child counselor licensed by the State Board of Behavioral Science Examiners.

(p) "Licensed mental health professional" means any of the following:

(1) A psychiatrist;

(2) A clinical psychologist;

(3) A licensed marriage, family and child counselor;

(4) A licensed clinical social worker;

(5) A licensed registered nurse with a masters or doctorate degree in psychiatric nursing.

(q) "Licensed nursing staff" means a licensed registered nurse, a licensed vocational nurse, or a licensed psychiatric technician as defined in this chapter, and employed by a CTF to perform functions within their scope of practice.

(r) "Licensed vocational nurse" means a person licensed as a licensed vocational nurse by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

(s) "Mental health program director" means the licensed mental health professional who has been designated by a CTF's certificate holder to oversee and implement the overall mental health treatment program.

(t) "Needs and Services Plan" or "NSP" is the written plan of all therapeutic, behavioral, and other interventions that are to be provided to the child, and that are necessary to achieve the desired outcomes or goals for that child.

(u) "Non–secure portion of the facility" means that part of a CTF which has entrances and exits, including windows, which are not controlled with locking mechanisms allowing egress or ingress from the premises to the children housed in this portion of the facility.

(v) "Physical restraint" means physically controlling a child's behavior. Physical control includes restricting movement by positioning staff, restricting motion by holding, the application of mechanical devices and involuntary placement of a child in a seclusion room or any other room in which they are involuntarily isolated.

(w) "Physician" means a person licensed as a physician and surgeon by the California Medical Board or by the Board of Osteopathic Examiners.

(x) "Progress notes" are written comments or descriptions of a child's participation and response to the provision of prescribed mental health treatment services.

(y) "Provider" means a "certificate holder" as defined in subsection (d).

(z) "Provision" or "provide" means whenever any regulation of this chapter specifies that any service, personnel, or other requirement be provided or that provision be made for, the provider shall do so directly or present documentation that the requirement has been met by some other means.

(aa) "Psychiatric technician" means a person licensed as a psychiatric technician by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

(bb) "Psychiatrist" means a physician and surgeon licensed by the Medical Board of California who can show evidence of having completed the required course of graduate psychiatric education as specified by the American Board of Psychiatry and Neurology in a program of training accredited by the Accreditation Council for Graduate Medical Education, the American Medical Association or the American Osteopathic Association.

(cc) "Registered nurse" means a person licensed as a registered nurse by the California Board of Registered Nursing.

(dd) "Seclusion" means the involuntary confinement of a child in a room.

(ee) "Secure portion of the facility" means that part of a CTF which has entrances and exits, including windows, which are controlled with locking mechanisms that are inaccessible to the children. Any additional outside spaces and recreational areas that are attached to the facility must similarly be enclosed to preclude egress or ingress from the premises.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

Article 2. Mental Health Program Certification Procedures

§ 1902. Application for Mental Health Program Certification.

(a) Any adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity desiring program certification for a CTF shall file an application with the Department which shall include the name of the adult, firm, partnership, association, corporation or governmental entity, the location of the proposed CTF, a proposed plan of operation as defined in Section 1919(c) of this chapter, and supporting documents as defined in subsection (c).

(b) Upon the Department's request, an applicant shall provide the Department with verification of the information submitted in their application and/or supporting documentation.

(c) Supporting documents are defined to include the following: previous or current experience in the provision of residential treatment services to children; letters of support or need from county mental health directors, county social service directors, county probation directors, and/or county or district offices of education; and a description of current or proposed relationships to transitional, less restrictive placements.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1903. Mental Health Program Certification of Separate Premises.

(a) A separate program certification is required by the Department for each CTF mental health program as described in Section 1919 that is maintained on separate premises.

(b) A separate program certification is not required for separate residential units on adjoining lots provided that the certificate holder operates the mental health programs as one program using the same administrator and mental health program director.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1904. Application Review.

(a) When an application is submitted pursuant to Section 1902 the Department will inform the applicant, within thirty (30) calendar days of receipt of the application, that the application is complete and accepted for filing or that the application is deficient and what specific information or documentation is required to complete the application.

(1) The Department shall inform each applicant of the statutory statewide limits on the number of licensed CTF beds imposed by Section 4094.7 of the Welfare and Institutions Code, regional restrictions on CTFs required by state law, and the effect that these limits will have on their application.

(2) The Department shall inform each applicant how the criteria used by the Department to determine the providers of CTF services within the state affected the certification or certification denial of their proposed mental health treatment program. The criteria will measure how the proposed mental health treatment program meets:

(A) Regional service needs;

(B) Treatment program needs of the target population;

(C) Fiscal accountability and stability; and

(D) Experience in providing residential treatment services.

(b) An application shall be considered complete when all documents or information required to be submitted with an application have been received by the Department.

(c) If an applicant fails to respond within thirty (30) calendar days to the Department's request pursuant to subsection (a) for additional information or documentation, the application shall be deemed to have been withdrawn by the applicant.

(d) Any applicant deemed to have withdrawn an application pursuant to subsection (c) may re–apply by submitting a new application.

(e) The Department shall notify the applicant in writing of the Department's decision regarding the application within sixty (60) calendar days of receipt of a completed application.

(f) If the Department fails to notify an applicant within the time period specified in subsection (e), the applicant may request a review by the Director of the Department or his designee. The written request shall include:

(1) The identity of the applicant;

(2) The date upon which the application was submitted;

(3) A copy of all correspondence between the Department and the applicant regarding the application;

(4) Any other information which the applicant wishes to submit regarding the timeliness of the Department's consideration of the application.

(g) Nothing in this section shall be construed to require mental health program certification by the Department.

(h) An applicant shall have the right to withdraw an application for an initial or renewal certification. The withdrawal notification shall be in writing.

(i) All applications for mental health program certification and requests for application withdrawal shall be filed with the Department headquarters office: State of California, Department of Mental Health, 1600 9th Street, Sacramento, CA 95814.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1905. Mental Health Program Certification.

(a) The Department shall issue a certificate of approval to applicants it approves to be a regional CTF provider.

(b) The Department shall notify the California Department of Social Services in writing of the certification of the program of a specific applicant.

(c) Mental health program certification shall expire one year from the date of issuance.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1906. Application for Renewal of Mental Health Program Certification.

(a) The Department shall renew certification of the certificate holder's program based on the results of a yearly site visit by a Department representative or designee which verifies that all requirements of this chapter and requirements of the California Department of Social Services continue to be met.

(b) The Department shall notify the certificate holder, in writing, of the certification renewal or non renewal with an explanation of the reasons for non renewal within sixty (60) calendar days of the site visit.

(c) The Department shall notify the California Department of Social Services of the renewal certification or non renewal of certification of each CTF program.

(d) Pending the issuance of a renewal certification pursuant to subsection (a) or the notification of non renewal pursuant to subsection (b), the current certification shall remain in effect.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1907. Submission of a New Application.

(a) A certificate holder shall be required to file a new application, as required in Section 1902, whenever there is a change in conditions or limitations described on the current license as issued by the California Department of Social Services, or other changes including but not limited to the following:

(1) Changes in the facility's plan of operation, as required in Section 1919 of this chapter;

(2) Changes in the limitations on the number of beds authorized for

mental health program certification on a statewide basis, as established in statute;

(b) The Department shall review the application as specified in Section 1904 and notify the certificate holder within thirty (30) calendar days of changes in state statute that affect the limitations on the mental health program certification of CTF beds.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

Article 3. Administrative Actions

§ 1908. Denial of Application for Mental Health Program Certification.

(a) The Department shall deny an application for mental health program certification if it is determined that the applicant is not in compliance with the provisions of this chapter.

(b) If the application for initial mental health program certification is denied, the Department shall notify the applicant and the California Department of Social Services of the denial in writing. The notification shall set forth the reason for the denial and advise the applicant of the right to petition for a hearing to appeal the decision.

(c) An applicant may contest a certification denial by submitting a written request for a hearing to appeal the decision to the Department within fifteen (15) calendar days of receipt of the denial notice. Upon receipt of a written request the Department will forward a copy of the request for hearing, along with any documentation, to the California Department of Social Services.

(d) A hearing concerning denial of mental health program certification and/or licensure shall be conducted by the California Department of Social Services and held jointly with the Department.

(e) The proceedings for the hearing shall be governed by Chapter 5, commencing with Section 11500, Part 1 of Division 3 of Title 2 of the Government Code.

(f) The Department shall provide consultation and documentation to the California Department of Social Services for any administrative proceeding regarding denial of a CTF license.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1909. Revocation or Suspension of Mental Health Program Certification.

(a) The Department may immediately suspend or revoke mental health program certification of a facility after a notice of noncompliance is given to the provider pursuant to Section 1915 on any of the following grounds:

(1) Violation of any provision of this chapter which places the health or safety of a child in jeopardy;

(2) Aiding, abetting, or permitting the violation of any provision of this chapter;

(3) Conduct by the certificate holder or any employee, or contractor to the certificate holder which represents an immediate or substantial threat to the physical health, mental health, or safety of any child in the facility.

(b) Upon completion of a site review and determination that grounds for revocation or suspension pursuant to subsection (a) have been met, the Department shall notify the certificate holder and the California Department of Social Services via facsimile transmission or mail within two (2) working days and proceedings shall be conducted in accordance with Chapter 5, commencing with Section 11500, Part 1 of Division 3 of Title 2 of the Government Code.

(c) A hearing concerning revocation or suspension of either mental health program certification, or California Department of Social Services licensure, or both shall be conducted by the California Department of Social Services and shall be held jointly with the Department.

(d) The Department shall provide consultation and documentation to the California Department of Social Services for any administrative proceeding regarding revocation or suspension of a CTF license.

(e) When notified of revocation of CTF licensure by the California Department of Social Services, the Department shall revoke the corresponding CTF mental health program certification.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

Article 4. Oversight and Enforcement Provisions

§ 1910. Department Oversight.

(a) A CTF shall participate fully in the ongoing oversight of a certified mental health treatment program by allowing announced and unannounced site visits by Department representatives and by submitting required reports as described in Section 1912 for monitoring by the Department.

(b) A CTF shall fully cooperate in the following:

(1) Periodic reviews of program and fiscal operations of a CTF by a Department representative to verify that all mental health treatment services are provided in compliance with this chapter;

(2) Immediate on–site investigations by a Department representative, as specified in Section 1914 of this chapter, of a CTF mental health treatment services program whenever there is a threat to the health or safety of the children placed in a CTF;

(3) Monitoring activities by a Department representative for compliance with all applicable patient's rights regulations and admission and discharge due process requirements and procedures as described in Sections 1923 through 1938 of this chapter.

(c) When Department activities described in subsection (b) result in the determination that a CTF is out of compliance with the regulations contained in this chapter, the Department shall provide the certificate holder with a written notice of noncompliance as defined in Section 1915. The notice of noncompliance will be left with a CTF mental health program director upon completion of a site review, or will be sent to a CTF certificate holder via facsimile transmission or mail within two (2) working days.

(d) The Department shall have authority to interview children residing in the facility or staff and to inspect and audit individual child facility records or program records immediately upon requesting to do so at either a regularly scheduled site visit or at an unscheduled complaint investigation.

(e) The certificate holder shall make provisions for the private interviews with any child or staff at a CTF, and for the examination of all records relating to the operation of the facility's mental health program.

(f) The Department shall have the authority to observe the physical condition of any child, including conditions which could indicate abuse, neglect or inappropriate placement, and to have any child physically examined by a licensed mental health professional or physician operating within their scope of practice.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1911. Inspection by Department.

(a) Any duly authorized representative of the Department shall, upon presentation of proper identification, be allowed to enter and inspect any location of a CTF or premise designated by an applicant as a proposed CTF at any time, with or without advance notice to the certificate holder or applicant, to ensure compliance with, or to prevent a violation of, any provisions of this chapter. The Department shall have the authority to make any number of visits to a CTF mental health program site in order to determine compliance with this chapter.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1912. Required Reporting.

(a) A certificate holder shall report to the Department the following information every six (6) months:

(1) Occupancy rate of the facility;

(2) Average length of stay, specifying the average number of days spent in secure settings and days spent in non– secure settings;

(3) Numbers of admissions of CTF residents to acute inpatient psychiatric settings;

(4) Listing of counties utilizing the facility and numbers of placements per county;

(5) Demographic information of admitted children, including age, gender, ethnicity and placing agency or authority;

(6) Number of requested pre–admission hearings conducted pursuant to In re Roger S. [19 Cal. 3d 921(1977)], hereinafter referred to as "Roger S.," administrative hearings, waivers of the right to such a hearing, and requests for writs of habeas corpus per the following categories of children placed within the facility: court ward; court dependent; educationally placed; and private pay.

(7) Other information requested by the Department to resolve any fiscal or programmatic issues raised by the information reported pursuant to this subsection.

(b) A certificate holder shall report special incidents related to a child to his appointed licensing agent of the California Department of Social Services according to Title 22, Section 84161 of the California Code of Regulations and to the Department.

(c) A certificate holder shall report to the Department changes of the facility's mental health program director within ten (10) calendar days of the date of hire.

(d) A certificate holder shall provide a summary of denials of personal rights to both the Department and the county patients' rights office on a quarterly basis.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1913. Complaints.

(a) Any person may submit a complaint to the Department concerning the operation of a CTF mental health program in accordance with the provisions of this chapter.

(b) The California Department of Social Services shall report to the Department when there is reasonable cause to believe that a CTF is not in compliance with the program standards established in this chapter.

(c) The complaint may be made to the Department either orally or in writing at 1600 9th Street, Sacramento, CA 95814, specifying enough details of the alleged violation to enable the Department to determine the date of the alleged violation, who was involved, and what the alleged violation was.

(d) The substance of the complaint shall be communicated to the certificate holder no earlier than at the time of the on–site investigation if silence regarding the complaint issue is necessary for purposes of conducting an unannounced investigation.

(e) Unless the complainant specifically requests otherwise, neither the substance of the complaint provided the certificate holder nor any copy of the complaint or any record published, released or otherwise made available to the certificate holder shall disclose the name of any person mentioned in the complaint except the name of any duly authorized representative of the Department or the California Department of Social Services, conducting the investigation or inspection pursuant to this chapter.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1914. Investigation Authority.

(a) Upon receipt of a complaint regarding an alleged violation of any provision of this chapter, the Department representative may do one or more of the following:

(1) Make a preliminary review and determine that there is or is not a reasonable basis for the complaint.

(A) If there is reasonable basis for the complaint, Department staff may schedule an on–site investigation within ten (10) calendar days after receiving the complaint.

(B) If there is reasonable basis for the complaint, Department staff may contact the certificate holder directly to further discuss the complaint and to determine if corrective actions are necessary.

(b) In either event cited in subsections (a)(1)(A) and (a)(1)(B), the complainant shall be promptly informed of the Department's proposed course of action.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1915. Notice of Noncompliance.

(a) Prior to completion of an inspection, investigation or record review, the certificate holder or his designee, and the Department representative shall meet to discuss any noncompliance, jointly develop a plan for correcting each noncompliance, and acknowledge receipt of the notice of noncompliance which shall include:

(1) A citation of the statute or the regulation which has been violated;

(2) A description of the nature of the noncompliance, stating the manner in which the certificate holder failed to comply with a specified statute or regulation;

(3) A plan developed for correcting each noncompliance;

(4) A date by which each noncompliance shall be corrected.

(b) When a Department representative conducts an inspection, investigation or record review, and determines that a CTF is in noncompliance with provisions of this chapter, the Department shall issue a notice of noncompliance, except in the following situations:

(1) When the noncompliance is not an immediate or substantial threat to the physical health, mental health, or safety of the child in the program and is corrected during the visit;

(2) When the noncompliance is corrected immediately through the provision of requested documents or information via fax transmission.

(c) A Department representative shall provide a written notice of noncompliance and plan of correction to the certificate holder by one of the following:

(1) Personal delivery to the administrator of the facility at the completion of the visit;

(2) Leaving the written notice with the person in charge of the mental health program at the completion of the visit when the administrator is not at a CTF site. A copy of the written notice shall also be mailed to the certificate holder.

(d) When the investigation or record review is conducted at Department offices, the notice of noncompliance and plan of correction shall be faxed, when possible, to the certificate holder and mailed within one (1) working day following the completion of the investigation.

(e) The date for correcting a deficiency shall not be more than thirty (30) calendar days following service of the notice of noncompliance, unless a Department representative determines that the deficiency cannot be completely corrected in thirty (30) calendar days.

(f) When the date for correcting the deficiency is more than thirty (30) calendar days following the service of the notice of noncompliance, the notice shall specify the corrective actions which must be taken within thirty (30) calendar days to begin correction, as well as a time frame for completion of the correction.

(g) A Department representative shall require correction of the deficiency within twenty–four (24) hours or less if there is an immediate threat to the physical or mental health or safety of the children.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1916. Determining Compliance.

(a) A follow–up visit may be conducted by the Department representative to determine compliance with the plan of correction specified in the notice of noncompliance.

(b) If a follow–up visit indicates that a deficiency was not corrected on or before the date specified in the notice of noncompliance, the Department shall initiate proceedings for the revocation or suspension of the mental health program certification.

(c) Notwithstanding Section 1916 (b), a Department representative shall have the authority to extend the date specified for corrections of a deficiency if warranted by the facts or circumstances presented in support of a request for extension.

(d) The certificate holder may request an extension in writing which the Department must receive at least seven (7) calendar days prior to the date specified in the notice of noncompliance for completion of the plan of correction.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1917. Administrative Review.

(a) A certificate holder may request an administrative review of a notice of noncompliance within ten (10) working days of receipt of such notice.

(1) The written request for an administrative review of a notice of noncompliance submitted by a certificate holder to the Department does not change the time limits for correcting the deficiency cited in the notice of noncompliance.

(b) The review shall be conducted by a Department reviewer who is a designee of the Department at a staff level senior to that of the Department representative who issued the notice.

(c) If the Department reviewer determines that a notice of noncompliance has not been issued in accordance with the provisions of this chapter, he shall have the authority to amend or dismiss the notice.

(d) The Department reviewer shall have the authority to extend the date specified for correction of a deficiency if warranted by the facts or circumstances presented in support of the request for extension or by the request for administrative review.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

Article 5. Continuing Requirements

§ 1918. Facility Requirements.

(a) The certificate holder shall comply with all regulations established by the California Department of Social Services pertaining to a licensed CTF.

(b) A CTF mental health program shall have the capacity to provide secure containment.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1919. Plan of Operation.

(a) An applicant shall submit a written plan of operation, as defined in Section 1919(c) of this article, as part of the application process for initial review and approval by the Department.

(b) Any changes to a plan of operation, as described in subsection (c) shall be mailed or faxed to the Department within ten (10) calendar days of the change.

(c) The plan of operation of a CTF, for the purposes of this chapter, shall include the following:

(1) The philosophy and goals of the facility's mental health services program including the proposed average length of stay and criteria under which a briefer or longer stay would be authorized;

(2) A description of the facility's proposed target population by range of age, gender, ethnicity, culture or special needs;

(3) A description of the array of mental health treatment services that can be made available to a child during his placement within a CTF;

(4) Written documentation demonstrating the proposed or existing facility's capability to provide those mental health services required by a child placed within the facility, to include:

(A) Job descriptions and staffing patterns for the mental health program director, services team staff, and licensed mental health professionals who will be working directly with children in a CTF with appropriate documentation of the staff's cultural competence as described in Section 5600.2(g) of the Welfare and Institutions Code;

(B) The name of the proposed mental health program director, with his professional license number, who shall be qualified in accordance with these regulations;

(C) An organizational chart which lists functions and licenses, if applicable, of the administrative and licensed mental health professional staff and contracted licensed mental health professionals providing the interventions and services described in the provider's overall program plan;

(D) A detailed staff development plan, describing staff orientation procedures, on–the–job training requirements and proposed continuing education activities;

(5) Written policies and procedures for providing access to community resources to be utilized in the delivery of prescribed services, including medical and crisis intervention, inpatient psychiatric hospitalization and educational placements and classes as necessary;

(6) Written policies, procedures and criteria for:

(A) Recording daily observations and interactions with each child by CTF staff;

(B) Admission;

(C) Discharge;

(D) Psychotropic medication control;

(E) The inclusion of the child and his parent or conservator in the development and implementation of an individualized needs and services plan, hereinafter referred to as NSP;

(F) The monthly review of each child's NSP;

(G) Physical restraint and seclusion;

(H) Staff training to ensure due process rights of children while in the CTF;

(I) Visitation and phone use;

(J) Confidentiality pursuant to Section 5328.15 of the Welfare and Institutions Code;

(K) Transitioning a child from a non–secure portion of the facility to a secure one and vice versa.

(L) Proposed documents to be used to inform children and their parents or conservators of the above requirements;

(7) A quality assurance program designed to enhance services and care through an objective assessment of the facility's overall program to ensure the correction of identified problems;

(A) The quality assurance program shall include procedures for ensuring the accountability of the facility's licensed mental health professionals and child care staff for the services and care provided to children residing in the facility and for the implementation of any necessary changes.

(8) A utilization review plan and program to monitor the appropriateness of a child's admission and continued stay or discharge to establish the basis for identifying and assessing the utilization of mental health program services and the continued need for placement;

(A) The utilization review plan shall include a description of the procedures to be used by the facility staff to determine the placement

or transfer of a child into either the secure or non–secure portion of the facility.

(B) These procedures shall include documentation of approval of the proposed change of a child's placement within the facility by a licensed mental health professional.

(9) A listing and copies of all agreements, contracts or memorandums of understanding with participating private or public mental health providers;

(10) Detailed plans of the buildings and grounds, including the number of beds in the secure and non–secure portions of the facility, security features and procedures, proposed offices, staff areas, visitor areas, physical restraint and seclusion rooms, educational sites and outdoor recreational areas;

(11) A proposed budget for the facility, including demonstration of sufficient funds or resources to ensure adequate start up activities and treatment services.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq. and 5600.2(g), Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1920. Mental Health Program Director Requirements and Responsibilities.

(a) A CTF shall have a mental health program director who shall be a licensed mental health professional as defined in this chapter. The mental health program director shall have at least three years of post graduate direct clinical experience with seriously emotionally disturbed children, at least one year of which shall be in the position of supervising direct care staff.

(b) The mental health program director shall be responsible for the following:

(1) Ensuring the provision of appropriate mental health services to the children in the facility;

(2) Ensuring timely completion of all activities, documentation and reports as required by Section 1927(a–j) of this chapter;

(3) Assessing the facility's mental health services on a quarterly basis and providing a signed and dated report summary to the CTF certificate holder with any recommendations that address identified problems;

(4) Supervising, or ensuring supervision by a qualified individual, of licensed mental health professionals and child care staff regarding specific roles and responsibilities in delivering and monitoring mental health services for each child in a CTF;

(5) Reviewing all incidents of physical restraint and seclusion within the facility, including all necessary staff debriefings, staff meetings, individual supervision of staff, recommended changes in facility staffing patterns, recommended additional training, and each child's NSP, for the purpose of reducing physical restraint and seclusion.

(c) If the mental health program director is not a board eligible psychiatrist, the provider must employ or contract with a board eligible psychiatrist to assume medical responsibility for mental health services.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1921. Licensed Mental Health Treatment Staffing.

(a) A certificate holder shall employ sufficient numbers of licensed mental health professionals and licensed nursing staff.

(b) All mental health professionals providing services in a CTF shall meet all professional licensing and certification requirements.

(c) All program nursing services shall be provided by licensed nursing staff. Program nursing services shall include but not be limited to physical assessment, dispensing psychotropic medication, providing discipline, and monitoring seclusion and restraint.

(d) All program nursing services shall be provided under the direction of a registered nurse who shall meet at least the following qualifications:

(1) A master's degree in psychiatric nursing or related field with experience in administration; or

(2) Two years of experience in psychiatric nursing; or

(3) Two years of experience in nursing administration or supervision and one year of experience in psychiatric nursing.

(e) A CTF shall not be required by the State Department of Mental Health to have 24–hour onsite licensed nursing staff, but shall retain at least one full–time, or full–time equivalent, registered nurse onsite if both of the following are applicable:

(1) The facility does not use mechanical restraint.

(2) The facility only admits children who have been assessed, at the point of admission, by a licensed primary care provider and a licensed psychiatrist, who have concluded, with respect to each child, that the child does not require medical services that require 24–hour nursing coverage. For purposes of this section, a "primary care provider" includes a person defined in Section 14254 of the Welfare and Institutions Code, or a nurse practitioner who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of care, and for initiating referral for specialist care.

(f) Other medical or nursing staff shall be available on call to provide appropriate services, when necessary, within one hour.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq. and 14254, Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1922. Required Staff Training.

(a) All staff persons working directly with children shall receive training in the following areas:

(1) Children's due process and patient's rights as defined in federal and state statutes, regulations and case law and appropriate management of requests from a child regarding his due process or patient's rights;

(2) Monitoring and documenting responses to psychotropic medications and recognizing possible side effects in children and adolescents;

(3) A staff member shall have participated in at least sixteen (16) hours of basic training in the areas of preventing and managing assaultive and self–injurious behaviors prior to participating in the physical restraint or seclusion of a child.

(4) All direct care staff shall be trained in first aid and cardiopulmonary resuscitation, and in emergency intervention techniques and methods approved by the Community Care Licensing Division of the State Department of Social Services.

(b) Staff participating in the physical restraint or seclusion of a child shall also participate in a required four (4) hours of bi–annual review of the above referenced subjects. All behavior management training courses shall be pre–approved by the Department to ensure the proposed courses' relevance to the safe seclusion and restraint of children.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1923. Admission Criteria.

(a) A CTF may only admit a child when the applicable conditions in subsections (b), (c) and (d) have occurred and are documented.

(b) A child, court, conservator or parents must submit one of the following types of admission applications and consent for treatment to a CTF:

(1) An application by a child of any age who is under the jurisdiction of the juvenile court and the court's consent to treatment shall be documented by a copy of the juvenile court ruling making the findings specified in Section 6552 of the Welfare and Institutions Code which must be included in the child's application for admission;

(2) An application made by the conservator for a child of any age, appointed in accordance with Section 5350 of the Welfare and Institutions Code shall be documented by the court documents appointing the conservator and specifying the conservator's

authorization to place the child in a CTF, as well as any other powers that may be relevant in this setting, along with the conservator's written consent for treatment;

(3) An application made by the parents of a child under the age of fourteen and a consent to treatment signed by both parents unless the admitting parent submits a court order demonstrating that he has sole custody and control of the child.

(4) An application made by the parents of a child fourteen (14) through seventeen (17) years old, a consent to treatment signed by both parents unless the admitting parent submits a court order demonstrating that he has sole custody and control of the child and one of the following:

(A) A statement signed by the child and the child's attorney or patients' rights advocate that the child has made a knowing and voluntary waiver of his right to a pre–admission hearing after being advised by the attorney or notified by the advocate of his rights to a pre–admission "Roger S." hearing. If the child waives his right to a pre–admission hearing based on the notification of rights by the advocate, the child's statement must also indicate that he has been notified of his right to receive the advice of an attorney and has made a knowing and voluntary waiver of that right as well; or

(B) The findings and order from a preadmission hearing held pursuant to Section 4094(g) of the Welfare and Institutions Code in accordance with the criteria delineated in "Roger S." and findings have been made that the child suffers from a mental disorder; that there is a substantial probability that treatment will significantly improve the child's mental disorder; that the proposed placement is the least restrictive setting necessary to achieve the purposes of treatment; and that there is no suitable alternative to CTF placement. A hearing held in accordance with this provision shall include but not be limited to the following:

1. A neutral and detached fact finder and decision maker who shall have no personal, administrative or financial ties to any parties represented at the hearing nor to the proposed placement facility;

2. Adequate written notice to the child before the hearing stating the basis for the proposed admission to a CTF;

3. An informal setting to minimize the anxiety of both parents and children and to promote cooperation and communication between all parties. All parties shall speak in terms the child understands and shall explain any terminology with which he is unfamiliar;

4. The stipulation that formal rules of evidence are not applicable and that the standard for decision shall be by a preponderance of the evidence;

5. The requirement that the hearing shall be closed to anyone other than the child, his parents or parent; the child's attorney, the person conducting the hearing, the professional person presenting evidence in favor of the commitment, and other persons requested to be in attendance by the child, or by the child's attorney;

6. Assistance provided by an attorney to the child who shall be allowed to call witnesses, examine evidence, present evidence on his own behalf and question persons presenting evidence in support of the admission; and

7. Maintenance of a record of the proceedings adequate to permit meaningful judicial or appellate review which shall be confidential in accordance with Section 5328 of the Welfare and Institutions Code.

(c) A written statement has been signed by an appropriate licensed mental health professional certifying that the child requires periods of containment to participate in and benefit from mental health treatment, the proposed treatment program is reasonably expected to improve the child's the mental disorder, the child is seriously emotionally disturbed as defined in Section 5600.3(a)(2) of the Welfare and Institutions Code and also meets one or more of the following requirements:

(1) Less restrictive interventions including, but not limited to outpatient therapy, family counseling, case management, family preservation efforts, special education classes, or nonpublic schooling have been attempted and proved insufficient.

(2) He is an inpatient in a psychiatric hospital, psychiatric health facility or residential treatment facility and is receiving services on either a voluntary or involuntary basis.

(d) A signed written statement from the placing county's or the parent's county of residence interagency placement committee must certify that:

(1) The child is in need of the level of care provided by a CTF to implement the proposed treatment program and meets the requirements of subsection (c);

(2) Informed consent for treatment has been given by a child's parents or the parent having sole legal custody and control of the child or the conservator.

(3) A pre–admission hearing officer has made the findings and order specified in Section 1923(b)(4)(B), when the child is 14 to 17 years old, under parental custody, and has not waived their right to a "Roger S" hearing.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1924. Continuing Stay Criteria.

(a) Continuing stay criteria used by a CTF shall include documentation by the CTF psychiatrist of the continuation of admission criteria in addition to written documentation from the appropriate interagency placement committee, or other designated external case manager, such as the probation department, county mental health department, or private insurance utilization review personnel, supporting the decision for continued placement of the child within a CTF. Continuing stay criteria shall be reviewed by a CTF in intervals not to exceed ninety (90) days. Findings shall be entered into each child's facility record.

(b) Individuals who are special education pupils identified in paragraph (4) of subdivision (c) of Section 56026 of the Education Code and who are placed in a CTF prior to age eighteen (18) pursuant to Chapter 26.5 of the Government Code may continue to receive services through age 21 provided the following conditions are met:

(1) They continue to satisfy the requirements of subsection (a);

(2) They have not graduated from high school;

(3) They sign a consent for treatment and a release of information for CTF staff to communicate with education and county mental health professionals after staff have informed them of their rights as an adult.

(4) A CTF obtains an exception from the California Department of Social Services to allow for the continued treatment of the young adult in a CTF pursuant to Section 80024, Title 22, Division 6, Chapter 1 of the California Code of Regulations.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1925. Discharge and Release Procedures.

(a) When it is deemed clinically appropriate a child shall be discharged from a CTF after completing normal discharge procedures.

(b) When it is not deemed clinically appropriate for a child to be discharged from a CTF a child shall be released under the following circumstances:

(1) A child admitted to the facility pursuant to Subsection (b)(1) of Section 1923 is deemed to be a voluntary patient and may revoke the voluntary status by giving notice of his desire to leave the facility to any member of the CTF staff. The child may make this notification directly or through an attorney or advocate. When staff is notified of a child's desire to revoke his voluntary consent to treatment, the court shall be notified no later than within one working day by a CTF staff person pursuant to Section 6552 of the Welfare and Institutions Code, and arrangements shall be made to return the child to the court. If the child leaves the care and custody of a CTF without permission prior to being discharged by a CTF, the juvenile court shall be notified immediately;

(2) A child admitted to a CTF pursuant to Subsection (b)(2) of

Section 1923 is deemed to be a voluntary patient and the child's conservator, appointed in accordance with Section 5350 of the Welfare and Institutions Code, may revoke the voluntary status by giving notice to the facility;

(3) A child admitted to a CTF pursuant to Subsection (b)(3) or (b)(4) of Section 1923 and the child's parents, or the parent entitled to sole custody of the minor may remove the child from a CTF after completing normal CTF discharge procedures.

(4) A special education pupil over the age of eighteen who is continuing to receive treatment pursuant to Section 1924(b) need only withdraw consent for treatment to be discharged if he is not a ward of the court or under the care and custody of a conservator.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code, and Section 1502, Health and Safety Code.

§ 1926. Habeas Corpus Hearings.

(a) Pursuant to Section 4094.6 of the Welfare and Institutions Code, every child placed in a CTF has a right to a hearing by writ of habeas corpus, including court appointed counsel, within two (2) days of filing a petition with the superior court of the county in which the facility is located. The child may make this request directly or through an attorney or advocate.

(b) Any member of a CTF staff to whom a request for release is made shall promptly do the following:

(1) Provide the child making the request with a form for a request for release or mark a copy of the form for the child. The form shall be substantially as follows:

(Name of the Facility)_____day of _____19__

I, _____ (member of the CTF staff) have today received a request for the release of _____ (name of child) from the undersigned child on his or her own behalf or from the undersigned person on behalf of the child.

_____

Signature or mark of child making request for release.

_____

Signature or mark of person making request for release on behalf of patient.

_____

Signature or mark of staff person receiving request for release

(2) Deliver the completed request form to the CTF administrator and note the request in the child's facility record;

(3) As soon as possible, but not longer than the next working day, a member of the facility staff shall submit the request for release form to the superior court of the county in which the facility is located;

(4) As soon as possible, but not longer than twenty–four (24) hours from the request for release, the member of the facility staff shall inform the individual who admitted the child of the request for release;

(5) A copy of the child's request for release, along with notification documents to the superior court shall be maintained in the child's facility record;

(6) The CTF administrator shall ensure that the child is informed as soon as possible of the date, time and location of the hearing.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1927. Mental Health Program Components and Documentation Requirements.

(a) The certificate holder of a CTF shall ensure that the required child facility records are kept on each child residing within the facility. Required child facility records include:

(1) A signed and dated copy of the interagency placement committee's placement authorization letter from the child's county of residence;

(2) Documentation of the child's, and his parents' or conservator's voluntary consent to treatment, when applicable;

(3) The intake report;

(4) The admission assessment;

(5) A psychiatric evaluation;

(6) A needs and services plan;

(7) Daily progress notes;

(8) Monthly clinical review reports;

(9) Written informed consent by the child for prescribed psychotropic medication, and, when applicable, by the parents, conservator or judge pursuant to Section 851 of Chapter 4;

(10) A copy of the court order for conservatorship if the child is conserved;

(11) A copy of the administrative hearing ruling if the child contested placement and a pre–admission administrative hearing was held or a copy of the form waiving this right signed by the child;

(12) A discharge summary;

(13) A discharge report.

(14) A Welfare and Institutions Code, Section 6552 order if the child is a ward or dependent of the court.

(b) The intake report shall be a typed document completed prior to admission which shall be signed by a member of the facility's licensed mental health professional staff and placed into the child's facility record upon intake that includes:

(1) Demographic information as defined in Section 84168.2(c)(1) of Title 22, California Code of Regulations;

(2) Presenting problems;

(3) Current DSM diagnosis;

(4) An assessment of danger to self and others;

(5) Medications;

(6) Immediate educational, service and treatment needs;

(c) The admission assessment shall be a typed document which shall be completed and signed by a member of the facility's licensed mental health professional staff within five (5) calendar days of admission. A typed copy of the admission assessment shall be provided to the child's parents, conservator, or the person designated by the court to manage the placement within ten (10) working days of assessment completion and it shall be included in the child's facility record. The admission assessment shall contain a prognosis and estimated length of stay based upon and including:

(1) The reasons for referral;

(2) A statement of presenting problems;

(3) Precipitating events;

(4) Factors relating to presenting problems;

(5) Psychiatric history including onset of symptoms and progressions;

(6) Medical history;

(7) Psychological history including a review and summary of existing psychological evaluation material;

(8) Academic and school history;

(9) Social history;

(10) Family history;

(11) Work history if applicable;

(12) Developmental status;

(13) DSM Diagnosis;

(14) A summary of the child's strengths and weaknesses as related to his family, school and social relationships.

(d) A psychiatric evaluation shall be completed by a psychiatrist within five (5) calendar days of admission but may be performed up to sixty (60) calendar days prior to admission unless CTF mental health professionals admitting the child feel it is no longer accurate. It shall be part of the admission assessment and shall include:

(1) A mental status examination;

(2) Indications and contraindications for medications; and

(3) Therapeutic response to medications, including an assessment of side effects, if available, and the child's compliance with medications when appropriate.

(e) Each child residing within a CTF shall have an NSP completed by a licensed mental health professional within fifteen (15) calendar days of admission which shall include:

(1) Identified specific behavioral goals and specific actions to be undertaken by facility staff to assist the child in accomplishing these goals within a defined period of time through appropriate behavioral interventions and treatment modalities which shall include but not be limited to a determination of the expected duration of each use of secure containment;

(2) Discharge goals that are general indicators of the child's readiness for transition to alternative treatment settings;

(3) Participation of the child, and, when appropriate, parent, conservator or person identified by the court to manage the child's placement in the development or modification of the NSP;

(4) A review at least every thirty (30) calendar days;

(5) Appropriate clinical oversight for a child involved with the maintenance of his residential unit. This participation shall be for the purpose of skill development in cooperative living to the extent the activities are age appropriate, and within the functioning level and physical capacity of the child. Clinically indicated restrictions to protect the safety and welfare of the child and the other children and facility staff shall be documented in the child's NSP.

(A) A child shall not be used as a substitute for employed staff and shall be supervised by treatment team staff while participating in any of the above cited activities contained within his NSP.

(f) When scheduled reviews of a child's participation within the facility's program activities indicate that the child requires transition to or from a secure portion of the facility for continued treatment at the facility, the mental health program director, or a designee, shall provide the child, and, when appropriate, parent, conservator, or the person identified by the court to manage the placement, with prior notification. This notification shall include an estimated treatment duration within the new portion of the facility. The method of notification, time, date, person doing the notification and the person notified shall be entered in the child's facility record.

(1) When a child is transferred from a non–secure portion to a secure portion of the facility based upon immediate need, the notification of the parent, conservator, or person identified by the court to manage the placement shall occur as soon as possible, but not more than twenty–four (24) hours after the transfer and shall include an estimated treatment duration within the secure portion of the facility.

(g) Progress notes shall be written daily to document a child's participation and responses to the prescribed mental health treatment services and additionally whenever a significant event occurs which affects or potentially affects the child's condition or course of treatment. The progress notes shall be maintained in the child's facility record. A licensed mental health professional shall review these progress notes on a regular basis, but not less than every thirty (30) calendar days, documented by a date and the initials of the reviewer.

(h) The monthly clinical review report is a typed document substantiating a child's status and progress in treatment, signed and dated by a licensed mental health professional, to be completed every thirty (30) days based on the date of the admission assessment. It shall include:

(1) The justification for decisions concerning admission or a continued stay for a child;

(2) The types and intensity of services provided to the child and family including the use of restraint and secure containment;

(3) The impact of these same services upon treatment goals, changes in or continuation of the treatment plan objectives;

(4) The facility's discharge planning activities and a summary of the progress of a child toward his discharge goals.

(i) A typed discharge summary for a child shall be completed and signed by a member of the facility's licensed mental health professional staff and provided to the child's parent, conservator, or the person identified by the court to manage the placement on the date of discharge which shall include:

(1) Demographic information as defined in Section 84168.2(c)(1) of Title 22, California Code of Regulations;

(2) Date of admission;

(3) DSM diagnosis;

(4) Current emotional and/or behavioral problems;

(5) Continuing therapeutic and educational needs;

(6) Medications;

(7) Reason for discharge.

(j) A typed discharge report shall be completed and signed by a member of the facility's licensed mental health professional staff within fourteen (14) calendar days of the date of discharge for each child, and a copy provided to the parent, conservator or the person identified by the court to manage the placement. It shall include:

(1) The reason for admission;

(2) The reason for discharge, referencing the child's discharge planning goals, or the reason for removal;

(3) The course of treatment, including medications and the child's response;

(4) The child's discharge diagnosis according to the current edition of the DSM;

(5) Medical and dental services received while in the CTF;

(6) The child's prognosis and recommendations for further mental health treatment, educational programs or placement;

(7) A signed written approval of discharge or removal from the child's parent, conservator, or the person identified by the court to manage the placement, and the name, address and relationship to the child of the person to whom the child was released. If the written approval cannot be secured, the child's record shall include an explanation of why the written approval was not obtained.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1928. Psychotropic Medication Control and Monitoring.

(a) A CTF shall have written protocols for psychotropic medication control and monitoring that require:

(1) Examination of each child by the prescribing physician, prior to prescribing any psychotropic medication which shall include screening for medical complications which may contribute to the child's mental disorder;

(2) A written medication review by the treating physician at least every thirty (30) days as clinically appropriate, based upon actual observations of the child and a review of a child's progress notes recorded by treatment team staff. This review shall be included in the child's facility record and shall include:

(A) Observations concerning the presence or absence of any side effects;

(B) Response to each psychotropic medication currently prescribed;

(C) Compliance with the medication plan;

(D) Justification for continued medication use and/or any changes in the medication plan.

(3) Appropriate documentation of informed consent from the child, and, when applicable, the parent, conservator, or judge pursuant to Title 9, Division 1, Chapter 4, Article 5.5, Section 851 of the California Code of Regulations;

(A) Psychotropic medications for a child placed in a CTF shall only be prescribed by the attending physician with the written informed consent of the child, and, when applicable, the parents, conservator or judge pursuant to Title 9, Division 1, Chapter 4, Article 5.5, Section 851 of the California Code of Regulations.

(B) No provisions included within the facility's written protocols shall allow for prior blanket consent for psychotropic medications to be prescribed for, administered to, or passed to a child.

(4) Procedures for monitoring psychotropic medications by a

person licensed to prescribe or dispense prescription drugs, with the current name and qualifications of the person who shall conduct the monitoring.

(b) Any psychotropic medication control and/or monitoring practices employed by a designated CTF licensed mental health professional shall ensure that any use of prescribed psychotropic medications are consistent with the goals and objectives of a child's NSP.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1929. Restraint and Seclusion.

(a) Physical restraint and seclusion shall be used only when alternative methods are not sufficient to protect the child or others from immediate injury.

(b) Physical restraint and seclusion shall not be used as aversive treatment, punishment, as a substitute for more effective programming, or for the convenience of the staff.

(c) Physical restraint and seclusion shall only be used with a written order designed to lead to a less restrictive way of managing, and ultimately eliminating, the behavior for which the physical restraint or seclusion is applied.

(d) A CTF shall adhere to written policies and procedures concerning the use of physical restraints and seclusion that include:

(1) A medical evaluation of each child upon admission to the facility to determine the existence of any condition that would contraindicate the use of physical restraint or seclusion;

(2) A requirement that they be used only with a signed order of a physician or licensed psychologist, except in an emergency as defined in Section 1901(K). In such an emergency a child may be placed in physical restraint at the discretion of a registered nurse. An order shall be received by telephone within sixty (60) minutes of the application of physical restraint, and shall be signed by the prescriber within twenty–four (24) hours. Telephone orders shall be received only by authorized mental health professional staff, and shall be recorded immediately in the child's facility record;

(A) The order shall include reasons for the physical restraint or seclusion in specific behavioral terms, type and number of points, if applicable, conditions for release or termination of physical restraint, with specific directions for discussing with the child the conditions that required the application of the physical restraint, the level of nursing care the child is entitled to while in physical restraint and the types of behaviors that will meet the criteria for terminating the order for physical restraint.

(B) Full documentation of the episode leading to the use of physical restraint, including the antecedent behaviors, and less restrictive means attempted by staff prior to the use of physical restraint, the type of physical restraint used, the length of effectiveness of the physical restraint time and the name of the individual applying such measures shall be entered in the child's facility record.

(C) At the time physical restraint or seclusion is initiated, or as soon as practical, but in every case within one (1) hour, information regarding the child's medical condition including vital signs, medications, current medical treatments and any relevant medical circumstances specific to the child shall be reviewed by the facility's on duty licensed nursing staff and noted in the child's facility record.

(D) All orders for physical restraint shall become invalid two (2) hours after the restraint or seclusion is initiated for children ages 9 to 17, one (1) hour for children under age 9, and four (4) hours for any special education pupils ages 18 through 21 remaining in the facility under continuing stay provisions. If continued physical restraint or seclusion is needed a new order shall be required.

(3) A prohibition that physical restraint shall not be allowed for longer than twenty–four (24) hours;

(4) A prohibition against as–needed, also known as "PRN" orders for physical restraint or seclusion.

(5) A description of acceptable forms of physical restraint or seclusion which shall be:

(A) Seclusion in either a designated seclusion room with a door which may be held shut to prevent a child's egress by a staff member or by a mechanism which releases upon removal of a staff person's foot and/or hand or in any other room or part of the facility where the child is prevented from physically leaving for any period of time, thus limiting their movement, activities and contact with the other children;

(B) Physical containment of a child by two or more trained staff persons utilizing methods approved by the Department;

(C) The application of mechanical devices such as well padded belts and cuffs, mittens without thumbs which are securely fastened about the wrist with a small tie and vests consisting of sleeveless cloth webbing;

(6) A requirement that restraint shall be applied in such a way as not to cause physical injury and to insure the least possible discomfort to the child;

(7) A requirement that restraints using mechanical devices shall be applied in such a manner that the device can be speedily removed in case of fire or other emergencies;

(8) A requirement that staff shall make provisions for regularly scheduled periods, at intervals not to exceed two (2) hours, for range of motion exercises, toileting and access to liquids and meals;

(9) A requirement that staff shall make provisions for responding promptly and appropriately to a child's request for services and assistance, and for repositioning the child when appropriate;

(10) A requirement for staff to take all precautions to insure the safety of children in restraints by insuring that they remain in staffs' line of vision, by isolating them from other children and by insuring that the restraints can be easily removed in case of fire or emergency;

(11) A requirement that staff shall make provisions to insure that a child placed in physical restraint shall be checked at a minimum of every fifteen (15) minutes by the licensed nursing staff to insure that the restraint remains properly applied and that the child has not harmed himself. A written record of each check shall be placed in the child's record and shall include:

(A) Vital signs which shall be measured at least every half hour, unless otherwise indicated by the prescribing professional;

(B) Justification for continued physical restraint;

(C) The child's responses to information regarding his behavioral criteria for termination of the physical restraint.

(e) A child's parent, conservator or the person identified by the court to manage the placement shall be informed of a restraint or seclusion within twenty four (24) hours, excepting weekends.

(f) Under no circumstances shall physical restraint be used as a disciplinary action.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1930. Discipline Practices.

(a) The applicant or certificate holder shall develop, maintain and implement written discipline practice policies that are consistent with the NSP of the child and ensure that all staff follow these procedures when disciplining a child including the following:

(1) A directive that under no circumstance shall physical restraint be used as a disciplinary action;

(2) Reviews, to include a licensed mental health professional, of each disciplinary action initiated by staff;

(3) Joint reviews by the program director, licensed mental health professionals, and the facility staff of discipline practices approved for use within the facility.

(b) A CTF shall provide placing agencies, children placed in a CTF, parents, conservators, or the person identified by the court to manage the placement with a copy of the facility's discipline practices upon admission.

(c) A CTF's discipline practices shall comply with the Title 22, California Code of Regulations, Division 6, Section 84072.1 which outlines the appropriate forms of discipline to be used within a licensed community care facility, except that no form of discipline shall deny the basic rights of a CTF resident delineated in Section 5325 of the Welfare and Institutions Code without following the procedures described in Section 1934 of this chapter and without establishing good cause for denial of the right as described in Section 1935 of this chapter.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code. Title 22, California Code of Regulations, Division 6, Sections 84072.1 and 84001d.(1).

Article 6. Personal Rights

§ 1931. Patient's Rights.

(a) Any child admitted to a CTF shall be afforded the legal and civil rights as prescribed in Article 7, Sections 4095, 5325, 5325.1, 5325.2 and 5326 of the Welfare and Institutions Code. In addition, any child admitted to a CTF shall have the right to participate in daily outdoor activities, weather permitting.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1932. Notification of Rights.

(a) The following shall remain posted in all wards and common living areas of a CTF:

(1) A list of the rights set forth in Sections 5325, 5325.1 and 5325.2 of the Welfare and Institutions Code;

(2) A statement that any child admitted to a CTF has the right to a hearing by writ of habeas corpus pursuant to Section 4095 of the Welfare and Institutions Code; and,

(3) The complaint procedure prescribed in Section 1933.

(b) Each child admitted to a CTF shall be personally notified of his rights in writing and in language he can understand, or shall have his rights brought to his attention by other means if he is unable to read or understand the information provided.

(c) A notation to the effect that notification, or an attempt to provide notification, has occurred shall be entered in the child's facility record within 24 hours of admission.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1933. Complaint Procedures.

(a) The list of rights and resources that must be posted, provided or explained to the children in a CTF pursuant to Section 1932 shall contain:

(1) Notification that any child who believes a right of his has been abused, punitively withheld or unreasonably denied may file a complaint with the Department or the county patients' rights advocate;

(2) The human rights unit of the Department and the name of the county patients' rights advocate who has been assigned to handle such complaints and his telephone number.

(b) When a complaint is received by the county patients' rights advocate he shall, within two working days, take action to investigate and resolve it.

(c) If the complainant expresses dissatisfaction to the county patients' rights advocate with the action taken, the matter shall be referred, within five (5) working days, to the local mental health director if the complaint originated in the mental disabilities program or to the regional center director if the complaint originated in the developmental disabilities program.

(d) If the complaint cannot be satisfactorily resolved by the local mental health director within ten (10) working days, it shall be referred to the patients' rights specialist at the Department whose responsibility it shall be to resolve the complaint. Appeal of the resolution provided by the patients' rights specialist may be made to the Director of the Department, or his designee.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1934. Denial of Rights.

(a) The rights listed in subsection (a) through (e) of Section 5325 of the Welfare and Institutions Code, and the right to participate in daily outdoor activities, weather permitting, may be denied a child in a CTF only upon the failure of all other means taken to resolve the behavior necessitating denial.

(b) Agreements and negotiations between the child, administrator and social worker shall be the primary means of resolving problems regarding the rights of the child.

(c) If a CTF, after complying with subsections (a) and (b) of this section, wishes to deny one or more of the rights delineated in subsection (a), the procedures outlined in Section 1935 must be followed.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1935. Good Cause for Denial of Rights.

(a) The rights delineated in Subsection (a) of Section 1934 may be denied only for good cause. Good cause for denying a child a right exists when the professional person in charge of a CTF or his designee has good reason to believe:

(1) That the exercise of the specific right would be injurious to the child;

(2) That there is evidence that the specific right, if exercised, would seriously infringe on the rights of others;

(3) That the facility would suffer serious damage if the specific right is not denied; and

(4) That there is no less restrictive way of protecting the interests specified in (1), (2), or (3).

(b) The reason used to justify the denial of a right to a child must be related to the specific right denied. A right shall not be withheld or denied as a punitive measure, nor shall a right be considered a privilege to be earned.

(c) Treatment modalities shall not include denial of any right specified in Section 1931. Waivers signed by the child, parent, conservator or person appointed by the court to manage the placement shall not be used as a basis for denying rights prescribed in Section 1931 in any treatment modality.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1936. Documentation of Denial of Rights.

(a) Each denial of a child's rights shall be noted in his facility record. Documentation shall take place immediately whenever a right has been denied. The notation shall include:

(1) Date and time the right was denied;

(2) Specific right denied;

(3) Good cause for denial of the right;

(4) Date of review if denial was extended beyond 30 days;

(5) Signature of the professional person in charge of the facility or his designee authorizing the denial of the right.

(b) The child shall be told the content of the notation.

(c) Each denial of a right shall be documented regardless of the gravity of the reason for the denial or the frequency with which a specific right is denied in a particular facility or to a particular child.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

§ 1937. Restoration of Rights.

(a) A right shall not continue to be denied to a child when the good cause for its denial no longer exists. When a right has been denied,

staff shall employ the least restrictive means of managing the behavior problem which led to the denial. The date a specific right is restored shall be documented in the child's facility record.

(b) A child who has been denied a patients' right shall have the good cause for this denial reviewed every five (5) days after the denial by a CTF mental health program director or his designee. This review shall result in either the restoration of the right to the child or continuation of the denial due to the determination that good cause for the denial of the right still exists. The results of the review will be documented in the child's facility record.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Section 4094.6, Welfare and Institutions Code.

§ 1938. Child and Family Involvement and Participation.

(a) A CTF certificate holder shall ensure that, upon admission, the child, parent, conservator or person identified by the court to manage the placement receive typed copies of the following:

(1) Admission criteria;

(2) Continued stay criteria;

(3) Criteria or guidelines regarding the transfer of a child to and from secure and non–secure portions of the facility including an estimated duration of treatment in each;

(4) A copy of the child's due process rights and patient's rights handbook;

(5) Family visitation guidelines;

(6) A description of the facility's discipline practices;

(7) A copy of the facility's policies and procedures regarding physical restraint and seclusion.

(b) A CTF certificate holder shall ensure, to the maximum extent possible, the participation of the child, parent, conservator or person identified by the court to manage the placement in the discussion and planning of the child's NSP.

(1) Activities undertaken by the CTF staff to achieve this participation shall be documented and included in the child's NSP, monthly clinical review report and facility record.

(2) The child's parent, conservator or person identified by the court to manage the placement shall be informed of the services to be provided which are stated in the child's NSP, and their written approval of any modification of the NSP shall be received prior to it's implementation.

NOTE: Authority cited: Section 4094, Welfare and Institutions Code. Reference: Sections 4094 et seq., Welfare and Institutions Code; and Section 1502, Health and Safety Code.

Chapter 14. Mental Health Services Act

Article 1. Application

§ 3100. Application of Chapter.

Chapter 14 sets forth regulations applicable to the Mental Health Services Act.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5898, Welfare and Institutions Code.

§ 3200.000. Act.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5840 et seq., Welfare and Institutions Code.

Article 2. Definitions

§ 3200.010. Adult.

"Adult" means an individual 18 years of age through 59 years of age.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5840(b)(2), Welfare and Institutions Code.

§ 3200.020. Bridge Funding.

"Bridge Funding" means funding that the County used which enabled the County to continue to provide services/programs from the date the funding for the program(s) or a portion of the program(s) specified below ended, until the County's initial Community Services and Supports component of the County's Three–Year Program and Expenditure Plan was approved and Mental Health Services Act funds became available. The use of bridge funding is limited to the following programs:

(1) The Children's System of Care Services.

(2) Integrated Services for the Homeless Mentally Ill.

(3) The Mentally Ill Offender Crime Reduction Act.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5892(a)(4) and 5898, Welfare and Institutions Code.

§ 3200.030. Children and Youth.

"Children and Youth" means individuals from birth through 17 years of age.

(1) Individuals age 18 and older who meet the conditions specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code are considered children and youth and are eligible to receive services.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5878.2, Welfare and Institutions Code.

§ 3200.040. Client.

"Client" means an individual of any age who is receiving or has received mental health services. As used in these regulations, the term "client" includes those who refer to themselves as clients, consumers, survivors, patients or ex–patients.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b)(6) and (7), Welfare and Institutions Code.

§ 3200.050. Client Driven.

"Client Driven" means that the client has the primary decision–making role in identifying his/her needs, preferences and strengths and a shared decision–making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d)(2) and (3), 5830(a)(2) and 5866, Welfare and Institutions Code; and Section 2(e), MHSA.

§ 3200.060. Community Collaboration.

"Community Collaboration" means a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5830(a)(3) and 5866, Welfare and Institutions Code.

§ 3200.070. Community Program Planning Process.

"Community Program Planning" means the process to be used by the County to develop Three–Year Program and Expenditure Plans, and updates in partnership with stakeholders to:

(1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act.

(2) Analyze the mental health needs in the community.

(3) Identify and re–evaluate priorities and strategies to meet those mental health needs.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d) and 5892(c), Welfare and Institutions Code.

§ 3200.080. Community Services and Supports.

"Community Services and Supports" means the component of the Three–Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children

and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care).

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(a)(2) and (3) and 5847(c), Welfare and Institutions Code.

§ 3200.090. County.

"County" means the County Mental Health Department, two or more County Mental Health Departments acting jointly, and/or city–operated programs receiving funds per Welfare and Institutions Code Section 5701.5.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5897(b), Welfare and Institutions Code.

§ 3200.100. Cultural Competence.

"Cultural Competence" means incorporating and working to achieve each of the goals listed below into all aspects of policy–making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

(1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.

(2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.

(3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.

(4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.

(5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.

(6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.

(7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

(8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.

(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d)(3), 5868(b), 5878.1(a), Welfare and Institutions Code; and Sections 2(e) and 3(c), MHSA.

§ 3200.110. Department.

"Department" means the State Department of Mental Health.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 4001(a), Welfare and Institutions Code.

§ 3200.120. Family Driven.

"Family Driven" means that families of children and youth with serious emotional disturbance have a primary decision–making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision–making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5822(h), 5840(b)(1), 5868(b)(2) and 5878.1, Welfare and Institutions Code.

§ 3200.130. Full Service Partnership.

"Full Service Partnership" means the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code.

§ 3200.140. Full Service Partnership Service Category.

"Full Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three–Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5847(a) and 5892(a)(5), Welfare and Institutions Code.

§ 3200.150. Full Spectrum of Community Services.

"Full Spectrum of Community Services" means the mental health and non–mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b), 5813.5(d), 5851 and 5868(b)(2), Welfare and Institutions Code.

§ 3200.160. Fully Served.

"Fully Served" means clients, and their family members who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client's recovery, wellness and resilience.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b), 5806, 5852 and 5813.5(d), Welfare and Institutions Code.

§ 3200.170. General System Development Service Category.

"General System Development Service Category" means the service category of the Community Services and Supports component of the Three–Year Program and Expenditure Plans under which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5892(a)(5) and 5847(a)(2) and (3), Welfare and Institutions Code.

§ 3200.180. Individual Services and Supports Plan.

"Individual Services and Supports Plan" means the plan developed by the client and, when appropriate the client's family, with the Personal Service Coordinator/Case Manager to identify the client's goals and describe the array of services and supports necessary to advance these goals based on the client's needs and preferences and, when appropriate, the needs and preferences of the client's family.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5699.4, 5806(b) through (d), 5813.5(d)(4) and 5868, Welfare and Institutions Code.

§ 3200.190. Integrated Service Experience.

"Integrated Service Experience" means the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5878.1(a), 5802, 5806(b), 5813.5(d)(4) and Section 2(e), MHSA, Welfare and Institutions Code.

§ 3200.210. Linguistic Competence.

"Linguistic Competence" means organizations and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures and dedicated resources are in place that enable organizations and individuals to effectively respond to the literacy needs of the populations being served.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5806(a)(2) and 5868(b)(3) and 5868(b)(4), Welfare and Institutions Code, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d et seq., Sections 2(e) and 3(c), MHSA.

§ 3200.220. Mental Health Services Act.

"Mental Health Services Act" means the laws that took effect on January 1, 2005 when Proposition 63 was approved by California voters and codified in the Welfare and Institutions Code.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Proposition 63, November 2004 California General Election.

§ 3200.230. Older Adult.

"Older Adult" means an individual 60 years of age and older.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5689.2, Welfare and Institutions Code.

§ 3200.240. Outreach and Engagement Service Category.

"Outreach and Engagement Service Category" means the service category of the Community Services and Supports component of the Three–Year Program and Expenditure Plan under which the County may fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5600.2, 5802(a)(1), 5806(a)(2) and 5814(b), Welfare and Institutions Code.

§ 3200.250. Planning Estimate.

"Planning Estimate" means the estimate provided by the Department to the County of the maximum amount of Mental Health Services Act funding that the County can request.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(a) and 5890(a), Welfare and Institutions Code.

§ 3200.260. Small County.

"Small County" means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: 9 CCR Section 1745.

§ 3200.270. Stakeholders.

"Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814.5(b)(1) and 5848(a), Welfare and Institutions Code.

§ 3200.280. Transition Age Youth.

"Transition Age Youth" means youth 16 years to 25 years of age.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(c), Welfare and Institutions Code.

§ 3200.300. Underserved.

"Underserved" means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out–of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814(d), 5814.5, 5830, 5840 and 5848, Welfare and Institutions Code.

§ 3200.310. Unserved.

"Unserved" means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis–oriented contact with and/or services from the County may be considered unserved.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814.5, 5830, and 5840 Welfare and Institutions Code.

Article 3. General Requirements

§ 3300. Community Program Planning Process.

(a) The County shall provide for a Community Program Planning Process as the basis for developing the Three–Year Program and Expenditure Plans and updates.

(b) To ensure that the Community Program Planning Process is adequately staffed, the County shall designate positions and/or units responsible for:

(1) The overall Community Program Planning Process.

(2) Coordination and management of the Community Program Planning Process.

(3) Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.

(A) Stakeholder participation shall include representatives of unserved and/or underserved populations and family members of unserved/underserved populations.

(4) Ensuring that stakeholders that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity have the opportunity to participate in the Community Program Planning Process.

(5) Outreach to clients with serious mental illness and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate.

(c) The Community Program Planning Process shall, at a minimum, include:

(1) Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.

(2) Participation of stakeholders, as stakeholders is defined in Section 3200.270.

(3) Training.

(A) Training shall be provided as needed to County staff designated responsible for any of the functions listed in 3300(b) that will enable staff to establish and sustain a Community Program Planning Process.

(B) Training shall be offered, as needed, to those stakeholders, clients, and when appropriate the client's family, who are participating in the Community Program Planning Process.

(d) Beginning with Fiscal Year 2006–07, or in fiscal years when there are no funds dedicated for the Community Program Planning Process, the County may use up to five (5) percent of its Planning Estimate, as calculated by the Department for that fiscal year, for the Community Program Planning Process.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5840, 5848(a), 5892(c), and 5813 Welfare and Institutions Code.

§ 3310. The Three–Year Program and Expenditure Plan.

(a) To receive Mental Health Services Act (MHSA) funds under this Chapter, the County shall submit a Three–Year Program and Expenditure Plan or update; obtain the necessary approvals in accordance with Welfare and Institutions Code Sections 5830, 5846, and 5847; and enter into a valid MHSA Performance Contract with the Department.

(1) A City–operated program, created pursuant to Welfare and Institutions Code Section 5701.5, may submit a Three–Year Program and Expenditure Plan separate from the County in which it is located. Plans of both the County and the City shall be developed in collaboration with one another to minimize gaps in the provision of mental health services and supports.

(b) Three–Year Program and Expenditure Plans shall address each of the following components:

(1) Community Services and Supports, for:

(A) Children and Youth, as defined in Section 3200.030.

(B) Transition Age Youth, as defined in Section 3200.280.

(C) Adults, as defined in Section 3200.010.

(D) Older Adults, as defined in Section 3200.230.

(2) Capital Facilities and Technological Needs.

(3) Education and Training.

(4) Prevention and Early Intervention.

(5) Innovative Programs.

(c) The County shall update Three–Year Program and Expenditure Plans at least annually.

(d) The County shall develop the Three–Year Program and Expenditure Plans and updates in collaboration with stakeholders, through the Community Program Planning Process, as specified in Section 3300.

(1) County programs and/or services shall only be funded if the Community Program Planning Process set forth in these regulations was followed.

(e) The Three–Year Program and Expenditure Plans and updates shall include a statement explaining how the requirements of Section 3300 were met.

(f) As part of the Three–Year Program and Expenditure Plans or updates, the County shall submit documentation of the local review process, as required by Section 3315.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5830, 5846, 5847, 5848(c), and 5897(a), Welfare and Institutions Code.

§ 3315. Local Review Process.

(a) Prior to submitting the Three–Year Program and Expenditure Plans or annual updates to the Department, the County shall conduct a local review process that includes:

(1) A 30–day public comment period.

(A) The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the draft Three–Year Program and Expenditure Plan, or annual update, to representatives of stakeholders' interests and any other interested parties who request the draft.

(2) Documentation that a public hearing was held by the local mental health board/commission, including the date of the hearing.

(3) A summary and analysis of any substantive recommendations.

(4) A description of any substantive changes made to the proposed Three–Year Program and Expenditure Plan or annual update that was circulated.

(b) For updates, other than the annual update required in Section 3310(c), the County shall conduct a local review process that includes:

(1) A 30–day public comment period.

(A) The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the update, to representatives of stakeholders' interests and any other interested parties who request the draft.

(2) A summary and analysis of any substantive recommendations.

(3) A description of any substantive changes made to the proposed update that was circulated.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5848(a) and (b), Welfare and Institutions Code.

§ 3320. General Standards.

(a) The County shall adopt the following standards in planning, implementing, and evaluating the programs and/or services provided with Mental Health Services Act (MHSA) funds. The planning, implementation and evaluation process includes, but is not limited to, the Community Program Planning Process; development of the Three–Year Program and Expenditure Plans and updates; and the manner in which the County delivers services and evaluates service delivery.

(1) Community Collaboration, as defined in Section 3200.060.

(2) Cultural Competence, as defined in Section 3200.100.

(3) Client Driven, as defined in Section 3200.050.

(4) Family Driven, as defined in Section 3200.120.

(5) Wellness, Recovery, and Resilience Focused.

(6) Integrated Service Experiences for clients and their families, as defined in Section 3200.190.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d), Welfare and Institutions Code; and Section 2(e), MHSA.

§ 3350. Amendment of MHSA Performance Contract.

(a) The County or the Department may initiate MHSA Performance Contract amendments at any time.

(b) The County shall initiate an MHSA Performance Contract amendment to:

(1) Eliminate an approved program.

(2) Request funding for a new program/service that was not part of the County's MHSA Performance Contract.

(3) Request an increase in the total amount of funding approved for the fiscal year of the MHSA Performance Contract.

(4) Request new or increased one–time funding.

(5) Change the MHSA Performance Contract timeframe.

(6) Modify any other MHSA Performance Contract term.

(c) The Department may require the County to submit an update to the Three–Year Program and Expenditure Plan.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 11010.5(a), Government Code.

§ 3360. Program Flexibility.

(a) The use of alternative practices, programs/services, procedures, and/or demonstration projects shall not be prohibited by these regulations provided that:

(1) Such alternatives meet the intent of the Mental Health Services Act and all applicable regulations.

(2) The County has submitted a written request and documentation supporting the alternative to the Department.

(3) Prior written approval from the Department has been received.

(b) The County shall maintain continuous compliance with all applicable regulations unless prior written approval of the alternative has been received from the Department.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 11010.5, Government Code; and Section 3, MHSA.

Article 4. Funding Provisions

§ 3400. Allowable Costs and Expenditures.

(a) The County shall utilize Mental Health Services Act (MHSA) funds only to establish or expand mental health services and/or supports for the components specified in Section 3310(b) and for the Community Program Planning Process specified in Section 3300.

(b) Programs and/or services provided with MHSA funds shall:

(1) Offer mental health services and/or supports to individuals/clients with serious mental illness and/or serious emotional disturbance, and when appropriate their families.

(A) The Prevention and Early Intervention component is exempt from this requirement.

(2) Be designed for voluntary participation. No person shall be denied access based solely on his/her voluntary or involuntary legal status.

(3) Comply with the requirements in Section 3410, Non– Supplant.

(c) To the extent allowed under (a) and (b) of this Section, the County may use MHSA funds to match other funding sources, such as Medi–Cal and the Healthy Families Program. The County shall not submit requests for MHSA funding solely for the purpose of increasing reimbursement for Medi–Cal or the Healthy Families Program.

(d) The County is not obligated to use MHSA funding to fund court mandates.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. References: Sections 5801, 5878.3(a), 5891 and 5892, Welfare and Institutions Code.

§ 3405. Allowable Use of Funds in the Service Categories of the Community Services and Supports.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5878.3(a) and 5813.5(b), Welfare and Institutions Code.

§ 3410. Non–Supplant.

(a) Funds distributed under this Chapter shall not be used to provide mental health programs and/or services that were in existence on November 2, 2004, except to:

(1) Expand mental health services and/or program capacity beyond what was previously provided.

(2) Continue programs funded in Fiscal Year 2004–2005 with bridge funding, as defined in Section 3200.020.

(b) Funds distributed under this Chapter shall not be used to supplant state or county funds required to be used for services and/or supports that were in existence in Fiscal Year 2004–2005. The only exceptions to this limitation are:

(1) The ten (10) percent of Realignment funds, described in Welfare and Institutions Code Section 17600.20, that the County may reallocate by transferring in or out of its mental health account.

(A) If the County reallocates any portion of the ten (10) percent of Realignment funds out of the mental health account, the County shall adhere to (a) above.

(2) County funds exceeding the amount required to be deposited into the mental health account in Fiscal Year 2004–2005, pursuant to Welfare and Institutions Code Section 17608.05.

(A) If the County elects to reduce funds exceeding the amount required to be deposited into the mental health account in Fiscal Year 2004–2005, the County shall adhere to (a) above.

(c) The County shall not use MHSA funds to pay the costs associated with inflation for programs and/or services that were in existence on November 2, 2004.

(d) The County shall not loan MHSA funds for any purpose.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. References: Sections 5891 and 5892(a)(5), Welfare and Institutions Code.

§ 3415. Non–Supplant Reporting Requirements.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. References: Sections 5891 and 5892, Welfare and Institutions Code.

Article 5. Reporting Requirements

§ 3500. Non–Supplant Certification and Reports.

(a) The Three–Year Program and Expenditure Plans, and updates, shall include certification by the County Mental Health Director that the County will comply with Section 3410, Non–Supplant.

(b) The County shall maintain documentation of all fund expenditures, and provide documentation to the Department upon request.

(c) As part of the Annual Cost and Financial Reporting System (”Cost Report”), as specified in Section 3505, the County shall certify that:

(1) Mental Health Services Act (MHSA) funds were used in compliance with Section 3410, Non–Supplant.

(2) Mental health funds, other than MHSA funds, required to be used to provide services and/or supports that were in existence in Fiscal Year 2004–2005 were used for the required purpose.

(d) The County shall maintain documentation of bridge funding, if bridge funding was used.

(1) The documentation shall specify the programs funded and the services provided, and shall include a statement that these programs/services were identified as priorities in the Community Program Planning Process.

(2) Acceptable documentation includes, but is not limited to: a resolution from the County Board of Supervisors, certification by the County Mental Health Director, or other official documentation indicating the County’s intent to use bridge funding.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5610, Welfare and Institutions Code.

§ 3505. Cost Report.

(a) As part of the Annual Cost and Financial Reporting System (”Cost Report”) the County shall complete and submit information on the revenue, distribution, and expenditures for programs and/or services funded by the Mental Health Services Act (MHSA).

(b) The County’s Local Mental Health Director and Auditor–Controller must certify the Cost Report information as being true and correct, and with respect to MHSA funding, certify that the County is in compliance with Chapter 14, Article 5, Section 3410, Non–Supplant.

(c) The reconciled Cost Report must be certified by the County’s Local Mental Health Director and Auditor–Controller that the information is true and correct, and with respect to MHSA funding, the County is in compliance with Chapter 14, Article 5, Section 3410, Non–Supplant.

(d) If the County does not submit the Cost Report and/or the reconciled Cost Report by the required deadlines, the Department may withhold MHSA funds.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5664(a), 5891, and 5892(g), Welfare and Institutions Code.

§ 3510. Annual MHSA Revenue and Expenditure Report.

(a) The County shall submit to the Department an Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report for Community Services and Supports (CSS). The Annual MHSA Revenue and Expenditure Report for the CSS component shall include, but not be limited to, the following:

(1) Administration Expenditures: The County shall report the actual total expenditures incurred and the revenues received for MHSA administration during the reporting fiscal year.

(A) The report shall include system–wide one–time costs that cannot be assigned to a specific program.

(2) Program Expenditures: The County shall report the actual total expenditures incurred by Service Category and revenues received during the reporting fiscal year and complete a separate Program Expenditure Report for each program funded through the County MHSA Performance Contract.

(A) The report shall include one–time costs associated with a specific program.

(3) One–Time Expenditures: The County shall report the amount approved in the County MHSA Performance Contract, and the actual total expenditures incurred during the reporting fiscal year, for each approved One–Time Expenditure listed in the County Performance Contract.

(A) The One–Time Expenditures shall also be included as either Program Expenditures or Administration Expenditures.

(4) MHSA Funding: The County shall report MHSA funds received from the Department and interest income earned during the reporting fiscal year.

(b) The County shall submit the Annual MHSA Revenue and Expenditure Report for the CSS component of the MHSA no later than December 31 following the end of the fiscal year.

(c) If the County does not submit the Annual MHSA Revenue and Expenditure Report by the required deadline, the Department may withhold MHSA funds.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5612(a)–(b), 5664(a), 5801(b)(10)–(11), and 5860(b), Welfare and Institutions Code; and Section 3(e) of MHSA.

§ 3520. Local Mental Health Services Fund Cash Flow Statement.

(a) The County shall complete and submit to the Department a Local Mental Health Services (MHS) Fund Cash Flow Statement no later than 30 days following the end of each six–month period.

(1) The six–month periods are April 1 through September 30 and October 1 through March 31.

(b) The Local MHS Fund Cash Flow Statement shall be based on the County financial records and shall include, but not be limited to, the following information:

(1) The amount of Mental Health Services Act (MHSA) funds in the Local MHS Fund at the beginning of the six–month period.

(2) Deposits to the Local MHS Fund during the six–month period.

(3) In addition to (b)(2) above, all MHSA fund transfers into/out of the Local MHS Fund during the six–month period.

(4) The earned interest on cash and investments in the Local MHS Fund during the six–month period.

(5) The amount of MHSA funds in the Local MHS Fund at the end of the six–month period.

(6) The amounts and purposes of MHSA funds reserved for, but not limited to, the following:

(A) Obligations, encumbrances, and/or commitments.

(B) CSS One–Time Funding expenditures that have been funded, but not yet incurred.

(C) Any other adjustment not included in (b)(6)(A) or (B) above.

(i) The County shall include an explanation of the proposed adjustments.

(ii) The County shall not include budgeted expenditures anticipated during the next six (6) months.

(D) Amounts reserved for Medi–Cal cost report settlements and other revenue adjustments.

(c) The unreserved balance of MHSA funds in the Local MHS Fund shall not exceed thirty–five (35) percent of the County's annual CSS Planning Estimate, which includes the ten (10) percent that the County may use as an operating reserve.

(1) The Department may withhold future fund distribution if the County exceeds the thirty–five (35) percent in (c) above.

(d) The Local MHS Fund Cash Flow Statement shall be signed by the County Mental Health Director, or his/her authorized designee, certifying that the information is true and complete.

(e) Future MHSA fund distribution may be delayed or withheld if the County does not comply with these reporting requirements.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(e), 5804(d) and 5892(f), Welfare and Institutions Code.

§ 3530. Client/Services Reporting Requirements.

(a) The County shall submit complete and accurate information, including, but not limited to, the following:

(1) Client and Service Information (CSI) System data, as specified in Section 3530.10.

(2) Quarterly Progress Reports, as specified in Section 3530.20.

(3) Full Service Partnership Performance Outcome data, as specified in Section 3530.30.

(4) Consumer Perception Semi–Annual Survey data, as specified in Section 3530.40.

(b) If the County does not submit the required information within the established timeframes, the Department may withhold MHSA funds.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5613(a), 5664(a) and 5814.5(c), Welfare and Institutions Code.

§ 3530.10. Client and Service Information System Data.

(a) The County shall submit Client and Service Information (CSI) System data, including but not limited to, client demographics and descriptions of services provided to each client.

(1) The CSI data shall be submitted no later than 60 days after the end of the month in which the services were provided.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5613(a), 5664(a) and 5814.5(c), Welfare and Institutions Code.

§ 3530.20. Quarterly Progress Report.

(a) A Quarterly Progress Report shall be submitted, by service category, for each approved program and/or service. The Report shall include, but not be limited to the following:

(1) The targeted number of individuals, clients, and families to be served in each reporting quarter.

(2) The total number of individuals, clients, and families actually served in each reporting quarter.

(b) The final Quarterly Progress Report shall include the total number of unduplicated individuals, clients, and family units served by each program/service during the fiscal year.

(c) The Quarterly Progress Report shall be submitted no later than 60 days following the end of each reporting quarter.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5613(a), 5664(a) and 5814.5(c), Welfare and Institutions Code.

§ 3530.30. Full Service Partnership Performance Outcome Data.

(a) The County shall submit Full Service Partnership Performance Outcome Data, as required in Section 3620.10.

(b) The data shall be submitted to the Department no later than 90 days after collection.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5613(a), 5664(a) and 5814.5(c), Welfare and Institutions Code.

§ 3530.40. Consumer Perception Semi–Annual Survey.

(a) The County shall conduct a semi–annual survey to collect Consumer Perception data.

(1) The data to be collected includes, but is not limited to, clients'/families' perceptions of quality and results of services provided.

(b) The data shall be submitted to the Department no later than 90 days after collection.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5613(a), 5664(a) and 5814.5(c), Welfare and Institutions Code.

§ 3540. Information Technology Project Status Report.

(a) The County shall submit to the Department a status report for any approved Information Technology (IT) project funded with Community Services and Supports (CSS) funds. The report shall include, but not be limited to, the following:

(1) Project name.

(2) Report period.

(3) Project start and end dates.

(4) Project objectives, as approved by the Department.

(5) Current overall project status.

(6) Status of major milestones.

(7) Budget information including funding sources, budgeted costs, and actual costs to date.

(8) Major accomplishments.

(9) Scheduled activities.

(10) A list of the issues regarding the project, potential risks and the actions that will be or have been taken to avoid or manage the risk or issue.

(b) The County shall submit the IT Projects Status Report no later than 30 days following the end of each fiscal quarter.

(c) A final report containing the information required in Section (a) above shall be submitted to the Department within 30 days of completion of each project. The final report shall also include, but is not limited to the following:

(1) A comparison between the objectives approved by the Department and the objectives achieved.

(2) Information regarding the acceptance of the completed project by users and management.

(3) A description of the lessons learned, best practices used to complete the project, and any other factors that contributed to the project's success or failure.

(A) If problems were encountered, a description of how they were handled.

(B) If the project failed, or had limited success, a description of corrective actions that could improve the project outcome.

(5) A description of future phases, enhancements or maintenance necessary for this project.

(d) If the County does not submit the required information within the established timeframes the Department may withhold MHSA funds.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5804(c), 5847(a), and 5848(c) Welfare and Institutions Code.

Article 6. Community Services and Supports

§ 3610. General Community Services and Supports Requirements.

(a) The following shall be incorporated into the mental health programs and/or services funded through the Community Services and Supports (CSS) component.

(1) The principles of the Adult and Older Adult Mental Health Systems of Care, including the Integrated Services for the Homeless Mentally Ill Program, in Welfare and Institutions Code (WIC) Section 5800 et. seq.

(2) The principles of the Children's Mental Health Services Act in WIC 5850 et. seq.

(3) The General Standards in Section 3320.

(b) The County shall establish peer support and family education support services or expand these services to meet the needs and preferences of clients and/or family members.

(1) The County shall conduct outreach to provide equal opportunities for peers who share the diverse racial/ethnic, cultural, and linguistic characteristics of the individuals/clients served.

(c) The County shall include a wrap–around program for services to children in accordance with WIC Section 18250 et. seq, or provide substantial evidence that it is not feasible to establish a wrap–around program.

(d) MHSA funds may only be used to pay for those portions of the mental health programs/services for which there is no other source of funding available.

(e) When CSS programs/services include collaboration with the juvenile or criminal justice systems, any law enforcement function and/or any function that supports a law enforcement purpose shall not be funded.

(f) The County shall not provide MHSA funded services to individuals incarcerated in state/federal prisons or for parolees from state/federal prisons.

(g) The County may use MHSA funds for programs/services provided in juvenile halls and/or county jails only for the purpose of facilitating discharge.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5714(f), 5802(d)(4), 5813.5, 5814(f)(2), 5851(c)(3), 5878.1, 5878.3(a), 5891 and 5892, Welfare and Institutions Code.

§ 3615. Community Services and Supports Service Categories.

(a) The Community Services and Supports (CSS) component contains three service categories:

(1) Full Service Partnership.

(2) General System Development.

(3) Outreach and Engagement.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5, 5814(a)(2), 5847(a)(2) and (3), 5848(c), 5890(a) and (c), 5897(e), Welfare and Institutions Code.

§ 3620. Full Service Partnership Service Category.

(a) The County shall develop and operate programs to provide services under the Full Service Partnership Service Category. The services to be provided for each client with whom the County has a full service partnership agreement may include the Full Spectrum of Community Services necessary to attain the goals identified in the Individual Services and Supports Plan (ISSP). The services to be provided may also include services the County, in collaboration with the client, and when appropriate the client's family, believe are necessary to address unforeseen circumstances in the client's life that could be, but have not yet been included in the ISSP.

(1) The Full Spectrum of Community Services consists of the following:

(A) Mental health services and supports including, but not limited to:

(i) Mental health treatment, including alternative and culturally specific treatments.

(ii) Peer support.

(iii) Supportive services to assist the client, and when appropriate the client's family, in obtaining and maintaining employment, housing, and/or education.

(iv) Wellness centers.

(v) Alternative treatment and culturally specific treatment approaches.

(vi) Personal service coordination/case management to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services.

(vii) Needs assessment.

(viii) ISSP development.

(ix) Crisis intervention/stabilization services.

(x) Family education services.

(B) Non–mental health services and supports including, but not limited to:

(i) Food.

(ii) Clothing.

(iii) Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing.

(iv) Cost of health care treatment.

(v) Cost of treatment of co–occurring conditions, such as substance abuse.

(vi) Respite care.

(C) Wrap–around services to children in accordance with WIC Section 18250 et. seq.

(b) The County may pay for the full spectrum of community services when it is cost effective and consistent with the ISSP.

(c) The County shall direct the majority of its Community Services and Supports funds to the Full–Service Partnership Service Category.

(1) Small Counties shall fulfill this requirement no later than Fiscal Year 2008–09.

(2) Services designed under General System Development and/or Outreach and Engagement that benefit clients and/or their families in Full Service Partnerships can be used on a pro–rated basis to meet the requirement in (c) above.

(d) The County shall give priority to populations that are unserved as defined in Section 3200.310.

(e) The County shall enter into a full service partnership agreement with each client served under the Full Service Partnership Service Category, and when appropriate the client's family.

(f) The County shall designate a Personal Service Coordinator/Case Manager for each client, and when appropriate the client's family, to be the single point of responsibility for that client/family.

(1) The County shall provide a sufficient number of Personal Service Coordinators/Case Managers to ensure that:

(A) Availability is appropriate to the service needs of the client/family.

(B) Individualized attention is provided to the client/family.

(C) Intensive services and supports are provided, as needed.

(g) The County shall ensure that an ISSP is developed for each client.

(h) The County shall ensure that the Personal Service Coordinator/Case Manager:

(1) Is responsible for developing the ISSP with the client, and when appropriate the client's family.

(A) The Personal Service Coordinator/Case Manager shall ensure that the ISSP is developed in collaboration with other agencies that have a shared responsibility for services and/or supports to the client, and when appropriate the client's family.

(2) Is culturally and linguistically competent, or at a minimum, is educated and trained in linguistic and cultural competence, and has knowledge of available resources within the client's/family's racial/ethnic community.

(i) The County shall ensure that a Personal Service Coordinator/Case Manager or other qualified individual known to the client/family is available to respond to the client/family 24 hours a day, 7 days a week to provide after–hour intervention.

(1) In the event of an emergency when a Personal Service Coordinator/Case Manager or other qualified individual known to the client/family is not available, the County shall ensure that another qualified individual is available to respond to the client/family 24 hours a day, 7 days a week to provide after–hour intervention.

(2) Small Counties may meet this requirement through the use of peers or community partners, such as community–based organizations, who are known to the client/family.

(j) The County shall provide services to all age groups; i.e., older adults, adults, transition age youth and children/youth, in the Full Service Partnerships Service Category.

(1) If Full Service Partnership services are not provided to all age groups, the County shall explain the reason, and specify how and when all age groups will be served.

(k) Notwithstanding Section 3400 (b)(2), the County may pay for short–term acute inpatient services, not to exceed 30 days, for clients in Full Service Partnerships when the client is uninsured for this service or there are no other funds available for this purpose.

(*l*) Long–term hospital and/or long–term institutional care cannot be paid for with MHSA funds.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5345, 5600.2(d), 5600.3(b), 5600.3(c), 5801, 5802(a)(1) and (4), 5806, 5813.5(a), 5813.5(d), 5813.5(f), 5840(a), 5847(a)(2) and (3), 5847(c), 5878(b) and 5878.1(a), Welfare and Institutions Code.

§ 3620.05. Criteria for Full Service Partnerships Service Category

(a) Individuals selected for participation in the Full Service Partnership Service Category must meet the eligibility criteria in Welfare and Institutions Code (WIC) Section WIC Section 5600.3(a) for children and youth, WIC Section 5600.3(b) for adults and older adults or WIC Section 5600.3(c) for adults and older adults at risk.

(b) Transition age youth, in addition to (a) above, must meet the criteria below.

(1) They are unserved or underserved and one of the following:

(A) Homeless or at risk of being homeless.

(B) Aging out of the child and youth mental health system.

(C) Aging out of the child welfare systems

(D) Aging out of the juvenile justice system.

(E) Involved in the criminal justice system.

(F) At risk of involuntary hospitalization or institutionalization.

(G) Have experienced a first episode of serious mental illness.

(c) Adults, in addition to (a) above, must meet the criteria in either (1) or (2) below.

(1) They are unserved and one of the following:

(A) Homeless or at risk of becoming homeless.

(B) Involved in the criminal justice system.

(C) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.

(2) They are underserved and at risk of one of the following:

(A) Homelessness.

(B) Involvement in the criminal justice system.

(C) Institutionalization.

(d) Older adults, in addition to (a) above, must meet the criteria in either (1) or (2) below:

(1) They are unserved and one of the following:

(A) Experiencing a reduction in personal and/or community functioning.

(B) Homeless.

(C) At risk of becoming homeless.

(D) At risk of becoming institutionalized.

(E) At risk of out–of–home care.

(F) At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.

(2) They are underserved and at risk of one of the following:

(A) Homelessness.
(B) Institutionalization.
(C) Nursing home or out–of–home care.
(D) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
(E) Involvement in the criminal justice system.
(e) This section shall not prevent the County from providing services to clients with co–occurring conditions, including substance abuse, physical conditions/disorders, and/or developmental disorders/disabilities.
NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5, 5878.1, and 5878.3, Welfare and Institutions Code.

§ 3620.10. Full Service Partnership Data Collection Requirements.

(a) The County shall conduct a Partnership Assessment of the client at the time the full service partnership agreement is created between the County and the client, and when appropriate the client's family. The County shall collect information as appropriate including, but not limited to:
(1) General administrative data.
(2) Residential status, including hospitalization or incarceration.
(3) Educational status.
(4) Employment status.
(5) Legal issues/designation.
(6) Sources of financial support.
(7) Health status.
(8) Substance abuse issues.
(9) Assessment of daily living functions, when appropriate.
(10) Emergency interventions.
(b) The County shall collect the following key event data:
(1) Emergency interventions.
(2) Changes in:
(A) Administrative data.
(B) Residential status.
(C) Educational status.
(D) Employment status.
(E) Legal issues/designation.
(c) The County shall review and update, through the Quarterly Assessment, the following information:
(1) Educational status.
(2) Sources of financial support.
(3) Legal issues/designation.
(4) Health status.
(5) Substance abuse issues.
(d) The data required by (a), (b), and (c) above shall be submitted to the Department within 90 days of collection, as required by Section 3530.30.
NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5610(a), 5610(d)(1), and 5664(a), Welfare and Institutions Code.

§ 3630. General System Development Service Category.

(a) The County may develop and operate programs to provide mental health services to clients specified in Welfare and Institutions Code Section 5600.3 (a), (b) or (c), and when appropriate the clients' families.
(b) General System Development Funds may only be used to:
(1) Provide one or more of the following mental health services and supports:
(A) Mental health treatment, including alternative and culturally specific treatments.
(B) Peer support.
(C) Supportive services to assist the client, and when appropriate the client's family, in obtaining employment, housing, and/or education.
(D) Wellness centers.
(E) Personal service coordination/case management/personal service coordination to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative or other community services.
(F) Needs assessment.
(G) Individual Services and Supports Plan development.
(H) Crisis intervention/stabilization services.
(I) Family education services.
(2) Improve the county mental health service delivery system for all clients and their families.
(3) Develop and implement strategies for reducing ethnic/racial disparities.
(c) When the County works in collaboration with other non–mental health community programs and/or services, only the costs directly associated with providing the mental health services and supports, as specified in (b) above, shall be paid under the General System Development Service Category.
NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(a), 5813.5(c) and (d) and 5878.1(a), Welfare and Institutions Code; and Sections 2(b), (c), (f) and 3(a), MHSA.

§ 3640. Outreach and Engagement.

(a) The County may develop and operate outreach programs/activities for the purpose of identifying unserved individuals who meet the criteria of Welfare and Institutions Code Sections 5600.3 (a), (b) or (c) in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services.
(b) Outreach and Engagement funds may be used to pay for:
(1) Strategies to reduce ethnic/racial disparities.
(2) Food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system.
(3) Outreach to entities such as:
(A) Community based organizations.
(B) Schools.
(C) Tribal communities.
(D) Primary care providers.
(E) Faith–based organizations.
(4) Outreach to individuals such as:
(A) Community leaders.
(B) Those who are homeless.
(C) Those that are incarcerated in county facilities.
(c) When the County works in collaboration with other non–mental health community programs and/or services, only the costs directly associated with providing mental health services and supports shall be paid under the Outreach and Engagement Service Category.
NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5600.2(d), 5600.3(b)(4), 5681(b), 5802(a)(1), 5802(d)(4), 5806(a)(2) and (3), 5813.5, 5814(a)(4)(A), 5814(d), and 5847(a)(2) and (3), Welfare and Institutions Code; and Section 3, MHSA.

§ 3650. Community Services and Supports Component of the Three–Year Program and Expenditure Plan.

(a) The Community Services and Supports (CSS) component shall include the following:
(1) Assessment of Mental Health Needs: The County shall assess and submit a narrative analysis of the mental health needs of unserved, underserved/inappropriately served, and fully served county residents who qualify for MHSA services.
(A) The analysis shall identify the number of older adults, adults, transition age youth and children/youth by gender, race/ethnicity and primary language.
(B) The assessment data used shall include racial/ethnic, age, and gender disparities.
(2) Identification of Issues: The County shall submit a list of community mental health issues resulting from lack of mental health

services and supports, as identified through the Community Program Planning Process required by Section 3300. The list shall:

(A) Categorize the issues by age group, i.e, older adults, adults, transition age youth and children/youth.

(B) Identify issues that will be priorities in the CSS component of the Three–Year Program and Expenditure Plans.

(C) For each of the issues identified as priorities in (B) above, describe the factors/criteria used to determine that the issue is a priority.

(D) For each of the issues identified as a priority, describe any racial/ethnic and gender disparities including, but not limited to:

(i) Access to services.

(ii) Quality of care.

(iii) Access disparities of Native Americans, rancherias and/or reservations.

(iv) Disproportionate representation in the homeless population.

(v) Disproportionate representation in the juvenile and/or criminal justice systems.

(vi) Disproportionate representation in foster care.

(vii) Disproportionate representation in school achievement, and drop–out rates.

(3) Identification of Full Service Partnership Population: The County shall provide an estimate of the number of clients, in each age group, to be served in the Full Service Partnership Service Category for each fiscal year of the Three–Year Program and Expenditure Plans. The County shall describe how the selections for Full Service Partnerships will reduce the identified disparities.

(4) Proposed Programs/Services: The County shall provide:

(A) A list of the proposed programs/services, identified by the service category under which the program/service will be funded.

(B) A description of each proposed program/service.

(C) An explanation of how each program/service relates to the issues identified in the Community Program Planning Process, including how each program/service will reduce or eliminate the disparities identified.

(5) County's Capacity to Implement: The County shall provide an assessment of its capacity to implement the proposed programs/services. The assessment shall include:

(A) The strengths and limitations of the County and service providers that impact their ability to meet the needs of racially and ethnically diverse populations. The evaluation shall include an assessment of bilingual proficiency in threshold languages.

(B) Percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served.

(C) Identification of possible barriers to implementing the proposed programs/services and methods of addressing these barriers.

(6) Program/Service Work Plans: The County shall submit a separate work plan for each proposed program/service. The work plan shall include, but not be limited to:

(A) A narrative description and summary of the program/service.

(B) A narrative explanation of the budget by fiscal year.

(C) A budget work sheet by fiscal year, including staffing details.

(D) The target number of clients/individuals to be served by fiscal year.

(E) A breakdown of the Full Service Partnership population by fiscal year, identifying:

(i) The number of clients to be served, according to gender, race/ethnicity, linguistic group, and age.

(ii) The percentage of unserved individuals and underserved clients.

(F) Small counties proposing to provide full service partnership programs/services in Fiscal Year 2008–09 must only identify the population to be served and the amount of funding to be reserved for this purpose. Prior to implementation, detailed work plans, time frames, budgets and staffing requirements will be required for each Full Service Partnership program to ensure review and approval by the Department and the Oversight and Accountability Commission (OAC), as appropriate.

(b) The Community Services and Supports component of the Three–Year Program and Expenditure Plan shall be signed by the County Mental Health Director.

NOTE: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5664(a), 5813.5, 5830(a)(1) and (2), 5830(a)(4), 5847(a)(2) and (3), 5847(c)–(e), 5848(c) and 5878.1, Welfare and Institutions Code.

TITLE 15. CRIME PREVENTION AND CORRECTIONS

Division 1. Board of Corrections

Chapter 1. Board of Corrections

Subchapter 4. Minimum Standards for Local Detention Facilities

Article 11. Medical/Mental Health Services

§ 1200. Responsibility for Health Care Services.

(a) In Type I, II, III and IV facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

Each facility shall have at least one physician available to treat physical disorders. In Type IV facilities, compliance may be attained by providing access into the community; however, in such cases, there shall be a written plan for the treatment, transfer, or referral in the event of an emergency.

(b) In court holding and temporary holding facilities, the facility administrator shall have the responsibility to develop written policies and procedures which ensure provision of emergency health care services to all inmates.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1201. Health Care Services—Type IV Facilities.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1202. Health Service Audits.

The health authority shall develop and implement a written plan for annual statistical summaries of health care and pharmaceutical services that are provided. The responsible physician shall also establish a mechanism to assure that the quality and adequacy of these services are assessed annually. The plan shall include a means for the correction of identified deficiencies of the health care and pharmaceutical services delivered.

Based on information from these audits, the health authority shall provide the facility administrator with an annual written report on health care and pharmaceutical services delivered.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1203. Health Care Staff Qualifications.

State and/or local licensure and/or certification requirements and restrictions apply to health care personnel working in the facility the same as to those working in the community. Copies of licensing and/or certification credentials shall be on file in the facility or at a central location where they are available for review.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1204. Health Care Staff Procedure.

Medical care performed by personnel other than a physician shall be performed pursuant to written protocol or order of the responsible physician.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1205. Medical/Mental Health Records.

(a) The health authority shall maintain individual, complete and dated health records which shall include, but not be limited to:

(1) receiving screening form/history;

(2) medical/mental health evaluation reports;

(3) complaints of illness or injury;

(4) names of personnel who treat, prescribe, and/or administer/deliver prescription medication;

(5) location where treated; and,

(6) medication records in conformance with section 1216.

(b) The physician/patient confidentiality privilege applies to the medical/mental health record. Access to the medical/mental health record shall be controlled by the health authority or designee.

The health authority shall ensure the confidentiality of each inmate's medical/mental health record file and such files shall be maintained separately from and in no way be part of the inmate's other jail records. The responsible physician or designee shall communicate information obtained in the course of medical/mental health screening and care to jail authorities when necessary for the protection of the welfare of the inmate or others, management of the jail, or maintenance of jail security and order.

(c) Written authorization by the inmate is necessary for transfer of medical/mental health record information unless otherwise provided by law or administrative regulations having the force and effect of law.

(d) Inmates shall not be used for medical/mental health recordkeeping.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1206. Health Care Procedures Manual.

The health authority shall, in cooperation with the facility administrator, set forth in writing, policies and procedures in conformance with applicable state and federal law, which are reviewed and updated at least annually and include but are not limited to:

(a) summoning and application of proper medical aid;

(b) contact and consultation with private physicians;

(c) emergency and non–emergency medical and dental services, including transportation;

(d) provision for medically required dental and medical prostheses and eyeglasses;

(e) notification of next of kin or legal guardian in case of serious illness which may result in death;

(f) provision for screening and care of pregnant and lactating women, including postpartum care, and other services mandated by statute;

(g) screening, referral and care of mentally disordered and developmentally disabled inmates;

(h) implementation of special medical programs;

(i) management of inmates suspected of or confirmed to have communicable diseases;

(j) the procurement, storage, repackaging, labeling, dispensing, administration/delivery to inmates, and disposal of pharmaceuticals;

(k) use of non–physician personnel in providing medical care;

(*l*) provision of medical diets;

(m) patient confidentiality and its exceptions;

(n) the transfer of pertinent individualized health care information, or individual documentation that no health care information is available, to the health authority of another correctional system, medical facility, or mental health facility at the time each inmate is transferred and prior notification pursuant to Health and Safety Code Sections 121361 and 121362 for inmates with known or suspected active tuberculosis disease. Procedures for notification to the transferring health care staff shall allow sufficient time to prepare the summary. The summary information shall identify the sending facility and be in a consistent format that includes the need for follow–up care, diagnostic tests performed, medications prescribed, pending appointments, significant health problems, and other information that is necessary to provide for continuity of health care.

Necessary inmate medication and health care information shall be provided to the transporting staff, together with precautions necessary to protect staff and inmate passengers from disease transmission during transport.

(o) forensic medical services, including drawing of blood alcohol samples, body cavity searches, and other functions for the purpose of prosecution shall not be performed by medical personnel responsible for providing ongoing care to the inmates.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1206.5. Management of Communicable Diseases in a Custody Setting.

(a) The responsible physician, in conjunction with the facility administrator and the county health officer, shall develop a written plan to address the identification, treatment, control and follow–up management of communicable diseases including, but not limited to, tuberculosis and other airborne diseases. The plan shall cover the intake screening procedures, identification of relevant symptoms, referral for a medical evaluation, treatment responsibilities during incarceration and coordination with public health officials for follow–up treatment in the community. The plan shall reflect the current local incidence of communicable diseases which threaten the health of inmates and staff.

(b) Consistent with the above plan, the health authority shall, in cooperation with the facility administrator and the county health officer, set forth in writing, policies and procedures in conformance with applicable state and federal law, which include, but are not limited to:

(1) the types of communicable diseases to be reported;

(2) the persons who shall receive the medical reports;

(3) sharing of medical information with inmates and custody staff;

(4) medical procedures required to identify the presence of disease(s) and lessen the risk of exposure to others;

(5) medical confidentiality requirements;

(6) housing considerations based upon behavior, medical needs, and safety of the affected inmates;

(7) provisions for inmate consent that address the limits of confidentiality; and,

(8) reporting and appropriate action upon the possible exposure of custody staff to a communicable disease.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 6030, 7501, and 7552, Penal Code.

§ 1207. Medical Receiving Screening.

With the exception of inmates transferred directly within a custody system with documented receiving screening, a screening shall be completed on all inmates at the time of intake. This screening shall be completed in accordance with written procedures and shall include but not be limited to medical and mental health problems, developmental disabilities, and communicable diseases, including, but not limited to, tuberculosis and other airborne diseases. The screening shall be performed by licensed health personnel or trained facility staff.

The facility administrator and responsible physician shall develop a written plan for complying with Penal Code Section 2656 (orthopedic or prosthetic appliance used by inmates).

There shall be a written plan to provide care for any inmate who appears at this screening to be in need of or who requests medical, mental health, or developmental disability treatment.

Written procedures and screening protocol shall be established by the responsible physician in cooperation with the facility administrator.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Sections 2656 and 6030, Penal Code.

§ 1207.5. Special Mental Disorder Assessment.

An additional mental health screening will be performed, according to written procedures, on women who have given birth within the past year and are charged with murder or attempted murder of their infants. Such screening will be performed at intake and if the assessment indicates postpartum psychosis a referral for further evaluation will be made.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1208. Access to Treatment.

The health authority, in cooperation with the facility administrator, shall develop a written plan for identifying, assessing, treating and/or referring any inmate who appears to be in need of medical, mental health or developmental disability treatment at any time during his/her incarceration subsequent to the receiving screening. This evaluation shall be performed by licensed health personnel.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1209. Mental Heath Services and Transfer to Treatment Facility.

(a) The health authority, in cooperation with the mental health director and facility administrator, shall establish policies and procedures to provide mental health services. These services shall include but not be limited to:

1. screening for mental health problems;

2. crisis intervention and management of acute psychiatric episodes;

3. stabilization and treatment of mental disorders; and,

4. medication support services.

(b) A mentally disordered inmate who appears to be a danger to himself or others, or to be gravely disabled, shall be transferred for further evaluation to a designated Lanterman Petris Short treatment facility designated by the county and approved by the State Department of Mental Health for diagnosis and treatment of such apparent mental disorder pursuant to Penal Code section 4011.6 or 4011.8 unless the jail contains a designated treatment facility. Prior to the transfer, the inmate may be evaluated by licensed health personnel to determine if treatment can be initiated at the correctional facility. Licensed health personnel may perform an onsite assessment to determine if the inmate meets the criteria for admission to an inpatient facility, or if treatment can be initiated in the correctional facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1210. Individualized Treatment Plans.

(a) For each inmate treated by a mental health service in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

(b) For each inmate treated for a major medical problem in a jail, the treatment staff shall develop a written treatment plan. The custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate. This treatment plan shall include referral to treatment after release from the facility when recommended by treatment staff.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1211. Sick Call.

There shall be written policies and procedures developed by the facility administrator, in cooperation with the health authority, which provides for a daily sick call conducted for all inmates or provision made that any inmate requesting medical/mental health attention be given such attention.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1212. Vermin Control.

The responsible physician shall develop a written plan for the control and treatment of vermin–infested inmates. There shall be written, medical protocols, signed by the responsible physician, for the treatment of persons suspected of being infested or having contact with a vermin–infested inmate.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1213. Detoxification Treatment.

The responsible physician shall develop written medical policies on detoxification which shall include a statement as to whether detoxification will be provided within the facility or require transfer to a licensed medical facility. The facility detoxification protocol shall include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

Facilities without medically licensed personnel in attendance shall not retain inmates undergoing withdrawal reactions judged or defined in policy, by the responsible physician, as not being readily controllable with available medical treatment. Such facilities shall arrange for immediate transfer to an appropriate medical facility.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1214. Informed Consent.

The health authority shall set forth in writing a plan for informed consent of inmates in a language understood by the inmate. Except for emergency treatment, as defined in Business and Professions Code Section 2397 and Title 15, Section 1217, all examinations, treatments and procedures affected by informed consent standards in the community are likewise observed for inmate care. In the case of minors, or conservatees, the informed consent of parent, guardian or legal custodian applies where required by law. Any inmate who has not been adjudicated to be incompetent may refuse non–emergency medical and mental health care. Absent informed consent in non–emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1215. Dental Care.

The facility administrator shall develop written policies and procedures to ensure emergency and medically required dental care is provided to each inmate, upon request, under the direction and supervision of a dentist, licensed in the state.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1216. Pharmaceutical Management.

(a) The health authority in consultation with a pharmacist and the facility administrator, shall develop written plans, establish procedures, and provide space and accessories for the secure storage, the controlled administration, and disposal of all legally obtained drugs. Such plans, procedures, space and accessories shall include, but not be limited to, the following:

(1) securely lockable cabinets, closets, and refrigeration units;

(2) a means for the positive identification of the recipient of the prescribed medication;

(3) procedures for administration/delivery of medicines to inmates as prescribed;

(4) confirming that the recipient has ingested the medication or accounting for medication under self–administration procedures outlined in Section 1216(d);

(5) that prescribed medications have or have not been administered, by whom, and if not, for what reason;

(6) prohibiting the delivery of drugs by inmates;

(7) limitation to the length of time medication may be administered without further medical evaluation; and,

(8) limitation to the length of time required for a physician's signature on verbal orders.

(9) A written report shall be prepared by a pharmacist, no less than annually, on the status of pharmacy services in the institution. The pharmacist shall provide the report to the health authority and the facility administrator.

(b) Consistent with pharmacy laws and regulations, the health authority shall establish written protocols that limit the following functions to being performed by the identified personnel:

(1) Procurement shall be done by a physician, dentist, pharmacist, or other persons authorized by law.

(2) Storage of medications shall assure that stock supplies of legend medications shall be accessed only by licensed health personnel. Supplies of legend medications that have been dispensed and supplies of over–the–counter medications may be accessed by either licensed or non–licensed personnel.

(3) Repackaging shall only be done by a physician, dentist, pharmacist, or other persons authorized by law.

(4) Preparation of labels can only be done by a physician, dentist, pharmacist or other persons, either licensed or non–licensed, provided the label is checked and affixed to the medication container by the physician, dentist, or pharmacist before administration or delivery to the inmate. Labels shall be prepared in accordance with section 4076, Business and Professions Code.

(5) Dispensing shall only be done by a physician, dentist, pharmacist, or persons authorized by law.

(6) Administration of medication shall only be done by licensed health personnel who are authorized to administer medication acting on the order of a prescriber.

(7) Delivery of medication may be done by either licensed or non–licensed personnel, e.g., custody staff, acting on the order of a prescriber.

(8) Disposal of legend medication shall be done in accordance with pharmacy laws and regulations and requires any combination of two of the following classifications: physician, dentist, pharmacist, or registered nurse. Controlled substances shall be disposed of in accordance with the Drug Enforcement Administration disposal procedures.

(c) Policy and procedures on "over–the–counter" medications shall include, but not be limited to, how they are made available, documentation when delivered by staff and precautions against hoarding large quantities.

(d) Policy and procedures may allow inmate self–administration of prescribed medications under limited circumstances. Policies and procedures shall include but are not limited to the following considerations:

(1) Medications permitted for self–administration are limited to those with no recognized abuse potential. Medications for treatment of tuberculosis, psychotropic medication, controlled substances, injectables and any medications for which documentation of ingestion is essential are excluded from self–administration.

(2) Inmates with histories of frequent rule violations of any type, or who are found to be in violation of rules regarding self–administration, are excluded from self–administration.

(3) Prescribing health care staff document that each inmate participating in self–administration is capable of understanding and following the rules of the program and instructions for medication use.

(4) Provisions are made for the secure storage of the prescribed medication when it is not on the inmate's person.

(5) Provisions are made for the consistent enforcement of self–medication rules by both custody and health care staff, with systems of communication among them when either one finds that an inmate is in violation of rules regarding self–administration.

(6) Provisions are made for health care staff to perform documented assessments of inmate compliance with self–administration medication regimens. Compliance evaluations are done with sufficient frequency to guard against hoarding medication and deterioration of the inmate's health.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1217. Psychotropic Medications.

The responsible physician, in cooperation with the facility administrator, shall develop written policies and procedures governing the use of psychotropic medications. An inmate found by a physician to be a danger to him/herself or others by reason of mental disorders may be involuntarily given psychotropic medication appropriate to the illness on an emergency basis. Psychotropic medication is any medication prescribed for the treatment of symptoms of psychoses and other mental and emotional disorders. An emergency is a situation in which action to impose treatment over the inmate's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

If psychotropic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition. The medication shall be prescribed by a physician in written form in the inmate's record or by verbal order in dosage appropriate to the inmate's need. Verbal orders shall be entered in the inmate's record and signed by a physician within 72 hours. The responsible physician shall develop a protocol for the supervision and monitoring of inmates involuntarily receiving psychotropic medication.

Psychotropic medication shall not be administered to an inmate absent an emergency unless the inmate has given his or her informed consent in accordance with Welfare and Institutions Code Section 5326.2, or has been found to lack the capacity to give informed consent consistent with the county's hearing procedures under the Lanterman–Petris–Short Act for handling capacity determinations and subsequent reviews.

There shall be a policy which limits the length of time both voluntary and involuntary psychotropic medications may be administered and a plan of monitoring and re–evaluating all inmates receiving psychotropic medications, including a review of all emergency situations.

The administration of psychotropic medication is not allowed for disciplinary reasons.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1218. Inmate Deaths.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1219. Suicide Prevention Program.

The facility administrator and the health authority shall develop a written plan for a suicide prevention program designed to identify, monitor, and provide treatment to those inmates who present a suicide risk.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1220. First Aid Kit(s).

First aid kit(s) shall be available in all facilities. The responsible physician shall approve the contents, number, location and procedure for periodic inspection of the kit(s). In Court and Temporary Holding facilities, the facility administrator shall have the above approval authority, pursuant to Section 1200 of these regulations.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

§ 1230. Food Handlers.

The responsible physician, in cooperation with the food services manager and the facility administrator, shall develop written procedures for medical screening of inmate food service workers prior to working in the facility kitchen. Additionally, there shall be written procedures for education and ongoing monitoring and cleanliness of these workers in accordance with Section 114020 of the Health and Safety Code, California Uniform Retail Food Facilities Law.

NOTE: Authority cited: Section 6030, Penal Code. Reference: Section 6030, Penal Code.

Division 3. Department of Corrections

Chapter 1. Rules and Regulations of the Director of Corrections

Subchapter 4. General Institution Regulations

Article 9. Mental Health Services

§ 3360. Availability of Mental Health Services.

(a) The department will provide a broad range of mental health services to inmates and parolees by assessing the needs of its population and developing specialized programs of mental health care, to the extent resources are available for this purpose. Necessary and appropriate mental health services will be provided to inmates and parolees, and adequate staff and facilities will be maintained for the delivery of such services.

(b) When an inmate is found to require mental health care not available within these resources, but which is available in the Department of Mental Health, the case will be referred to the director for consideration of temporary transfer to that department pursuant to Penal Code section 2684.

(c) Recognizing that many parolees have unique treatment needs not readily met by community mental health programs, and that the promptness and appropriateness of those needs affect public safety, the department provides outpatient clinics for parolees. These clinics are conducted in widely distributed locations throughout the state at times and places such that they are available to parolees, and that they shall maintain close working relationships with parole supervisors, paroling authorities, and the community in which the parolee resides.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Sections 2684 and 5054, Penal Code.

§ 3361. Responsibility.

(a) All required mental health treatment or diagnostic services shall be provided under the supervision of a psychiatrist licensed to practice in this state, or a psychologist licensed to practice in this state and who holds a doctoral degree and has at least two years of experience in the diagnosis and treatment of emotional and mental disorders. Facilities for mental health treatment and diagnostic services shall be under the direction of such a psychiatrist or psychologist. A psychiatrist shall be available to assume responsibility for all acts of diagnosis or treatment that may only be performed by a licensed physician and surgeon.

(b) When an inmate or an inmate's guardian or relative, or an attorney or other interested party desires to have an inmate examined by a private psychiatrist or other mental health professional, a request shall be submitted in writing by such person or persons to the warden. After consulting with the institution's chief psychiatrist or, in his absence, the chief medical officer, the warden will grant the request unless there are specific case factors which, in the judgment of the warden, warrant denial. If the request is denied, the person making the request will be notified in writing of the reason for the denial and the right to appeal the decision, to the director. Any financial responsibility or obligation for private consultants or examinations will be assumed by the inmate or the person requesting the service. Private consultants will not be permitted to order mental health treatment for any inmate. However, the private consultant may be asked to make a report of findings and recommendations to the warden.

(c) Recognizing that mental health care often involves revealing deeply personal and private matters, all mental health care shall be provided in such a manner as to maintain the dignity of the inmate. Professional relationships shall be conducted with proper privacy, with due regard to the professional to take necessary and appropriate action to prevent harm to the patient or to others. Records of mental health diagnosis, evaluation and treatment prepared or maintained by the department shall remain the property of the department and are subject to all applicable laws governing their confidentiality and disclosure. Treatment will be in accord with sound principles of practice and will not serve a punitive purpose.

NOTE: Authority cited: Sections 5058 and 5079, Penal Code. Reference: Section 5054, Penal Code.

§ 3362. Availability of Treatment.

All persons committed to the department shall be informed that mental health services are available to them. They shall be informed that, upon their request, an evaluative interview will be provided within a reasonable period of time by a licensed practitioner, or a specially trained counselor supervised by a licensed practitioner. Upon request, they will be provided with information as to what specialized treatment programs may be available in the department and how such treatment may be obtained.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3363. Right to Refuse Treatment.

Inmates/Parolees shall be informed any time they are the object of particular mental health diagnosis or treatment procedure. Such persons shall have the right to refuse assignment to such a program of diagnosis or treatment without being subject to discipline or other deprivation, except as indicated in the following:

(a) When mental health evaluation is required by law or ordered by a court.

(b) When an inmate is placed in a mental health program for diagnostic study by the action of a classification committee, which acted upon documented information or observations that gave reasonable cause to believe the inmate was suffering from a mental illness which poses a danger to self or others, or is gravely disabled. A physician or other licensed practitioner may act in an emergency situation to place an inmate in psychiatric segregation under observation and treatment for a period of up to five working days pending classification action, providing the reasons for this action are documented.

(c) When diagnostic study has led to a diagnosis of existing or recurrent mental illness which renders the inmate dangerous to self or others, or gravely disabled.

(d) If there is a special condition of parole requiring attendance at a parole outpatient clinic, interviews may be imposed upon the parolee. However, no medication will be administered by these clinics without the specific informed consent of the patient.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3364. Involuntary Medication.

(a) If medication used in the treatment of mental disease, disorder or defect is administered in an emergency, as that term is defined in section 3351, such medication shall only be that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the inmate. If it is determined that further administration of such medication involuntarily is necessary for a period of longer than 72 hours, the following provisions shall be followed:

(1) The administration of involuntary medication to inmates in excess of three days shall be in compliance with those procedures required in *Keyhea v. Rushen*, Solano County Superior Court No. 67432, Order Granting Plaintiffs' Motion for Clarification and Modification of Injunction and Permanent Injunction, filed October 31, 1986.

(2) The administration of involuntary medication to inmates in excess of ten days shall be in compliance with those procedures required in *Keyhea v. Rushen*, supra.

(3) The administration of involuntary medication to inmates in excess of 24 days shall be in compliance with those procedures required in *Keyhea v. Rushen*, supra. The judicial hearing for the authorization for the involuntary administration of psychotropic medication provided for in part III of *Keyhea v. Rushen*, supra, shall

be conducted by an administrative law judge. The hearing may, at the direction of the director, be conducted at the facility where the inmate is located.

(b) Involuntary antipsychotic medication shall not normally be administered to an inmate in his or her housing unit. An inmate shall normally be transferred to the hospital, clinic, emergency room or infirmary room at the institution prior to the administration of the medication. If a psychiatrist determines that the prior transfer of the inmate to such a setting would pose a greater risk to the inmate and staff than the risk involved to the inmate in receiving the medication in a non–medical setting, the involuntary medication may be administered in the inmate's cell, provided that:

(1) Medical staff shall alert security staff, orally and in writing, of the fact that such medication has been administered, of the date and time of administration, of possible side–effects, if any, which could develop, and shall provide security staff with instructions for contacting medical staff immediately upon the development of any such side effects. On–call medical staff shall make periodic observations of the inmate and shall respond to any emergency request for medical aid.

(2) In all cases where it is both feasible and medically desirable, a fast–acting medication shall be utilized to facilitate the inmate's rapid transfer to a medical setting.

(3) The inmate shall be considered for transfer from his or her cell to a medical setting at least once a day after the injection by a staff psychiatrist, or if a psychiatrist is not available by a staff physician, for the effective duration of the medication. The staff psychiatrist or physician shall note his or her observations and decision in writing. The inmate shall be transferred to a medical setting no later than 72 hours after the injection if the effective duration of the drug administered exceeds that time period.

(c) Each institution's chief psychiatrist, or in his or her absence, chief medical officer, shall ensure that a log is maintained in which is recorded each occasion of involuntary treatment of any inmate. The log entries shall identify the inmate by name and number, and shall include the name of the ordering physician, the reason for medication, and the time and date of medication. In institutions with a designated psychiatric treatment unit, a separate log shall be maintained for recording involuntary treatment and medication administered to inmates in that unit. The log shall be reviewed by the institution's chief psychiatrist, or in his or her absence, the chief medical officer, at least monthly. Such logs shall be made available for review by the departmental medical director upon request.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Sections 2600 and 5054, Penal Code; *Whitaker v. Rushen, et al.*, USDC No. C–81–3284 SAW (N.D. Cal.); and *Keyhea v. Rushen*, Solano County Superior Court No. 67432, Order Granting Plaintiffs' Motion for Clarification and Modification of Injunction and Permanent Injunction, filed October 31, 1986.

§ 3365. Suicide Prevention and Response.

(a) Each institution head shall ensure that all employees whose assignments routinely involve inmate contact are trained to recognize signs and symptoms associated with suicide risk, the appropriate procedures for staff intervention, and the appropriate procedures to be followed in response to emergency situations resulting from self–injurious or suicidal actions. This training shall be conducted as in–service training, in compliance with Section 3435.

(b) Each institution head shall implement a Suicide Prevention Program for inmates who display self–injurious or suicidal behavior or symptoms. These programs shall include the following components:

(1) Suicide Watch. When medical staff determine that an inmate is actively suicidal, a licensed physician or psychologist shall order placement of the inmate on suicide watch in a General Acute Care Hospital (GACH), Correctional Treatment Center (CTC), Skilled Nursing Facility (SNF), Outpatient Housing Unit (OHU), or other appropriate health care facility, for continual observation.

(2) Suicide Precaution. When medical staff determine that an inmate is at high risk of attempting self–injurious behavior, a licensed physician or psychologist shall order placement of the inmate on suicide precaution in a GACH, CTC, SNF, OHU, or other appropriate health care facility, for periodic monitoring.

(3) Follow–up Treatment. Discharge from suicide watch or suicide precaution shall occur when an interdisciplinary team of clinicians determines that the inmate no longer presents a suicide risk. A written treatment plan and follow–up outpatient treatment shall be provided by a mental health clinician.

(c) When a suicide attempt is discovered in progress, medical assistance shall be summoned immediately to provide emergency medical care. Security and safety procedures shall be followed, including the use of required equipment and procedures to deal with bodily fluids. A cut–down kit shall be immediately accessible on each unit and shall be used by staff in case of an attempted suicide by hanging. All subsequent activities and procedures shall comply with local institutional emergency plans, as developed in compliance with Section 3301.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3366. Mental Health Advisory Board.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3367. Psychosurgery.

Psychosurgery, including lobotomy, stereotactic surgery, chemical or other destruction of brain tissue, or implantation of electrodes into brain tissue, is not and will not be performed on persons committed to or in the custody of the Department of Corrections.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3368. Aversive Therapy.

The use of any drug, electronic stimulation of the brain, or infliction of physical pain when used as an aversive or reinforcing stimulus in a program of aversive, classical or operant conditioning is not and will not be performed on persons committed to or in the custody of the Director of Corrections. Nothing in this section prohibits the administration of drugs intended to cause negative physical reactions to the ingestion of alcohol or drugs unless part of a program of aversive conditioning.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3369. Shock Therapy.

(a) Shock therapy is the only form of organic therapy, as defined by law, which may be used in the treatment of persons committed to the custody of the Director of Corrections. No inmate who is competent and capable of giving informed consent will be administered any form of shock therapy without having given his or her consent. Prior authorization of a superior court is also required before shock therapy may be administered for any treatment purpose other than as an emergency lifesaving measure.

(1) Shock therapy as a lifesaving emergency medical measure may be administered to an inmate who is competent and capable of giving informed consent and who has given consent, or an inmate who is incompetent or incapable of giving informed consent, without prior court authorization. However, all pertinent clinical data relating to the nature of the emergency and the treatment given will be presented to the court for review within 10 days of the first instance of emergency shock treatment.

(2) When an inmate is competent and capable of giving informed consent and has done so, and the court has authorized such treatment, shock therapy may be administered in a nonemergency course of treatment. No form of shock therapy may exceed three months of continuous treatment nor more than three months in any 12–month period.

(b) Informed Consent. The term, "Informed Consent," means that a person must knowingly and intelligently, without duress or coercion, and clearly and explicitly consent to the proposed shock therapy. The inmate's consent must be given in writing and in the presence of the attending physician. It must be preserved and be available to the inmate, the inmate's attorney, guardian, or conservator.

(c) Determining Need. If the attending physician determines that shock therapy is required for the health and safety of the inmate, permission may be requested of the warden or superintendent to administer the therapy.

(1) The warden or superintendent will appoint a committee of physicians, two of whom are board certified or eligible for board certification in psychiatry or neurosurgery, to review the inmate's treatment record and the determination of the attending physician. At least one of the attending physicians must not be a full–time employee of the department.

(2) Before shock treatment may be administered, this committee must unanimously agree with the attending physician's determination that it is required and, if it is to be performed under the provisions of subsection (b), that the inmate has the ability to give informed consent and has in fact given informed consent.

(d) Withdrawal of Consent. Any inmate who has given informed consent may withdraw it at any time. The shock therapy must cease immediately.

(e) Court Petition.

(1) An inmate, or inmate's attorney, guardian or conservator may file a petition with the superior court of the county in which the inmate is confined for an order to prohibit the administration of shock therapy upon the inmate. This petition must be served by the county clerk upon the warden or superintendent on the same day it is filed and constitutes a refusal of consent or withdrawal of any prior consent.

(2) The warden or superintendent has 10 days to file a response to the petition. The superior court may grant a continuance of 10 additional days. The response must be served upon the inmate, and upon the inmate's attorney, guardian or conservator on the same day it is filed with the clerk of the superior court.

(f) Correspondence Regarding Shock Therapy. The inmate is entitled to communicate in writing with his or her attorney, and by writing or visits with his or her parents, guardian or conservator regarding any proposed administration of shock therapy or organic therapy. Any mail regarding shock therapy will not be prevented from leaving the institution.

(g) Incapable of Informed Consent.

(1) If the inmate is incapable of giving informed consent to a program of shock therapy, and the attending physician believes that such treatment is required for the health and safety of the inmate, the attending physician may request the permission of the warden or superintendent. If the warden or superintendent agrees with the request and the committee, appointed pursuant to subsection (c)(1), also unanimously agrees that such therapy is required, the warden or superintendent will forward the request to the Chief, Medical Services for review and recommendation to the director. If the director concurs in the course of treatment, the warden or superintendent will petition the superior court for permission to conduct the hearing. No treatment will be conducted until after a hearing at which the inmate is represented by counsel and after a court order authorizing the treatment is issued.

(2) In an extraordinary case, the attending physician may determine that shock treatment is required for a longer period of time than three months, or more frequently than three months in the period of one year. The same procedures as in paragraph (1) of this subsection will be followed before any further shock therapy will be administered.

(h) Inmate Rights. If the attending physician determines that an inmate should be administered shock therapy, the inmate will be informed of his or her rights under this article. A copy of Penal Code Sections 2670 through 2680 will be made and will be given to the inmate at that time.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Section 5054, Penal Code.

§ 3369.1. Inmate/Parolee Placements in Department of Mental Health Hospitals.

(a) Inmates considered for placement in a Department of Mental Health hospital pursuant to Penal Code section 2684 shall be informed of their rights to a hearing on the placement and to waive such a hearing. Except as provided in (b) below, inmates who do not waive their right to the hearing shall be provided the following:

(1) A written notice of the placement hearing at least 72 hours prior to the hearing.

(2) An independent and qualified staff member to assist the inmate with their preparation for the hearing. Any costs or expenses incurred related to independent assistance obtained by the inmate on their own shall be the sole responsibility of the inmate.

(3) An opportunity to present documentary evidence and the oral or written testimony of witnesses, and to refute evidence and cross examine witnesses unless the hearing officer indicates a good cause for prohibiting such evidence or witnesses.

(4) A hearing officer who shall be the institution head or a designee which shall be a correctional administrator, physician, psychiatrist, or psychologist who is not involved with treating the inmate.

(5) A copy of the written decision within 72 hours after the hearing which shall include the reason for the decision and the evidence relied upon in making the decision.

(b) Inmates and parolees who require emergency psychiatric hospitalization shall be entitled to a certification review hearing pursuant to Welfare and Institutions Code section 5256 at the Department of Mental Health hospital in lieu of the above hearing and waiver requirements.

(c) Inmates and parolees housed in Department of Mental Health hospitals remain under the jurisdiction of the department and shall not be permitted to leave the hospital grounds without the specific authorization of the director.

NOTE: Authority cited: Section 5058, Penal Code. Reference: Sections 5150 and 5250 through 5256, Welfare and Institutions Code; Sections 2684, 2974 and 5054, Penal Code; and Vitek v. Jones (1980) 445 U.S. 480, 100 S.CT. 1254.

Division 4. Department of the Youth Authority

Chapter 3. Institutions and Camps Services

Subchapter 3. Services to Wards

Article 1. Medical and Dental Services

§ 4730. Medical and Dental Treatment.

Medical and dental treatment shall be provided Youth Authority wards according to the following guidelines:

(a) Emergencies, acute illnesses, and traumatic conditions of recent origin shall be treated promptly.

(b) Emergent conditions shall be treated when such treatment is indicated for the welfare of the individual in order to preserve health, prevent permanent disability, or prevent permanent impairment of the health and welfare of the ward. In borderline cases, health care decisions shall be based upon the judgment of the physician or the dentist acting in accordance with the guidelines for the Utilization Review Committee.

(c) Ongoing medical treatment which is necessary for the maintenance of health, including the treatment of chronic conditions such as diabetes mellitus or epilepsy, shall be provided.

(d) Significant functional defects, which would include those incurred prior to Youth Authority commitment or while in a Youth Authority facility, may be corrected if:

(1) There is marked functional disability, or

(2) The delay in the correction of such a disability would result in further loss of function or health impairment.

(e) A ward requiring extensive or long–term medical, surgical, or psychiatric treatment shall, when possible, be considered for return to the committing county or home environment for such care.

(f) Correction of cosmetic defects shall not be provided except where there is marked clinical evidence and expectation that the ward's physical and psychological state may be greatly benefited by the correction of such cosmetic defect.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752, 1755.3 and 1755.5, Welfare and Institutions Code.

§ 4731. Treatment Centers.

NOTE: Authority cited: Sections 1001, 1002, 1004, 1711.3 and 1751, Welfare and Institutions Code. Reference: Sections 1002, 1711.3, 1752, 1755.3 and 1755.5, Welfare and Institutions Code.

§ 4732. Medical and Dental Examination.

(a) A ward shall receive a complete baseline health evaluation, including a dental examination, and the physician shall record in the ward's medical record the following:

(1) The ward's complete medical history.

(2) Medical findings.

(3) Treatment recommendations.

(b) (Reserved)

(c) A physical examination for a parole violator returned to a reception center and clinic:

(1) Shall consist of an interval history and physical examination when the previous medical record is available and when, in the judgment of the chief medical officer, the previous information is sufficient.

(2) Shall consist of a complete history, physical examination and laboratory tests when the medical record is not available.

(d) A ward scheduled for transfer to a camp shall be examined to determine fitness and shall receive priority for the necessary dental and/or medical treatment to prepare the ward for camp clearance. The ward may be held for completion of such treatment before being transferred to a camp.

(e) A ward returning to a facility after furlough or escape shall not be permitted to come in contact with other wards until he or she has been examined for infectious diseases and cleared by medical staff.

(f) A ward shall have a physical examination prior to being assigned to work as a food handler or in food service areas.

(g) A ward shall receive a physical examination, and the medical and dental staff shall review his or her medical and dental records upon notification of a projected date for release to parole. When a ward with a disability, illness, or condition requiring continuous medical treatment and medication is released to parole, the chief medical officer shall approve the provision of a 30 day supply of the required medication. For those wards prescribed psychotropic medications that could pose a serious health risk if taken in a suicide attempt, the chief medical officer shall approve the provision of a three (3) day supply of medication and a 15 day prescription. This section does not authorize the dispensing of Drug Enforcement Administration regulated medication or other drugs of high abuse potential unless withdrawal could create side effects.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4733. Consent for Medical or Dental Treatment.

(a) Consent shall be obtained for all medical or dental treatment. Treatment and procedures which are complex, as identified by the physician or dentist, and psychotropic medication require informed consent. Informed consent is defined as consent which is obtained without duress or coercion and which clearly and explicitly manifests consent to the proposed medication, treatment or procedure in writing.

(b) A ward 18 years of age or older, or a ward who has emancipated minor status, who is competent to make an informed decision, may give his or her own consent for medical or dental treatment.

(c) A ward 18 years of age or older or a ward who has emancipated minor status, who is not competent to give informed consent, is a ward, who in the professional opinion of a physician or psychiatrist, is considered incompetent to refuse psychiatric treatment or psychotropic medication, or lacks the capacity to refuse medical or dental treatment, or medication. This includes a ward who lacks the ability to knowingly and intelligently act upon the medical information provided.

(d) For a ward under 18 years of age, who legally cannot give informed consent, medical or dental treatment shall be given as follows:

(1) Primary care treatment may be approved by the superintendent in the event that a parent or guardian cannot be located.

(2) Complex treatment, as identified by the physician or dentist, or psychotropic medication for wards under 18 require informed consent from a parent or guardian.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4734. Refusal of Medical or Dental Treatment.

(a) A ward, or a parent or guardian if the ward is under 18 years of age, may refuse medical, surgical, mental and/or dental treatment, including the administration of medication; and if the treatment is accepted, may revoke that acceptance at any time in the future. However, necessary medical or dental treatment may be administered to a ward, either an adult or a minor, without consent, or in the absence of a parent or guardian's consent and against his or her will and in accordance with Section 4735. Involuntary psychotropic medication may be administered in accordance with Article 1.5, Section 4747.

(b) The Youth Authority physician or dentist shall explain the consequences of the refusal to the ward or a parent or guardian if the ward is under 18 and record the refusal in the medical record, including a statement of the possible consequences if the medical, surgical, mental and/or dental treatment is not administered.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4735. Compulsory Medical or Dental Treatment.

(a) Authorization may be sought from a court to compel necessary medical and/or dental treatment for a ward 18 years of age or older or for a ward under 18, when a parent or guardian refuses to consent or is not available if:

(1) In the professional opinion of the treating physician, the treatment is immediately necessary for the prevention of death or severe physical disability to the ward in question, or

(2) In the opinion of the chief medical officer and the chief of the health care services division, there would be a resultant danger to the welfare and/or safety of the institution and/or staff or wards as a result of the refusal.

(b) Medical or dental treatment, as defined in subsection (a)(1) and (a)(2) may be initiated immediately and continued pending resolution by the court.

(c) Involuntary psychotropic medication may be administered in accordance with Article 1.5, Section 4747.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4739. Off–Site Medical and Dental Treatment.

Off–site health care services may be provided when emergency or other necessary medical, surgical, mental, or dental treatment cannot be provided at a Youth Authority facility. The chief medical officer shall arrange to send the ward to a medical facility with which a contract has been negotiated for emergency and inpatient service, unless the Emergency Medical System makes the decision as to the receiving hospital.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752, 1755.3, 1755.5 and 1756, Welfare and Institutions Code.

Article 1.5. Mental Health

§ 4742. Availability of Mental Health Services.

(a) The Department shall provide wards, who have been diagnosed by a Youth Authority Global Assessment of Function (YA–GAF) as having a mental disorder, with available mental health treatment services.

(b) Mental health services shall be provided in a manner consistent with the community standards of mental health care.

(c) The goal shall be to achieve a standardized and integrated system of care designed to augment current treatment programs and to create a continuum of services as follows:

(1) Treatment in a Correctional Treatment Center (CTC), which provides licensed hospital inpatient acute and nonacute care.

(2) Treatment in an Intensive Treatment Program (ITP), which provides residential intensive treatment.

(3) Treatment in a Special Counseling Program (SCP) which provides residential specialized counseling services and therapy.

(4) Treatment while housed in a general population program, which provides therapy with a psychiatrist or psychologist.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4743. Mental Health Records.

(a) The Unified Health Record is the official and chronological record of mental health treatment and shall be used to document that appropriate care has been delivered.

(b) The Unified Health Record shall be subject to the Information Practices Act of 1977 of the Civil Code, Sections 1798–1798.82 of Chapter 1 governing confidentiality and disclosure.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4744. Suicide Prevention, Assessment, and Response.

(a) The superintendent of each facility shall establish a suicide prevention, assessment, and response policy that is consistent with the following elements:

(1) Identification and screening based on a file review and a face–to–face interview with each ward upon intake at each reception center and clinic, institution, or camp.

(2) Assessment and referral to include:

(A) Referral of any potentially suicidal ward to the appropriate mental health professional.

(B) Assessment of the ward's suicidal status at each progress case conference.

(C) Immediate referral to the appropriate mental health professional for any ward who appears to need intervention.

(3) Crisis management based on direct daily contact with wards and skills in observation and awareness of changes in mood or behavior.

(4) Immediate intervention after direct visual evidence of a suicide attempt, a suicide threat, or indications of suicidal ideation.

(5) Monitoring guidelines for actively suicidal wards to include:

(A) Constant sight supervision by staff on a one–on–one basis unless video monitoring is available.

(B) Personal and verbal contact at no more than 15 minute intervals with documentation of each 15 minute check.

(C) A determination by the appropriate mental health professional of the level of housing, supervision, and programming necessary to effectively manage the crisis. The decision to remove a ward from suicide watch is to be made only by a designated psychiatrist or psychologist.

(6) Training for all staff in the recognition of signs of suicidal ideation or intent and suicide prevention.

(A) Orientation for all volunteers and others working with wards in the recognition of suicidal ideation or intent.

(B) Annual training for mental health professionals designated as the primary caregiver for suicidal wards.

(7) Standardized reporting and collection of data regarding suicide threats, gestures, and attempts with review by a Suicide Prevention and Review Committee at each institution and a Branch Committee.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4745. Youth Authority Global Assessment of Functioning (YA–GAF).

(a) The YA–GAF is the primary diagnostic assessment of mental disorder for Youth Authority wards and the basis for assignment to mental health treatment programs.

(b) The YA–GAF shall:

(1) Describe symptoms and behavior unique to adolescent and young adult wards in Youth Authority facilities.

(2) Identify wards who will receive the most benefit from the mental health treatment programs.

(3) Identify wards who are not appropriate for the mental health treatment programs and who require an alternative approach.

(4) Ensure a consistent screening for mental health treatment programs through the use of a standardized YA–GAF screening form, YA 8.216 (Revised 2/01).

(c) The YA–GAF screening shall consist of a face–to–face assessment of wards by a trained team of two mental health professionals, one of whom must be a clinical psychologist or psychiatrist.

(d) Oversight of the YA–GAF screening process shall be provided by a Utilization Review Panel at each facility, which shall review a random sample of at least two YA–GAF screenings every 30 days.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4746. Psychotropic Medication.

(a) Psychotropic medication shall be ordered and administered

only after a psychiatrist, in consultation with the treatment team, has evaluated the ward, arrived at a differential diagnosis, and concluded that the ward would benefit from a psychotropic medication.

(b) The psychotropic medication shall be justified with a YA–GAF evaluation and a full and proper Diagnostics and Statistics Manual IV (DSM IV) diagnosis with linkage for a specific effect to the mental health diagnosis in Axis I or the behavioral diagnosis in Axis II

(c) All psychotropic medication shall be administered by directly observed therapy by nursing personnel and shall be properly recorded in the Unified Health Record.

(d) Informed consent shall be obtained for the administration of voluntary psychotropic medication in accordance with Article 1, Section 4733.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code.

§ 4746.5. Voluntary Psychotropic Medication to Minors.

(a) Voluntary psychotropic medication may be administered to a minor committed to the Youth Authority only for treatment of signs and symptoms of a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (2000) (DSM–IV–TR tm), diagnosis with linkage for a specific effect to the mental health diagnosis in Axis I or the behavioral diagnosis in Axis II.

(b) In order to administer psychotropic medication to minors committed to the Department informed consent shall be obtained in accordance with Article 1, Section 4733. If the Department is unable to locate a parent or legal guardian to receive informed consent, voluntary psychotropic medication may be administered under the following circumstances:

(1) When two physicians have reviewed the need and agree that it is medically appropriate, and

(2) When the minor agrees to the administration of psychotropic medication and an Application for Order for Psychotropic Medication–Juvenile (Judicial Council form JV 220 (New 1/1/01)) is filed with the juvenile court of commitment.

(c) If the medication is administered according to the above procedures and the court denies the Application for Order, the medication shall terminate. The termination of medication shall be done in keeping with medical standards.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752, 1753.3 and 1755.4, Welfare and Institutions Code.

§ 4747. Involuntary Psychotropic Medication.

(a) Involuntary psychotropic medication may be administered in an emergency. An emergency exists when:

(1) There is a marked change in the ward's condition that indicates that action is immediately necessary for the preservation of life or the prevention of bodily harm to self or others, and

(2) It is impracticable or impossible to obtain informed consent.

(b) The administration of psychotropic medication in an emergency shall be only that which is required to treat the emergency condition and shall be provided in ways which are the least restrictive to the personal liberty of the ward.

(c) The administration of psychotropic medication in an emergency may be continued for 72 hours on the order of the psychiatrist or physician.

(d) The chief medical officer at each facility shall ensure that a log is maintained in which each occasion of involuntary psychotropic medication is recorded for each ward.

(1) The log shall identify the ward by name and number, and shall include the name of the ordering physician, the reason for medication and the time and date of medication.

(2) The log shall be reviewed by the chief medical officer at least monthly and shall be made available for review by the chief of the health care services division upon request.

(e) The administration of involuntary psychotropic medication in excess of 72 hours for wards 18 years of age or older or emancipated minors shall be prohibited unless such wards are provided with the protections required in Keyhea v. Rushen, Solano County Superior Court No. 67432, Order Granting Plaintiffs Motion for Clarification and Modification of Injunction and Permanent Injunction, filed October 31, 1986.

(1) The administration of involuntary psychotropic medication in excess of ten days shall be prohibited unless such wards are provided with the protections required in Keyhea v. Rushen, supra.

(2) The administration of involuntary psychotropic medication in excess of 24 days shall be prohibited unless such wards are provided with the protections required in Keyhea v. Rushen, supra.

(A) The judicial hearing for the authorization for the involuntary administration of psychotropic medication provided for in part III of Keyhea v. Rushen, supra, shall be conducted by an administrative law judge.

(B) The judicial hearing may, at the direction of the director, be conducted at the facility where the ward is located.

(f) The administration of involuntary psychotropic medication in excess of the 72 hours for wards under the age of 18 who are not emancipated minors shall be in accordance with the following and shall occur only when a parent or guardian denies consent as defined in Article 1, Section 4733 or when a parent or guardian is not available:

(1) If consent is denied by a parent or guardian and the ward meets the criteria identified in Keyhea v. Rushen, supra, the procedures in subsection (c)(1) through (c)(4) shall be initiated.

(2) If consent is denied by a parent or guardian and the ward does not meet the criteria identified in Keyhea v. Rushen supra but has a diagnosed mental health condition that would benefit from psychotropic medication, medication shall not be administered. Psychotherapy shall be initiated and the progress and outcome recorded in the Unified Health Record.

(3) If the parent or guardian is not available and the ward meets the criteria identified in Keyhea v. Rushen, supra, the procedures in subsection (c)(1) through (c)(4) shall be initiated.

(4) If the parent or guardian is not available and the ward does not meet the criteria identified in Keyhea v. Rushen, supra, consultation from a community psychiatrist shall be obtained. Administration of psychotropic medication shall be based on the recommendation of the community psychiatrist.

NOTE: Authority cited: Section 1712, Welfare and Institutions Code. Reference: Sections 1001, 1002, 1004, 1752 and 1755.3, Welfare and Institutions Code; *Keyhea* v. *Rushen*, Solano County Superior Court No. 67432, Order Granting Plaintiffs' Motion for Clarification and Modification of Injunction and Permanent Injunction, filed October 31, 1986.

TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS

Division 13.1. Board of Psychology

Article 1. General Provisions

§ 1380. Citation and Authority.

This chapter may be cited and referred to as the "Psychology Regulations."

NOTE: Authority and reference cited: Section 2930, Business and Professions Code.

§ 1380.1. Location of Principal Office.

The principal office of the Board of Psychology is located at 1422 Howe Avenue, Suite 22, Sacramento, California 95825–3200.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2930, Business and Professions Code.

§ 1380.2. Tenses, Gender and Number.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1380.3. Definitions.

For the purpose of the regulations contained in this chapter, the term "board" means the Board of Psychology, and the term "code" means the Business and Professions Code.

NOTE: Authority and reference cited: Section 2930, Business and Professions Code.

§ 1380.4. Delegation of Functions.

Except for those powers reserved exclusively to the "agency itself " under the Administrative Procedure Act (section 11500 et seq. of the Government Code), the board delegates and confers upon the executive officer for the board, or in his or her absence, the chairperson of the board, or in his or her absence, the vice chairperson of the board, all functions necessary to the dispatch of business of the board in connection with investigative and administrative proceedings under the jurisdiction of the board.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2928 and 2965, Business and Professions Code; and Section 11500, Government Code.

§ 1380.5. Filing of Address.

Each person holding a license as a psychologist shall file with the board his proper and current mailing address, and shall report immediately to the board at its Sacramento office any and all changes of address, giving both his old and new address.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2982, Business and Professions Code.

§ 1380.6. Display of License Number.

Pursuant to Section 137 of the code, every licensed psychologist shall include his or her number in any advertising, public directory or solicitation, regardless of whether such a presentment is made under the licensee's own name, a fictitious business or group name or a corporate name.

This requirement shall not apply to psychologists practicing in governmental organizations, nonprofit organizations which are engaged in research, education or services which services are defined by a board composed of community representatives and professionals.

NOTE: Authority cited: Sections 137 and 2930, Business and Professions Code. Reference: Section 137, Business and Professions Code.

§ 1380.7. Declaratory Decisions.

No decision or opinion issued by the Board of Psychology is a declaratory decision under Government Code Sections 11465.10–11456.70 unless the decision or opinion specifically states that it is a "Declaratory Decision".

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 11465.10–11465.70, Government Code.

§ 1380.10. Emergency Meetings and Additions to Meeting Agendas.

NOTE: Authority cited: Section 2930, Business and Professions Code.

Article 1.5. Psychological Assistants

Article 2. Applications

§ 1381. Applications

All applications shall be accompanied by such evidence, statements or documents as therein required to establish that the applicant meets all of the requirements for licensing or registration as set forth in the code.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2940 and 2941, Business and Professions Code.

§ 1381.1. Abandonment of Applications.

An application shall be denied without prejudice when, in the discretion of the board, an applicant does not exercise due diligence in the completion of his or her application, in furnishing additional information or documents requested or in the payment of any required fees.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2940, Business and Professions Code.

§ 1381.2. Petition for Hearing.

An applicant for examination or licensure whose credentials indicate ineligibility shall be notified of the deficiency. The applicant may correct the deficiency indicated or in the alternative file a request for hearing before the appropriate committee.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2940, Business and Professions Code.

§ 1381.3. Appearances Before the Committee.

§ 1381.4. Failure to Appear for Examination—Withdrawal of Application.

Any applicant approved to take or retake a board licensing examination who fails to appear for such examination in any twelve month period shall have his or her application withdrawn. An applicant who subsequently decides to take the examination shall be required to file a new application and pay the current application and examination fees.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2914, 2931, 2940, 2941, and 2942, Business and Professions Code.

§ 1381.5. Failure to Pay Initial License Fee.

An application shall be deemed to have been abandoned if an applicant fails to pay the initial license fee within three years after notification by the board. An applicant whose application has been deemed abandoned may again be eligible for licensure upon the filing of a new application and upon meeting the requirements set forth in section 1388.6(e) of these regulations.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2940 and 2983, Business and Professions Code.

§ 1381.6. Permit Processing Times.

"Permit" as defined by the Permit Reform Act of 1981 means any license, certificate, registration permit or any other form of authorization required by a state agency to engage in a particular activity or act. Processing times for the board's various programs are set forth below. The actual processing times apply to those applicants who have passed all appropriate examinations.

Program	*Maximum time for notifying the applicant, in writing, that the application is complete and accepted for filing, or that the application is deficient and what specific information is required*	*Maximum time after receipt of a complete application to issue or deny license*	*ACTUAL PROCESSING TIMES FOR ISSUANCE OF A LICENSE BASED ON PRIOR TWO YEARS*		
			Minimum	*Median*	*Maximum*
Psychological Assistants	60	60	31	69	202
Psychologists	60	180	102	403	1,832
Registered Psychologists	180	–0– (Retroactive approval to date of completion)	1	15	216

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 15736, Government Code.

Article 3. Education and Experience

§ 1382. Human Sexuality Training.

Unless otherwise exempted, all persons applying for a license as a psychologist shall, in addition to all other requirements for licensure, have completed coursework or training in human sexuality which meets the requirements of this section. Such training shall:

(a) Be completed after January 1, 1970.

(b) Be obtained

(1) In an accredited or approved educational institution, as defined in section 2901 of the Code, including extension courses offered by such institutions, or

(2) In an educational institution approved by the Department of Education pursuant to section 94310 of the Education Code, or

(3) From a continuing education provider approved by a professional association, or

(4) In a course sponsored or offered by a professional association, or

(5) In a course sponsored, offered or approved by a local, county or state department of health or mental health or by health agencies of the Federal Government.

(c) Have a minimum length of ten (10) contact hours.

(d) Include the study of physiological–psychological and social–cultural variables associated with sexual identity, sexual behavior or sexual disorders.

All applicants shall provide the board with documentation of completion of the required human sexuality training.

It is the intent of the board that all persons licensed to practice psychology have minimal training in human sexuality. It is not intended that by complying with the requirements of this section only, a practitioner is fully trained in the subject of sex therapy.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 25, Business and Professions Code.

§ 1382.1. Human Sexuality Training Required for Licensees.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 25, Business and Professions Code.

§ 1382.2. Exemption from Human Sexuality Training Requirement.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 25, Business and Professions Code.

§ 1382.3. Training in Alcoholism/Chemical Dependency Detection and Treatment.

The requirements set forth in Section 2914 (e) of the code shall be satisfied by completion of a graduate level course which meets the following criteria:

(a) The course shall be devoted solely to the topic of alcoholism and chemical dependency detection and treatment and shall not be less than a semester or a quarter term in length.

(b) The course must be obtained at an educational institution, or in an extension course offered by an institution, which is either credited under Education Code Section 94310.1, or approved under Education Code Section 94310.2, by the State Department of Education.

(c) An original transcript indicating successful completion of the course shall be deemed sufficient evidence for purposes of satisfying this requirement.

(d) The course shall include training in each of the following subjects as they relate to alcoholism and chemical dependency:

(1) The definition of alcoholism and other chemical dependency, and the evaluation of the user.

(2) Current theories of, and research on, the etiology of substance abuse.

(3) Physiological and medical aspects and effects of alcoholism and other chemical dependency.

(4) Psychopharmacology and the interaction of various classes of drugs, including alcohol.

(5) Diagnosing and differentiating alcoholism and substance abuse in patients referred for other clinical symptoms, such as depression, anxiety, psychosis, and impotence.

(6) Populations at risk with regard to substance abuse.

(7) Cultural and ethnic considerations.

(8) Prenatal effects.

(9) Adolescent substance abuse.

(10) Implications for the geriatric population.

(11) Iatrogenic dependency.

(12) Major treatment approaches to alcoholism and chemical dependency, including research and application.

(13) The role of persons and systems which support or compound abuse.

(14) Family issues which include treatment approaches with families of alcoholics and/or substance abusers.

(15) The process of referring affected persons.

(16) Community resources offering assessment, treatment and follow-up for the abuser and family.

(17) Ethical and Legal issues for clinical practice.

(18) Prevention of substance abuse.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914(e), Business and Professions Code.

§ 1382.4. Child Abuse Assessment Training Requirements.

All persons applying for a license or renewal of a license as a psychologist shall in addition to all other requirements for licensure, have completed coursework or training in child abuse assessment and reporting and shall submit documentation thereof to the board. The coursework or training in child abuse assessment and reporting shall consist of not less than 7 instructional hours and shall include training in each of the subject areas described in section 28 of the Code. The coursework or training shall be:

(a) Obtained at an educational institution, or in an extension course offered by an institution which is accredited by the Western Association of Schools and Colleges, the Northwest Association of Secondary and Higher Schools, or an essentially equivalent accrediting agency as determined by the board or approved by the State Department of Education pursuant to section 94310.2 of the Education Code; or

(b) Obtained from a statewide professional association representing the professions of psychology, social work, or marriage, family and child counseling; or

(c) Obtained from or sponsored by a local county, state or federal governmental entity.

(d) Completed after January 1, 1983.

NOTE: Authority cited: Sections 28 and 2930, Business and Professions Code. Reference: Section 28, Business and Professions Code.

§ 1382.5. Spousal or Partner Abuse Assessment, Detection, and Intervention Strategies Training Requirements.

All persons applying for a license as a psychologist who began their graduate training on or after January 1, 1995 shall, in addition to all other requirements for licensure, have completed coursework in spousal or partner abuse assessment, detection, and intervention strategies and shall submit documentation thereof to the board. The coursework in spousal or partner abuse assessment, detection, and intervention strategies shall consist of not less than a combined total of two (2) hours focused on this topic. All persons applying for a license as a psychologist who began their graduate training on or after January 1, 2004 shall also meet the above requirement, however, such course shall consist of at least fifteen (15) contact hours.

The coursework shall be:

(a) taken in fulfillment of other educational requirements in the applicant's graduate and/or doctoral training, or

(b) taken in a separate course approved by the board's recognized continuing education accrediting agency, or

(c) taken in a separate course provided by a sponsor approved by the American Psychological Association.

(d) completed after January 1, 1995.

An applicant may request an exemption from this requirement if he or she intends to practice in an area that does not include the direct provision of mental health services.

NOTE: Authority cited: Sections 2914(f) and 2930, Business and Professions Code. Reference: Section 2914(f), Business and Professions Code.

§ 1382.6. Aging and Long–Term Care Training Requirements.

All persons applying for a license as a psychologist who began their graduate training on or after January 1, 2004, shall, in addition to all other requirements for licensure, have completed coursework in aging and long–term care which shall include but not be limited to the biological, social, and psychological aspects of aging, and shall submit documentation thereof of the board. The coursework in aging and long–term care shall consist of not less than a combined total of ten (10) contact hours focused on this topic.

The coursework shall be:

(a) taken in fulfillment of other educational requirements in the applicant's graduate and/or doctoral training, or

(b) taken in a separate course approved by the board's recognized continuing education accrediting agency, or

(c) taken in a separate course provided by a sponsor approved by the American Psychological Association.

(d) completed after January 1, 2004.

NOTE: Authority cited: Section 2915.5 and 2930, Business and Professions Code. Reference: Section 2915.5, Business and Professions Code.

§ 1383. Comparable Programs.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1383.1. Criteria for Approval of Comparable Programs.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1383.2. W.A.S.C. Accreditation.

§ 1384. Criteria for Evaluation of Equivalent Education.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1384.5. Effect of Revised Criteria for Evaluation of Equivalent Education.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1384.6. Revised Criteria for Evaluation of Education.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1384.7. Original Research Dissertation Requirement Defined.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1385. Foreign Graduates.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2914 and 2940, Business and Professions Code.

§ 1386. Revised Criteria for Evaluation of Education.

(a) Only those doctorate degrees which are designated as being earned in a department or school of psychology, educational psychology or education with the field of specialization in counseling psychology or educational psychology shall be accepted as an earned doctorate degree as specified in section 2914, subdivisions (b)(1) through (3), of the code. If it is not evident on the official transcript, the board may require that any doctorate degree earned in education with the field of specialization in counseling psychology or educational psychology be certified by the registrar as such a degree.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1386.5. Effect of Revised Criteria for Evaluation of Experience.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1387. Supervised Professional Experience.

This section applies to all trainees, pre– or post–doctoral, who intend for hours of supervised professional experience (SPE) to count toward meeting the licensing requirement stated in section 2914(c) of the Business and Professions Code. Those trainees accruing hours of supervised experience in areas of psychology that do not include direct mental health services should refer to section 1387.3 for information on establishing an alternate plan for SPE.

SPE is defined as an organized program that consists of a planned, structured and administered sequence of professionally supervised comprehensive clinical training experiences. SPE shall have a logical

training sequence that builds upon the skills and competencies of trainees to prepare them for the independent practice of psychology once they become licensed.

SPE shall include socialization into the profession of psychology and shall be augmented by integrated modalities including mentoring, didactic exposure, role–modeling, enactment, observational/vicarious learning, and consultative guidance.

SPE shall include activities which address the integration of psychological concepts and current and evolving scientific knowledge, principles, and theories to the professional delivery of psychological services to the consumer public.

SPE shall include only the time spent by the trainee engaged in psychological activities that directly serve to prepare the trainee for the independent practice of psychology once licensed. SPE shall not include custodial tasks such as filing, transcribing or other clerical duties.

The term "formal internship" as used in these regulations means a placement which is accredited by the American Psychological Association (APA) or which is a member of or meets the membership requirements of the Association of Psychology Postdoctoral and Internship Centers (APPIC) or which is a member of or meets the membership requirements of the California Psychology Internship Council (CAPIC).

The term "trainee" as used in these regulations means a psychology trainee working under one of the conditions listed in subsections (a)(1) and (a)(2) of this section.

(a) Pursuant to section 2914(c) of the code, two years of qualifying SPE shall be completed and documented prior to licensure. One year of SPE shall be defined as 1500 hours. At least one year of SPE shall be completed postdoctorally. Each year of SPE shall be completed within a thirty (30) consecutive month period. If both years of SPE (3000 hours) are completed postdoctorally, they shall be completed within a sixty (60) month period. Upon showing of good cause as determined by the board, these specified time limitations may be reasonably modified.

(1) Predoctoral SPE: Up to 1500 hours of SPE may be accrued predoctorally but only after completion of 48 semester/trimester or 72 quarter units of graduate coursework in psychology not including thesis, internship or dissertation. Predoctoral SPE may be accrued only as follows:

(A) In a formal internship placement pursuant to section 2911 of the code and registration with the board is not required; or

(B) As an employee of an exempt setting pursuant to section 2910 of the code and registration with the board is not required; or

(C) As a psychological assistant pursuant to section 2913 of the code and registration with the board prior to commencing work is required; or

(D) Pursuant to a Department of Mental Health Waiver (5751.2 Welfare and Institutions Code) for which registration with the board is not required.

(2) Postdoctoral SPE: At least 1500 hours of SPE shall be accrued postdoctorally. "Postdoctorally" means after the date certified as "meeting all the requirements for the doctoral degree" by the Registrar or Dean of the educational institution, or by the Director of Training of the doctoral program. Postdoctoral SPE may be accrued only as follows:

(A) As a registered psychologist pursuant to section 2909(d) of the code and registration with the board prior to commencing work is required; or

(B) As an employee of an exempt setting pursuant to section 2910 of the code and registration with the board is not required; or

(C) As a psychological assistant pursuant to section 2913 of the code and registration with the board prior to commencing work is required; or

(D) Pursuant to a Department of Mental Health Waiver (5751.2 Welfare and Institutions Code) for which registration with the board is not required.

(b) Supervision Requirements:

(1) Primary supervisors shall meet the requirements set forth in section 1387.1.

(2) Delegated supervisors shall meet the requirements set forth in section 1387.2.

(3) Trainees shall have no proprietary interest in the business of the primary or delegated supervisor(s) and shall not serve in any capacity which would hold influence over the primary or delegated supervisor(s)' judgment in providing supervision.

(4) Trainees shall be provided with supervision for 10% of the total time worked each week. At least one hour per week shall be face–to–face, direct, individual supervision with the primary supervisor.

(5) A maximum of forty four (44) hours per week will be credited toward meeting the SPE requirement. This shall include the required 10% supervision.

(6) The primary supervisor shall be employed by the same work setting as the trainee and be available to the trainee 100% of the time the trainee is accruing SPE. This availability may be in–person, by telephone, by pager or by other appropriate technology.

(7) Primary supervisors shall ensure that a plan is in place to protect the patient/client in the event a patient/client crisis or emergency occurs during any time the supervisor is not physically present at the established site at which the trainee is working. The primary supervisor shall ensure that the trainee thoroughly understands the plan in the event of a crisis/emergency.

(8) SPE shall not be obtained from supervisors who have received payment, monetary or otherwise, from the trainee for the purpose of providing such supervision.

(9) SPE gained while the trainee is functioning in under another mental health license or credential, shall not be credited toward meeting the requirements for the psychologist's license.

(10) Prior to the start of the experience, the primary supervisor and the trainee shall together prepare a document which identifies at least the following:

- Name and signature of primary supervisor;
- Name and signature of trainee:
- Statutory authority under which the trainee will function;
- Start date of the experience and the anticipated completion date;
- Duties to be performed;
- Address of the locations at which the duties will be performed and,
- Goals and objectives of the plan for supervised professional experience.

Additionally, the document shall reflect that both supervisor and trainee have discussed and understand each term of SPE as required by the California Code of Regulations. The primary supervisor shall maintain the document until the hours of supervised experience are completed. Once the supervised experience outlined in the document has been completed, the primary supervisor shall submit directly to the board both the document and a verification of the experience signed by the primary supervisor under penalty of perjury. The verification shall certify to completion of the hours consistent with the terms of the supervision agreement document. The supervisor must indicate, in his/her best professional judgment, whether the trainee demonstrated an overall performance at or above the level of minimal competence expected for the trainee's level of education, training and experience. When SPE is accrued as part of a formal predoctoral internship, the internship training director shall be authorized to perform the verification and rating duties of the primary supervisor provided that the internship training director is a licensed psychologist who possesses a valid, active license free of any disciplinary action.

(c) Delegated Supervision Requirements:

(1) Except as provided in 1391.5, which regulates the supervision of psychological assistants, primary supervisors may delegate supervision to other qualified psychologists or to other qualified mental health professionals including licensed marriage and family therapists, licensed educational psychologists, licensed clinical social workers and board certified psychiatrists.

(2) The primary supervisor remains responsible for providing the minimum one hour per week of direct, individual face–to–face supervision.

(3) The primary supervisor remains responsible for ensuring compliance with this section.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.1. Qualifications and Responsibilities of Primary Supervisors.

All primary supervisors shall be licensed psychologists, except that board certified psychiatrists may be primary supervisors of their own registered psychological assistants. In this regard, a maximum of 750 hours of experience out of the required 3000, can be supervised by a board certified psychiatrist and can be counted toward meeting the SPE licensing requirements.

(a) Primary supervisors shall possess and maintain a valid, active license free of any formal disciplinary action, and shall immediately notify the supervisee of any disciplinary action, including revocation, surrender, suspension, probation terms, or changes in licensure status including inactive license, delinquent license or any other license status change that affects the primary supervisor's ability or qualifications to supervise.

(b) Primary supervisors who are licensed by the board shall complete a minimum of six (6) hours of supervision coursework every two years.

(1) Primary supervisors shall certify under penalty of perjury to completion of this coursework requirement each time the supervisor completes a verification form as referenced in section 1387(b)(10).

(c) Primary supervisors shall be in compliance at all times with the provisions of the Psychology Licensing Law and the Medical Practice Act, whichever is applicable, and the regulations adopted pursuant to these laws.

(d) Primary supervisors shall be responsible for ensuring compliance at all times by the trainee with the provisions of the Psychology Licensing Law and the regulations adopted pursuant to these laws.

(e) Primary supervisors shall be responsible for ensuring that all SPE including record keeping is conducted in compliance with the Ethical Principles and Code of Conduct of the American Psychological Association.

(f) Primary supervisors shall be responsible for monitoring the welfare of the trainee's clients.

(g) Primary supervisors shall ensure that each client or patient is informed, prior to the rendering of services by the trainee (1). that the trainee is unlicensed and is functioning under the direction and supervision of the supervisor; (2). that the primary supervisor shall have full access to the treatment records in order to perform supervision responsibilities and (3). that any fees paid for the services of the trainee must be paid directly to the primary supervisor or employer.

(h) Primary supervisors shall be responsible for monitoring the performance and professional development of the trainee.

(i) Primary supervisors shall ensure that they have the education, training, and experience in the area(s) of psychological practice they will supervise.

(j) Primary supervisors shall have no familial, intimate, business or other relationship with the trainee which would compromise the supervisor's effectiveness, and/or which would violate the Ethical Principles and Code of Conduct of the American Psychological Association.

(k) Primary supervisors shall not supervise a trainee who is now or has ever been a psychotherapy client of the supervisor.

(*l*) Primary supervisors shall not exploit trainees or engage in sexual relationships or any other sexual contact with trainees.

(m) Primary supervisors shall require trainees to review the pamphlet "Professional Therapy Never Includes Sex."

(n) Primary supervisors shall monitor the supervision performance of all delegated supervisors.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.2. Qualifications and Responsibilities of Delegated Supervisors.

Delegated supervisors shall be qualified psychologists or those other qualified mental health professionals listed in section 1387(c). The delegated supervisor(s) shall be employed in the same work setting as the trainee.

(a) Delegated supervisors shall have and shall maintain a valid, active license free of any formal disciplinary action, shall immediately notify the trainee and the primary supervisor of any disciplinary action, including revocation, surrender, suspension, probation terms, or changes in licensure status including inactive license, or any other license status change that affects the supervisor's ability or qualifications to supervise.

(b) Delegated supervisors shall be in compliance at all times with the provisions of the Psychology Licensing Law, and the regulations adopted pursuant to these laws.

(c) Delegated supervisors shall be responsible for ensuring compliance by the trainee with the provisions of the Psychology Licensing Law and the regulations adopted pursuant to these laws.

(d) Delegated supervisors shall be responsible for ensuring that all SPE and record keeping performed under the supervision delegated to them is conducted in compliance with the Ethical Principles and Code of Conduct of the American Psychological Association.

(e) Delegated supervisors shall be responsible for monitoring the welfare of the trainee's clients while under their delegated supervision.

(f) Delegated supervisors shall be responsible for monitoring the performance and professional development of the trainee and for reporting this performance and development to the primary supervisor.

(g) Delegated supervisors shall ensure that they have the education, training, and experience in the area(s) of psychological practice to be supervised.

(h) Delegated supervisors shall have no familial, intimate, business or other relationship with the trainee which would compromise the supervisor's effectiveness and/or which would violate the Ethical Principles and Code of Conduct of the American Psychological Association.

(i) Delegated supervisors shall not supervise a trainee who is now or has ever been a psychotherapy client of the supervisor.

(j) Delegated supervisors shall not exploit trainees or engage in sexual relationships, or any other sexual contact with trainees.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.3. SPE for Trainees Preparing for Practice in Non–Mental Health Services.

This section pertains only to those trainees who are preparing for practice, once licensed, in the non–mental health areas of the profession of psychology.

(a) Due to lack of training sites and qualified supervisors, typically in the area of applied psychological research, industrial–organizational psychology, and social–experimental psychology, but not including those involving direct mental health services, a plan for supervised experience shall be submitted by the trainee to the Board for approval on a case–by–case basis as provided for in section 2914(c) of the code.

(b) For training approved pursuant to this section, the trainee may be supervised by an appropriate unlicensed individual only if the trainee has obtained an agreement within the provisions of this section with a licensee who meets the qualifications set forth in section 1387.1, and who is educated and experienced in the trainee's area of education and training, to serve as co–supervisor. The qualifications and responsibilities of both the supervisor and co–supervisor shall be stated in the plan for supervised professional experience submitted by the trainee to the board for approval.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.4. Out of State Experience.

(a) All out of state SPE must be (1) supervised by a primary supervisor who is a psychologist licensed at the doctoral level in the state, U.S. territory or Canadian province in which the SPE is taking place, (2) in compliance with all laws and regulations of the jurisdiction in which the experience was accrued and (3) in substantial compliance with all the supervision requirements of section 1387.

(b) Supervised professional experience can be accrued at a U.S. military installation so long as the experience is supervised by a qualified psychologist licensed at the doctoral level in the U.S. or Canada.

(c) SPE can be accrued in countries outside the U.S. or Canada which regulate the profession of psychology pursuant to the same requirements as set forth in section 2914 of the code. SPE accrued in countries outside the U.S., its Territories or Canada must comply with all the supervision requirements of section 1387. The burden shall be upon the applicant to provide the necessary documentation and translation that the board may require to verify the qualification of the SPE.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.5. SPE Log.

(a) The trainee shall maintain a written weekly log of all hours of SPE earned toward licensure. The log shall contain a weekly accounting of the following information and shall be made available to the board upon request:

(1) The specific work setting in which the SPE took place.

(2) The specific dates for which the log is being completed.

(3) The number of hours worked during the week.

(4) The number of hours of supervision received during the week.

(5) An indication of whether the supervision was direct, individual, face–to–face, group, or other (specifically listing each activity).

(6) An indication of whether the SPE performed that week was satisfactory.

(b) This log must also contain the following information:

(1) The trainee's legibly printed name, signature and date signed.

(2) The primary supervisor's legibly printed name, signature, license type and number, and date signed.

(3) Any delegated supervisors' legibly printed name, license type and number, and date signed.

(4) A description of the psychological duties performed during the period of supervised professional experience.

(5) A statement signed by the primary supervisor attesting to the accuracy of the information.

(c) When SPE is accrued as part of a formal internship, the internship training director shall be authorized to provide all information required in section 1387.5(b).

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2914, Business and Professions Code.

§ 1387.6. Psychological Assistants.

In order to accrue hours of SPE, a psychological assistant shall at all times be in compliance with the supervision requirements of section 1387 and with the requirements for psychological assistants set forth in Article 5.1 of this chapter.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1387.7. Registered Psychologists.

Persons working as registered psychologists pursuant to section 2909 of the code in order to accrue postdoctoral hours of SPE shall at all times be in compliance with the supervision requirements of section 1387 and with the requirements for registered psychologists set forth in Article 5 of this chapter.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2909, Business and Professions Code.

§ 1387.8. Spousal or Partner Abuse Assessment, Detection, and Intervention Training Requirements.

NOTE: Authority cited: Sections 2914(f) and 2930, Business and Professions Code. Reference: Section 2914(f), Business and Professions Code.

Article 4. Examination

§ 1388. Examinations.

(a) The board recognizes the expertise of the Department of Consumer Affairs' (DCA) Office of Examination Resources (OER). The board shall utilize the services of the OER in licensing examination development and validation through an interagency agreement.

(b) An applicant shall successfully complete the licensing examination prior to being licensed. The licensing examination shall consist of the Association of State and Provincial Psychology Boards' (ASPPB) Examination for Professional Practice in Psychology (EPPP) and the California Psychology Supplemental Examination (CPSE), except that the EPPP shall be waived for those applicants who meet the criteria in section 1388.6 of this chapter.

(c) An applicant is eligible to take the EPPP upon completion of a qualifying doctorate degree and 1500 hours of qualifying professional experience. An applicant shall pass the EPPP and complete all 3000 hours of supervised professional experience prior to being eligible for the CPSE.

(d) Upon application, the board will notify applicants of their eligibility to take the EPPP. Applicants are responsible for completing any administrative requirements for taking the EPPP established by ASPPB or its agent, including paying any fees. This subsection applies to those re–taking the EPPP as well as to those taking it for the first time.

(e) For forms of the EPPP taken prior to September 1, 2001, the passing score is the score that was recognized by the board at that time. For computer administered forms of the EPPP, the board shall apply a scaled score of 500 as recommended by ASPPB.

(f) Qualified applicants desiring to take the CPSE shall submit to the board the fee set forth in section 1392 of this chapter. Applicants shall comply with all instructions established by the DCA examination vendor for taking the CPSE.

(g) An individual receiving at least a passing score on the CPSE shall have successfully completed the CPSE. The passing score on the CPSE shall be determined for each form of the examination by a criterion referenced procedure performed by OER.

NOTE: Authority cited: Sections 2930 and 2942, Business and Professions Code. Reference: Sections 123, 496, 2941, 2942, 2943 and 2960, Business and Professions Code.

§ 1388.5. Oral Examinations.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2931, 2941, 2942 and 2945, Business and Professions Code; and Section 12944, Government Code.

§ 1388.6. License Requirements and Waiver of Examination.

(a) When a California–licensed psychologist has been licensed for at least five years and has allowed his/her license to expire by not renewing the license for at least three years, the psychologist shall not be required to take the EPPP.

(b) If an applicant for licensure as a psychologist has been licensed

in another state, Canadian province, or U.S. territory, for at least five years the applicant shall not be required to take the EPPP.

(c) An applicant for licensure as a psychologist who holds a Certificate of Professional Qualification (CPQ) issued by the Association of State and Provincial Psychology Boards (ASPPB), shall not be required to take the EPPP. Such an applicant shall be deemed to have met the educational and experience requirements of subdivisions (b) and (c) of Code section 2914.

(d) An applicant for licensure as a psychologist who is credentialed as a Health Service Provider in Psychology by the National Register of Health Service Providers in Psychology (NRHSPP) and has been licensed based on a doctoral degree in another state, Canadian province, or U.S. territory for a minimum of five years shall not be required to take the EPPP. Such an applicant shall be deemed to have met the educational and experience requirements of subdivisions (b) and (c) of Code section 2914.

(e) An applicant for licensure as a psychologist who has abandoned his or her application pursuant to section 1381.5 of these regulations and thereby must reapply for a license, shall not be required to take the EPPP.

(f) Although the EPPP is waived under this section, an applicant must file a complete application and meet all current licensing requirements not addressed above, including payment of any fees, take and pass the California Psychology Supplemental Examination (CPSE), and not been subject to discipline.

NOTE: Authority cited: Sections 2930 and 2946, Business and Professions Code. Reference: Section 2946, Business and Professions Code.

§ 1389. Reconsideration of Examinations.

(a) There shall be no reconsideration of the grade received on the EPPP or on the CPSE.

(b) Nothing in this section shall be construed to deprive an applicant of his or her rights of appeal as afforded by other provisions of law.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2942 and 2944, Business and Professions Code.

§ 1389.1. Inspection of Examinations.

(a) All examination materials, except those owned by an examination service, shall be retained by the board at the board's office in Sacramento for a period of two (2) years after the date of the examination.

(b) No inspection is allowed of the written examination administered by the board.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2942 and 2944, Business and Professions Code; and Section 12944, Government Code.

Article 5. Registered Psychologists

§ 1390. Citation.

This article may be cited and referred to as the "Registered Psychologist Regulations."

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2909, Business and Professions Code.

§ 1390.1. Registration.

Any person desiring to register at a qualifying agency as a registered psychologist shall submit an application on a form provided by the board.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2909, Business and Professions Code.

§ 1390.2. Withdrawal of Applications.

Applications for registration which have not been completed within ninety (90) days after additional information has been requested shall be deemed to be withdrawn.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2909, Business and Professions Code.

§ 1390.3. Statement of Purpose.

A person meeting the requirements set forth in section 2909(d) of the code, may provide psychological services under supervision at a non–profit community agency that receives at least 25% of its funding from a governmental source for the purpose of training and providing services so long as that person registers with the board as a registered psychologist. The employing agency must provide the board with evidence of the requisite level of government funding.

(a) The registered psychologist is authorized to function only in the agency to which he or she is registered and only after a registration number has been issued by the board;

(b) The registration shall be in effect for two years from the date of issuance and cannot be renewed and the registrant cannot re–register as a registered psychologist to the same agency;

(c) The registered psychologist shall at all times be under the primary supervision of a qualified licensed psychologist who is employed by the same agency. The primary supervisor shall be available to the trainee 100% of the time that the trainee is working in such a capacity. This availability can be in–person, by telephone, by pager or by other appropriate technology.

(1) The primary supervisor shall comply with the coursework requirements set forth in section 1387.1(b) of the code.

(2) The primary supervisor shall ensure that a plan is in place in the event a patient/client crisis or emergency occurs during any time the supervisor is not physically present at the established site at which the trainee is working. The primary supervisor shall ensure that the trainee thoroughly understands the plan in the event of such an emergency.

(d) In order to qualify as "supervised professional experience" pursuant to section 2914(c) of the code, experience gained as a registered psychologist must comply with section 1387.

(e) Each patient or client of a registered psychologist shall be informed, prior to the rendering of services, that the registrant is unlicensed and under the supervision of a qualified licensed psychologist as an employee of the agency and that the supervisor shall have access to the patient's chart in fulfilling his/her supervisorial duties.

(f) No supervisor or employing agency of a registered psychologist may charge a fee or otherwise require monetary payment in consideration for the employment or supervision of a registered psychologist.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2909, Business and Professions Code.

Article 5.1. Psychological Assistants

§ 1391. Citation.

This article may be cited and referred to as the "Psychological Assistant Regulations."

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.1. Registration.

Any person desiring to supervise a psychological assistant shall submit an application on a form provided by the board.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.2. Withdrawal of Applications.

Applications for registration which have not been completed within ninety (90) days after additional information has been requested shall be deemed to be withdrawn.

§ 1391.3. Required Training.

Any person who possesses a doctorate degree which will qualify for licensure as a psychologist pursuant to Section 2914 of the code, shall be deemed to have completed "one fully matriculated year of graduate training in psychology" and will be eligible for registration as a psychological assistant upon compliance with other provisions of Section 2913 of the code.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.4. Limited Psychological Functions.

As used in Section 2913 of the code, the phrase "limited psychological functions" means those functions which are performed under the direction and supervision of the qualified supervisor pursuant to the American Psychological Association's (APA) January 1, 1997 version of the Guidelines and Principles for Accreditation of Programs in Professional Psychology and the APA Code of Conduct and Ethical Principles.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.5. Statement of Purpose; Supervision Required.

(a) A psychological assistant shall be under the direction and supervision of a licensed psychologist or board–certified psychiatrist who is employed in the same setting in which the psychological assistant is employed. A licensed psychologist who is supervising psychological assistants must comply with the supervision course requirements set forth in section 1387.1.

(b) The supervisor shall provide a minimum of one (1) hour per week of individual supervision to the psychological assistant, unless more such supervision is required under Section 1387 or by the nature of the psychological functions performed by the psychological assistant.

(c) A registered psychological assistant employed by one of the organizations specified in section 2913 of the code may receive delegated supervision pursuant to section 1387(c) from a qualified psychologist or a board certified psychiatrist other than the supervisor to whom he/she is registered if the delegated supervisor is also employed within the same organization. Otherwise, supervision may not be delegated under a psychological assistant registration.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.6. Supervisor's Responsibility.

(a) Every supervisor of a psychological assistant shall be responsible for supervising the psychological functions performed by the psychological assistant and ensuring that the extent, kind and quality of the psychological functions performed by the assistant are consistent with the supervisor's training and experience, and that the assistant complies with the provisions of the code, the board's regulations, and the standards established by the American Psychological Association.

(b) The supervisor shall inform each client or patient prior to the rendering of services by the psychological assistant that the assistant is unlicensed and is under the direction and supervision of the supervisor as an employee and that the supervisor shall have access to the patient's chart in fulfilling his/her supervision duties.

(c) The supervisor shall be available to the assistant 100% of the time the assistant is performing psychological functions. The availability can be in–person, by telephone, by pager or by other appropriate technology.

(d) The supervisor shall ensure that a plan is in place to protect the patient or client in the event a patient/client crisis or emergency occurs during any time the supervisor is not physically present at the established site at which the supervisee is working. The supervisor shall ensure that the supervisee thoroughly understands the plan in the event a patient crisis or emergency occurs.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.7. Supervised Professional Experience.

In order to qualify as "supervised professional experience" pursuant to Section 2914(c) of the code, experience gained as a psychological assistant must comply with Section 1387.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.8. Employer–Employee Business Relationship.

(a) No supervisor or employer of a psychological assistant may charge a fee or otherwise require monetary payment in consideration for the employment or supervision of a psychological assistant. The supervisor or employer shall supply all provisions necessary to function as a psychological assistant.

(b) The psychological assistant shall have no proprietary interest in the business of the supervisor or the employer.

(c) The psychological assistant shall not rent, lease, sublease, or lease–purchase office space from any entity for purposes of functioning as a psychological assistant.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.9. Continuing Education.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1391.10. Annual Reports.

On or before January 31 of each year, every supervisor of a psychological assistant shall submit to the board on a form provided by the board a report for the preceding calendar year showing:

(a) The nature of the psychological functions performed by the psychological assistant being supervised;

(b) Certification of employment.

(c) The locations at which the psychological assistant provided the psychological functions and the type, extent and amount of supervision.

(d) A certification that the psychological functions performed by the psychological assistant were performed at a level satisfactory to ensure safety to the public.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.11. Notification of Termination.

Within thirty (30) days after the termination of the employment of a psychological assistant, the employer shall notify the board in writing of such termination, setting forth the date thereof.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.12. Psychological Assistant Renewals.

(a) The registration of a psychological assistant shall be renewed by the employer no later than January 31 of each year.

(b) Those registrations renewed 30 days after the deadline must be accompanied by the delinquency fee required in section 1392.1.

(c) A psychological assistant who has been registered with the board but whose registration has not been renewed by the employer shall not function as a psychological assistant.

(d) A psychological assistant employed and registered by more than one employer shall have his or her registration renewed by each employer.

(e) Those registrations not renewed within 60 days after the renewal date shall become void and a new application for registration shall be submitted by the employer.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Section 2913, Business and Professions Code.

§ 1391.13. Effect of Violation, Psychological Assistant.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1391.14. Effect of Violation, Employer.

NOTE: Authority cited: Section 2930, Business and Professions Code.

Article 5.5. Psychological Corporations

NOTE: Authority cited: Sections 2119 and 2151.9, Business and Professions Code.

Article 6. Fees

§ 1392. Psychologist Fees.

(a) The application fee for a psychologist is $40.00.

(b) The fee for the California Psychology Supplemental Examination (CPSE) is $129.00.

(c) An applicant taking or repeating either licensing examination shall pay the full fee for that examination.

(d) The initial license fee and the biennial renewal fee for a psychologist are $400.00. except that if an initial license will expire less than one year after its issuance, then the initial license fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the license is issued.

(e) The biennial renewal fee for an inactive license is $40.00.

NOTE: Authority cited: Sections 2930, 2987 and 2989, Business and Professions Code. Reference: Sections 2987, 2988 and 2989, Business and Professions Code.

§ 1392.1. Psychological Assistant Fees.

(a) The application fee for registration of a psychological assistant which is payable by the supervisor is $40.00.

(b) The annual renewal fee for registration of a psychological assistant is $40.00.

(c) The delinquency fee for a psychological assistant is $20.00.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2688 and 2689, Business and Professions Code.

§ 1392.2. Professional Corporation Fees.

NOTE: Authority cited: Section 2930, Business and Professions Code.

Article 7. Restoration of Suspended or Revoked Licenses

§ 1393. Requirements for Psychologists on Probation.

Each psychologist who has been placed on probation by the board shall be subject to the board's probation program and shall be required to fully cooperate with the assigned probation monitor.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2960 and 2961, Business and Professions Code.

§ 1394. Substantial Relationship Criteria.

For the purposes of denial, suspension, or revocation of a license or registration pursuant to Division 1.5 (commencing with Section 475) of the code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license or registration under the Psychology Licensing Law (Chapter 6.6 of Division 2 of the Code), if to a substantial degree it evidences present or potential unfitness of a person holding a license or registration to perform the functions authorized by his or her license or registration or in a manner consistent with the public health, safety, or welfare. Such crimes or acts shall include but not be limited to those involving the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of that law.

(b) Conviction of a crime involving fiscal dishonesty.

NOTE: Authority cited: Sections 481 and 2930, Business and Professions Code. Reference: Sections 481, 490, 2960 and 2963, Business and Professions Code.

§ 1395. Rehabilitation Criteria for Denials and Reinstatements.

When considering the denial of a license or registration under section 480 of the code, or a petition for reinstatement under section 11522 of the Government Code, the board in evaluating the rehabilitation of the applicant and his or her present eligibility for a license or registration, will consider the following criteria:

(1) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under section 480 of the Code.

(3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (1) or (2).

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.

(5) Evidence, if any, of rehabilitation submitted by the applicant.

NOTE: Authority cited: Sections 482 and 2930, Business and Professions Code. Reference: Sections 480, 482, 2960, 2962 and 2963, Business and Professions Code.

§ 1395.1. Rehabilitation Criteria for Suspensions or Revocations.

When considering the suspension or revocation of a license or registration on the ground that a person holding a license or registration under the Psychology Licensing Law (chapter 6.6 of division 2 of the code) has been convicted of a crime the board in evaluating the rehabilitation of such person and his or her eligibility for a license or registration will consider the following criteria:

(1) Nature and severity of the act(s) or offense(s).

(2) Total criminal record.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the licensee or registration holder has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person.

(5) If applicable, evidence of expungement proceedings pursuant to section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the licensee or registration holder.

NOTE: Authority cited: Sections 482 and 2930, Business and Professions Code. Reference: Sections 482, 2960 and 2963, Business and Professions Code.

Article 8. Rules of Professional Conduct

§ 1396. Competence.

A psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Section 2936, Business and Professions Code.

§ 1396.1. Interpersonal Relations.

It is recognized that a psychologist's effectiveness depends upon his or her ability to maintain sound interpersonal relations, and that temporary or more enduring problems in a psychologist's own personality may interfere with this ability and distort his or her appraisals of others. A psychologist shall not knowingly undertake any activity in which temporary or more enduring personal problems in the psychologist's personality integration may result in inferior professional services or harm to a patient or client. If a psychologist is already engaged in such activity when becoming aware of such personal problems, he or she shall seek competent professional assistance to determine whether services to the patient or client should be continued or terminated.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Section 2936, Business and Professions Code.

§ 1396.2. Misrepresentation.

A psychologist shall not misrepresent nor permit the misrepresentation of his or her professional qualifications, affiliations, or purposes, or those of the institutions, organizations, products and/or services with which he or she is associated.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Section 2936, Business and Professions Code.

§ 1396.3. Test Security.

A psychologist shall not reproduce or describe in public or in publications subject to general public distribution any psychological tests or other assessment devices, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the techniques; and shall limit access to such tests or devices to persons with professional interests who will safeguard their use.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Section 2936, Business and Professions Code.

§ 1396.4. Professional Identification.

(a) When engaged in any professional psychological activity, whether for a fee or otherwise, a psychologist shall at all times and under all circumstances identify himself or herself as a psychologist.

(b) A psychological assistant shall at all times and under all circumstances identify himself or herself to patients or clients as a psychological assistant to his or her employer or responsible supervisor when engaged in any psychological activity in connection with that employment.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Sections 2913 and 2936, Business and Professions Code.

§ 1397. Advertising.

A licensed psychologist may advertise the provision of any services authorized to be provided by such license within the psychologist's field of competence in a manner authorized under Section 651 of the code, so long as such advertising does not promote the excessive or unnecessary use of such services.

NOTE: Authority cited: Sections 651, 2930 and 2936, Business and Professions Code. Reference: Sections 651, 2936 and 2960, Business and Professions Code.

§ 1397.1. Child Abuse Reporting Requirements.

Failure to comply with the reporting requirements contained in Penal Code Section 11166 shall constitute unprofessional conduct.

NOTE: Authority cited: Sections 2930 and 2936, Business and Professions Code. Reference: Sections 2936 and 2960 (i), Business and Professions Code.

§ 1397.2. Effect of Violation.

NOTE: Authority cited: Section 2936, Business and Professions Code. Reference: Sections 2913, 2936, and 2960, Business and Professions Code.

§ 1397.3. Competence.

§ 1397.4. Interpersonal Relations.

§ 1397.5. Misrepresentation.

§ 1397.6. Confidentiality.

§ 1397.7. Test Security.

§ 1397.8. Professional Identification.

§ 1397.9. Employment of Psychological Assistant.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1397.10. Unprofessional Conduct.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1397.11. Advertising.

NOTE: Authority cited: Sections 651, 2930 and 2936, Business and Professions Code. Reference: Sections 651, 651.3, 2936 and 2960, Business and Professions Code.

§ 1397.12. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the administrative adjudication provisions of the Administrative Procedure Act (Government Code Section 11400 et seq.), the Board of Psychology shall consider the disciplinary guidelines entitled "Disciplinary Guidelines," as amended 2/4/06" which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation is appropriate where the Board of Psychology in its sole discretion determines that the facts of the particular case warrant such a deviation—for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Section 2930, Business and Professions Code. Reference: Sections 2960, 2960.05, 2960.1, 2960.5, 2960.6, 2961, 2962, 2963, 2964, 2964.3, 2964.5, 2964.6, 2965, 2966 and 2969, Business and Professions Code; and Section 11425.50(e), Government Code.

§ 1397.30. Citation.

These regulations may be cited and referred to as the "Psychology Corporation Regulations."

NOTE: Authority and reference cited: Sections 2930 and 2999, Business and Professions Code.

§ 1397.31. Professional Relationships and Responsibilities Not Affected.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1397.32. Office for Filing.

NOTE: Authority cited: Section 2930, Business and Professions Code.

§ 1397.33. Application.

NOTE: Section 2930, Business and Professions Code.

§ 1397.34. Approval and Issuance of Certificates.

NOTE: Section 2930, Business and Professions Code.

§ 1397.35. Requirements for Professional Corporations.

A professional corporation shall comply with the following provisions:

(a) The corporation is organized and exists pursuant to the general corporation law and is a professional corporation within the meaning of the Moscone–Knox Professional Corporation Act (Part 4, Division 3, Title 1 of the Corporations Code).

(b) Each shareholder, director and officer (except as provided in Section 13403 of the Corporations Code and Section 2997 of the code) holds a valid psychology license; provided that, a licensed physician, podiatrist, marriage, family, and child counselor, licensed clinical social worker, chiropractor, optometrist or registered nurse may be a shareholder, director or officer of a psychology corporation so long as such licensees own no more than 49% of the total shares issued by the psychology corporation and the number of licensed physicians, podiatrists, marriage, family, and child counselors, licensed clinical social workers, chiropractors, optometrists or registered nurses owning shares in the psychology corporation does not exceed the number of psychologists owning shares in such a corporation. A psychologist may be a shareholder in more than one psychology corporation.

(c) Each professional employee of the applicant who will practice psychology, podiatry, medicine, marriage, family and child counseling, clinical social work, chiropractic, optometry or professional nursing, whether or not a shareholder, director or officer, holds a valid license.

NOTE: Authority cited: Sections 2930 and 2999, Business and Professions Code. Reference: Section 2995, Business and Professions Code; and Sections 13401, 13401.5, 13403, 13406 and 13407, Corporations Code.

§ 1397.36. Namestyle.

NOTE: Authority cited: Sections 2930 and 2996.6, Business and Professions Code. Reference: Section 2995.8, Business and Professions Code. Section 13409, Corporations Code.

§ 1397.37. Shares: Ownership and Transfer.

(a) Where there are two or more shareholders in a psychology corporation and one of the shareholders:

(1) Dies; or

(2) Becomes a disqualified person as defined in Section 13401(d) of the Corporations Code, his or her shares shall be sold and transferred to the corporation, its shareholders or other eligible licensed persons on such terms as are agreed upon. Such sale or transfer shall not be later than six (6) months after any such death and ninety (90) days after the shareholder becomes a disqualified person. The requirements of this subsection shall be set forth in the psychology corporation's articles of incorporation or bylaws.

(b) A corporation and its shareholders may, but need not, agree that shares sold to it by a person who becomes a disqualified person may

be resold to such person if and when he or she again becomes an eligible shareholder.

(c) The share certificates of a psychology corporation shall contain an appropriate legend setting forth the restrictions of subsection (a).

(d) Nothing in these regulations shall be construed to prohibit a psychology corporation from owning shares in a nonprofessional corporation.

NOTE: Authority cited: Sections 2930 and 2999, Business and Professions Code. Reference: Section 2999, Business and Professions Code; and Sections 13401, 13403, 13406 and 13407, Corporations Code.

§ 1397.38. Certificates of Registration: Continuing Validity and Reports.

NOTE: Authority cited: Sections 2930 and 2996.6, Business and Professions Code. Reference: Sections 2995.4 and 2995.6, Business and Professions Code.

§ 1397.39. Corporate Activities.

(a) A psychology corporation may perform any act authorized in its articles of incorporation or bylaws so long as that act is not in conflict with or prohibited by these rules, the Psychology Licensing Law, the Medical Practice Act, the Optometry Law or the Nursing Practice Act or the regulations adopted pursuant thereto.

(b) A psychology corporation may enter into partnership agreements with other psychologists practicing individually or in a group or with other psychology corporations.

NOTE: Authority cited: Sections 2930 and 2999, Business and Professions Code. Reference: Section 2996.6, Business and Professions Code; and Sections 13403, 13408 and 13410, Corporations Code.

§ 1397.40. Trusts.

The restrictions on the ownership of the shares of psychology corporations shall apply to both the legal and equitable title to such shares.

NOTE: Authority cited: Sections 2930 and 2999, Business and Professions Code. Reference: Sections 13406 and 13407, Corporations Code.

§ 1397.41. Effect of Surrendered or Revoked Certificates; Probate.

NOTE: Authority cited: Section 2999, Business and Professions Code.

Article 9. Citations and Fines

§ 1397.50. Citations and Fines.

(a) For purposes of this article, "board official" shall mean the executive officer of the board or his or her representative.

(b) A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed psychologist of the statutes referred to in section 1397.51.

(c) A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail, return receipt requested.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1397.51. Amount of Fines.

The amount of any fine to be levied by a board official shall take into consideration the factors listed in subdivision (b)(3) of section 125.9 of the code and shall be within the range set forth below.

(a) A board official may issue a citation under section 1397.50 for a violation of the provisions listed in this section. The fine for a violation of the following code sections shall be from $100 to $2500:

(1) Business and Professions Code section 125
(2) Business and Professions Code section 125.6
(3) Business and Professions Code section 475(a)(1)
(4) Business and Professions Code section 490
(5) Business and Professions Code section 496
(6) Business and Professions Code section 580
(7) Business and Professions Code section 581
(8) Business and Professions Code section 582
(9) Business and Professions Code section 583
(10) Business and Professions Code section 584
(11) Business and Professions Code section 650
(12) Business and Professions Code section 651
(13) Business and Professions Code section 654.2
(14) Business and Professions Code section 702
(15) Business and Professions Code section 810
(16) Business and Professions Code section 2903
(17) Business and Professions Code section 2960(a)
(18) Business and Professions Code section 2960(c)
(19) Business and Professions Code section 2960(d)
(20) Business and Professions Code section 2960(f)
(21) Business and Professions Code section 2960(g)
(22) Business and Professions Code section 2960(h)
(23) Business and Professions Code section 2960(i)
(24) Business and Professions Code section 2960(k)
(25) Business and Professions Code section 2960(*l*)
(26) Business and Professions Code section 2960(m)
(27) Business and Professions Code section 2960(n)
(28) Business and Professions Code section 2960(p)
(29) Business and Professions Code section 2960(q)
(30) Business and Professions Code section 2960(r)
(31) Business and Professions Code section 2960.6
(32) Business and Professions Code section 17500
(33) Penal Code section 11166.5
(34) Business and Professions Code section 2913(c)
(35) Business and Professions Code section 2914(c)
(36) Business and Professions Code section 2915

(b) At his or her discretion, a board official may issue a citation with an order of abatement without levying a fine for the first violation of any provision set forth above.

(c) Notwithstanding the administrative fine amounts specified in this section, a citation may include a fine between $2,501 and $5,000 if one or more of the following circumstances apply:

(1) The citation involves a violation that has an immediate relationship to the health and safety of another person;

(2) The cited person has a history of two or more prior citations of the same or similar violations;

(3) The citation involves multiple violations that demonstrate a willful disregard of the law;

(4) The citation involves a violation or violations perpetrated against a child, elderly person or person with a disability.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1397.52. Compliance with Orders of Abatement.

(a) If a cited person who has been issued an order of abatement is unable to complete the correction with the time set forth in the citation because of conditions beyond his or her control after the exercise of reasonable diligence, the person cited may request an extension of time in which to complete the correction from the board official who issued the citation. Such a request shall be in writing and shall be made within the time set forth for abatement.

(b) When an order of abatement is not contested or if the order is appealed and the person cited does not prevail, failure to abate the violation charged within the time allowed shall constitute a violation and failure to comply with the order of abatement. An order of abatement shall either be personally served or mailed by certified mail, return receipt requested. The time allowed for the abatement of a violation shall begin when the order of abatement is final and has been served or received. Such failure may result in disciplinary action

being taken by the Board of Psychology or other appropriate judicial relief being taken against the person cited.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1397.53. Citations for Unlicensed Practice.

A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a psychologist is required under the laws and regulations relating to the practice of psychology. Each citation issued shall contain an order of abatement. Where appropriate, a board official shall levy a fine for such unlicensed activity in accordance with subdivision (b)(3) of section 125.9 of the code. The provisions of section 1397.50 and 1397.52 shall apply to the issuance of citations for unlicensed activity under this subsection. The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1397.54. Contest of Citations.

(a) In addition to requesting a hearing as provided for in subdivision (b)(4) of section 125.9 of the code, the person cited may, within ten (10) days after service or receipt of the citation, notify the board official who issued the citation in writing of his or her request for an informal conference with the board official regarding the acts charged in the citation. The time allowed for the request shall begin the first day after the citation has been served or received.

(b) The board official who issued the citation shall, within 30 days from the receipt of the request, hold an informal conference with the person cited and/or his or her legal counsel or authorized representative. At the conclusion of the informal conference the board official may affirm, modify or dismiss the citation, including any fine levied or order of abatement issued. The board official shall state in writing the reasons for his or her action and serve or mail a copy of his or her findings and decision to the person cited within ten (10) days from the date of the informal conference, as provided in subsection (b) of section 1397.52. This decision shall be deemed to be a final order with regard to the citation issued, including the fine levied and the order of abatement.

(c) The person cited does not waive his or her request for a hearing to contest a citation by requesting an informal conference after which the citation is affirmed by a board official. If the citation is dismissed after the informal conference, the request for a hearing on the matter of the citation shall be deemed to be withdrawn. If the citation, including any fine levied or order of abatement, is modified, the citation originally issued shall be considered withdrawn and new citation issued. If a hearing is requested for the subsequent citation it shall be requested within 30 days in accordance with subdivision (b)(4) of section 125.9 of the code.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1397.55. Disconnection of Telephone Service.

(a) If, upon investigation, the board official has probable cause to believe that an unlicensed person, who is not otherwise exempt from licensure, has advertised to provide psychological services in an alphabetical or classified directory in violation of section 2903 of the code, the board official may issue a citation containing an order of abatement pursuant to section 1397.50 of these regulations. The order of abatement shall require the unlicensed person to cease the unlawful advertising and to notify the telephone company furnishing services to the cited person to (1) disconnect the telephone services furnished to any telephone number contained in the unlawful advertising, and (2) that subsequent calls to that number shall not be referred by the telephone company to any new number obtained by that person. The cited person shall provide written evidence of compliance to the board official.

(b) If the person to whom a citation is issued under subdivision (a) submits a written request to the board official to appeal the citation, the board official shall afford an opportunity for a hearing, as provided in section 1397.54 of these regulations.

(c) If the person to whom the citation and order of abatement is issued fails to comply with the order of abatement after the order is final as provided in section 1398.54(b) of these regulations, the board official shall inform the Public Utilities Commission of the violation in accordance with Business and Professions Code section 149.

NOTE: Authority cited: Sections 125.9, 148 and 2930, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

Article 10. Continuing Education

§ 1397.60. Definitions.

As used in this article:

(a) An "accreditation agency" means an organization recognized by the board which evaluates and approves each provider of continuing education, evaluates and approves each course offering, and monitors the quality of the approved continuing education courses.

(b) A "provider" means an organization, institution, association, university, or other person or entity assuming full responsibility for the course offered, whose qualifications as a continuing education provider have been approved by a board recognized accreditation agency.

(c) A "course" or "presentation" means an approved systematic learning experience of at least one hour in length. One hour shall consist of 60 minutes of actual instruction. Courses or presentations less than one hour in duration shall not be approved.

(d) "Continuing education" means the variety of forms of learning experiences, including, but not limited to, lectures, conferences, seminars, workshops, grand rounds, in–service training programs, video conferencing, and independent learning technologies.

(e) A "conference" means a course consisting of multiple concurrent or sequential free–standing presentations. Approved presentations must meet all standards of an approved continuing education course.

(f) "Grand rounds" or "in–service training program" means a course consisting of sequential, free–standing presentations designed to meet the internal educational needs of the staff or members of an organization and is not marketed, advertised or promoted to professionals outside of the organization. Approved presentations must meet all standards of an approved continuing education course.

(g) "Independent learning" means the variety of forms of organized and directed learning experiences that occur when the instructor and the student are not in direct visual or auditory contact. These include, but are not limited to, courses delivered via the Internet, CD–ROM, satellite downlink, correspondence and home study. Self–initiated, independent study programs without an approved CE sponsor are not acceptable for continuing education. Except for qualified individuals with a disability who apply to and are approved by the board pursuant to section 1397.62(c), independent learning can be used to meet no more than 75% (27 hours) of the continuing education required in each renewal cycle. Independent learning courses must meet all standards of an approved continuing education course.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Sections 29 and 2915, Business and Professions Code.

§ 1397.61. Continuing Education Requirements.

(a) Except as provided in section 2915(e) of the Business and Professions Code and section 1397.62 of these regulations, each licensed psychologist shall submit with the application for license renewal

proof satisfactory to the board that he or she has completed the continuing education requirements set forth in section 2915 of the code. A licensee who renews his or her license for the first time after the initial issuance of the license is only required to accrue continuing education for the number of months that the license was in effect, including the month the license was issued, at the rate of 1.5 hours of approved continuing education per month. Continuing education earned via independent learning pursuant to section 1397.60(g) shall be accrued at no more than 75% of the continuing education required for the first time renewal. The required hours of continuing education may not be accrued prior to the effective date of the initial issuance of the license. A licensee who falsifies or makes a material misrepresentation of fact on a renewal application or who cannot verify completion of continuing education by producing verification of attendance certificates, whenever requested to do so by the board, is subject to disciplinary action under section 2960 of the code.

(b) Any person renewing or reactivating his or her license shall certify under penalty of perjury to the Board of Psychology as requested on the application for license renewal, that he or she has obtained training in the subject of laws and ethics as they apply to the practice of psychology in California. The training shall include recent changes/updates on the laws and regulations related to the practice of psychology; recent changes/updates in the *Ethical Principles of Psychologists and Code of Conduct* published by the American Psychological Association; accepted standards of practice; and other applications of laws and ethics as they affect the licensee's ability to practice psychology with safety to the public. Training pursuant to this section may be obtained in one or more of the following ways:

(1) Formal coursework in laws and ethics taken from an accredited educational institution;

(2) Approved continuing education course in laws and ethics;

(3) Workshops in laws and ethics;

(4) Other experience which provide direction and education in laws and ethics including, but not limited to, grand rounds or professional association presentation.

If the licensee chooses to apply a specific continuing education course on the topic of laws and ethics to meet the foregoing requirement, such a course must meet the content requirements named above, must comply with section 1397.60(c) of this Article, and may be applied to the 36 hours of approved continuing education required in Business and Professions Code section 2915(a).

(c) Those licensees who began graduate training prior to January 1, 2004, shall, prior to his or her first license renewal after January 1, 2004, take continuing education instruction in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. Such course shall be taken within the two years prior to the licensee's renewal date and shall be no less than one (1) hour in length. This is a one–time only continuing education requirement.

(d) Those licensees who began graduate training prior to January 1, 2004, shall, prior to his or her first license renewal after January 1, 2005, take continuing education instruction in the biological, social, and psychological aspects of aging and long–term care. Such course shall be taken within the two years prior to the licensee's renewal date and shall be no less than three (3) hours in length. This is a one–time only continuing education requirement.

(e) Licensees are encouraged to participate in periodic training in subject matter for which the Legislature or the board finds cause, including but not limited to: geriatric pharmacology; the characteristics and methods of assessment and treatment of HIV disease; and issues of human diversity.

(f) This subsection shall become effective on January 1, 2006.

(1) The Board of Psychology recognizes and accepts for continuing education credit courses that are:

(A) provided by American Psychological Association (APA) approved sponsors;

(B) Continuing Medical Education (CME) courses specifically applicable and pertinent to the practice of psychology and that are accredited by the California Medical Association (CMA) or the Accreditation Council for Continuing Medical Education (ACCME);

(C) sponsored by the Academies of the specialty boards of the American Board of Professional Psychology (ABPP).

(2) The board may recognize other entities to perform an accrediting function if the entity:

(A) Has had at least 10 years experience managing continuing education programs for psychologists on a statewide basis, including, but not limited to:

(i) Maintaining and managing records and data related to continuing education programs.

(ii) Monitoring and approving courses.

(B) Has a means to avoid a conflict of interest between any provider and accreditation functions.

(C) Submits a detailed plan of procedures for monitoring and approving the provider functions. The plan must demonstrate that it has the capacity to evaluate each course, including provisions requiring the following:

(i) Topics and subject matter shall be pertinent to the practice of psychology. Courses predominantly focused on business issues, marketing, or exploring opportunities for personal growth are not eligible for credit. Course material must have a relevance or direct application to a consumer of psychological services.

(ii) Each continuing education course shall have written educational goals and specific learning objectives which are measurable and which serve as a basis for an evaluation of the effectiveness of the course.

(iii) Instructors shall be competent in the subject matter of the course and shall be qualified by education, training, experience, scope of practice and licensure.

(iv) Each continuing education course shall have a syllabus which provides a general outline of the course.

(v) When an approved provider works with others on the development, distribution and/or presentation of a continuing education course (joint sponsorship), there shall be procedures to identify and document the functions of each participating party.

(vi) An evaluation mechanism shall be completed by each participant to evaluate the continuing education course.

(vii) Respond to complaints from the board concerning its activities.

(viii) The entity agency shall provide services to all licensees without discrimination.

(D) An entity must submit, in writing, evidence that it meets the qualifications in this subdivision.

(E) Upon written confirmation from the board that the entity has been recognized, the entity may advertise that it has been recognized by the board.

(3) Any licensee who receives approved continuing education course credit hours pursuant to this section shall submit verification of course completion and the participant report recording fee specified in section 1397.69 to a board recognized accrediting agency.

(g) Failure of the entity to substantially comply with the provisions as set forth in subsection (f) shall constitute cause for revocation of recognition by the board. Recognition can be revoked only by a formal board action, after notice and hearing, and for good cause.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Sections 29, 2915 and 2915.7, Business and Professions Code.

§ 1397.62. Continuing Education Exemptions and Exceptions.

At the time of making application for renewal of a license, a psychologist may as provided in this section request an exemption or an exception from all or part of the continuing education requirements.

(a) The board shall grant an exemption only if the psychologist verifies in writing that, during the two year period immediately prior to the expiration date of the license, he or she:

(1) Has been residing in another country or state for at least one year reasonably preventing completion of the continuing education requirements; or

(2) Has been engaged in active military service; or

(3) Has been prevented from completing the continuing education requirements for reasons of health or other good cause which includes:

(A) Total physical and/or mental disability of the psychologist for at least one year; or

(B) Total physical and/or mental disability of an immediate family member for at least one year where the psychologist has total responsibility for the care of that family member.

Verification of a physical disability under subsection (a)(3) shall be by a licensed physician and surgeon or, in the case of a mental disability, by a licensed psychologist or a board certified or board eligible psychiatrist.

(b) An exception to the requirements of Business and Professions Code section 2915(d) may be granted to licensed psychologists who are not engaged in the direct delivery of mental health services for whom there is an absence of available continuing education courses relevant to their specific area of practice.

(1) An exception granted pursuant to this subsection means that the board will accept continuing education courses that are not approved pursuant to sections 1397.61(d), (e), (f) provided that they are directly related to the licensee's specific area of practice and offered by recognized professional organizations. The board will review the licensee's area of practice, the subject matter of the course, and the provider on a case–by–case basis. This exception does not mean the licensee is exempt from completing the continuing education required by Business and Professions Code section 2915 and this article.

(2) Licensees seeking this exception shall provide all necessary information to enable the board to determine the lack of available approved continuing education and the relevance of each course to the continuing competence of the licensee. Such a request shall be submitted in writing and must include a clear statement as to the relevance of the course to the practice of psychology and the following information:

(A) Information describing, in detail, the depth and breadth of the content covered (e.g., a course syllabus and the goals and objectives of the course), particularly as it relates to the practice of psychology.

(B) Information that shows the course instructor's qualifications to teach the content being taught (e.g., his or her education, training, experience, scope of practice, licenses held and length of experience and expertise in the relevant subject matter), particularly as it relates to the practice of psychology.

(C) Information that shows the course provider's qualifications to offer the type of course being offered (e.g., the provider's background, history, experience and similar courses previously offered by the provider), particularly as it relates to the practice of psychology.

(3) This subsection does not apply to licensees engaged in the direct delivery of mental health services.

(c) Psychologists requiring reasonable accommodation according to the Americans with Disabilities Act may be granted an exemption from the on–site participation requirement and may substitute all or part of their continuing education requirement with an American Psychological Association or accreditation agency approved independent learning continuing education program. A qualified individual with a disability must apply to the board to receive this exemption.

(d) Any licensee who submits a request for an exemption or exception which is denied by the board shall complete any continuing education requirements within 120 days of the notification that the request was denied.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.63. Hour Value System.

(a) Licensees will earn one hour continuing education credit for each hour of approved instruction. One 3–unit academic quarter is equal to 10 hours of continuing education credit and one 3–unit academic semester is equal to 15 hours of continuing education credit.

(b)(1) Licensees who serve the Board of Psychology as selected participants in any examination development related function will receive one hour of continuing education credit for each hour served. Selected board experts will receive one hour of continuing education credit for each hour attending Board of Psychology sponsored Expert Training Seminars. Any licensee who receives approved continuing education credit as set forth in subsection (b)(1) shall have his/her credit reported by the board to the board recognized accrediting agency.

(2) Licensees who serve as examiners for the Academies of the specialty boards of the American Board of Professional Psychology (ABPP) will receive one hour of continuing education credit for each hour served, not to exceed fours hours each two year renewal period. Any licensee who receives continuing education credit as set forth in subsection (b)(2) shall submit verification and the course attendee fee specified in section 1397.68 to the board recognized accreditation agency.

(c) An approved instructor may claim the course for his/her own credit only one time that he/she teaches the approved course during a renewal cycle, receiving the same credit hours as the participant.

(d) No course may be taken and claimed more than once during a renewal period for continuing education credit.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.64. Accreditation Agencies.

(a) Upon written application to the board, continuing education accreditation agencies will be recognized if the board determines that the organization meets the criteria set forth in section 2915(f) of the code and:

(1) the organization submits a plan demonstrating that it has the capacity to evaluate each continuing education provider's course in accordance with the following criteria:

(A) Topics and subject matter shall be pertinent to the practice of psychology. Courses predominantly focused on business issues, or marketing, or that are predominantly designed to explore opportunities for personal growth are not eligible for credit. Course material must have a relevance or direct application to a consumer of psychological services.

(B) Each continuing education course shall have written educational goals and specific learning objectives which are measurable and which serve as a basis for an evaluation of the effectiveness of the course.

(C) Instructors shall be competent in the subject matter of the course and shall be qualified by education, training, experience, scope of practice and licensure.

(D) Each continuing education course shall have a syllabus which provides a general outline of the course.

(E) When an approved provider works with others on the development, distribution and/or presentation of a continuing education course (joint sponsorship), there shall be procedures to identify and document the functions of each participating party.

(F) An evaluation mechanism shall be completed by each participant to evaluate the continuing education course.

(2) The accreditation agency agrees to perform the following:

(A) Maintain a list of the names and addresses of the persons designated as responsible for the provider's continuing education courses and records. The accreditation agency shall require that any

change in the designated responsible person's identity shall be reported to the agency within 30 days of the effective date of such change.

(B) Notify the board of names, addresses and responsible party of each provider and each course on a quarterly basis. Provide without charge to any licensee who makes a request, a current list of providers and approved courses.

(C) Verify attendance of licentiates at specific courses by maintaining a record of approved continuing education courses completed by licensees. The record must include the licensees' name and license number, and all agency approved continuing education courses successfully completed by each licensee. In addition, and for an activity reporting fee paid by the licensee and on forms acceptable to the agency (see form No. 07M–BOP–15(New 10/94)), incorporate into licensee's record all non–agency approved continuing education courses as defined in sections 1397.61 and 1397.63 of these regulations. The accreditation agency shall provide a copy of this combined record to the board upon request. The records must be retrievable by license number.

(D) Respond to complaints from the board concerning activities of any of its approved providers or their course(s). Respond to complaints and inquiries regarding providers, courses, and general continuing education questions presented by any licensee. The accreditation agency shall provide services to all licensees without discrimination.

(E) Audit at least 10% of the continuing education courses approved by the agency, for compliance with the agency's requirements and requirements of the board, and on request, report the findings of such audits to the board.

(F) Take such action as is necessary to assure that the continuing education course material offered by its providers meets the continuing education requirements of the board as defined in sections 1397.64(a)(1) and 1397.65 of these regulations.

(G) Establish a procedure for reconsideration of its decision that a provider or a provider's course does not meet statutory or regulatory criteria.

(b) Failure of a recognized accreditation agency to substantially comply with the provisions as set forth in this article shall constitute cause for revocation of recognition by the board. Recognition can be revoked only by a formal board action, after notice and hearing, and for good cause.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.65. Requirements for Approved Providers.

(a) Providers of continuing education courses in psychology shall apply to a board recognized accreditation agency for approval as a provider, and for approval of each course, prior to offering any such courses.

(b)(1) Upon satisfactory completion of the provider requirements of the accreditation agency, including payment of the appropriate fees and receipt of written approval therefrom, a continuing education provider may represent itself as a California approved provider of continuing education courses for psychologists for one year.

(2) Upon presentation of satisfactory evidence, organizations approved by the American Psychological Association (APA) as Sponsors of Continuing Education for Psychologists will be recognized as California approved providers of continuing education courses for psychologists during the duration of their APA approval, and shall be exempt from the annual continuing education provider fee described in section 1397.68. Such APA providers shall be held to all other requirements of California approved providers of continuing education for psychologists except for the individual course review requirement.

(c) The provider is responsible for assuring the educational quality of its course material. All continuing education course material shall meet the standards set forth in section 1397.64(a)(1) of these regulations and shall be:

(1) approved in advance by an accreditation agency (except for those courses offered by providers defined in section 1397.61(d), (e) and (f));

(2) specifically applicable and pertinent to the practice of psychology;

(3) accurate and timely;

(4) presented in an organized manner conducive to the learning process;

(5) complete and objective, and not reflecting predominantly any commercial views of the provider or presenter or of anyone giving financial assistance to the provider or presenter;

(6) based on stated educational goals and objectives; and

(7) accompanied by a syllabus which contains, at a minimum, the instructional objectives for each course and a summary containing the main points of each topic.

(d) All providers shall furnish a list of course participants, with the accompanying course attendee fee as required in section 1397.68, to the accreditation agency, and verification of attendance certificates to all participants within 45 days of course completion. The list and the certificate shall contain the name of the licensee and license number, name and number of the provider, title of the course, number of completed hours, date of completion, course number, if applicable, and the name of the accreditation agency.

(e) Every approved provider shall apply to the accreditation agency, on forms approved by the board (see form No. 07M–BOP–14(New 10/94)), at least 30 days in advance, for each continuing education course offered or presented, whether for the first time or repeated.

(f) The approved provider shall be required to maintain attendance records for three (3) years for each continuing education course. Acceptable documentation of participation shall include attendance rosters, sign–in and sign–out sheets, and completed course evaluation forms.

(g) The approved provider's course shall be valid for up to one year following the initial approval provided a notification and activity registration fee is submitted to the accreditation agency at least 30 days in advance for each time the course is offered or presented.

(h) The approved provider's advertisements for approved courses shall clearly indicate the provider's name, course title, course approval number, the number of credit hours, and the name of the accrediting agency.

(i) The approved provider shall have a written policy, available upon request, which provides information on:

1. refunds in case of non–attendance
2. time period for return of fees
3. notification if course is canceled.

(j) Providers may not grant partial credit for continuing education courses. However, conferences, in–service training programs and grand rounds consisting of a series of presentations may obtain approval for the entire conference, in–service training program or grand round as one course wherein credit may be granted to participants separately for each individual presentation in such courses.

(k) Provider approval is non–transferable. Approved providers shall inform the accrediting agency in writing within 30 days of any changes in organizational structure and/or person(s) responsible for continuing education program, including name and address changes.

(*l*) Providers are responsible for meeting all applicable local, state and federal standards which include, but are not limited to, the Americans with Disabilities Act.

(m) Providers may obtain approval for grand rounds activities for an entire year with one application provided the staff person responsible for grand rounds submits to the accreditation agency a general descriptive outline of grand rounds activities for the year. This outline shall be of sufficient detail regarding content to be covered in the weekly grand rounds activities to allow the accreditation agency to determine whether the activities are appropriate for continuing education credit for licensed psychologists.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.66. Provider Audit Requirements.

Upon written request from the accreditation agency or the board, relating to an audit of course material, each approved provider shall submit such materials as are required by the accreditation agency or the board.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.67. Renewal After Inactive or Delinquent Status.

(a) To activate licenses which have been placed on inactive status pursuant to section 2988 of the code, the licensee must submit evidence of completion of the requisite 36 hours of qualifying continuing education courses for the two–year period prior to establishing the license as active.

(b) For the renewal of a delinquent psychologist license within three years of the date of expiration, the applicant for renewal shall provide documentation of completion of the required hours of continuing education.

After a license has been delinquent for three years, the license is automatically cancelled and the applicant must submit a complete licensing application, meet all current licensing requirements, and successfully pass the licensing examination just as for the initial licensing application unless the board grants a waiver of the examination pursuant to section 2946 of the code.

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, 2984, 2986, and 2988, Business and Professions Code.

§ 1397.68. Provider Fees.

(a) The following fees are established to be paid to an accreditation agency by the course provider:

(1) Continuing education annual provider approval fee $200

(2) Continuing education course registration fee $35

(3) Continuing education conference fee $100

(4) Continuing education course attendee fee . . . . . $7 per licensee

These fees are to be paid by the provider to an accreditation agency as defined in section 1397.65(b), (d), and (g).

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.69. Participant Fees.

The following fees are established to be paid by the course participant:

(a) Participant report recording fee $35

This fee is to be paid to an accreditation agency to report non–accrediting agency approved courses taken by the participant as defined in section 1397.61(d), 1397.63(b) and 1397.64(a)(2)(C).

NOTE: Authority cited: Sections 2915(g) and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

ACCREDITING AGENCY
LOGO W/ADDRESS AND PHONE

Mandatory Continuing Education for Psychologists (MCEP)

NON–ACCREDITING AGENCY MCEP CREDIT REPORTING FORM

This form is used to report courses that are directly authorized for MCEP credit by law or BOP regulation rather than by a recognized accrediting agency. The purpose of this report is to integrate MCEP credit from all sources into one complete record for each psychologist. If you need further assistance with this report, call the accrediting agency at the number above.

DATE:_____ Psychology License #:_____

Last Name:_____

First Name:_____Phone #:_____

Address:_____

Address:_____

City:_____State:_____Zip:_____

Course/ Date	Provider Name	Course Title	# of Credit Hrs

Verification must be submitted for each course listed. Licensee must retain proof of attendance in the event the Board of Psychology requests verification. If more room is needed to list courses, please attach additional copies of this form. In order for this report to be processed, the regulated $35 filing fee must be enclosed.

07M–BOP–15(New 10/94)

Accrediting Agency

TEL:
FAX:

Course Application

Failure to complete this cover sheet and application will result in the return of the course application without further review. A separate course form is required for each course. Some of the information supplied may be published. Responses must be typed in the spaces provided.

Cover Sheet

A. Provider Information:

Provider Name:	
MCEP Provider #:	Phone:
MCEP Program Administrator:	MCEP Program Developer:

B. Course Information:

Course Title:	
Standard Course Fee: Discounts available? ☐ Yes ☐ No	
Course Description (limit to 50 words):	
Course Date(s):	Course Time(s):
Course Site Address	Phone:
	City State Zip
Course Level (choose one): ☐ Introductory (useful for psychologists new to this field) ☐ Intermediate (useful for psychologists with limited experience in this field) ☐ Advanced (useful for psychologists with extensive experience in this field)	Target Audience ☐ Licensed Psychologists ☐ Other Non–Mental Health Professionals ☐ MFCC/LCSW/LED's ☐ General Public ☐ MD/RN's
Total Instructional Time:	

C. Co–Sponsorship Information:

Is this course co–sponsored? ☐ Yes ☐ No	Name of co–sponsoring organization:
Contact Name:	Phone:
Address:	
	City State Zip

D. Primary Instructor Information:

Name:	Daytime Phone:	Fax:
Address:		
	City State Zip	

MCEP Course Application
California Psychological Association Accrediting Agency

Section I—Course Material

Standard: Course material will be pertinent, accurate and will clearly contribute in the area of practice, theory or methodology at a post–doctorate level.

Please enclose the following documents:

√ Course syllabus containing:
- ☐ Course Outline
- ☐ Description of Content
- ☐ Course Goals and Objectives

√ Primary Instructor vita.

Section II—Evaluation Process

Standard: Every course shall include an evaluation process that assesses both the effectiveness of the course and participant achievement in accordance to the course's goals and objectives.

Are the course evaluations part of a larger evaluation or needs assessment process? If yes, please describe their use.

Please enclose the following documents:

√ Course evaluation form

√ Describe the evaluation mechanism you will use for participants to assess their achievement in accordance with course objectives.

Section III—Administration

Standard: Course monitoring procedures (attendance list, credit assignment) and record keeping is in accordance with state regulations and policy.

A. Course Monitoring

1. Describe your procedures for monitoring course attendance.

2. How do you plan to identify psychology licensees who attend your programs?

MCEP Course Application *page 2 of 2*
California Psychological Association Accrediting Agency
Please enclose the following documents.

√ Sample attendee list format √ Sample attendance certificate √ Signed After Course Agreement

B. Co–sponsorship
If this course, or the larger event this course is part of, is sponsored in full or in part by another organization, this section of the application must be completed.

Identify the organization responsible for each of the following areas:

Course content
Course presentation
Course monitoring
Course records
Advertising/Marketing
Financial Arrangements
Administrative Policies

Section IV—Authorization

I certify, on behalf of _____, that the preceding statements and the enclosed
provider organization
documents are true. I understand that any false statements may result in the revocation of provider approval. I understand that I am responsible for maintaining all standards outlined in the provider application and that this course may be subject to either an unannounced on–site course audit or an administrative audit.

_____ _____
Program Developer Signature Date

_____ _____
Program Administrator Signature Date

Both signatures are required to process application.

Section V—Payment

A non–refundable MCEP course application fee of $35, made payable to the California Psychological Association Accrediting Agency must accompany 3 copies of the application including all attachments.

☐ Check enclosed ☐ Please bill my credit card:
☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Account #: _____ Exp. Date: _____

Signature: _____

Important

Completion of this form does not constitute MCEP course approval status. If granted, MCEP course approval will become effective on the date set forth in the notification of approval letter.

§ 1397.70. Sanctions for Noncompliance.

(a) If documentation of the CE requirement is improper or inadequate, the license becomes invalid for renewal. The continued practice of psychology is prohibited while the license is invalid for renewal, and the renewal is forfeited. Notwithstanding section 2984, the licensee shall correct the deficiency within six months. If the deficiency is not corrected within six months, the license remains invalid for renewal. Continued practice without a valid license shall constitute grounds for appropriate disciplinary action pursuant to sections 148 and/or 2960 of the code.

(b) Misrepresentation of compliance shall constitute grounds for disciplinary action.

NOTE: Authority cited: Sections 2915 and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

§ 1397.71. Denial, Suspension and Revocation of CE Provider Status.

(a) A board recognized accreditation agency may deny, suspend, place on probation with terms and conditions, or revoke its approval of an applicant or provider of continuing education for good cause. Good cause includes, but is not limited to, one or more of the following:

(1) Conviction of a felony or misdemeanor substantially related to the activities of an accreditation agency approved provider.

(2) Failure of an applicant or provider who is a psychologist, psychological assistant, psychological intern or registered psychologist to comply with any provisions of the Psychology License Law (Business and Professions Code Section 2900 *et seq.*) or the regulations adopted pursuant thereto in Division 13.1 of Title 16 (commencing with section 1380) of the California Code of Regulations.

(3) Failure of an applicant or provider, who is a licensee of another healing arts board, to comply with the statutes and regulations governing that license.

(4) Making a material misrepresentation of fact in information submitted to the board recognized accreditation agency or to the board.

(5) Failure to comply with provisions of the Psychology License Law (Business and Professions Code Section 2900 *et seq.*), or the regulations adopted pursuant thereto in Division 13.1 of Title 16 (commencing with section 1380) of the California Code of Regulations, applicable to continuing education providers.

(b) After a thorough case review, if the board recognized accreditation agency denies, suspends, places on probation with terms or conditions, or revokes its approval of a provider, it shall give the applicant or provider written notice setting forth its reasons for the denial, suspension, placing on probation with terms and conditions, or revocation. The applicant or provider may appeal the action in writing within fifteen (15) days after receipt of the notice, and request a hearing before a panel appointed by the recognized accreditation agency. A suspension or revocation of approval shall be stayed upon the filing of an appeal. A denial of approval shall not be stayed.

The panel shall consist of three persons who have not been involved in the determination to deny, suspend or revoke the approval of the applicant or provider. The panel shall hear the appeal within 60 days of the receipt of the appeal, and maintain a record of the proceedings. A decision in writing shall be issued within 30 days of the date of the hearing.

If the appointed panel sustains the denial, placing on probation with terms and conditions, suspension or revocation, the applicant or provider may appeal the decision of the panel to a Continuing Education Appeals Committee (CE Appeals Committee) of the board. The CE Appeals Committee shall be appointed by the board's president and consist of two board members, one public member and one licensed psychologist member. The appeal must be filed with the board within seven (7) days after receipt of the panel's decision. Upon filing of the appeal, the CE Appeals Committee chairperson shall have discretion to extend the stay of the suspension or revocation. The hearing of the CE Appeals Committee shall take place at a date and location established by the Committee chairperson, the date not to exceed 60 days from the date of the filing of the appeal. The record of the panel's hearing shall be made available to the CE Appeals Committee. The Committee shall issue a written decision within 30 days of the date of the hearing.

The decision of the CE Appeals Committee is final. An applicant or provider who has had his or her application or provider status denied or revoked may not reapply for provider status for a period of one year from the date of the CE Appeals Committee's decision.

NOTE: Authority cited: Sections 2915 and 2930, Business and Professions Code. Reference: Section 2915, Business and Professions Code.

Division 18. Board of Behavioral Sciences

(Originally Printed 12–5–46)

Article 1. General Provisions

§ 1800. Declaratory Decisions.

No decision or opinion issued by the Board is a declaratory decision under Government Code Sections 11465.10.–11465.70. unless the decision or opinion specifically states that it is a "Declaratory Decision".

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 11465.10–11465.70, Government Code.

§ 1801. Tenses, Gender, and Number.

§ 1802. Definitions.

For the purpose of the rules and regulations contained in this chapter, the term "board" means the Board of Behavioral Sciences; and the term "Code" means the Business and Professions Code.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4990 and 4990.1, Business and Professions Code.

§ 1803. Delegation of Certain Functions.

The power and discretion conferred by law upon the board to receive and file accusations; issue notices of hearing, statements to respondent and statements of issues; receive and file notices of defense; determine the time and place of hearings under Section 11508 of the Government Code; issue subpoenas and subpoenas duces tecum; set and calendar cases for hearing and perform other functions necessary to the efficient dispatch of the business of the board in connection with proceedings under the provisions of Section 11500 through 11528 of the Government Code, prior to the hearing of such proceedings; and the certification and delivery or mailing of copies of decisions under Section 11518 of said code are hereby delegated to and conferred upon the executive officer, or, in his or her absence from the office of the board, the acting executive officer.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.07, 4990.8 and 4990.13, Business and Professions Code; and Section 11500–11528, Government Code.

§ 1804. Filing of Addresses.

Each person or professional corporation regulated by the board shall maintain a current mailing address with the board and shall notify the board within thirty (30) days concerning any change of address giving both the old and new addresses.

NOTE: Authority cited: Sections 4980.60, 4990.11 and 4990.14, Business and Professions Code. Reference: Sections 4980.07, 4990.11 and 4990.13, Business and Professions Code.

§ 1805. Applications.

(a) Applications submitted to the board for registration or licensure shall be on a form prescribed by the board.

(b) The board may issue final filing dates for all examinations not to exceed ninety (90) days prior to any examination. An applicant who fails to submit a complete examination application to the board by a final filing date shall not be eligible for that examination and his or her application shall be considered abandoned if it meets the criteria in Section 1806(c).

NOTE: Authority cited: Sections 4980.60, 4988.2 and 4990.14, Business and Professions Code. Reference: Sections 4980.30, 4980.40, 4986.20, 4987.6, 4992 and 4996.2, Business and Professions Code.

§ 1805.1. Permit Processing Times.

"Permit" as defined by the Permit Reform Act of 1981 means any license, certificate, registration, permit or any other form of authorization required by a state agency to engage in a particular activity or act. Processing times for the board's various programs are set forth below. The actual processing times reflect the period from the date the board receives an application to the date a license or registration is issued, and apply to those persons who take and pass the first actual available examination.

Program	*Maximum time for notifying that application is complete or deficient*	*Maximum time after receipt of a complete application to issue or deny license or registration*	*ACTUAL PROCESSING TIMES BASED ON PRIOR TWO YEARS*		
			Minimum	*Median*	*Maximum*
MFT Intern Registration	60 days	30 days	15	100	186
MFT License	90 days	120 days	104	182	260
LCSW Associate Registration	60 days	30 days	15	53	90
LCSW License	90 days	120 days	104	178	253
LEP License	90 days	120 days	98	179	260
CE Provider Approval	30 days	30 days	n/a	n/a	n/a
MFT Referral Service Registration	30 days	30 days	n/a	n/a	n/a
All Renewals	30 days	60 days	28	42	56

NOTE: Authority cited: Sections 650.4, 4980.60 and 4990.14, Business and Professions Code. Reference: Section 15376, Government Code.

§ 1806. Abandonment of Application.

An application shall be deemed abandoned if:

(a) The application has not been completed by the applicant within one (1) year after it has been filed. An application shall be deemed complete when all documents and information required have been submitted to the board; or

(b) The applicant does not submit information that he or she has corrected the deficiencies specified in a deficiency letter within one (1) year from the date of the deficiency letter; or

(c) The applicant fails to sit for examination within one (1) year after being notified of eligibility; or

(d) The applicant fails to pay the initial license fee within one (1) year after notification by the board of successful completion of examination requirements.

An application submitted subsequent to the abandonment of a prior application shall be treated as a new application.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.30, 4980.35, 4984.7, 4986.20, 4986.80, 4992 and 4996.3, Business and Professions Code.

§ 1807. Human Sexuality Training.

The human sexuality training required of marriage and family therapists and clinical social workers by Sections 25 and 4980.41 of the Code shall:

(a) Consist of a minimum of ten (10) hours of training or coursework.

(b) Include the study of physiological–psychological and social–cultural variables associated with sexual identity, sexual behavior or sexual disorders.

(c) Have been completed after January 1, 1970, and shall have been obtained from one of the educational institutions or entities specified herein:

(1) An educational institution accredited by one or more of those entities specified in Section 1832 of these regulations, including extension courses offered by such institutions; or

(2) An educational institution approved by the Bureau for Private Postsecondary and Vocational Education pursuant to Sections 94900 and 94901 of the Education Code; including extension courses offered by such institutions; or

(3) A continuing education provider approved by the board; or

(4) A course sponsored by a professional association; or

(5) A course sponsored, offered, or approved by a state, county, or local department of health services or department of mental health.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 25, 4980.41, 4980.54 and 4996.22, Business and Professions Code.

§ 1807.1. Human Sexuality Training; Renewal and Documentation.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Section 25, Business and Professions Code.

§ 1807.2. Child Abuse Assessment Training Requirements.

All persons applying for a license or renewal of a license as a marriage and family therapist or clinical social worker shall in addition to all other requirements for licensure, have completed coursework or training in child abuse assessment and reporting and shall submit documentation to the board. The coursework or training in child abuse assessment and reporting shall consist of not less than 7 classroom hours and shall include training in each of the subject areas described in Section 28 of the Code. The coursework or training shall be:

(a) Obtained at an educational institution, or in an extension course offered by an institution which is accredited by the Western Association of Schools and Colleges, or approved by the Bureau for Private Postsecondary and Vocational Education, pursuant to Sections 94900 and 94901 of the Education Code; or

(b) Obtained from a statewide professional association representing the professions of psychology, social work or marriage and family therapy; or

(c) Obtained from or sponsored by a local, county, state or federal governmental entity, or licensed health facility; or

(d) Obtained from a continuing education provider approved by the board.

(e) Completed after January 1, 1983.

NOTE: Authority cited: Sections 28, 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 28, 4980.54 and 4996.22, Business and Professions Code; and Sections 11165 and 11166, Penal Code.

§ 1808. Surrender of Suspended or Revoked Licenses.

§ 1809. Results of Examination.

NOTE: Authority cited: Section 17806, Business and Professions Code. Reference: Sections 17800, 17800.2, 17800.3, 17800.7, 17801, 17803, 17804, 17804.1, 17804.2, 17804.3, 17804.4, 17804.5, 17805, 17806, 17820 and 17847, Business and Professions Code.

§ 1810. Alcoholism and Other Chemical Substance Dependency Training.

(a) The instruction and training in alcoholism and other chemical substance dependency required by Sections 4980.41, 4980.80, 4980.90, 4996.2, and 4996.17 of the Code shall consist of not less than fifteen hours of classroom training or coursework and shall include each of the following areas:

(1) The definition of alcoholism and other chemical dependency, and the evaluation of the abuser.

(2) Medical aspects of alcoholism and other chemical dependency.

(3) Current theories of the etiology of substance abuse.

(4) The role of persons and systems that support or compound the abuse.

(5) Major treatment approaches to alcoholism and chemical dependency.

(6) Legal aspects of substance abuse.

(7) Knowledge of certain populations at risk with regard to substance abuse.

(8) Community resources offering assessment, treatment and follow–up for the abuser and family.

(9) The process of referring affected persons.

(10) Education concerning and prevention of substance abuse.

(b) For persons subject to Section 4980.41(d) of the Code, the training or coursework shall be:

(1) Obtained from an educational institution or in an extension course offered by an institution that is either accredited by one or more of the entities specified in Section 1832 of these regulations or is approved by the Bureau for Private Postsecondary and Vocational Education pursuant to Sections 94900 and 94901 of the Education Code;

(c) For all others, the training or coursework shall be:

(1) Obtained from the educational institutions identified in subsection (b)(1); or

(2) Obtained from or sponsored by a local, county, state or federal governmental entity; or

(3) Obtained from a licensed health facility; or

(4) Obtained from a continuing education provider approved by the board.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.41, 4980.80, 4980.90, 4996.2 and 4996.17, Business and Professions Code.

§ 1811. Use of License Number in Directories and Advertisements.

All persons or referral services regulated by the board who advertise their services shall include their license or registration number in the advertisement unless such advertisement contains the following specific information:

(a) The full name of the licensee or registered referral service as filed with the board; and

(b) A designation of the type of license or registration held as follows:

(1) Licensed Marriage and Family Therapist.

(2) Licensed Educational Psychologist.

(3) Licensed Clinical Social Worker.

(4) Registered MFT Referral Service.

(c) An unlicensed Marriage and Family Therapist Registered Intern may advertise if such advertisement complies with Section 4980.44(a)(4) of the Code making disclosures required by that section.

(d) An unlicensed Associate Clinical Social Worker may advertise if such advertisement complies with Section 4996.18(e) of the Code making disclosures required by that section.

NOTE: Authority cited: Sections 137, 650.4, 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 137, 4980.44 and 4996.18, Business and Professions Code.

§ 1812. Substantial Relationship Criteria.

For purposes of denial, suspension, or revocation of a license or registration pursuant to Division 1.5 (commencing with Section 475) of the Code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a person holding a license under Chapter 17 of Division 3 and Chapter 4 of Part 3 of Division 7 of the Code if to a substantial degree it evidences present or potential unfitness of a person holding a license to perform the functions authorized by his or her license in a manner consistent with the public health, safety or welfare.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 481, 490 and 4982, Business and Professions Code.

§ 1813. Criteria for Rehabilitation—Denial of Licensure.

When considering the denial of a license or registration under Section 480 of the Code, the board, in evaluating the rehabilitation of the applicant and his or her present eligibility for a license or registration shall consider the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(b) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480 of the Code.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in Section 480 of the Code.

(d) The extent to which the applicant has complied with any terms of probation, parole, restitution, or any other sanctions lawfully imposed against the applicant.

(e) Evidence, if any, of rehabilitation submitted by the applicant.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 482 and 4982, Business and Professions Code.

§ 1814. Criteria for Rehabilitation—Suspensions or Revocations.

(a) When considering the suspension or revocation of a license, the board, in evaluating the rehabilitation of such person and his or her eligibility for a license will consider the following criteria:

(1) Nature and severity of the act(s) or crime(s) under consideration as grounds for suspension or revocation.

(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for suspension or revocation under Section 490 of the Code.

(3) The time that has elapsed since commission of the act(s) or crime(s) giving rise to the suspension or revocation.

(4) Whether the licensee has complied with any terms of probation, parole, restitution or any other sanctions lawfully imposed against such person.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, concerning the degree to which a false statement relative to application for licensure may have been unintentional, inadvertent or immaterial.

(7) Efforts made by the applicant either to correct a false statement once made on an application or to conceal the truth concerning facts required to be disclosed.

(8) Evidence, if any, of rehabilitation submitted by the licensee.

(b) When considering a petition for reinstatement of a license or registration under the provisions of Section 11522 of the Government Code, the board shall evaluate evidence of rehabilitation submitted by the petitioner considering those criteria specified in Section 1813 of this article.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 482 and 4982, Business and Professions Code.

§ 1815. Oral Examination Appeals.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.50, 4984.7, 4986.80, 4992.1 and 4996.3, Business and Professions Code.

Article 2. Fees

§ 1816. Renewal Fees.

(a) The biennial renewal fee for a marriage and family therapist is one hundred fifty dollars ($150.00). For those persons whose license expires on or after July 1, 1998, the biennial renewal fee shall be one hundred thirty dollars ($130.00) except for the period of time in subsection (h).

(b) The biennial renewal fee for a licensed clinical social worker is one hundred fifty dollars ($150.00). For those persons whose license expires on or after July 1, 1998, the biennial renewal fee shall be one hundred dollars ($100.00) except for the period of time in subsection (i).

(c) The biennial renewal fee for a licensed educational psychologist is eighty dollars ($80.00) for each person whose license expires on or after July 1, 1998 except for the period of time in subsection (j).

(d) The biennial renewal fee for a board–approved continuing education provider is two hundred dollars ($200.00).

(e) The annual renewal fee for intern registration is seventy–five dollars ($75.00).

(f) The annual renewal fee for associate clinical social worker registration is seventy–five dollars ($75.00).

(g) The fee for associate clinical social worker extension is fifty dollars ($50.00).

(h) For the period of January 1, 2001 through December 31, 2002, the biennial renewal fee for a marriage and family therapist is twenty–five dollars ($25.00).

(i) For the period of January 1, 2001 through December 31, 2002, the biennial renewal fee for a licensed clinical social worker is twenty–five dollars ($25.00).

(j) For the period of January 1, 2001 through December 31, 2002, the biennial renewal fee for a licensed educational psychologist is twenty–five dollars ($25.00).

NOTE: Authority cited: Sections 4980.54, 4980.60, 4990.14 and 4994.1, Business and Professions Code. Reference: Sections 4980.54, 4984.7, 4986.80, 4994.1, 4996.6, 4996.18 and 4996.22, Business and Professions Code.

§ 1816.1. Initial License and Registration Fees.

(a) On or after July 1, 1998, the fee for issuance of the initial marriage and family therapist license shall be one hundred thirty dollars ($130.00).

(b) On or after July 1, 1998, the fee for issuance of the initial clinical social worker license shall be one hundred dollars ($100.00).

(c) On or after July 1, 1998, the fee for issuance of the initial educational psychologist license shall be eighty dollars ($80.00).

(d) The fee for issuance of the initial intern registration shall be seventy–five dollars ($75.00).

(e) The fee for issuance of the initial associate clinical social worker registration shall be seventy–five dollars ($75.00).

NOTE: Authority cited: Sections 4980.60, 4990.14 and 4994.1, Business and Professions Code. Reference: Sections 4984.7, 4986.80, 4994.1, 4996.3 and 4996.18, Business and Professions Code.

§ 1816.2. Written Examination and Re–Examination Fees.

(a) The examination and re–examination fee for the standard written examination of the licensed clinical social worker shall be one hundred dollars ($100.00).

(b) The examination and re–examination fee for the written clinical vignette examination of the licensed clinical social worker shall be one hundred dollars ($100.00).

(c) The examination and re–examination fee for the standard written examination of the marriage and family therapist shall be one hundred dollars ($100.00).

(d) The examination and re–examination fee for the written clinical vignette examination of the marriage and family therapist shall be one hundred dollars ($100.00).

(e) The examination and re–examination fee for the written examination of the licensed educational psychologist shall be one hundred dollars ($100.00).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.7, 4986.80, 4996.3(a) and 4996.4, Business and Professions Code.

§ 1816.3. Examination Rescoring Fees.

The fee for rescoring any marriage and family therapist, licensed clinical social worker, or licensed educational psychologist written examination shall be twenty dollars ($20.00).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.7, 4986.80 and 4996.3, Business and Professions Code.

§ 1816.4. Examination Application Fees.

(a) The examination application fee for the marriage and family therapist shall be one hundred dollars ($100.00).

(b) The examination application fee for the licensed clinical social worker shall be one hundred dollars ($100.00).

(c) The examination application fee for the licensed educational psychologist shall be one hundred dollars ($100.00).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.7, 4986.80 and 4996.3, Business and Professions Code.

§ 1816.5. Replacement and Certification Fees.

(a) The fee for issuance of any replacement registration, license, or certificate shall be twenty dollars ($20.00).

(b) The fee for issuance of a certificate or letter of good standing shall be twenty–five dollars ($25.00).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.7, 4986.80 and 4996.6, Business and Professions Code.

§ 1816.6. Inactive License Fees.

(a) The fee for issuance of the inactive marriage and family therapist license shall be sixty–five dollars ($65.00) except for the period of time in subsection (d).

(b) The fee for issuance of the inactive licensed clinical social worker license shall be fifty dollars ($50.00) except for the period of time in subsection (e).

(c) The fee for issuance of the inactive licensed educational psychologist license shall be forty dollars ($40.00) except for the period of time in subsection (f).

(d) For the period of January 1, 2001 through December 31, 2002, the fee for issuance of the inactive marriage and family therapist license shall be twelve dollars and fifty cents ($12.50).

(e) For the period of January 1, 2001 through December 31, 2002, the fee for issuance of the inactive licensed clinical social worker license shall be twelve dollars and fifty cents ($12.50).

(f) For the period of January 1, 2001 through December 31, 2002, the fee for issuance of the inactive licensed educational psychologist license shall be twelve dollars and fifty cents ($12.50).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.8, 4986.82 and 4997, Business and Professions Code.

§ 1816.7. Delinquent License Fees.

(a) The delinquency fee for the marriage and family therapist license shall be sixty–five dollars ($65.00) except for the period of time in subsection (d).

(b) The delinquency fee for the licensed clinical social worker license shall be fifty dollars ($50.00) except for the period of time in subsection (e).

(c) The delinquency fee for the licensed educational psychologist license shall be forty dollars ($40.00) except for the period of time in subsection (f).

(d) For the period of January 1, 2001 through December 31, 2002, the delinquency fee for the marriage and family therapist license shall be twenty–five dollars ($25.00).

(e) For the period of January 1, 2001 through December 31, 2002, the delinquency fee for the licensed clinical social worker license shall be twenty–five dollars ($25.00).

(f) For the period of January 1, 2001 through December 31, 2002, the delinquency fee for the licensed educational psychologist license shall be twenty–five dollars ($25.00).

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4984.7, 4986.80 and 4996.6, Business and Professions Code.

§ 1817. Professional Corporation Fees.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4987.6, 4987.7, 4998.1 and 4998.2, Business and Professions Code.

§ 1818. Licensed Educational Psychologist Fees.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 152.6 and 4986.80, Business and Professions Code.

§ 1819. Refund of Application Fee.

§ 1819.1. Continuing Education Provider Fees.

The application fee for board approval as a continuing education provider is two hundred dollars ($200.00). This fee also covers the issuance of the initial two–year continuing education provider approval.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

Article 3. Registered Social Workers

§ 1820. Definition of Registered Social Worker.

§ 1821. Eligibility for Examination.

NOTE: Reference: Section 9023, Business and Professions Code.

§ 1821.5. Verification.

NOTE: Reference: Sections 9022 and 9023, Business and Professions Code.

§ 1822. Graduates of Foreign Schools.

§ 1823. Results of Examination.

NOTE: Reference: Sections 9006 and 9011, Business and Professions Code.

Article 4. Marriage and Family Therapist

§ 1829. Examinations.

The written examinations shall consist of the following:

(a) A standard written examination designed to determine an applicant's knowledge, familiarity with the field, and practical understanding of the principles, techniques, objectives, theory and laws under which he or she must operate; and

(b) A written clinical vignette examination designed to assess the applicant's judgment, knowledge of the application of psychosocial and psychotherapeutic methods and measures in treatment, and ability to assume professional responsibilities.

NOTE: Authority cited: Sections 4980.40 and 4980.60, Business and Professions Code. Reference: Section 4980.40, Business and Professions Code.

§ 1830. Education Requirements of Application.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 25, 4980.40 and 4980.41, Business and Professions Code.

§ 1831. Minimum Educational Requirements.

§ 1832. Equivalent Accrediting Agencies.

The following accrediting agencies are essentially equivalent to Western College Association, which has been renamed the Western Association of Schools and Colleges, and Northwest Association of Secondary and Higher Schools:

(a) Middle States Association of Colleges and Secondary Schools.

(b) New England Association of Schools and Colleges.

(c) North Central Association of Colleges and Secondary Schools.

(d) Southern Association of Colleges and Schools.

(e) The Credentials Evaluation Service of the International Education Research Foundation, Inc. when it evaluates the foreign degree as being equivalent to the required degrees, and those foreign degree programs meet the educational requirements for equivalent degrees and the specific course content and educational requirements as set forth in sections 4980.40 and 4980.41 of the Code.

(f) State of California, Department of Education, Bureau of School Approvals with respect to its functions under Education Code section 29023(a)(2), when applied to master's degree and/or doctoral programs which meet the requirements for an equivalent degree pursuant to section 1830 of these regulations, and the specific course content and educational requirements as set forth in sections 4980.40 and 4980.41, of the Code.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference:Sections 4980.40 and 4980.41, Business and Professions Code.

§ 1833. Experience.

(a) In order for experience to qualify under Section 4980.40(f) of the code, it must meet the following criteria:

(1) It must have been gained in accordance with Sections 4980.42 through 4980.45 of the Code and the regulations contained in this article.

(2) Experience shall not be credited for more than forty (40) hours in any week.

(3) No more than five hundred (500) hours of experience will be credited for providing group therapy or group counseling.

(4) No more than two hundred fifty (250) hours of experience will be credited for administering and evaluating psychological tests of counselees, writing clinical reports, writing progress notes, or writing process notes; except that for any person who enrolled in a qualifying degree program prior to January 1, 1990, no more than five hundred (500) hours of experience may be credited for such activities.

(5) For any person who enrolls in a qualifying degree program on or after January 1, 1990, no more than two hundred fifty (250) hours of experience will be credited for actual time spent counseling or crisis counseling on the telephone.

(6) For any person who enrolls in a qualifying degree program on or after January 1, 1990, not less than five hundred (500) total hours of experience shall have been gained in diagnosing and treating couples, families and children.

(b) The term "supervision", as used in this article, includes ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised; reviewing client/patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the intern or trainee; monitoring and evaluating the ability of the intern or trainee to provide services at the site(s) where he or she will be practicing and to the particular clientele being served; and ensuring compliance with laws and regulations governing the practice of marriage and family therapy. Supervision shall include that amount of direct observation, or review of audio or video tapes of therapy, as deemed appropriate by the supervisor. Supervision shall be credited only upon the following conditions:

(1) During each week in which experience is claimed and for each work setting in which experience is gained, an applicant shall have at least one (1) hour of one–on–one, individual, face–to–face supervisor contact or two (2) hours of face–to–face supervisor contact in a group of not more than eight (8) persons receiving supervision. No more than five (5) hours of supervision, whether individual or group, shall be credited during any single week.

(2) The applicant shall have received at least one (1) hour of one–on–one, individual, face–to–face supervisor contact per week for a minimum of fifty–two (52) weeks.

(3) Any experience obtained under the supervision of a spouse, relative, or domestic partner shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal or business relationship which undermines the authority or effectiveness of the supervisor shall not be credited toward the required hours of supervised experience.

(4) In a setting which is not a private practice, the authorized supervisor may be employed by the applicant's employer on either a paid or a voluntary basis. If such employment is on a voluntary basis, a written agreement must be executed between the supervisor and the organization, prior to commencement of supervision, in which the supervisor agrees to ensure that the extent, kind, and quality of counseling performed by the intern or trainee is consistent with the intern or trainee's training, education, and experience, and is appropriate in extent, kind, and quality. The agreement shall contain an acknowledgment by the employer that the employer:

(A) Is aware of the licensing requirements that must be met by the intern or trainee and agrees not to interfere with the supervisor's legal and ethical obligations to ensure compliance with those requirements; and

(B) Agrees to provide the supervisor access to clinical records of the clients counseled by the intern or trainee.

(c) Professional enrichment activities may be credited toward the experience requirement as specified in this article and by Section 4980.43(d)(1) of the Code.

(1) No more than two hundred fifty (250) hours of verified attendance, with the approval of the applicant's supervisor, at workshops, seminars, training sessions, or conferences directly related to marriage and family therapy will be credited.

(2) No more than one hundred (100) hours of psychotherapy, which will be triple counted, received as specified in Section 4980.43(d)(2) of the Code, will be credited.

(d) Experience gained by interns and trainees shall be subject to the following conditions, as applicable:

(1) When an intern employed in private practice is supervised by someone other than the employer, the supervisor must be employed by and practice at the same site(s) as the intern's employer.

(2) A trainee shall not perform services in a private practice.

(3) Interns and trainees may only perform services as employees or volunteers and not as independent contractors.

(e) Effective January 1, 1991, trainees and interns shall maintain a log of all hours of experience gained toward licensure. The log shall be in the form specified below and shall be signed by the supervisor on a weekly basis. An applicant shall retain all logs until such time as the applicant is licensed by the board. The board shall have the right to require an applicant to submit all or such portions of the log as it deems necessary to verify hours of experience.

STATE OF CALIFORNIA

WEEKLY SUMMARY OF HOURS OF EXPERIENCE

1800 37A–524(REV. 1/99)

BOARD OF BEHAVIORAL SCIENCES
400 R ST., SUITE 3150, SACRAMENTO, CA 95814–6240
TELEPHONE: (916)445–4933 TDD: (916)322–1700
WEBSITE ADDRESS: http://www.bbs.ca.gov

Note: Child Counseling can be logged in any appropriate category as specified by your supervisor.

THIS FORM SHALL BE COMPLETED PURSUANT TO TITLE 16, CALIFORNIA CODE OF REGULATIONS SECTION 1833(e).

(Use a separate log for each supervised work setting and for each status indicated below.)

YEAR_____

Name of MFCC Intern/Trainee_____ BBS File No. *(if known)*_____

Work Setting:_____
Name and Address of Employer

Date enrolled in graduate degree program _____

Indicate the status of the MFCC Intern for the hours logged:

☐ Trainee ☐ Post–Degree with Application Pending for Intern Registration [B & P Code Section 4980.43(h)]

☐ Trainee in Practicum ☐ Registered Intern (MFCC Intern No. _____)

WEEK OF:														Total Hours
Individual Psychotherapy (performed by you)														
Couples, Families, and Children (min. 500 hrs.)														
Group Therapy or Counseling (performed by you)														
Telephone Counseling (actual counseling time performed by you)														
Administering & Evaluating Psych. Tests, Writing Clinical Reports, writing progress or process notes														
Supervision, Individual Face–to–Face														
Supervision, Group														
Workshops, Seminars, Training Sessions or Conferences														
Total Per Week														
SIGNATURE OF SUPERVISOR														

This form may be reproduced

NOTE: Authority cited: Sections 4980.35 and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40(f), and 4980.42 through 4980.45, Business and Professions Code.

§ 1833.1. Requirements for Supervisors.

(a) Any person supervising an intern or trainee (hereinafter "supervisor") within California shall comply with the requirements set forth below and shall, prior to the commencement of such supervision, sign under penalty of perjury the "Responsibility Statement for Supervisors of a Marriage and Family Therapist Trainee or Intern" revised 12/05, requiring that:

(1) The supervisor possesses and maintains a current valid California license as either a marriage and family therapist, licensed clinical social worker, licensed psychologist, or physician who is certified in psychiatry as specified in Section 4980.40(f) of the Code and has been so licensed in California for at least two years prior to commencing any supervision; or

(A) Provides supervision only to trainees at an academic institution that offers a qualifying degree program as specified in Section 4980.40(a) of the Code; and

(B) Has been licensed in California as specified in Section 4980.40(f) of the Code, and in any other state, for a total of at least two years prior to commencing any supervision.

(2) If such supervisor is not licensed as a marriage and family therapist, he or she shall have sufficient experience, training, and education in marriage and family therapy to competently practice marriage and family therapy in California.

(3) The supervisor keeps himself or herself informed of developments in marriage and family therapy and in California law governing the practice of marriage and family therapy.

(4) The supervisor has and maintains a current license in good standing and will immediately notify the intern or trainee of any disciplinary action, including revocation or suspension, even if stayed, probation terms, inactive license status, or lapse in licensure, that affects the supervisor's ability or right to supervise.

(5) The supervisor has practiced psychotherapy for at least two (2) years within the five (5) year period immediately preceding any supervision and has averaged at least five (5) patient/client contact hours per week.

(6) The supervisor has had sufficient experience, training and education in the area of clinical supervision to competently supervise trainees or interns.

(A) Effective January 1, 2000, supervisors who are licensed by the board shall complete a minimum of six (6) hours of supervision training or coursework every two years. This training or coursework may apply towards the continuing education requirements set forth in Sections 4980.54 and 4996.22 of the Code.

(B) Supervisors who are licensed by the board who have completed a minimum of six (6) hours of supervision training or coursework between January 1, 1997, and December 31, 1999, may apply that training towards the requirement described in subsection (A).

(C) Supervisors who are licensed by the board who commence supervision on and after January 1, 2000, and have not met requirements of subsection (A), shall complete a minimum of six (6) hours of supervision training or coursework within sixty (60) days of commencement of supervision.

(7) The supervisor knows and understands the laws and regulations pertaining to both the supervision of trainees and interns and the experience required for licensure as a marriage and family therapist.

(8) The supervisor shall ensure that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the intern or trainee.

(9) The supervisor shall monitor and evaluate the extent, kind, and quality of counseling performed by the intern or trainee by direct observation, review of audio or video tapes of therapy, review of progress and process notes and other treatment records, or by any other means deemed appropriate by the supervisor.

(10) The supervisor shall address with the intern or trainee the manner in which emergencies will be handled.

(b) Each supervisor shall provide the intern or trainee with the original signed "Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee" revised 12/05 prior to the commencement of any counseling or supervision. The intern shall provide the board with his or her signed "Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee" revised 12/05 from each supervisor upon application for licensure. The trainee shall provide the board with his or her signed "Responsibility Statement for Supervisors of a Marriage and Family Therapist Intern or Trainee" revised 12/05 from each supervisor upon application for internship.

(c) A supervisor shall give at least one (1) week's written notice to an intern or trainee of the supervisor's intent not to certify any further hours of experience for such person. A supervisor who has not provided such notice shall sign for hours of experience obtained in good faith where such supervisor actually provided the required supervision.

(d) The supervisor shall obtain from any intern or trainee for which supervision will be provided, the name, address, and telephone number of the intern's or trainee's most recent supervisor and employer.

(e) In any setting that is not a private practice, a supervisor shall evaluate the site(s) where an intern or trainee will be gaining hours of experience toward licensure and shall determine that: (1) the site(s) provides experience which is within the scope of marriage and family therapy; and (2) the experience is in compliance with the requirements set forth in this section.

(f) Upon written request of the board, the supervisor shall provide to the board any documentation which verifies the supervisor's compliance with the requirements set forth in this section.

(g) The supervisor responsibility statement required by this section shall be used for supervisorial relationships commencing on or after 1–1–98.

(h) The board shall not deny hours of experience gained towards licensure by any supervisee due to failure of his or her supervisor to complete the training or coursework requirements in subsection (a)(6).

NOTE: Authority cited: Sections 4980.35, 4980.40(f) and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40(f), 4980.42–4980.45, 4980.54 and 4996.22, Business and Professions Code.

§ 1833.2. Supervision of Experience Gained Outside of California.

Experience gained outside of California on or after January 1, 1991 must have been supervised in accordance with the following criteria:

At the time of supervision, the supervisor was licensed or certified by the state in which the supervision occurred and possessed a current license which was not under suspension or probation. The supervisor was licensed or certified by that state, for at least two (2) years prior to acting as supervisor, as either a psychologist, clinical social worker, physician certified in psychiatry as specified in Section 4980.40(f) of the code, or a marriage and family therapist or similarly titled marriage and family practitioner.

In a state which does not license or certify marriage and family therapists or similarly titled marriage and family practitioners, experience may be obtained under the supervision of a person who at the time of supervision held a clinical membership in the American Association of Marriage and Family Therapists for at least two years and who maintained such membership throughout the period of supervision.

NOTE: Authority cited: Sections 4980.35, 4980.40(f) and 4980.60, Business and Professions Code. Reference: Sections 4980.35, 4980.40(f), 4980.42–4980.45 and 4980.90, Business and Professions Code.

§ 1833.3. Reexamination.

An applicant who fails any examination may within one (1) year from the date of that failure retake that examination as regularly scheduled without further application upon payment of the required examination fees. Thereafter, the applicant shall not be eligible for further examination unless a new application is filed, meeting all requirements, and required fees are paid.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 4980.40 and 4980.50, Business and Professions Code.

§ 1834. Improper Advertising.

§ 1834.5. Notification of Degrees.

NOTE: Authority cited: Sections 9012 and 17806, Business and Professions Code. Reference: Sections 9023, 17804, 17808, 17820, Business and Professions Code.

§ 1834.6. Criteria for Use of Hypnosis.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 4980.02 and 4980.40, Business and Professions Code.

§ 1835. Licensure Required.

NOTE: Authority cited: Section 17806, Business and Professions Code. Reference: Sections 17800, 17800.2, 17800.3, 17800.7, 17801, 17803, 17804, 17804.1, 17804.2, 17804.3, 17804.4, 17804.5, 17805, 17806, 17820 and 17847, Business and Professions Code.

§ 1836. Supervision of Unlicensed Counselors.

§ 1840. Display of License.

§ 1841. Human Sexuality Training.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1841.1. Human Sexuality Training Required for Licensees.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1841.2. Renewal Dependent upon Training Documentation.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1845. Unprofessional Conduct.

As used in Section 4982 of the code, unprofessional conduct includes, but is not limited to:

(a) Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

(b) Permitting a trainee or intern under his or her supervision or control to perform or permitting the trainee or intern to hold himself or herself out as competent to perform professional services beyond the trainee's or intern's level of education, training and/or experience.

(c) Failing to comply with the child abuse reporting requirements of Penal Code Section 11166.

(d) Failing to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institutions Code Section 15630.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 4980.03, 4980.60 and 4982, Business and Professions Code; Section 11166, Penal Code; and Section 15630, Welfare and Institutions Code.

§ 1846. Marriage and Family Therapist Interns.

The registration of each intern shall expire at midnight one year from the last day of the month in which the registration was issued.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 4980.03(b), 4980.44 and 4984.7(e), Business and Professions Code.

§ 1846.1. Notification of Employment and Termination of a Registered Marriage and FamilyTherapist Intern.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Sections 4980.40, 4980.42 and 4980.60, Business and Professions Code.

§ 1848. Surrender of Suspended or Revoked Licenses.

Article 4.5. Professional Corporations

§ 1850. Citation of Rules.

NOTE: Authority cited: Sections 9012, 9077, 17806 and 17882, Business and Professions Code. Reference for Article 4.5: Section 17875, et seq., Business and Professions Code; Section 13400, et seq., Corporations Code.

§ 1850.1. Definitions as Used in This Article.

§ 1850.2. Professional Relationships, Responsibilities and Conduct Not Affected

§ 1850.3. Office for Filing.

§ 1850.4. Application: Review of Refusal to Approve.

§ 1850.5. Requirements for Issuance of Certificate of Registration.

§ 1850.6. Name of Corporation.

The wording or abbreviation denoting corporate existence shall be limited to one of the following: "Professional Corporation," "Prof. Corp.," "Corporation," "Corp.," "Incorporated," or "Inc."

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4987.8 and 4998.3, Business and Professions Code.

§ 1850.7. Shares: Ownership and Transfer.

(a) The shares of a marriage and family therapist corporation may be issued or transferred only to the issuing corporation or to an appropriately licensed person in accordance with Section 13401.5 of the Corporations Code.

(b) The shares of a licensed clinical social worker corporation may be issued or transferred only to the issuing corporation or to an appropriately licensed person in accordance with Section 13401.5 of the Corporations Code.

(c) Where there are two or more shareholders in a corporation and one of its shareholders dies, or becomes a disqualified person as defined in Section 13401(d) of the Corporations Code, for a period exceeding ninety (90) days, his or her shares shall be sold and transferred to a licensed person or to the issuing corporation, on such terms as are agreed upon. Such sale or transfer shall not be later than six (6) months after any such death and not later than ninety (90) days after the date the shareholder became a disqualified person.

(d) A corporation and its shareholders may, but need not, agree that shares sold to it by a person who becomes a disqualified person may be resold to such person if and when he or she again ceases to become a disqualified person.

(e) The restrictions of subdivisions (a) or (b) where appropriate and, if appropriate, subdivision (c) of this section shall be set forth in the corporation's by–laws or articles of incorporation.

(f) The income of the corporation attributable to professional, licensed services rendered while a shareholder is a disqualified person shall not in any manner accrue to the benefit of such shareholder or his or her shares.

(g) The share certificates of the corporation shall contain either:

(1) An appropriate legend setting forth the restriction of subdivision (a) or (b) where appropriate , and where applicable, the restriction of subdivision (c), or

(2) An appropriate legend stating that ownership and transfer of the shares are restricted and specifically referring to an identified section of the by–laws or articles of incorporation of the corporation wherein the restrictions are set forth.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4987.9, 4988, 4998.4 and 4998.5, Business and Professions Code; and Sections 13401, 13401.5, 13403 and 13407, Corporations Code.

§ 1850.8. Certificate of Registration: Continuing Validity: Reports.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4987.6, 4987.7, 4998, 4998.1 and 4998.2, Business and Professions Code.

Article 5. Licensed Educational Psychologists

§ 1854. Equivalent Degrees.

Degrees deemed equivalent to those specified in Section 4986.20(a) of the Code shall include a master's degree or its equivalent obtained from a college or university accredited by one of the following agencies:

(a) Western Association of Schools and Colleges.

(b) Northwest Association of Secondary and Higher Schools.

(c) Middle States Association of Colleges and Secondary Schools.

(d) New England Association of Colleges and Secondary Schools.

(e) North Central Association of Colleges and Secondary Schools.

(f) Southern Association of Colleges and Schools.

(g) The Credentials Evaluation Service of the International Education Research Foundation, Inc., where it evaluates the foreign degree as being equivalent to the required degree or degrees.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Section 4986.20(a), Business and Professions Code.

§ 1855. Equivalent Experience in Pupil Personnel Services.

Semester hours in instructing a course in pupil personnel services approved by the board and offered by an institution accredited by one of the accrediting agencies set forth in Section 1854 above shall be deemed equivalent, within the meaning of Section 4986.20(d) of the Code, to semester hours of postgraduate work devoted to pupil personnel services under the following conditions:

(1) The applicant has instructed the particular course for at least two semesters;

(2) The particular course has not been submitted by the applicant for credit as a postgraduate course; and

(3) The particular course is not a practicum or field work course. In addition to the above, the board may, in its discretion, recognize other experience as equivalent to semester hours of postgraduate work devoted to pupil personnel services.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Section 4986.20, Business and Professions Code.

§ 1856. Experience Equivalent to Three (3) Years Full–Time Experience as Credentialed School Psychologist.

(a) No more than one year of experience will be granted for any 12 month period.

(b) Part time experience may be accumulated provided that the experience is obtained within six (6) calendar years.

(c) Experience as a credentialed school psychologist employed by a parochial or private school may, at the board's discretion, be deemed equivalent to experience as a credentialed school psychologist in the public schools.

(d) Persons meeting this requirement must verify this experience by written statements from their sponsors as specified in Section 4986.20 of the Code. These statements shall include information regarding the applicant's:

(1) Skill in the administration of standardized individual tests for subjects varying from three (3) to twenty–one (21) years of age.

(2) Skill in the interpretation of results to parents, teachers, administrators, admissions committees, or other appropriate parties.

(3) Skill in the classification of subjects for special programming based on existing legislation.

(4) Recognition and diagnosis of learning problems with recommendations for solution of the problems.

(5) Recognition and amelioration of behavior problems.

(6) Interpretation of scores of standardized group tests.

(7) Skills in the use of psychological counseling or other therapeutic techniques with children and parents.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Section 4986.20, Business and Professions Code.

§ 1857. Experience Equivalent to One Year of Supervised Professional Experience.

(a) An applicant who has completed a minimum of seven hundred and twenty (720) clock hours under professional supervision as specified herein in the following experiences shall be deemed to have suitable experience equivalent to one year of supervised professional experience in an accredited school psychology program, or under the direction of a licensed psychologist:

(1) Utilization of all instruments presented within the prescribed course of study in the educational institution attended, with a wide variety of subjects (generally inclusive of WAIS, WISC, Binet, and group tests).

(2) Administration of additional tests commonly employed in the field by school psychologists.

(3) Consulting with teachers concerning learning and behavior problems of children enrolled in special education programs.

(4) Referral to and use of community agencies.

(5) Oral and written communication of results in accordance with the local supervisor's requirements.

(b) The local supervisor shall consult with the intern at least once weekly during the period of internship and shall:

(1) Possess a valid credential in school psychology; and

(2) Have a minimum of two (2) years experience in the field of school psychology.

(c) The general supervisor shall arrange for and coordinate intern placement with the local supervisor, and shall consult with the intern and/or the local supervisor at least three times during the period of internship. A general supervisor shall be qualified as one of the following:

(1) A credentialed school psychologist;

(2) A licensed psychologist;

(3) A licensed educational psychologist;

(4) A state or accredited training institution designated supervisor of school psychology trainees.

NOTE: Authority cited: Section 4980.60, Business and Professions Code. Reference: Section 4980.20, Business and Professions Code.

§ 1858. Unprofessional Conduct.

The Board may suspend or revoke the license of a licensee who:

(a) Misrepresents the type or status of license held by the licensee.

(b) Impersonates a licensee or who allows another person to use his or her license.

(c) Aids or abets an unlicensed person to engage in conduct requiring a license.

(d) Intentionally or recklessly causes physical or emotional harm to a client.

(e) Commits any dishonest, corrupt, or fraudulent act which is substantially related to the qualifications, functions or duties of a licensee.

(f) When employed by another person or agency, encourages, either orally or in writing, the employer's or agency's clientele to utilize his or her private practice for further counseling without the approval of the employing agency or administration.

(g) Misrepresents or permits the misrepresentation of his or her professional qualifications, affiliations, or purposes.

(h) Has sexual relations with a client, or who solicits sexual relations with a client, or who commits an act of sexual abuse, or who commits an act of sexual misconduct, or who commits an act punishable as a sexual related crime if such act or solicitation is substantially related to the qualifications, functions or duties of an educational psychologist.

(i) Performs or holds himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

(j) Permits a person under his or her supervision or control to perform or permits such person to hold himself or herself out as competent to perform professional services beyond the level of education, training and/or experience of that person.

(k) Fails to maintain the confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client during the course of treatment and all information about the client which is obtained from tests or other such means.

(*l*) Prior to the commencement of treatment, fails to disclose to the client, or prospective client, the fee to be charged for the professional services, or the basis upon which such fee will be computed.

(m) Advertises in a manner which is false or misleading.

(n) Reproduces or describes in public or in publications subject to general public distribution, any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate such test or device. An Educational Psychologist shall limit access to such test or device to persons with professional interests who can be expected to safeguard their use.

(o) Fails to comply with the child abuse reporting requirements of Penal Code Section 11166.

(p) Fails to comply with the elder and adult dependent abuse reporting requirements of Welfare and Institutions Code Section 15630.

NOTE: Authority cited: Section 4987, Business and Professions Code. Reference: Sections 730, 4986.70, 4986.71 and 4987, Business and Professions Code; Section 11166, Penal Code; and Section 15630, Welfare and Institutions Code.

§ 1863. Application and Renewal Fees.

Article 6. Licensed Clinical Social Workers

§ 1870. Requirements for Associate Clinical Social Worker Supervisors.

(a) Any person supervising an associate clinical social worker registered with the board on and after May 10, 1999, (hereinafter called "supervisor") within California shall comply with the requirements set forth below and shall, prior to the commencement of such supervision, sign under penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Worker" (revised 12/05), which requires that:

(1) The supervisor possesses and will maintain a current valid California license as either a licensed clinical social worker or a licensed mental health professional acceptable to the Board as specified in Section 4996.21(a) of the Code and Section 1874 of California Code of Regulations.

(2) The supervisor has and will maintain a current license in good standing and will immediately notify the associate of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive license, or lapse in licensure, that affects the supervisor's ability or right to supervise.

(3) The supervisor has practiced psychotherapy as part of his/her clinical experience for at least two (2) years within the last five (5) years immediately preceding supervision.

(4) The supervisor has had sufficient experience, training and education in the area of clinical supervision to competently supervise associates. Effective January 1, 2001, supervisors who are licensed by the board shall have:

(A) A minimum of fifteen (15) contact hours in supervision training obtained from a state agency or approved continuing education provider. This training may apply towards the approved continuing education requirements set forth in Sections 4980.54 and 4996.22 of the Code. The content of such training shall include, but not be limited to:

1. familiarity with supervision literature through reading assignments specified by course instructors;

2. facilitation of therapist–client and supervisor–therapist relationships;

3. evaluation and identification of problems in therapist–client and supervision–therapist relationships;

4. structuring to maximize supervision, including times and conditions of supervision sessions, problem solving ability, and implementing supervisor interventions within a range of supervisory modalities including live, videotape, audiotape, and case report methods;

5. knowledge of contextual variables such as culture, gender, ethnicity, and economic issues; and

6. the practice of clinical social work, including the mandated reporting laws, and knowledge of ethical and legal issues.

(5) The supervisor knows and understands the laws and regulations pertaining to both supervision of associates and the experience required for licensure as a clinical social worker.

(6) The supervisor shall ensure that the extent, kind and quality of clinical social work performed is consistent with the training and experience of the person being supervised and shall review client/patient records, monitor and evaluate assessment and treatment decisions of the associate clinical social worker, and monitor and evaluate the ability of the associate to provide services at the site(s) where he or she will be practicing and to the particular clientele being served, and ensure compliance with all laws and regulations governing the practice of clinical social work.

(7) Effective January 1, 1999, the supervisor and the associate shall develop the "Supervisory Plan" as described in Section 1870.1. of the California Code of Regulations. This original signed plan shall be submitted to the board upon application for licensure.

(8) The supervisor shall provide the board with the original, signed "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" (revised 12/05), within 30 days of commencement of any supervision. A copy of this form shall be provided to the associate by the supervisor.

(9) A supervisor shall give at least one (1) week's written notice to an associate of the supervisor's intent not to certify any further hours of experience for such person. A supervisor who has not provided such notice shall sign for hours of experience obtained in good faith where such supervisor actually provided the required supervision.

(10) Effective January 1, 1999, the supervisor shall complete an assessment of the ongoing strengths and limitations of the associate. The assessments shall be completed at least once a year and at the completion or termination of supervision. A copy of all assessments shall be provided to the associate by the supervisor.

(11) Upon written request of the board, the supervisor shall provide to the board any documentation which verifies the supervisor's compliance with the requirements set forth in this section.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Section 4996.21, Business and Professions Code.

§ 1870.1. Supervisory Plan.

(a) On and after January 1, 1999, all associate clinical social workers and licensed clinical social workers or licensed mental health professionals acceptable to the board as defined in Section 1874 who assume responsibility for providing supervision shall develop a

supervisory plan that describes the goals and objectives of supervision and shall complete and sign under penalty of perjury the "Supervisory Plan", (form no. 1800 37A–521, revised 12/05), hereby incorporated by reference.

(b) This supervisory plan shall be completed by each supervisor providing supervision and the original signed plan shall be submitted by the associate clinical social worker to the board upon application for licensure.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Sections 4996.18 and 4996.21, Business and Professions Code.

§ 1873. Experience.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Sections 4992.1 and 4996.2, Business and Professions Code.

§ 1874. Definition of Acceptable Mental Health Professionals.

For purposes of Sections 4996.20(b) and 4996.21(a), a licensed mental health professional acceptable to the board is one who, at the time of supervision, has possessed for at least two years a valid license as a psychologist, marriage and family therapist or physician certified in psychiatry by the American Board of Psychiatry and Neurology.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Sections 4996.20 and 4996.21, Business and Professions Code.

§ 1876. Professional Supervision or Consultation.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Sections 4992.1 and 4996.2, Business and Professions Code.

§ 1877. Examinations.

The written examinations shall consist of the following:

(a) A standard written examination designed to determine an applicant's knowledge, familiarity with the field, and practical understanding of the principles, techniques, objectives, theory and laws under which he or she must operate; and

(b) A written clinical vignette examination designed to assess the applicant's judgment, knowledge of the application of psychosocial and psychotherapeutic methods and measures in treatment, and ability to assume professional responsibilities.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Section 4992.1, Business and Professions Code.

§ 1878. Human Sexuality Training.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1878.1. Human Sexuality Training Required for Licensees.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1878.2. Renewal Dependent upon Training Documentation.

NOTE: Authority cited: Sections 25, 9012 and 17806, Business and Professions Code. Reference: Sections 25, 9042 and 17804, Business and Professions Code.

§ 1880. Unlicensed Assistants.

An unlicensed person employed under Section 4996.15 of the Code to perform limited social work functions shall inform each patient or client prior to performing any such functions that he or she is not a licensed clinical social worker and is under the supervision of a licensed clinical social worker, a licensed psychologist or a licensed psychiatrist, whichever is applicable.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Section 4996.15, Business and Professions Code.

§ 1880.1. Notification of Employment and Termination of an Apprentice Clinical Social Worker.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Section 4996.17, Business and Professions Code.

§ 1881. Unprofessional Conduct.

The board may suspend or revoke the license of a licensee or may refuse to issue a license to a person who:

(a) Misrepresents the type or status of license held by such person or otherwise misrepresents or permits the misrepresentation of his or her professional qualifications or affiliations.

(b) Impersonates a licensee or who allows another person to use his or her license.

(c) Aids or abets an unlicensed person to engage in conduct requiring a license.

(d) Intentionally or recklessly causes physical or emotional harm to a client.

(e) Commits any dishonest, corrupt, or fraudulent act which is substantially related to the qualifications, functions or duties of a licensee.

(f) Has sexual relations with a client, or who solicits sexual relations with a client, or who commits an act of sexual abuse, or who commits an act of sexual misconduct, or who commits an act punishable as a sexual related crime if such act or solicitation is substantially related to the qualifications, functions or duties of a Licensed Clinical Social Worker.

(g) Performs or holds himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.

(h) Permits a person under his or her supervision or control to perform or permits such person to hold himself or herself out as competent to perform professional services beyond the level of education, training and/or experience of that person.

(i) Fails to maintain the confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client during the course of treatment and all information about the client which is obtained from tests or other such means.

(j) Prior to the commencement of treatment, fails to disclose to the client, or prospective client, the fee to be charged for the professional services, or the basis upon which such fee will be computed.

(k) Advertises in a manner which is false or misleading.

(*l*) Reproduces or describes in public or in publications subject to general public distribution, any psychological test or other assessment device, the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate such test or device. The licensee shall limit access to such test or device to persons with professional interest who are expected to safeguard their use.

(m) Commits an act or omission which falls sufficiently below that standard of conduct of the profession as to constitute an act of gross negligence.

(n) Pays, accepts or solicits any consideration, compensation or remuneration for the referral of professional clients. All consideration, compensation or remuneration must be in relation to professional counseling services actually provided by the licensee. Nothing in this section shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for such collaboration except when disclosure of such fee is made in compliance with subparagraph (j) above.

(o) Fails to comply with the child abuse reporting requirements of Penal Code Section 11166.

(p) Fails to comply with the elder and dependent adult abuse reporting requirements of Welfare and Institutions Code Section 15630.

NOTE: Authority cited: Section 4990.14, Business and Professions Code. Reference: Sections 4990.14, 4992.3, 4992.33 and 4996.11, Business and Professions Code; Section 11166, Penal Code; and Section 15630, Welfare and Institutions Code.

Article 6.5. Licensed Clinical Social Workers Corporations

NOTE: Additional authority cited: Section 9077, Business and Professions Code. Reference: Sections 9070–9076, Business and Professions Code; Sections 13400–13410, Corporations Code.

Article 7. Citations and Fines

§ 1886. Authority to Issue Citations and Fines.

The executive officer of the board is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed marriage and family therapist (MFT), licensed educational psychologist (LEP), licensed clinical social worker (LCSW), MFT Intern, or Associate Clinical Social Worker of the statutes and regulations enforced by the Board of Behavioral Sciences.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

§ 1886.10. Citations for Unlicensed Practice.

The executive officer of the board is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines against persons, as defined in Section 302(d) of the Code, who are performing or who have performed services for which a license is required under the statutes and regulations enforced by the Board of Behavioral Sciences. Each citation issued for unlicensed activity shall contain an order of abatement. Where appropriate, the executive officer shall levy a fine for such unlicensed activity in accordance with section 1886.40 of these regulations. The provisions of sections 1886–1886.80 shall apply to the issuance of citations for unlicensed activity under this section. The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 125.95, 148, 149 and 302(d), Business and Professions Code.

§ 1886.20. Citation Format.

A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of each violation, including a reference to the statute(s) or regulation(s) alleged to have been violated. The citation shall inform the cited person of the right to contest the citation. The citation shall be served upon the cited person personally or by certified mail in accordance with the provisions of Section 11505(c) of the Government Code.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

§ 1886.30. Citation Factors.

In assessing an administrative fine or issuing an order of abatement, the executive officer of the board shall give due consideration to the following factors:

(a) The gravity of the violation.

(b) The good or bad faith exhibited by the cited person.

(c) The history of previous violations of the same or similar nature.

(d) Evidence that the violation was or was not willful.

(e) The extent to which the cited person has cooperated with the board's investigation.

(f) The extent to which the cited person has mitigated or attempted to mitigate any damage or injury caused by the violation.

(g) Any other factors as justice may require.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

§ 1886.40. Amount of Fines.

(a) For purposes of this section, a "citable offense" is defined as any violation of the statutes and regulations enforced by the Board of Behavioral Sciences, including Chapters 13 and 14 of Division Two of the Business and Professions Code and Title 16, Division 18, California Code of Regulations.

(b) The executive officer of the board may assess fines for citable offenses which shall not exceed two thousand five hundred dollars ($2,500) for each investigation except as otherwise provided in this section. The executive officer shall not impose any duplicate fines for the same violation.

(c) The executive officer of the board may assess fines for citable offenses which shall not exceed five thousand ($5,000) for each investigation if the violation or count includes one or more of the following circumstances:

(1) The cited person has a history of two or more prior citations for similar violations, except for citations withdrawn or dismissed after appeal.

(2) The citation involves multiple violations that demonstrate a willful disregard of the statutes or regulations.

(3) The citation is for a violation or violations involving a minor, elder or dependent adult, or a person with a physical or mental disability as defined in Section 12926 of the Government Code.

(4) The citation involves unlicensed practice.

(5) The citation involves an unlawful or unauthorized breach of confidentiality.

(d) The executive officer of the board may assess fines which shall not exceed five thousand dollars ($5,000) for each violation or count if the violation or count involves fraudulent billing submitted to an insurance company, the Medi–Cal program, or Medicare.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 123, 125, 125.9, 136, 141, 148, 149, 480, 651, 654.2, 703, 728, 4980, 4980.02, 4980.30, 4980.43, 4980.44, 4980.45, 4980.46, 4980.48, 4982, 4982.25, 4984, 4986.10, 4986.50, 4986.70, 4987.7, 4987.8, 4987.9, 4988, 4988.1, 4988.5, 4992.3, 4992.36, 4996, 4996.5, 4996.7, 4996.8, 4996.9, 4996.16, 4996.18, 4996.19, 4996.20, 4998.2, 4998.3 and 4998.4, Business and Professions Code; and Section 15630, Welfare and Institutions Code.

§ 1886.50. Exceptions.

A citation shall not be issued in any of the following circumstances:

(a) The violation is of such a nature and/or severity that revocation of the license or restrictions on the cited person are necessary in order to ensure consumer protection.

(b) The cited person failed to comply with any requirement of any previous citation, including any order of abatement or fine.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

§ 1886.60. Compliance with Citation/Order of Abatement.

(a) If a cited person who has been issued an order of abatement is unable to complete the correction within the time set forth in the citation because of conditions beyond his or her control after the exercise of reasonable diligence, the cited person may request an extension of time in which to complete the correction from the executive officer of the board. Such a request shall be in writing and shall be made within the time set forth for abatement.

(b) If a citation is not contested, or if the citation is contested and the cited person does not prevail, failure to abate the violation or to pay the assessed fine within the time allowed shall constitute a violation and a failure to comply with the citation or order of abatement.

(c) Failure to timely comply with an order of abatement or pay an assessed fine may result in disciplinary action being taken by the board or other appropriate judicial action being taken against the cited person.

(d) If a fine is not paid after a citation has become final, the fine shall be added to the cited person's license or registration renewal fee. A license or registration shall not be renewed without payment of the renewal fee and fine.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code; and Section 11505(c), Government Code.

§ 1886.70. Contested Citations and Request for a Hearing or Informal Citation Conference.

(a) If a cited person wishes to contest the citation, assessment of the administrative fine, or order of abatement, the cited person shall, within thirty (30) days after service of the citation, file in writing a request for an administrative hearing to the executive officer regarding the acts charged in the citation, as provided for in subdivision (b)(4) of Section 125.9 of the Code.

(b) In addition to or instead of requesting an administrative hearing, as provided for in subdivision (b)(4) of Section 125.9 of the Code, the cited person may, within 30 days after service of the citation, contest the citation by submitting a written request for an informal citation conference to the executive officer or his/her designee.

(c) Upon receipt of a written request for an informal citation conference, the executive officer or his/her designee shall, within 60 days, hold an informal citation conference with the cited person. The cited person may be accompanied and represented at the informal conference by an attorney or other authorized representative.

(d) If an informal citation conference is held, the request for an administrative hearing shall be deemed to be withdrawn and the executive officer or his/her designee may affirm, modify or dismiss the citation, including any fine levied or order of abatement issued, at the conclusion of the informal citation conference. If affirmed or modified, the citation originally issued shall be considered withdrawn and an affirmed or modified citation, including reasons for the decision, shall be issued. The affirmed or modified citation shall be mailed to the cited person and his/her counsel, if any, within 10 days from the date of the informal citation conference.

(e) If a cited person wishes to contest an affirmed or modified citation, the cited person shall, within 30 days after service of the citation, contest the affirmed or modified citation by submitting a written request for an administrative hearing, as provided for in subdivision (b)(4) of Section 125.9 of the Code, to the executive officer or his or her designee. An informal citation conference shall not be held on affirmed or modified citations.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

§ 1886.80. Disconnection of Telephone Service.

Nothing in this section shall preclude the board from using the provisions of Section 149 of the Code in addition to any citation issued to an unlicensed person.

NOTE: Authority cited: Sections 125.9, 148, 149, 4980.60, 4987 and 4990.14, Business and Professions Code. Reference: Sections 125.9, 148 and 149, Business and Professions Code.

Article 8. Continuing Education Requirements for Marriage and Family Therapist and Licensed Clinical Social Workers

§ 1887. Definitions.

As used in this article:

(a) A continuing education "course" means a form of systematic learning at least one hour in length including, but not limited to, academic studies, extension studies, lectures, conferences, seminars, workshops, viewing of videotapes or film instruction, viewing or participating in other audiovisual activities including interactive video instruction and activities electronically transmitted from another location which has been verified and approved by the continuing education provider, and self–study courses.

(b) A "self–study course" means a form of systematic learning performed at a licensee's residence, office, or other private location including, but not limited to, listening to audiotapes or participating in self–assessment testing (open–book tests that are completed by the member, submitted to the provider, graded, and returned to the member with correct answers and an explanation of why the answer chosen by the provider was the correct answer).

(c) A continuing education "provider" means an accredited or approved school, or an association, health facility, governmental entity, educational institution, individual, or other organization that offers continuing education courses and meets the requirements contained in this article.

(d) A "renewal period" means the two–year period which spans from a license's expiration date to the license's next expiration date.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.1. License Renewal Requirements.

(a) Except as provided in Section 1887.2, a licensee shall certify in writing, when applying for license renewal, by signing a statement under penalty of perjury that during the preceeding renewal period the licensee has completed thirty–six (36) hours of continuing education credit as set forth in Sections 4980.54 and 4996.22 of the Code.

(b) A licensee who falsifies or makes a material misrepresentation of fact when applying for license renewal or who cannot verify completion of continuing education by producing a record of course completion, upon request by the board, is subject to disciplinary action under Sections 4982(b) and 4992.3(b) of the Code.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.2. Exceptions from Continuing Education Requirements.

(a) An initial licensee shall complete at least eighteen (18) hours of continuing education, of which no more than six (6) hours may be earned through self–study courses, prior to his or her first license renewal.

(b) A licensee is exempt form the continuing education requirement if their license is inactive pursuant to Sections 4984.8 and 4997 of the Code.

(c) A licensee may submit a written request for exception form the continuing education requirement for any of the reasons listed below. The board will notify the licensee, within thirty (30) working days after receipt of the request for exception, whether the exception was granted. If the request for exception is denied, the licensee is responsible for completing the full amount of continuing education required for license renewal. The board shall grant the exception if the licensee can provide evidence, satisfactory to the board, that:

(1) For at least one year during the licensee's previous license renewal period the licensee was absent from California due to military service;

(2) For at least one year during the licensee's previous license renewal period the licensee resided in another country; or

(3) During the licensee's previous renewal period, the licensee or an immediate family member, where the licensee has primary responsibility for the care of that family member, was suffering from or suffered a disability. A disability is a physical or mental impairment that substantially limits one or more of the major life activities of an individual. The disability must be verified by a licensed physician or psychologist with special expertise in the area of disability. Verification of the disability must include:

(A) the nature and extent of the disability;

(B) an explanation of how the disability would hinder the licensee from completing the continuing education requirement; and

(C) the name, title, address, telephone number, professional license or certification number, and original signature of the licensed physician or psychologist verifying the disability.

NOTE: Authority cited: Sections 4980.54, 4980.60, 4990.14 and 4996.22, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.3. Continuing Education Course Requirements.

(a) A licensee shall accrue at least thirty–six (36) hours of continuing education courses as defined in Section 1887.4. A licensee may accrue no more than twelve (12) hours of continuing education earned through self–study courses during a single renewal period.

(b) Pursuant to Section 29 of the Code, a licensee who started graduate study prior to January 1, 1986, shall take a continuing education course in the detection and treatment of alcohol and other chemical substance dependency during their first renewal period after the adoption of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 29 of the Code. This is a one–time requirement for those licensees specified above.

Equivalent alcohol and other chemical substance dependency courses taken prior to the adoption of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board upon request in lieu of this requirement; however, this coursework or experience shall not be credited as hours toward the continuing education requirements.

(c) Pursuant to Section 32 of the Code, a licensee shall take a continuing education course in the characteristics and methods of assessment and treatment of people living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) during their first renewal period after the adoption of these regulations. The course shall be at least seven (7) hours in length and its content shall comply with the requirements of Section 32 of the Code. This is a one–time requirement for all licensees.

Equivalent HIV and AIDS courses taken prior to the adoption of these regulations, or proof of equivalent teaching or practice experience, may be submitted to the board upon request in lieu of this requirement; however, this coursework or experience shall not be credited as hours toward the continuing education requirements.

(d) Any person renewing his or her license on and after January 1, 2004 shall have completed not less than six (6) hours of continuing education in the subject of law and ethics for each renewal period. The six (6) hours shall be considered part of the thirty–six (36) hour continuing education requirement.

(e) If a licensee teaches a course, the licensee may claim credit for the course only one time during a single renewal period, receiving the same amount of hours of continuing education credit as a licensee who attended the course.

(f) A licensee may not claim the same course more than once during a single renewal period for hours of continuing education credit.

(g) A licensee who takes a course as a condition of probation resulting from disciplinary action by the board may not apply the course as credit towards the continuing education requirement.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 29, 32, 4980.54 and 4996.22, Business and Professions Code.

§ 1887.4. Continuing Education Course Content.

(a) A provider shall ensure that the content of a course shall be relevant to the practice of marriage and family therapy or clinical social work and meet the requirements set forth in sections 4980.54 and 4996.22 of the Code. The content of a course shall also be related to direct or indirect patient/client care.

(1) Direct patient/client care courses cover specialty areas of therapy (e.g., theoretical frameworks for clinical practice; intervention techniques with individuals, couples, or groups).

(2) Indirect patient/client care courses cover pragmatic aspects of clinical practice (e.g., legal or ethical issues, consultation, record-keeping, office management, insurance risks and benefits, managed care issues, research obligations, supervision training).

(b) A provider shall ensure that a course has specific objectives that are measurable.

(c) Upon completion of a course, a licensee shall evaluate the course through some type of evaluation mechanism.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.5. Hours of Continuing Education Credit.

(a) One hour of instruction is equal to one hour of continuing education credit.

(b) One academic quarter unit is equal to ten (10) hours of continuing education credit.

(c) One academic semester unit is equal to fifteen (15) hours of continuing education credit.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.6. Continuing Education Providers.

A continuing education course shall be taken from:

(a) an accredited or approved postsecondary institution that meets the requirements set forth in Sections 4980.54(f)(1) or 4996.22(d)(1) of the Code; or

(b) a board–approved provider with a valid, current approval as provided in Section 1887.7.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.7. Board–Approved Providers.

(a) A continuing education provider must meet the board's course content and instructor qualifications criteria, as provided under this article, to qualify to become a board–approved provider.

(b) A continuing education provider shall submit a completed Continuing Education Provider Application (form no. 37A–633, new 5/97), hereby incorporated by reference, remit the appropriate fees, and obtain a continuing education provider number from the board to become a board–approved provider.

(c) A provider approval issued under this section shall expire on the last day of the twenty–fourth month after the approval issue date. To renew an unexpired provider approval, the provider shall, on or before the expiration date of the approval, pay the two–year renewal fee set forth in Section 1816 of these regulations.

A provider approval which is not renewed by the expiration date may not be renewed, restored, reinstated, or reissued thereafter, but the provider may apply for a new approval.

(d) Board–approved provider status is non–transferable.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.8. Revocation and Denial of Board–Approved Provider Status.

(a) The board may revoke its approval of a provider or deny a provider application for good cause. Good cause includes, but is not limited to, the following:

(1) a provider is convicted of a felony or misdemeanor offense substantially related to the activities of a board–approved provider;

(2) a provider, who is a licensee of the board, fails to comply with any provisions of Chapters 13 and 14 of the Business and Professions Code or Title 16, Division 18 of the California Code of Regulations; or

(3) a provider makes a material misrepresentation of fact in information submitted to the board.

(b) After a thorough case review, should the board decide to revoke or deny its approval of a provider, it shall give the provider written notice setting forth its reasons for revocation or denial. The provider may appeal the revocation or denial in writing, within fifteen (15) days after receipt of the revocation or denial notice, and request a hearing with the board's designee. The revocation is stayed at this point.

Should the board's designee decide to uphold the revocation or denial, the provider may appeal the decision of the board's designee in writing, within seven (7) days after receipt of the decision of the board's designee, and request a hearing with a continuing education appeals committee appointed by the board chairperson. The hearing will take place at the next regularly scheduled board meeting, provided the appeal is received before the meeting is noticed to the public. It is at the discretion of the board's designee whether to stay the revocation further.

The continuing education appeals committee shall contain three board members, one public board member and two members representing two of the three license types regulated by the board. The decision of the continuing education appeals committee is final.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.9. Course Advertisements.

A provider shall ensure that information publicizing a continuing education course is accurate and includes the following:

(a) the provider's name;

(b) the provider number, if a board–approved provider;

(c) the statement "Course meets the qualifications for ____ hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences";

(d) the provider's policy on refunds in cases of non–attendance by the registrant; and

(e) a clear, concise description of the course content and objectives.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.10. Course Instructor Qualifications.

(a) A provider shall ensure that an instructor teaching a course has at least two of the following minimum qualifications:

(1) a license, registration, or certificate in an area related to the subject matter of the course. The license, registration, or certificate shall be current, valid, and free from restrictions due to disciplinary action by this board or any other health care regulatory agency;

(2) a master's or higher degree from an educational institution in an area related to the subject matter of the course;

(3) training, certification, or experience in teaching subject matter related to the subject matter of the course; or

(4) at least two years' experience in an area related to the subject matter of the course.

(b) During the period of time that any instructor has a healing arts license that is restricted pursuant to a disciplinary action in California or in any other state or territory, that instructor shall notify all approved continuing education providers for whom he or she provides instruction of such discipline before instruction begins or immediately upon notice of the decision, whichever occurs first.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54, 4982.15 and 4996.22, Business and Professions Code.

§ 1887.11. Records of Course Completion.

Upon completion of a course, a provider shall issue a record of course completion to a licensee (e.g., letters of verification of attendance, certificates, gradeslips, transcripts) containing the following information:

(a) name of license and license number or other identification number;

(b) course title;

(c) provider name and address;

(d) provider number, if a board–approved provider;

(e) date of course;

(f) number of hours of continuing education credit; and

(g) signature of course instructor, provider, or provider designee.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

§ 1887.12. Licensee and Provider Course Records.

(a) A licensee shall maintain records of course completion for a period of at least two (2) years from the date of license renewal for which the course was completed.

(b) A provider shall maintain records related to continuing education courses for a period of at least four (4) years. Records shall include:

(1) syllabi for all courses;

(2) the time and location of all courses;

(3) course advertisements;

(4) course instructors' vitaes or resumes;

(5) attendance rosters with the names and license numbers of licensees who attended the courses;

(6) sign–in sheets; and

(7) records of course completion issued to licensees who attended the courses.

(c) The board may audit the course records of a provider to ensure compliance with the board's continuing education requirements.

NOTE: Authority cited: Sections 4980.60 and 4990.14, Business and Professions Code. Reference: Sections 4980.54 and 4996.22, Business and Professions Code.

Article 9. Disciplinary Guidelines

§ 1888. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Board of Behavioral Sciences shall consider the disciplinary guidelines entitled "Board of Behavioral Sciences Disciplinary Guidelines" [Rev. May 21, 2004] which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Board in its discretion determines that the facts of the particular case warrant such a deviation—for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Sections 4980.60, 4987 and 4990.14, Business and Professions Code; and Section 11400.20, Government Code. Reference: Sections 4982, 4986.70 and 4992.3, Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

Article 10. Group Advertising and Referral Services for Marriage, Family, and Child Counselors

§ 1889. Definitions.

An "MFT referral service" means a group advertising and referral service for marriage and family therapists as provided for in Section 650.4 of the Code.

NOTE: Authority cited: Sections 650.4 and 4980.60, Business and Professions Code. Reference: Section 650.4, Business and Professions Code.

§ 1889.1. Registration.

(a) The board shall issue a registration for an MFT referral service to an applicant who submits:

(1) a completed MFT Referral Service Registration Application (form no. 37A–309, new 8/97), hereby incorporated by reference;

(2) a copy of the service's standard form contract regulating its relationship with member marriage and family therapists, demonstrating compliance with Section 650.4 of the Code and this article; and

(3) a copy of the service's advertising, demonstrating compliance with Section 650.4 of the Code and this article.

(b) An MFT referral service registration issued under this section shall remain valid until suspended or revoked, or until the MFT referral service notifies the board in writing that the service has discontinued referrals to any marriage and family therapists and no longer de-

sires registration, provided there are no pending disciplinary actions on the MFT referral service's registration.

(c) It is unlawful for any MFT referral service to make referrals to participating or member marriage and family therapists unless at the time of so doing such service holds a registration that is valid and in good standing.

(d) An MFT referral service registration is non–transferrable.

(e) An MFT referral service shall notify the board within thirty (30) days concerning any changes or modifications to the service's standard form contract regulating its relationship with member marriage and family therapists, providing a copy of the new contract to the board.

NOTE: Authority cited: Sections 650.4 and 4980.60, Business and Professions Code. Reference: Section 650.4, Business and Professions Code.

§ 1889.2. Revocation or Denial of Registration.

(a) The board may revoke its registration of an MFT referral service or deny an MFT referral service application for good cause. For the purposes of this subsection, "responsible party" includes any owner, co–owner, or member on the board of directors of an MFT referral service. Good cause includes, but is not limited to, the following:

(1) The responsible party of an MFT referral service is convicted of a felony or misdemeanor offense substantially related to the activities of an MFT referral service;

(2) the responsible party of an MFT referral service, who is a licensee of the board, fails to comply with any provisions of Chapters 13 and 14 of the Business and Professions Code or Title 16, Division 18 of the California Code of Regulations;

(3) an MFT referral service fails comply with any provisions of Sections 650, 650.4, or 651 of the Code or these regulations; or

(4) an MFT referral service makes a material misrepresentation of fact in information submitted to the board.

(b) After a thorough case review, should the board decide to revoke or deny its registration of an MFT referral service, it shall give the MFT referral service written notice setting forth its reasons for revocation or denial. The MFT referral service may appeal the revocation or denial in writing, within fifteen (15) days after service of the revocation or denial notice, and request a hearing with the board's designee. The revocation is stayed at this point.

Should the board's designee decide to uphold the revocation or denial, the MFT referral service may appeal the decision of the board's designee in writing, within fifteen (15) days after service of the decision of the board's designee, and request a hearing with a referral services appeals committee appointed by the board chairperson. The hearing will take place at the next regularly scheduled board meeting, provided the appeal is received before the meeting is noticed to the public. It is at the discretion of the board's designee whether to stay the revocation further.

The referral services appeals committee shall contain three board members, one of whom shall be a public member, and two whom shall be members representing two of the three license types regulated by the board. The decision of the referral services appeals committee is final.

NOTE: Authority cited: Sections 650.4 and 4980.60, Business and Professions Code. Reference: Section 650.4, Business and Professions Code.

§ 1889.3. Advertising and Referral Guidelines.

(a) An MFT referral service shall advertise and make referrals in accordance with Sections 650.4 and 651 of the Code and Section 1811 of these regulations.

(b) An MFT referral service shall only make referrals to marriage and family therapists with current, valid licenses. Referrals made to marriage and family therapists on probation shall be made in accordance with the terms of probation set by the board.

NOTE: Authority cited: Sections 650.4 and 4980.60, Business and Professions Code. Reference: Section 650.4, Business and Professions Code.

Division 25. Board of Vocational Nurse and Psychiatric Technician Examiners of the State of California

Chapter 2. Psychiatric Technicians

Article 1. General Provisions

§ 2560. Location of Offices.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4501, Business and Professions Code.

§ 2561. Tenses, Gender, and Number.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 14.1, Business and Professions Code.

§ 2562. Definitions.

As used in this chapter, unless the context otherwise requires:

(a) "Board" means the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(b) "Code" means the Business and Professions Code.

(c) "Accredited school for psychiatric technicians," "accredited school," and "school" means a school for the training of psychiatric technicians which has been accredited by the Board pursuant to Sections 4530–4532 of the code (the Psychiatric Technicians Law), and whose graduates, if otherwise qualified, are eligible to apply for a license to practice as a psychiatric technician.

(d) "Approved equivalency school" and "approved equivalency program" mean a psychiatric technician course approved by the Board pursuant to Section 2575(c) of this chapter, and whose graduates, if otherwise qualified, are eligible to apply for a license as a psychiatric technician.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 101, 4501 and 4511, Business and Professions Code.

§ 2563. Delegation of Certain Functions.

The power and discretion conferred by law upon the Board to receive and file accusations; issue notices of hearings, statements to respondent and statements of issues; receive and file notices of defense; determine the time and place of hearings under Section 11508 of the Government Code; issue subpoenas and subpoenas duces tecum; set and calendar cases for hearing and perform other functions necessary to the businesslike dispatch of the business of the Board in connection with proceedings under the provisions of Section 11500 through 11528 of the Government Code, prior to the hearing of such proceedings; and the certification and delivery or mailing of copies of decisions under Section 11518 of said code are hereby delegated to and conferred upon the executive officer, or, in the absence of the executive officer from the office of the Board, the assistant executive officer.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4503, Business and Professions Code.

§ 2564. Filing of Addresses.

All persons holding a license from the Board shall file their current mailing address with the Board at its office in Sacramento, and shall immediately notify the Board of any and all changes of mailing address, within 30 days after the change, giving both their old and new addresses and license number.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 136 and 4545, Business and Professions Code.

Article 2. Application for License

§ 2565. Form.

Applications for licensure shall be made upon the form prescribed and provided by the Board, accompanied by such evidence, statements, or documents as therein required.

§ 2566. Place of Filing.

Applications for licensure shall be filed with the Board's principal office in Sacramento.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4501, Business and Professions Code.

§ 2567. Permit Processing Times.

"Permit" as defined by the Permit Reform Act of 1981 means any license, certificate, registration, permit or any other form of authorization required by a state agency to engage in a particular activity or act. Processing times for the board's various permits are set forth below. The actual processing times apply to those persons who apply by the specified filing deadlines (if applicable) and who take and pass the first available examination.

Permit	*Maximum Period of time in which the board will notify applicant in writing that the application is complete and accepted for filing or that the application is deficient and what specific information is required*	*Maximum Period of time after the filing of a complete application in which the Board will notify applicant of a permit decision.*	*Actual Processing Time Based on Prior Two Years Minimum/Median/ Maximum*		
Initial License	90 days	365 days	15	30	385 days
Interim Permit	30 days	60 days	30	45	60 days
Renewals–License	60 days	90 days	30	45	60 days
Continuing Education (CE) Providers	30 days	30 days	1	15	30 days
Blood Withdrawal Certificate	30 days	60 days	1	15	30 days
Blood Withdrawal Course Provider (Initial)	30 days	60 days	1	15	30 days
Blood Withdrawal Course Provider (Renewal)	30 days	60 days	1	15	30 days

NOTE: Authority cited: Section 2854, Business & Professions Code and Section 15376, Government Code. Reference: Sections 15375 and 15376, Government Code.

Article 3. Examinations

§ 2570. Scope of Examinations.

Examinations shall be designed to test the minimal competency of the applicant to safely practice as a psychiatric technician and to protect the health and safety of the consumer.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4510, Business and Professions Code.

§ 2570.1. Failure to Take Assigned Examination.

An applicant who fails to take an assigned examination shall be removed from the eligible list of applicants. To be scheduled for a

subsequent examination the applicant shall notify the Board and shall pay the reexamination fee as prescribed by Section 2590 of this Chapter.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4548, Business and Professions Code.

§ 2571. Abandonment of Application.

(a) An application shall be deemed to have been abandoned and the application fee forfeited when:

(1) The applicant fails to complete the application within two years after it is originally submitted;

(2) The applicant fails to complete the application within two years after the last notification of deficiency; or

(3) The applicant without good cause fails to take the examination within one year after being scheduled.

(b) An application submitted subsequent to the abandonment of a former application shall be treated as a new application.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4512 and 4515, Business and Professions Code.

§ 2572. Examination Procedure.

No one except as authorized by the Board shall solicit, accept, or compile information regarding the contents of written examination questions, either before, during, or after the administration of any examination.

(a) Applications and all required supporting documentation and fees must be received by the Board prior to the applicant being scheduled for examination.

(b) Psychiatric technician programs shall file a transcript of record for each student who completes the course on a form provided by the Board.

(c) Schools shall submit in duplicate a list of all students whose applications for examination are submitted to the Board by the school.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4512, 4513 and 4548, Business and Professions Code.

Article 4. Licenses

§ 2574. Eligibility for Licensure.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4511, Business and Professions Code.

§ 2575. Equivalent Study and Training.

Persons applying for licensure under this section must meet one of the following:

(a) Completion of 576 hours of theory and 954 hours of supervised clinical experience within the ten years prior to the date of application. Any or all of the supervised clinical experience may be satisfied by paid work experience. The hours of theory and clinical experience shall include a minimum of each of the following:

(1) 54 hours of theory in pharmacology, covering the content described in Section 2587(a).

(2) 126 hours of theory and 270 hours of supervised clinical experience in nursing science, covering the content described in Section 2587(b).

(3) 108 hours of theory and 270 hours of supervised clinical experience in mental disorders, covering the content described in Section 2587(c).

(4) 108 hours of theory and 270 hours of supervised clinical experience in developmental disabilities, covering the content described in Section 2587(d).

(b) Completion of an armed forces course involving neuropsychiatric nursing and an armed forces or civilian course from a accredited school in the care of the developmentally disabled client.

(1) One year of verified full time paid work experience, including at least six months in a military clinical facility caring for clients with mental disorders and at least six months in a military or civilian clinical facility caring for clients with developmental disabilities shall be required.

(2) Verified full time paid work experience in a civilian clinical facility for treatment of clients with developmental disabilities may be utilized, in part, to satisfy application requirements.

(c) Completion of the course described below and completion of a minimum of 18 months of paid work experience in the care of physically ill, mentally disordered, and developmentally disabled patients, within the 36 months prior to the date of application. Curriculum content shall be present as specified in Section 2587(a), (b), (c), (e), and (f) of this Chapter. The faculty of such course shall meet the requirements of Section 2584. Facilities utilized for supervised clinical experience shall be approved as provided in Section 2588. The school shall meet the requirements specified in Section 2585. The course must be approved by the Board, and shall include the content described in Section 2587. The course must have a minimum of 450 hours of theory instruction, and the following minimum hours shall be included:

(1) 54 hours of theory in pharmacology.

(2) 126 hours of theory and 100 hours of supervised clinical experience in nursing science.

(3) 108 hours of theory and 100 hours of supervised clinical experience in mental disorders.

(4) 108 hours of theory and 100 hours of supervised clinical experience on developmental disabilities.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511 and 4515, Business and Professions Code.

§ 2576. Renewal of License. Eligibility for Renewal After License Has Expired.

Any person who has been issued an equivalent license in another state during the period since the expiration of a license in California, or can otherwise establish to the satisfaction of the Board, that they are qualified to engage in practice as a licensed psychiatric technician, shall be exempted from such examination requirements.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4515 and 4545, Business and Professions Code.

§ 2576.5. Scope of Psychiatric Technician Practice.

The licensed psychiatric technician performs services requiring technical and manual skills which include the following:

(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

(b) Provides direct patient/client care by which the licensee:

(1) Performs basic nursing services as defined in subdivision (a);

(2) Administers medications;

(3) Applies communication skills for the purpose of patient/client care and education; and

(4) Contributes to the development and implementation of a teaching plan related to self–care for the patient/client.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 101.6, 108, 4502, 4503, 4517, 4520 and 4521(a), Business and Professions Code; and Section 11215, Health and Safety Code.

§ 2576.6. Performance Standards.

(a) A licensed psychiatric technician shall safeguard patients'/clients' health and safety by actions which include but are not limited to the following:

(1) Reporting to the Board unprofessional conduct as defined in Section 4521(a) of the Business and Professions Code;

(2) Documenting patient/client care in accordance with standards of the profession; and

(3) Performing services in accordance with Section 125.6 of the Business and Professions Code.

(b) A licensed psychiatric technician shall adhere to standards of the profession and shall incorporate ethical and behavioral standards of professional practice which include but are not limited to the following:

(1) Maintaining current knowledge and skills for safe and competent practice;

(2) Maintaining patient/client confidentiality;

(3) Maintaining professional boundaries with the patient/client; and

(4) Abstaining from chemical/substance abuse.

(c) A violation of this section constitutes unprofessional conduct for purposes of initiating disciplinary action.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 101.6, 108, 4502, 4503, 4517, 4520 and 4521(a), Business and Professions Code; Section 11166, Penal Code; and Section 15630(a), Welfare and Institutions Code.

§ 2577. Gross Negligence.

As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521 "gross negligence" means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed psychiatric technician, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard care.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4521, Business and Professions Code.

§ 2577.1. Incompetence.

As set forth in Section 4521 of the code, incompetence is deemed unprofessional conduct and is grounds for disciplinary action. As used in Section 4521, "incompetence" means the lack of possession of and the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by responsible licensed psychiatric technicians.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4521, Business and Professions Code.

§ 2577.2. Child Abuse Reporting.

Pursuant to Penal Code Section 11166, psychiatric technicians are mandated to report known or suspected child abuse cases to a child protective agency. Failure to make a child abuse report as required shall constitute unprofessional conduct within the meaning of Business and Professions Code Section 4521(a).

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4521(a), Business and Professions Code; and Section 11166, Penal Code.

§ 2577.3. Elder Abuse Reporting.

Pursuant to Welfare and Institutions Code Section 9381, psychiatric technicians are mandated to report any known or suspected instance of elder physical abuse to an elder protective agency. Failure to make an elder physical abuse report as required shall constitute unprofessional conduct within the meaning of Business and Professions Code Section 4521(a).

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4521(a), Business and Professions Code; and Section 9381, Welfare and Institutions Code.

§ 2577.4. Dependent Adult Abuse Reporting.

Pursuant to Welfare and Institutions Code Section 15630(a), psychiatric technicians are mandated to report any known or suspected instance of dependent adult physical abuse to an adult protective agency. Failure to make a dependent adult physical abuse report as required shall constitute unprofessional conduct within the meaning of Business and Professions Code Section 4521(a).

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4521(a), Business and Professions Code; and Section 15630(a), Welfare and Institutions Code.

§ 2578. Substantial Relationship Criteria.

For the purposes of denial, suspension, or revocation of a license pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a licensed psychiatric technician if to a substantial degree it evidences present or potential unfitness of a licensed psychiatric technician to perform the functions authorized by his license in a manner consistent with the public health, safety, or welfare. Such crimes or acts shall include but not be limited to those involving the following:

(a) Procuring a license by fraud, misrepresentation, or mistake.

(b) A conviction of practicing medicine without a license in violation of Chapter 5 of Division 2 of the Business and Professions Code.

(c) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of Chapter 10, Division 2 of the Business and Professions Code.

(d) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 13, Chapter 5, Division 2 of the Business and Professions Code.

(e) Conviction of a crime involving fiscal dishonesty.

(f) Any crime or act involving the sale, gift, administration, or furnishing of "narcotics or dangerous drugs or dangerous devices" as defined in Section 4022 of the Business and Professions Code.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 475, 480, 490, 4520, 4521 and 4523, Business and Professions Code.

§ 2579. Criteria for Rehabilitation.

When considering the denial of a license under Section 480 of the Business and Professions Code, the Board, in evaluating the rehabilitation of the applicant and his present eligibility for a license, will consider the following criteria:

(a) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

(b) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480 of the Business and Professions Code.

(c) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (a) or (b).

(d) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.

(e) Evidence, if any, of rehabilitation submitted by the applicant.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 488 and 492, Business and Professions Code.

§ 2579.1. Rehabilitation Criteria for Suspensions or Revocations.

(a) When considering the suspension or revocation of a license on the ground that a licensed psychiatric technician has been convicted of a crime, the Board, in evaluating the rehabilitation of such person and his eligibility for a license will consider the following criteria:

(1) Nature and severity of the act(s) or offense(s).

(2) Total criminal record.

(3) The time that has elapsed since commission of the act(s) or offense(s).

(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

(6) Evidence, if any, of rehabilitation submitted by the licensee.

(b) Petition for Reinstatement. When considering a petition for reinstatement of a license under the provisions of Section 11522 of the

Government Code, the Board shall evaluate evidence of rehabilitation submitted by the petitioner, considering those criteria specified in Section 2579 of this article.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 475, 480, 490, 4520, 4521 and 4523, Business and Professions Code.

§ 2579.2. Citations and Fines—Content and Service.

(a) The executive officer of the board or his/her designee, in lieu of filing an accusation against any licensee, may issue a citation which may contain an administrative fine and/or order of abatement against that licensee for any violation of law which would be grounds for discipline or of any regulation adopted by the board pursuant thereto.

(b) Each citation shall be in writing, shall indicate the classification of the citation, and shall describe with particularity the nature and facts of each violation specified in the citation, including a reference to the statute or regulation alleged to have been violated.

(c) The citation may contain an assessment of an administrative fine, an order of abatement fixing a reasonable time for abatement of the violation or both.

(d) The citation shall inform the cited person of the right to an informal conference concerning the matter and of the right to an administrative hearing.

(e) The citation shall be served upon the cited person personally or by certified and regular mail.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.3. Exceptions.

A citation shall not be issued in any of the following circumstances:

(a) The violation is of such a nature and/or severity that revocation of the license or restrictions on the license are necessary in order to ensure consumer protection.

(b) The licensee's conduct displayed a conscious disregard for the patient and/or the patient's rights. This includes but is not limited to physical abuse; neglect; fiduciary abuse (as defined in the Welfare and Institutions Code); or the deprivation of care or services which are necessary to avoid physical harm or mental suffering.

(c) The licensee failed to comply with any requirement of any previous citation, including any order of abatement or fine.

(d) The licensee has been previously disciplined by the board or has previously been denied a license by the board for the same or similar actions.

(e) The violation involves unprofessional conduct related to controlled substances or dangerous drugs.

(f) The violation involves unprofessional conduct related to sexual abuse, misconduct, or relations with a patient.

(g) The licensee was convicted of an offense substantially related to the qualifications, functions, and duties of a licensed psychiatric technician and there is insufficient evidence of rehabilitation.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.4. Violation Classifications.

(a) There shall be two classes of violations:

(1) Class "A", and

(2) Class "B".

(b) In determining the violation class, the following factors shall be considered:

(1) Nature and severity of the violation.

(2) Length of time that has passed since the date of the violation.

(3) Consequences of the violation, including potential or actual patient harm.

(4) History of previous violations of the same or similar nature.

(5) Evidence that the violation was willful.

(c) The fine for each class "A" violation shall be not less than $1,001 nor more than $2,500. A class "A" violation includes:

(1) A violation which resulted in or could have resulted in patient harm and where there is no evidence that revocation or other disciplinary action is required to ensure consumer safety. Such violations include but are not limited to patient abandonment and falsifying nursing notes.

(2) Any violation which is neither directly or potentially detrimental to patients nor directly or potentially impacts their care. Such violations include, but are not limited to, a violation committed for personal and/or financial gain.

(3) A minor or technical violation which continues for six months or more in duration; or

(4) A minor or technical violation with one or more "B" citations.

(d) The fine for each class "B" violation shall not exceed $1,000. A class "B" violation is a minor or technical violation which is neither directly or potentially detrimental to patients nor directly or potentially impacts their care and which continues for less than six months duration. Such violations include but are not limited to practicing with an expired license, precharting, charting errors, verbal abuse.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.5. Citations for Unlicensed Practice.

The executive officer of the board or his/her designee may issue citations, in accordance with Section 148 of the Code, against any person (as defined in section 302 of the Code) who is performing or who has performed services for which licensure is required under the Psychiatric Technician Law or regulations adopted pursuant thereto. Each citation issued under this section shall contain an order of abatement. The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.6. Criteria to be Considered in Assessing a Fine.

In any citation which includes a fine, the following factors shall be considered in determining the amount of the fine to be assessed:

(a) Gravity of the violation.

(b) History of previous violations of the same or a similar nature.

(c) The good or bad faith exhibited by the cited person.

(d) Evidence that the violation was willful.

(e) The extent to which the cited person cooperated with the board's investigation.

(f) The extent to which the cited person has remediated any knowledge and/or skills deficiencies which could have injured a patient.

(g) Any other mitigating or aggravating factors.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.7. Contested Citations.

(a) In addition to requesting a hearing provided for in subdivision (b)(4) of Section 125.9 of the Code, the cited person may, within 14 calendar days after service of the citation, submit a written request for an informal citation review with the executive officer or his/her designee. A request for a citation review shall be deemed a request for an administrative hearing.

(b) The executive officer or his/her designee shall, within 30 calendar days from receipt of the written request, hold an informal conference with the person cited and his/her legal counsel or authorized representative, if desired.

(c) The executive officer or his/her designee may affirm, modify or dismiss the citation, including any fine or order of abatement, at the conclusion of the informal conference. A written decision stating the reasons for the decision shall be mailed to the cited person and his/her legal counsel, if any, within 14 calendar days from the date of the informal conference.

If the citation is dismissed, the request for a hearing shall be deemed withdrawn. If the citation is affirmed or modified, the cited person may, in his/her discretion, withdraw the request for a hearing or proceed with the administrative hearing process.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.8. Compliance with Citation/Order of Abatement.

(a) Orders of abatement may be extended for good cause. If a cited person who has been issued an order of abatement is unable to complete the correction within the time set forth in the citation because of conditions beyond his/her control after the exercise of reasonable diligence, then he/she may request from the executive officer or his/her designee an extension of time within which to complete the correction. Such a request shall be in writing and shall be made within the time set forth for the abatement.

(b) If a citation is not contested, or if the order is appealed and the person cited does not prevail, failure to abate the violation or to pay the assessed fine within the time allowed shall constitute a violation and a failure to comply with the citation or order of abatement.

(c) Failure to timely comply with an order of abatement or pay an assessed fine may result in disciplinary action being taken by the board or other appropriate judicial relief being taken against the person cited.

(d) If a fine is not paid after a citation has become final, the fine shall be added to the cited person's license renewal fee. A license shall not be renewed without payment of the renewal fee and fine.

NOTE: Authority cited: Sections 125.9, 148 and 4504, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.9. Notification to Other Boards and Agencies.

The issuance and disposition of a citation shall be reported to other regulatory agencies.

NOTE: Authority cited: Sections 125.9, 148 and 4520, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 2579.10. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.) the Board shall consider the disciplinary guidelines entitled "Disciplinary Guidelines", (Rev. 1/1/2000), which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Board, in its sole discretion, determines that the facts of the particular case warrant such a deviation — for example: the presence of mitigating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Section 4504, Business and Professions Code; and Section 11425.50(e), Government Code. Reference: Sections 4520 and 4521, Business and Professions Code; and Section 11425.50(e), Government Code.

Article 5. Schools for Preparation of Psychiatric Technicians

§ 2580. Accredited Schools for Preparation of Psychiatric Technicians.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4530, 4531 and 4532, Business and Professions Code.

§ 2581. Procedure for Accreditation.

(a) The institution shall apply to the Board for accreditation. Written documentation shall be prepared by the director and shall include:

(1) Philosophy of the program.

(2) Conceptual framework.

(3) Terminal objectives to indicate expected student outcomes upon successful completion of the program.

(4) Curriculum objectives.

(5) Course outlines.

(6) Course objectives.

(7) Instructional Plan.

(8) Evaluation methodology for curriculum.

(9) Faculty who meet the qualifications set forth in Section 2584.

(10) Clinical facilities.

(11) Evaluation methodology for clinical facilities.

(12) Admission criteria.

(13) Screening and selection criteria.

(14) Number of students.

(A) A school may admit alternate students in each new class to replace students who drop out.

(B) The number of alternate students admitted may not exceed 10% of the school's Board–approved number of students per class.

(C) Prior to admission, alternate students must be informed in writing of their alternate status and that they may be dropped from the program.

(D) Alternate students may participate in classes until the commencement of scheduled clinical experience at approved clinical facilities.

(E) Upon commencement of clinical experience at approved clinical facilities, the actual number of students in the class may not exceed the number of students approved by the Board for that particular class.

(15) Evaluation methodology for student progress.

(16) Student policies:

(A) Credit granting.

(B) Attendance.

(C) Grievance.

(17) Organizational chart.

(18) Proposed starting date.

(19) Evidence of program need to include, but not be limited to:

(A) Description of the geographic area and community to be served by the proposed program;

(B) Clinical affiliations available for student clinical experience; and

(C) Existing nursing and psychiatric technician programs with which clinical affiliations are shared.

(b) An institution may commence a new psychiatric technician program upon Board approval.

(c) A Board representative shall make a survey visit prior to graduation of the initial class. A program shall not commence another class without prior Board approval.

(d) Accreditation will be granted by the Board when a psychiatric technician program demonstrates that it meets all requirements as set forth in this chapter and in Chapter 10, Division 2, of the Business and Professions Code.

(e) The accreditation period shall be for a term of four years unless the Board grants an extension.

(1) An extension may be granted when the program demonstrates to the satisfaction of the Board that it is in full compliance with all requirements as set forth in this chapter and in Chapter 10, Division 2 of the Business and Professions Code.

(2) The extension may be granted for a period not to exceed four years.

(f) Six months prior to the date of accreditation expiration, a program may apply for continued accreditation based upon submission of documentation satisfactory to the Board. A subsequent survey visit may be conducted by a Board representative.

(g) A material misrepresentation of fact by a psychiatric technician program in any information submitted to the Board is cause for denial or revocation of accreditation or provisional accreditation.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4515, 4530, 4531 and 4532, Business and Professions Code.

§ 2581.1. Provisional Accreditation.

(a) Provisional accreditation means a program has not met all requirements as set forth in this chapter and in Chapter 10, Division 2 of the Business and Professions Code.

(b) Provisional accreditation shall be granted for a period not to exceed two years unless the Board grants an extension.

(c) The Board may place any program on provisional accreditation when a program does not meet all requirements as set forth in this chapter and in Section 2581. A provisional accreditation may be extended when a program demonstrates to the satisfaction of the Board a good faith effort to correct all deficiencies.

(d) Any program holding provisional accreditation may not admit "new" classes beyond the established pattern of admission previously approved by the Board.

(e) A program placed on provisional accreditation shall receive written notification from the Board. The notification to the program shall include specific areas of noncompliance and requirements for correction. A program's failure to correct delineated areas of noncompliance is cause for revocation of provisional accreditation.

(f) A material misrepresentation of fact by a psychiatric technician program in any information submitted to the Board is cause for revocation of provisional accreditation.

(g) A revocation of provisional accreditation is cause for removal from the Board's list of accredited programs.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4515 and 4532, Business and Professions Code.

§ 2582. Reports.

(a) The Board shall require such reports by schools and conduct such investigations as necessary to determine whether or not accreditation will be continued.

(b) A school shall report to the Board within ten days of the termination of a faculty member.

(c) A material misrepresentation of fact by a psychiatric technician program in any information submitted to the Board is cause for denial or revocation of accreditation or provisional accreditation.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511 and 4515, Business and Professions Code.

§ 2583. Faculty. Report of Changes.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4531, Business and Professions Code.

§ 2584. Faculty Qualifications.

(a) A school shall submit qualifications of the proposed faculty members for approval by the Board prior to employment.

(b) Each psychiatric technician program shall have one faculty member, designated as director who meets the requirements of subsection (c)(1) herein who shall actively administer the program. The director is responsible for compliance with all regulations in Chapter 2, Article 5 (commencing with Section 2580 et seq.).

(c) Requirements for specific faculty positions are as follows:

(1) Director: A director of a psychiatric technician program shall have completed a course or courses offered by an accredited school with instruction in administration, teaching, and curriculum development and shall meet the qualifications of subsection (A) or (B) below:

(A) Registered Nurse

1. Hold a current California active license as a Registered Nurse; and

2. Hold a baccalaureate degree from an accredited school; and

3. Have a minimum of 3 years experience as a registered nurse; one year shall be in teaching or clinical supervision, or a combination thereof, in a state accredited or approved registered nursing or vocational or practical nursing, or psychiatric technician school within the last five years; or a minimum of three years experience in nursing administration or nursing education within the last five years.

(B) Licensed Psychiatric Technician

1. Hold a current California active license as a psychiatric technician; and

2. Hold a baccalaureate degree from an accredited school; and

3. Have a minimum of three (3) years experience as a psychiatric technician; one (1) year shall be in teaching or clinical supervision, or a combination thereof, in a state accredited or approved psychiatric technician school within the last five (5) years; or have a minimum of three (3) years experience in mental health administration or education within the last five (5) years.

(2) Assistant Director: An assistant director of a psychiatric technician program shall have completed a course or courses offered by an accredited school with instruction in (1) teaching, (2) curriculum development, and (3) administration, and shall meet the qualifications of subsection (A) or (B) below:

(A) Registered Nurse

1. Hold a current California active license as a Registered Nurse; and

2. Hold a baccalaureate degree from an accredited school; and

3. Have a minimum of 3 years experience as a registered nurse; one year shall be in teaching or clinical supervision, or a combination thereof, in a state accredited or approved registered nursing or vocational or practical nursing, or psychiatric technician school within the last five years; or have a minimum of three years experience in nursing administration or nursing education within the last five years.

(B) Licensed Psychiatric Technician

1. Hold a current California active license as a Psychiatric Technician; and

2. Hold a baccalaureate degree from an accredited school; and

3. Have a minimum of 3 years experience as a licensed psychiatric technician; one year shall be in teaching or clinical supervision, or a combination thereof, in a state accredited or approved psychiatric technician school within the last five years; or have a minimum of three years experience in mental health administration or education within the last five years.

(3) Instructor: An instructor in a psychiatric technician program shall have had or be currently attending a course in teaching and shall meet the requirements of subsection (A) or (B) below:

(A) Registered Nurse

1. Hold a current California active license as a Registered Nurse; and

2. Hold a baccalaureate degree from an accredited school; or a valid teaching credential; or have completed a minimum of one year full–time teaching experience in a state accredited or approved registered nursing or vocational or practical nursing, or psychiatric technician school within the last five years; or met community college or state university teaching requirements in California; and

3. Have a minimum of 2 years experience as a registered nurse or licensed psychiatric technician within the last 5 years.

(B) Licensed Psychiatric Technician

1. Hold a current active California license as a psychiatric technician; and

2. Hold a baccalaureate degree from an accredited school; or a valid teaching credential; or have completed a minimum of one year full–time teaching experience in a state accredited or approved registered nursing or vocational or practical nursing, or psychiatric technician school within the last five years; or met community college or state university teaching requirements in California; and

3. Have a minimum of two years experience as a psychiatric technician within the last five years.

(4) Additional Faculty: Persons who have the qualifications to teach in a community college or a state university in California, or hold a baccalaureate degree in the field related to the curriculum con-

tent taught, or meet the requirements for vocational education credential may teach curriculum content as specified in Section 2587(e).

(5) Teacher Assistant: A teacher assistant in a psychiatric technician program shall:

(A) Hold a current active California license as a psychiatric technician or registered nurse; and

(B) Have a minimum of two years of experience as a psychiatric technician or registered nurse in the care of mentally disordered or developmentally disabled clients within the last five years.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4531 and 4532, Business and Professions Code.

§ 2585. General Requirements.

(a) The program shall have sufficient resources, faculty, clinical facilities, library, staff and support services, physical space, skills laboratory, and equipment to achieve the program's objectives.

(b) Regular faculty meetings shall be held. Minutes shall be available to the Board's representative.

(c) Clinical faculty shall have no other responsibilities during the hours they are assigned to the clinical instruction of students.

(d) Each teacher assistant shall work under the direction of an approved instructor. No more than one teacher assistant may be assigned to each instructor. Each teacher assistant shall assist the instructor in skills lab and clinical teaching only. The instructor to whom the teacher assistant is assigned shall be available to provide direction to the teacher assistant as needed.

(e) Each instructor shall have a daily lesson plan which correlates the theory and practice offered to the student. A copy of this plan shall be available to the director.

(f) The program's instructional plan shall be available to all faculty.

(g) Each school shall have on file proof that each enrolled student has completed an approved general education course of study through the 12th grade or evidence of completion of the equivalent thereof.

(h) Each school shall have an attendance policy approved by the Board. The policy shall include but not be limited to, criteria for attendance and the specific course objectives for which make–up time is required. Acceptable methods for make–up include:

(1) Theory: case studies, independent study, written examination, attendance at seminars or workshops, auto–tutorial laboratory, and research reports.

(2) Clinical: performance evaluation in skills laboratory or additional time in the clinical area with clients/patients.

(i) The school shall evaluate student performance to determine the need for remediation or removal from the program.

(j) Each school shall advise students, in writing, of the following:

(1) Right to contact the Board of program concerns.

(2) Credit for previous education and experience.

(3) School's grievance policy.

(4) List of Board approved clinical facilities.

(k) The program shall have prior Board approval to increase the number of students per class and/or increase the frequency of admission of classes. Criteria to evaluate a school's request to increase the number of students per class and/or increase the frequency of class admissions include but are not limited to:

(1) Sufficient program resources as specified in section 2585(a);

(2) Adequacy of clinical experience as specified in section 2588.

(3) Licensure examination pass rates as specified in section 2585(*l*).

(*l*) The program shall maintain a yearly average minimum pass rate on the licensure examination that does not fall below 10 percentage points of the state average pass rate for first time candidates of accredited psychiatric technician schools for the same period.

(1) Failure to achieve the required yearly average minimum pass rate within two years of initial approval may be cause to place a program on provisional accreditation.

(2) Failure to maintain the required yearly average minimum pass rate for two years or four consecutive biannual periods may be cause to place a program on provisional accreditation.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511 and 4515, Business and Professions Code.

§ 2585.1. Credit for Previous Education and Experience.

Each school shall have a policy, approved by the Board, for giving credit toward the curriculum requirements.

(a) Transfer credit shall be given for related previous education completed within the last five years. This includes the following courses:

(1) Accredited vocational or practical nursing courses.

(2) Accredited registered nursing courses.

(3) Accredited psychiatric technician courses.

(4) Armed services nursing courses.

(5) Certified nurse assistant courses.

(6) Other courses the school determines are equivalent to courses in the program.

(b) Competency–based credit shall be granted for knowledge and/or skills acquired through experience. Credit shall be determined by written and/or practical examinations.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511 and 4511.2, Business and Professions Code.

§ 2586. Curriculum Hours.

(a) The course for preparation of psychiatric technicians shall consist of not less than 1530 hours or 50 semester units. The course may be offered on a full or part time basis. One hour of instruction for purposes of computing the total hours of instruction or for calculating semester units as specified in this section shall consist of not less than 50 minutes of actual class time.

(b) The course shall consist of not less than 576 hours of theory and 954 hours of supervised clinical experience. The hours of theory and clinical experience shall include a minimum of each of the following:

	Theory Hours	*Clinical Hours*
Pharmacology	54	
Nursing science	126	270
Mental disorders	108	270
Developmental disabilities	108	270

(c) The school week shall not exceed 40 hours per week.

(d) School days that consist of class attendance only or a combination of class attendance and clinical experience shall not exceed eight hours in length.

(e) Students may be assigned to shifts of up to and including 12–hour length for clinical experience, only.

(f) Students may be granted holidays and vacation days equivalent to those granted by community colleges.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4531 and 4532, Business and Professions Code.

§ 2587. Curriculum Content.

(a) Psychiatric technician programs shall include theory and correlated clinical experience.

(b) The curriculum shall develop the knowledge, skills, and abilities necessary to care for patients of all ages in current health care settings.

(c) Curriculum content shall be taught in a sequence that results in students' progressive mastery of knowledge, skills, and abilities.

(d) The curriculum content shall include:

(1) Anatomy and physiology

(2) Nutrition

(3) Psychology

(4) Normal growth and development

(5) Nursing process

(6) Communication

(7) Nursing science, which shall include:

(A) Nursing fundamentals

(B) Medical/surgical nursing

(C) Communicable diseases, which shall include but not be limited to Human Immunodeficiency Virus (HIV)

(D) Gerontological nursing

(8) Patient education

(9) Pharmacology, which shall include:

(A) Knowledge of commonly used drugs and their actions

(B) Computation of dosages

(C) Preparation of medications

(D) Principles of administration

(10) Classifications, treatment programs, and interventions for developmental disabilities.

(11) Classifications, treatment programs, and interventions for mental disorders, which shall include addictive behaviors and eating disorders.

(12) Leadership

(13) Supervision

(e) The following related courses may be taught by additional faculty. Additional faculty are persons who have qualification to teach in a community college or a state university in California or hold a baccalaureate degree in the field related to the curriculum content taught, or meet the requirement for a vocational credential.

Courses	*Maximum Hours of Instruction By Other Professionals Accepted by the Board*
Anatomy and physiology	54
Psychology	54
Pharmacology	54
Nutrition	54
Normal Growth and Development.	54

(f) All curricular changes that significantly alter the program philosophy, conceptual framework, content, objectives, or other written documentation as required in Section 2581, shall be approved by the Board prior to implementation. Proposed curricular changes must be submitted to the Board in final form by the fifteenth day of the second month preceding the month of the Board meeting at which the changes will be considered. Revisions should include:

(1) Explanation of changes;

(2) Rationale for proposed revision;

(3) Description of revised curriculum materials; and

(4) Changes to behavioral objectives, if applicable.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4515, 4531 and 4532, Business and Professions Code.

§ 2588. Clinical Experience.

(a) Schools shall apply on a form provided by the Board for approval of each clinical facility prior to use.

(b) Schools shall have clinical facilities adequate as to number, type, and variety of patients treated, to provide clinical experience for all students in the areas specified by Section 2587. There must be available for student assignment, an adequate daily census of patients to afford a variety of clinical experience consistent with competency–based objectives and theory being taught. Clinical objectives which students are expected to master shall be posted in client care areas utilized for clinical experience.

(c) For supervision of clinical experience, there shall be a maximum of 15 students for each instructor.

(d) Schools are responsible for the continuous review of clinical facilities to determine if the students' clinical objectives for each facility are being met.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4531 and 4532, Business and Professions Code.

§ 2588.1. Clinical Preceptorships.

(a) With prior Board approval, each psychiatric technician program may offer an optional clinical preceptorship during the last nine weeks of the program.

(b) Preceptorship means an optional clinical experience for selected psychiatric technician students, which is conducted in the last nine (9) weeks of the psychiatric technician program.

(c) Preceptor means a registered nurse or a psychiatric technician on staff at the clinical facility in which the preceptorship will occur who is specially selected and prepared to work with a student during the preceptorship and who shall be responsible for on–site direction of the student's preceptorship.

(d) The program director or designee shall be responsible for the overall management of the preceptorship and final student outcomes.

(e) General Requirements

(1) The preceptorship may be conducted in any health care setting (including acute, subacute, clinic or a combination of settings) wherein the specific clinical objectives can be met.

(2) The goal of the preceptorship shall be the facilitation of students' maximal application of newly acquired knowledge, skills, and abilities in a realistic setting that simulates actual job performance.

(3) Preceptorships shall not be used for clinical make–up time or remediation.

(4) Prior to implementation of the preceptorship, the director shall apply for Board approval and specify the clinical objectives to be accomplished by the student in the preceptorship facility.

(5) The total length of a student's preceptorship shall not exceed 160 hours.

(6) The total hours per week required of a student for theory and preceptorship attendance shall not exceed 40 hours.

(7) The total hours per day required of a student for theory and preceptorship attendance shall not exceed eight (8) hours.

(8) The preceptorship shall be conducted within the last nine (9) weeks of the program or when presentation of new theory and correlated clinical content has been completed, whichever occurs later.

(9) The maximum instructor–to–preceptorship student ratio is 1:15.

(10) The maximum preceptor–to–student ratio is 1:1.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511, 4531 and 4532, Business and Professions Code.

§ 2589. Transcript of Records.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 4511 and 4513, Business and Professions Code.

Article 6. Revenue

§ 2590. Fees.

The following fees are established:

(a) The application fee is twenty–five dollars ($25).

(b) The biennial renewal fee is ninety dollars ($90). The delinquent fee is 50% of the renewal fee in effect at the time of renewal.

(c) Notwithstanding subsection (b), licensees shall renew according to the following schedule:

(1) In 1992, for licensing periods beginning on or after July 1, 1992, licensees with an even birth year shall renew for two years and the biennial renewal fee shall be ninety dollars ($90). Licensees with an odd birth year shall renew for one year and the annual renewal fee shall be forty–five dollars ($45).

(2) In 1993, licensees with an odd birth year shall renew for two years and the biennial renewal fee shall be ninety dollars ($90). Licensees with an even birth year who were initially licensed or renewed between January 1, 1992 and June 30, 1992 shall renew for one year and the renewal fee shall be forty–five dollars ($45).

(3) On or after January 1, 1994, all renewing licensees shall renew for two years and the biennial renewal fee shall be ninety dollars ($90).

(d) The reexamination fee for any examination after the first is thirty–five dollars ($35).

(e) For licensing periods beginning on or after July 1, 1992, the fee for an initial license shall be ninety dollars ($90). Licenses shall expire at two year intervals on the last day of the month in which the

licensee's birthday occurs, beginning with the second birthday following the date on which the license was issued.

(f) The penalty fee for submitting insufficient funds or fictitious check, draft or order on any bank or depository for payment of any fee to the Board is ten dollars ($10).

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Sections 152.6, 4544 and 4548, Business and Professions Code; and Section 6157, Government Code.

§ 2590.1. Provider Fees.

Pursuant to Section 4518 of the Code the application fee for approval as a continuing education provider is one hundred fifty dollars ($150) every two years.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4518, Business and Professions Code.

§ 2591. Waiver of Initial Certificate Fee.

Article 7. Continuing Education

§ 2592.1. Hour Requirements.

(a) Each licensee renewing a license under Section 4544 of the code shall submit proof of having completed, during the preceding two years, thirty (30) hours of continuing education acceptable to the Board.

(b) This section shall not apply to the first license renewal following initial issuance of a license.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.2. Continuing Education Courses.

(a) The Board will accept each hour of theory or course related clinical experience as one (1) hour of continuing education.

(b) Continuing education courses approved by psychiatric technician or nursing licensing agencies of this or of other states, or psychiatric technician or nursing organizations of this or other states, or courses considered comparable by the Board will be accepted.

(c) Courses which are prerequisite to or part of a registered nursing or vocational nursing program, or college and university courses related to the psychiatric technician scope of practice will be accepted.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.3. Course Approval.

(a) Providers applying for approval of a continuing education course must submit written documentation which shall include:

(1) A description of the subject matter of the course as it relates to recent developments in the psychiatric technician field or in any area of psychiatric technician practice:

(2) The course objectives;

(3) Method of instruction;

(4) Length of the course, date the course will start, total number of hours in the course and the course location;

(5) Any enrollment restrictions or prerequisites;

(6) Identification of the course instructor's qualifications, as specified in Section 2592.4;

(b) The Board will issue approval to the provider. A course will not be approved for more than a two year period.

(c) Any material misrepresentation of fact in the application filed by a continuing education provider shall constitute cause for the Board to withdraw its course approval.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.4. Approval of Course Instructors.

For approval, instructors shall meet two of the following:

(a) Completion of specialized training in the subject matter of the course within two years preceding course approval;

(b) Completion of academic studies related to the subject matter of the course within two years preceding course approval;

(c) Teaching experience in a course with similar subject matter content within the previous two years;

(d) Six months of work experience in the subject matter of the course within the previous three years;

(e) Experience in the development of academic courses within two years preceding course approval.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.5. Course Completion Certificates and Reporting.

(a) At the completion of the course, the provider shall issue a certificate to each licensee.

(b) At the time of license renewal, the licensee shall provide a written statement indicating (1) the date each course was completed; (2) provider and course number; (3) course title; and (4) total hours of the course.

(c) Licensees are required to maintain a record of continuing education courses taken during the last four (4) years.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.6. Inactive Licenses.

(a) A license will be placed on inactive status when the renewal fee is paid and continuing education requirements have not been met.

(b) To reactivate an inactive license the licensee must submit proof of thirty hours of continuing education taken during the preceding two years.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

§ 2592.7. Exemption from Continuing Education Requirements.

(a) At the time of making application for renewal, an applicant for exemption from the continuing education requirements shall make written application to the Board.

(b) The applicant must show evidence satisfactory to the Board, that during the two–year period immediately prior to the expiration date of the applicant's license, the licensee:

(1) Has been residing in another country for a period of one year or longer reasonably preventing completion of continuing education requirements; or

(2) Has been absent from California because of military or missionary service for a period of one year or longer preventing completion of continuing education requirements; or

(3) Should be exempt from the continuing education requirements for reasons of health or other good cause which includes;

(A) Total physical or mental disability for one year or more and the ability to return to work, as verified by a licensed physician and surgeon or licensed clinical psychologist.

(B) Total physical or mental disability for one year or longer of an immediate family member for whom the licensee has total responsibility, as verified by a licensed physician and surgeon or licensed clinical psychologist.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4517, Business and Professions Code.

Article 8. Blood Withdrawal

§ 2593. Blood Withdrawal.

A licensed psychiatric technician applying for certification by the Board to withdraw peripheral venous blood from a patient with a mental illness or developmental disability shall complete and submit an application form supplied by the Board entitled "Application to be Certified in Blood Withdrawal for Psychiatric Technicians" (Form 56C–1, 9/98) hereby incorporated by reference. Applicants may qualify for certification in one of the following ways:

(a) Written verification as submitted to the Board by one of the persons specified in Section 2593.3 that the licensed psychiatric technician is competent in the performance of blood withdrawal procedures according to the subject areas specified in Section 2593.2.

Written verification shall be provided on a form entitled "Blood Withdrawal Verification for Psychiatric Technicians" (Form 56C–2, 9/98) hereby incorporated by reference.

(b) Satisfactory completion of a course in blood withdrawal, as defined in Section 2593.2 and taught by an approved course provider as specified in Section 2593.3.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.2, Business and Professions Code.

§ 2593.1. Procedure for Course Provider Approval.

(a) A person or institution applying for approval of a course in blood withdrawal shall complete and submit an application form supplied by the Board entitled "Application to be a Course Provider in Blood Withdrawal for Psychiatric Technicians" (Form 56C–3, 9/98) hereby incorporated by reference that indicates compliance with the course of instruction delineated in Section 2593.2.

(b) A blood withdrawal course of instruction shall be approved by the Board before a course in blood withdrawal is offered to licensees by the provider.

(c) Approval of a psychiatric technician blood withdrawal certification course may be withdrawn if the Board later discovers misrepresentation in an advertisement or in any information required by the Board in accordance with this Article.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.2, Business and Professions Code.

§ 2593.2. Approval of Course Content.

(a) A course of instruction in blood withdrawal shall be taught by an instructor approved as provided in Section 2593.3 and shall include, but not be limited to, the following:

(1) Anatomy and physiology pertinent to peripheral venous blood withdrawal.

(2) Specimen handling:

(A) Container and preservative selection;

(B) Amount of specimen required;

(C) Test requirements, including, but not limited to, acceptable time periods from specimen collection to laboratory processing, temperature requirements, and effect of container motion; and

(D) Patient and specimen container identification techniques.

(3) Selection of appropriate equipment:

(A) Lancet;

(B) Syringe;

(C) Vacuum tube;

(D) Needle (The term "needle" does not include the equipment, methods and procedures used outside of peripheral venous blood withdrawal.); and

(E) Safety measures related to equipment.

(4) Methods of blood withdrawal:

(A) Capillary blood withdrawal; and

(B) Venipuncture.

(5) Withdrawal site:

(A) Selection;

(B) Preparation;

(C) Technique (including safety measures to protect patients and staff); and

(D) Post–procedure care.

(6) Sterile technique.

(7) Universal and standard precautions for infection control.

(8) Possible complications.

(9) Psychological preparation of the patient.

(10) Practice in peripheral venous blood withdrawal shall include at least 5 successful individually supervised venipunctures on live human subjects and 3 successful individually supervised capillary blood withdrawals on live human subjects.

(b) The course shall consist of 10 hours theory and 6 hours clinical practice.

(c) A course will not be approved for more than a two–year period.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.2, Business and Professions Code.

§ 2593.3. Qualifications of Blood Withdrawal Course Instructors.

To be approved by the Board, a course in peripheral venous blood withdrawal for licensed psychiatric technicians shall be taught by one of the following persons:

(a) A physician and surgeon licensed by the Medical Board of California who within the last five years has had a minimum of 6 months of experience:

(1) Performing blood withdrawal; or

(2) Teaching courses in blood withdrawal.

(b) A nurse licensed by the California Board of Registered Nursing who within the last five years has had a minimum of 6 months of experience:

(1) Performing blood withdrawal; or

(2) Teaching courses in blood withdrawal.

(c) A clinical laboratory scientist (technologist), licensed by the California Department of Health Services who within the last five years has had a minimum of 6 months of experience:

(1) Performing blood withdrawal; or

(2) Teaching courses in blood withdrawal.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.2, Business and Professions Code.

§ 2593.4. Reports to the Board that the Licensee is Eligible for Board–Certification.

(a) The course provider in blood withdrawal for licensed psychiatric technicians shall submit to the Board verification of course completion, which shall include:

(1) Course title;

(2) Date of course completion;

(3) Licensee's name, address, telephone number and psychiatric technician license number;

(4) Course number issued by the Board; and

(5) Number of course hours, specified as theory and clinical hours.

(b) The course provider shall maintain a list of all psychiatric technician licensees who have completed the blood withdrawal course within the preceding four years.

(c) A licensed psychiatric technician is deemed to be Board–certified to withdraw peripheral venous blood upon written notification from the Board.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.2, Business and Professions Code.

Article 9. Immunizations and Skin Tests

§ 2594. Immunizations and Skin Tests.

(a) A psychiatric technician, when prescribed by a physician and surgeon, may perform the activities delineated in Section 4502.3 of the Business and Professions Code provided the psychiatric technician has demonstrated competence.

(b) Clinical competence in the administration of immunizations and skin tests by psychiatric technicians shall be determined by a licensed physician and surgeon, physician's assistant, registered nurse, licensed psychiatric technician or licensed vocational nurse who is clinically competent in the performance of the aforenoted procedures.

NOTE: Authority cited: Section 4504, Business and Professions Code. Reference: Section 4502.3, Business and Professions Code.

TITLE 22. SOCIAL SECURITY

Division 3. Health Care Services

Subdivision 1. California Medical Assistance Program*

(Originally Filed 2–28–66)

NOTE: Authority cited for Subdivision 1: Sections 14100, 14105 and 14106, Welfare and Institutions Code. Additional authority cited for regulations filed on 9–30–71: Sections 14005.6, 14106.5, 14122, 14124.5, 14134, W. & I. Code, and Sec. 53.6 of Chapter 577, Stats. of 1971. Additional authority cited: Section 14124.5, Welfare and Institutions Code. Additional authority cited for regulation filed 1–18–74: Sections 10541, 10553.1, 10554, 10554.1, 11004, 11050, 11100, 14000, 14005.1, 14005.2, 14005.4, 14005.7, 14008, 14016, 14017, 14023, 14051, 14053, 14053.6, 14060, 14061, 14100.1, 14132, 14184 and 14329, Welfare and Institutions Code. Reference: Sections 11004, 11050, 11100, 14000, 14005.1, 14005.2, 14005.4, 14005.6, 14005.7, 14008, 14016, 14017, 14023, 14051, 14053, 14053.6, 14059, 14100.1, 14132, 14133, 14184, 14256, 14261, 14301 and 14329, Welfare and Institutions Code.

Chapter 3. Health Care Services

Article 1. Application and Enrollment

§ 51000.2. Beneficiary.

"Beneficiary" means any person certified as eligible for services under the Medi–Cal program.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14000 and 14005, Welfare and Institutions Code.

Article 1.3. General Provisions

§ 51003. Prior Authorization.

(a) "Prior authorization," "reauthorization," or "approval" means authorization granted by a designated Medi–Cal consultant or by a PCCM plan, as applicable, in advance of the rendering of a service, unless otherwise specifically stated, after appropriate medical, dental or other review. Authorization may be granted by a PCCM plan only for beneficiaries enrolled in that PCCM plan. The responsibilities of the Medi–Cal consultant shall not be delegated, except to the extent provided under Sections 51013 and 51014. The responsibilities of the PCCM plan shall not be delegated except as provided under Section 51003.7.

(b) Retroactive approval of requests for prior authorization may be granted only under the following conditions:

(1) When certification of the Medi–Cal beneficiary's eligibility by the county welfare department was delayed;

(2) When "other coverage" (i.e., Medicare or other health insurance programs) denied payment of a claim for services;

(3) When communication with the Medi–Cal consultant or PCCM plan could not be established and provision of the required service should

not have been delayed; under this condition the request for retroactive authorization must be received by the Medi–Cal consultant or PCCM plan within 10 working days after the service is provided or initiated.

(4) When a patient does not identify himself to the provider as a Medi–Cal beneficiary by deliberate concealment or because of physical or mental incapacity to so identify himself;

(A) The request for retroactive authorization shall be accompanied by a statement from the provider certifying that the patient did not identify himself and the date the patient was so identified, provided such date is within one year after the month in which service was rendered.

(B) The request for retroactive authorization shall be submitted within 60 days following the certified date of beneficiary identification.

(5) When the Department determines that the provider was prevented from submitting a timely request for reauthorization because of a reason that meets one of the criteria specified in paragraph (A), (B) or (C). The provider shall submit factual documentation deemed necessary by the Department with the reauthorization request. Any additional documentation requested by the Department shall be submitted within 60 days of the request. The documentation shall verify that the late submission was due to:

(A) A natural disaster which has:

1. Destroyed or damaged the provider's business office or records.

2. Substantially interfered with a provider's agent's processing of the provider's Treatment Authorization Requests (TARs).

(B) Delay caused by other circumstances beyond the control of the provider which have been reported to the appropriate law enforcement or fire agency when applicable. Circumstances which shall not be considered beyond the control of the provider include but are not limited to:

1. Negligence by employees.

2. Misunderstanding of program requirements.

3. Illness or absence of any employee trained to prepare TARs.

4. Delays caused by the United States Postal Service or any private delivery service.

(6) When the Department has imposed postservice prepayment audits as set forth in section 51159(b), for emergency services pursuant to section 51056(b)(2), by requiring providers to utilize the procedures for obtaining authorization on a retroactive basis.

(c) "Reauthorization" means authorization of a request for previously authorized services. No services will be reauthorized for any period prior to receipt by the Medi–Cal consultant or PCCM plan of a request for reauthorization, unless the criteria in Medi–Cal program regulations for retroactive authorization apply.

(1) "Request for Nonacute Continuing Services," as used in Section 51014.1(e), means a reauthorization request received by the Medi–Cal Field Office prior to or no later than ten (10) working days after expiration of the immediately preceding approved authorization for services in the following categories:

(A) Long–Term Care, specifically Skilled Nursing Facility, Intermediate Care Facility and Subacute levels of care.

(B) Chronic Hemodialysis, including all related services.

(C) Hospice Care.

(D) In–Home Medical Care Waiver Services, including all related services.

(E) Skilled Nursing Facility Waiver Services, including all related services.

(F) Model Community Based Waiver Services, including all related services.

(G) All other nonacute services under the Medi–Cal program when the treating physician (i.e., the physician, podiatrist, or dentist who is treating the patient and certifying that the services must be continued) substantiates on or with the request that the same level or frequency of services should be continued because the treatment goal approved on the original TAR has not been achieved. To meet the requirement to substantiate the need for continuing care, the treating physician must submit sufficient information (narrative or other evidence) in support of his or her conclusion that services must be continued because treatment goals have not been met. Information submitted is sufficient if the field office consultant determines that a reasonable, competent physician might agree, based on the information submitted, that treatment goals have not been met.

(H) Nursing Facility Waiver Services for beneficiaries.

(2) "Request for Acute Continuing Care Services," as used in section 51014.1(f), means a request for extension (EDS form 18–1, 2/87) of approval for acute care services in hospitals with on–site Medi–Cal reviewers when:

(A) The treating physician (i.e., the physician, dentist or podiatrist certifying the need for acute care pursuant to section 51327(a)(3)(A)) has determined that the beneficiary cannot safely be discharged because acute care services continue to be medically necessary, for one of the following reasons:

1. Further acute care is needed for the purpose of treating the condition or conditions for which acute care was originally approved for an acute admission requiring prior authorization.

2. Complications directly related to the diagnosis for which acute care was originally approved have arisen and necessitate further acute care.

3. Further acute care is needed for an illness contracted during the course of an approved acute admission if the illness most likely occurred because the patient was hospitalized.

4. Further acute care is needed for the purpose of treating a diagnosed condition or conditions for which a length of stay was previously approved after an emergency or urgent admission.

5. Further diagnostic procedures and/or treatments are needed after a previously approved emergency or urgent admission, for which no length of stay was approved and the acute care stay has been at least five (5) days in duration at the time of the request; and

(B) The medical record contains documentation consistent with subdivision (c)(2)(A) above.

(d) All authorization requests shall include adequate information and justification for the service requested for the beneficiary.

(e) Authorization may be granted only for Medi–Cal benefits that are medically necessary and do not exceed health care services received by the public generally for similar medical conditions. The "Manual of Criteria for Medi–Cal Authorization," published by the Department in January 1982, last revised April 15, 2004, and herein incorporated by reference in its entirety, shall be the basis for the professional judgments of Medi–Cal consultants or PCCM plans in their decisions on authorizations for services or conditions listed in the Manual. Such authorization shall be valid for the number of days specified by the consultant or PCCM plan up to a maximum of 180 days, unless otherwise specified in this chapter. The consultant or PCCM plan may grant authorization for up to a maximum of two years when the treatment as authorized is clearly expected to continue unmodified for up to or beyond two years.

(f) Authorization may be granted only for the lowest cost item or service covered by the program that meets the patient's medical needs.

(g) A provider may appeal the decision of a Medi–Cal Consultant on a TAR. Such an appeal shall be received by the administrator of the Medi–Cal field office which denied the initial request within 60 calendar days from the date of provider notification of the Medi–Cal consultant's decision. A provider appealing the decision of a PCCM plan on a TAR shall file the appeal in accordance with Section 56262.

(1) The appeal shall be submitted in writing to the administrator of the local Medi–Cal field office.

(2) If the administrator of the local Medi–Cal field office finds no basis for altering the original decision of the Medi–Cal consultant, the provider shall be informed in writing, within 60 calendar days of receipt of the appeal, of the local Medi–Cal field office administrator's decision, the basis therefor, and the provider's right to resubmit the appeal to the Field Services Headquarters.

(3) An appeal to the Field Services Headquarters shall be initiated within 30 calendar days from the date of provider notification of the local Medi–Cal field office administrator's decision. The Department shall act on the appeal and inform the provider directly of the Department's decision, and the basis therefor, within 60 calendar days from the receipt of the appeal submitted to the Field Services Headquarters.

*NOTE: The December 1996 revision of this provision was made by emergency regulation package R–60–96E. Implementation of R–60–96E was enjoined on November 26, 1996 (*Carmen Doe, et al.* v. *Wilson, et al.*, City and County of San Francisco Superior Court No. 982521). The change to the Manual of Criteria for Medi–Cal Authorization included in R–60–96E that would have occurred in December 1996 is of no force or effect.

NOTE: Authority cited: Sections 10725, 14105, 14124.5, 14132.22, 14132.5 and 14133, Welfare and Institutions Code; and Section 1267.7, Health and Safety Code. Reference: Sections 14053, 14064, 14081, 14087, 14088, 14088.16, 14088.2, 14103.6, 14105.12, 14132, 14132.22, 14132.25, 14132.5, 14132.42, 14132.8, 14133, 14133.1, 14133.25 and 14133.3, Welfare and Institutions Code; *Jeneski* v. *Meyers* (1984) 163 Cal. App.3d 18, 209 Cal. Rptr. 178; *Duran* v. *Belshé*, San Diego County Superior Court Case No. 674204, (1995); and *Fresno Community Hospital and Medical Center v. State of California, et al.*, Fresno County, Superior Court Case No. 555694–9, (1996).

Article 4. Scope and Duration of Benefits

§ 51335. Skilled Nursing Facility Services.

Skilled nursing facility services necessary for the treatment of illness or injury, are covered subject to the following:

(a) Skilled nursing facility services are covered only after prior authorization has been obtained from the designated Medi–Cal consultant for the district where the skilled nursing facility is located. The authorization request shall be initiated by the facility and shall be signed by the attending physician.

(b) An initial Treatment Authorization Request shall be required for each admission.

(1) An initial authorization may be granted for periods up to one year from the date of admission.

(2) An approved initial Treatment Authorization Request shall be required prior to the transfer of a beneficiary between skilled nursing facilities.

(3) For Medicare/Medi–Cal covered services (crossover services) a request for authorization shall be received by the Medi–Cal consultant's office on or before the 20th calendar day of skilled nursing facility care. Medi–Cal shall not pay coinsurance for skilled nursing facility care unless an authorization request has been approved covering the 21st and subsequent days of skilled nursing facility care. When the authorization request is received by the Medi–Cal consultant's office after the 20th day of skilled nursing facility care, one day of coinsurance authorization shall be denied for each day the request is late.

(c) A request for reauthorization must be received by the appropriate Medi–Cal consultant on or before the first working day following the expiration of a current authorization. When the request is received by the Medi–Cal consultant later than the first working day after the previously authorized period, one day of authorization shall be denied for each day the request is late.

(1) Reauthorizations may be granted for periods up to one year.

(d) The Medi–Cal consultant shall deny an authorization request or reauthorization request or shall cancel any authorization or reauthorization in effect when services or placement are not appropriate to the needs of the patient (beneficiary).

(1) Where the reauthorization request is denied or an existing authorization is cancelled, the beneficiary shall be notified in writing of the Department's decision to deny ongoing services; the provider will be notified simultaneously. If the beneficiary does not agree with the Department's decision, the beneficiary has the right to request a fair hearing pursuant to section 51014.1 herein. If the beneficiary requests a fair hearing within ten days of the date of the notice, the Department will institute aid paid pending the hearing decision pursuant to section 51014.2 herein.

(2) Medi–Cal consultants shall deny any initial authorization

request if the skilled nursing facility is not participating in Medicare as a skilled nursing facility and the patient is qualified for skilled nursing facility care. Medicare benefits shall be utilized to their fullest extent; failure to utilize such benefits shall result in denial of Medi–Cal benefits under this section for the same period of time Medicare benefits would have been available. Exception to this rule may be made:

(A) When skilled nursing facility benefits are known to have been exhausted.

(B) When Medicare rejects skilled nursing facility level of care and the Medi–Cal consultant determines the medical necessity for skilled nursing facility care.

(C) When it can be determined that there are no skilled nursing facility care beds available in or near the community.

(e) The attending physician must recertify, at least every 60 days, the patient's need for continued care in accordance with the procedures specified by the Director. The attending physician must comply with this requirement prior to the start of the 60–day period of stay for which the patient is being recertified. The facility must present proof of this recertification at the time of billing for services rendered.

(f) Medi–Cal beneficiaries in the facility shall be visited by their attending physician no less often than once every 30 days for the first 90 days following admission. Subsequent to the 90th day, an alternative schedule of visits may be proposed, subject to approval by the Medi–Cal consultant. At no time, however, shall an alternative schedule of visits result in more than 60 days elapsing between physician visits.

(g) Services are not covered unless provided on the signed order of the physician responsible for the care of the patient.

(h) There shall be a periodic medical review, not less often than annually, of all beneficiaries receiving skilled nursing facility services by a medical review team as defined in section 50028.2.

(i) Leave of absence from skilled nursing facilities is reimbursed in accordance with section 51535 and is covered for the maximum number of days per calendar year as indicated below:

(1) Developmentally disabled patients: 73 days.

(2) Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic program approved and certified by a local mental health director: 30 days.

(3) All other patients: 18 days. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:

(A) The request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well–being of the patient.

(B) At least five days inpatient care must be provided between each approved leave of absence.

(j) In order to qualify for skilled nursing facility services, a patient shall have a medical condition which needs visits by a physician at least every 60 days and constantly available skilled nursing services. The following criteria together with the provisions of section 51124, will assist in determining appropriate placement:

(1) Need for patient observation, evaluation of treatment plans, and updating of medical orders by the responsible physician;

(2) Need for constantly available skilled nursing services. A patient may qualify for nursing home services if the patient has one or more of the following conditions:

(A) A condition which needs therapeutic procedures. A condition such as the following may weigh in favor of nursing home placement.

1. Dressing of postsurgical wounds, decubiti, leg ulcers, etc. The severity of the lesions and the frequency of dressings will be determining factors in evaluating whether they require nursing home care.

2. Tracheostomy care, nasal catheter maintenance.

3. Indwelling catheter in conjunction with other conditions. Its presence without a requirement for other skilled nursing care is not a sufficient criterion for nursing home placement.

4. Gastrostomy feeding or other tube feeding.

5. Colostomy care for initial or debilitated patients. Facilities shall be required to instruct in self–care, where such is feasible for the patient. Colostomy care alone should not be a reason for continuing nursing home placement.

6. Bladder and bowel training for incontinent patients.

(B) A condition which needs patient skilled nursing observation. Patients whose medical condition requires continuous skilled nursing observation of the following may be in a nursing home dependent on the severity of the condition. Observation must, however, be needed at frequent intervals throughout the 24 hours to warrant care in a nursing home:

1. Regular observation of blood pressure, pulse, and respiration is indicated by the diagnosis or medication and ordered by the attending physician.

2. Regular observation of skin for conditions such as decubiti, edema, color, and turgor.

3. Careful measurement of intake and output is indicated by the diagnosis or medication and ordered by the attending physician.

(C) The patient needs medications which cannot be self–administered and requires skilled nursing services for administration of the medications. Nursing home placement may be necessary for reasons such as the following:

1. Injections administered during more than one nursing shift. If this is the only reason for nursing home placement, consideration should be given to other therapeutic approaches, or the possibility of teaching the patient or a family member to give the injections.

2. Medications prescribed on an as needed basis. This will depend on the nature of the drug and the condition being treated and frequency of need as documented. Many medications are now self–administered on an PRN basis in residential care facilities.

3. Use of restricted or dangerous drugs, if required more than during the daytime, requiring close nursing supervision.

4. Use of new medications requiring close observation during initial stabilization for selected patients. Depending upon the circumstances, such patients may also be candidates for intermediate care facilities.

(D) A physical or mental functional limitation.

1. Physical limitations. The physical functional incapacity of certain patients may exceed the patient care capability of intermediate care facilities.

a. Bedfast patients.

b. Quadriplegics, or other severe paralysis cases. Severe quadriplegics may require such demanding attention (skin care, personal assistance, respiratory embarrassment) as to justify placement in nursing homes.

c. Patients who are unable to feed themselves.

2. Mental limitations. Persons with a primary diagnosis of mental illness (including mental retardation), when such patients are severely incapacitated by mental illness or mental retardation.

The following criteria are used when considering the type of facility most suitable for the mentally ill and mentally retarded person where care is related to his mental condition.

a. The severity of unpredictability of the patient's behavior or emotional state.

b. The intensity of the care, treatment, services, or skilled observation that his condition requires and,

c. The physical environment of the facility, its equipment, and the qualifications of staff and,

d. The impact of the particular patient on other patients under care in the facility.

(3) The general criteria identified above are not intended to be either all–inclusive or mutually exclusive. In practice, they should be applied as a total package in evaluation of an approved admission.

(k) Special program services for the mentally disordered (as defined in chapter 3, division 5, title 22) provided in skilled nursing facilities are covered when prior authorization has been granted by the Department for such services. Payment for these services will be made in accordance with Section 51511.1.

(*l*) A need for a special services program for the mentally disordered is not sufficient justification for a beneficiary to be placed in a skilled nursing facility. All beneficiaries admitted to skilled nursing facilities must meet the criteria found in paragraph (i) of this section.

(m) A need for a special services program for the developmentally disabled or mentally disordered is not sufficient justification for a beneficiary to be placed in a skilled nursing facility. All beneficiaries admitted to skilled nursing facilities must meet the criteria found in paragraph (j) of this section.

(n) The placement criteria established in Section 14091.21 of the Welfare and Institutions Code must be met except in either of the following circumstances:

(1) The beneficiary's physician and the discharge planner determine that the beneficiary requires short–term nursing facility care for postsurgical, rehabilitation, or therapy services which are curative rather than palliative in nature; or

(2) The beneficiary's attending physician certifies in the medical record that transfer to a freestanding nursing facility would cause specific physical or psychological harm to the beneficiary.

NOTE: Authority cited: Sections 10725, 14105, 14108, 14108.1 and 14124.5, Welfare and Institutions Code. Reference: Sections 10725, 14091.21, 14105, 14108, 14108.1, 14108.2, 14124.5 and 14132, Welfare and Institutions Code; *Hudman v Kizer*, Sacramento County Superior Court Case No. 362172, and *Laguna Honda Hospital and Rehabilitation Center of the City and County of San Francisco v Kizer*, U.S. District Court, EDCA, No. CIV–S90–1239 MLS EM.

Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

Chapter 2. Acute Psychiatric Hospital

Article 1. Definitions

§ 71001. Meaning of Words.

Words shall have their usual meaning unless the context or a definition clearly indicates a different meaning. Words used in the present tense include the future; words in the singular number include the plural number; words in the plural number include the singular number and words in the masculine include the feminine. Shall means mandatory. May means permissive. Should means suggested or recommended.

§ 71003. Hospital.

Hospital, where used in these regulations means an acute psychiatric hospital.

§ 71004. Acute Psychiatric Care Bed Classification.

Acute psychiatric care bed classification means beds designated for acute psychiatric, developmentally disabled or drug abuse patients receiving 24–hour medical care.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71005. Acute Psychiatric Hospital.

(a) Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24–hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services.

(b) An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

NOTE: Authority cited: Section 1250.1(e), Health and Safety Code. Reference: Section 1250(b), Health and Safety Code.

§ 71007. Alteration.

Alteration means any work other than maintenance in an existing building and which does not increase the floor or roof area or the volume of enclosed space.

§ 71009. Autoclaving.

Autoclaving means the process of sterilization by steam under pressure.

§ 71011. Basic Services.

Basic services means those essential services required by law for licensure as a hospital including medical, nursing, rehabilitative, pharmacy and dietary services.

§ 71012. Certificate of Exemption.

Certificate of Exemption means a document containing Department approval for the exemption of a specified project from Certificate of Need review.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71012.1. Certificate of Need.

Certificate of Need means a document containing Department approval for a specified project.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71013. Child.

Child means a person who is 13 years of age or under.

§ 71015. Cleaning.

Cleaning means the process employed to free a surface from dirt or other extraneous material.

§ 71017. Conservator.

Conservator means a person appointed by the court to take care of the person or the property, or both, of a conservatee under Section 5350, et seq., of the Welfare and Institutions Code or under Section 1701, et seq., of the Probate Code.

§ 71019. Defined.

Defined means written.

§ 71021. Department.

Department means the State Department of Health Services.

NOTE: Authority cited: Sections 208, 1255, 1266, 1275, 1402 and 1426, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 1222, 1229, 1250, 1251, 1251.5, 1252–1257, 1265, 1265.5, 1265.7, 1265.8, 1266–1270, 1275–1280, 1282, 1294–1298, 1300, 1315–1318, 1400–1405, 1410–1412, 1417.1, 1418–1432, 1437, 1439, 1729, 1734, 38254 and 38255, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Specific reference: Chapter 1252, Statutes of 1977.

§ 71023. Director.

Director means the Director of the State Department of Health Services.

NOTE: Authority cited: Sections 208, 1255, 1266, 1275, 1402 and 1426, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 1222, 1229, 1250, 1251, 1251.5, 1252, 1253–1257, 1265, 1265.5, 1265.7, 1265.8, 1266–1270, 1275–1280, 1282, 1294–1298, 1300, 1315, 1316–1318, 1400–1405, 1410–1412, 1417.1, 1418–1432, 1437, 1439, 1729, 1734, 38254 and 38255, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Specific reference: Chapter 1252, Statutes of 1977.

§ 71025. Disinfection.

Disinfection means the process employed to destroy harmful microorganisms but ordinarily not viruses and bacterial spores.

§ 71027. Distinct Part.

Distinct part means an identifiable unit accommodating beds and related facilities including but not limited to contiguous rooms, a wing, floor or building that is approved by the Department for a specific purpose.

§ 71029. Drug Administration.

Drug administration means the act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously labeled container, including a unit dose container, verifying the dose with the prescriber's orders, giving the individual dose to the proper patient and promptly recording the time and dose given.

§ 71031. Drug Dispensing.

Drug dispensing means the act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, packaging, labeling and issuance of the drug or biological for a patient or for a service unit of the hospital.

§ 71033. Existing Hospital Building.

Existing hospital building means an extant structure intended for proper hospital use. This excludes physician offices contiguous with the hospital and independent of the hospital as far as ownership.

§ 71035. Governing Body.

Governing body means the person, persons, board of trustees, directors or other body in whom the authority and responsibility is vested for conduct of the hospital.

§ 71037. Guardian.

A guardian means a person appointed by the court to take care of the person or the property, or both, of a ward under Section 1400, et seq., of the Probate Code.

§ 71038. Intermediate Care Bed Classification.

"Intermediate care bed classification" means beds designated for patients requiring skilled nursing and supportive care on less than a continuous basis.

NOTE: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71039. License.

License means a basic document issued by the Department permitting the operation of a hospital. This document constitutes the authority to receive patients and to perform the services included within the scope of these regulations and as specified on the hospital license.

§ 71040. License Category.

(a) License category means any of the following categories:

(1) General acute care hospital.

(2) Acute psychiatric hospital.

(3) Skilled nursing facility.

(4) Intermediate care facility.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71041. Licensee.

Licensee means the person, persons, firm, partnership, association, corporation, political subdivision of the State or other governmental agency within the State to whom a license has been issued.

§ 71043. Maintenance.

Maintenance means the upkeep of a building and equipment to preserve the original functional and operational state.

§ 71044. Modernization.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71045. New Construction.

(a) New construction means any of the following:

(1) New buildings.

(2) Additions to existing buildings.

(3) Conversion of existing buildings or portions thereof not currently licensed as a hospital.

§ 71047. Nursing Unit.

Nursing unit means a designated patient care area of the hospital which is planned, organized, operated and maintained to function as a unit. It includes bedrooms with adequate supporting facilities, services and personnel providing nursing care and necessary management of patients.

§ 71049. Outpatient Service.

An outpatient service means an organizational unit of the hospital which provides nonemergency health care services to patients.

§ 71051. Patient.

(a) Patient means a person who is receiving diagnostic or preventive health services or who is under observation or treatment for illness or injury or care during and after pregnancy.

(1) Inpatient. An inpatient means a person who has been formally admitted for observation, diagnosis or treatment and who is expected to remain overnight or longer.

(2) Outpatient. An outpatient means a person who has been registered or accepted for care but not formally admitted as an inpatient and who does not remain over 24 hours.

(3) Ambulatory. Ambulatory means a patient who is capable of demonstrating the mental competence and physical ability to leave a building without assistance or supervision of any person under emergency conditions.

(4) Nonambulatory. Nonambulatory means a patient who is unable to leave a building unassisted under emergency conditions. It includes, but is not limited to, those persons who depend upon mechanical aids such as crutches, walkers or wheelchairs, profoundly or severely mentally retarded persons and shall include totally deaf persons.

§ 71052. Permanently Converted.

Permanently converted means space which is not available for patient accommodation because the facility has converted the patient accommodation space to some other use and such space could not be reconverted to patient accommodation within 24 hours.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71053. Personnel.

(a) Unless otherwise specified in this chapter, the following definitions shall apply to health care personnel:

(1) Accredited Record Technician.

Accredited record technician means a person who is accredited by the American Medical Record Association.

(2) Administrator. Administrator means the individual who is appointed by the governing body to act in its behalf in the overall management of the hospital.

(3) Art Therapist. Art therapist means a person who has a master's degree in art therapy or in art with emphasis in art therapy, including an approved clinical internship from an accredited college or university; or a person who is registered or eligible for registration with the American Art Therapy Association.

(4) Consultant. Consultant means a person who is professionally qualified to provide expert information on a particular subject.

(5) Dance Therapist. Dance therapist means a person who is registered or eligible for registration as a dance therapist registered by the American Dance Therapy Association.

(6) Dietitian. Dietitian means a person who is registered or eligible by registration as a registered dietitian by the American Dietetic Association.

(7) Licensed Psychiatric Technician. Licensed psychiatric technician means a person who is licensed as a licensed psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(8) Licensed Vocational Nurse. Licensed vocational nurse means a person who is licensed as a licensed vocational nurse by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(9) Mental Health Worker. Mental health worker means an unlicensed person who through experience, in–service training or formal education is qualified to participate in the care of the psychiatric patient.

(10) Music Therapist. Music therapist means a person who is registered or eligible for registration as a registered music therapist by the National Association for Music Therapy.

(11) Occupational Therapist. Occupational therapist means a person who is certified or eligible for certification as an occupational

therapist registered by the American Occupational Therapy Association.

(12) Occupational Therapy Assistant. Occupational therapy assistant means a person who is certified or eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association.

(13) Pharmacist. Pharmacist means a person who is licensed as a pharmacist by the Board of Pharmacy.

(14) Physician. Physician means a person licensed as a physician and surgeon by the Board of Medical Examiners or by the Board of Osteopathic Examiners.

(15) Psychologist. Psychologist means a person who is licensed as a psychologist by the Board of Medical Examiners.

(16) Psychiatrist. Psychiatrist means a person who is licensed as a physician and surgeon by the Board of Medical Examiners or the Board of Osteopathic Examiners and who has specialized training and/or experience in psychiatry.

(17) Recreation Therapist. Recreation therapist means a person who is certified or eligible for certification as a registered recreator with specialization in therapeutic recreation by the California Board of Park and Recreation personnel or the National Therapeutic Recreation Society.

(18) Registered Nurse. Registered nurse means a person who is licensed by the Board of Registered Nursing.

(19) Registered Record Administrator. Registered record administrator means a person who is registered or eligible for registration as a registered record administrator by the American Medical Record Association.

(20) Social Worker. Social worker means a person who is licensed as a clinical social worker by the Board of Behavioral Science Examiners.

NOTE: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71055. Restraint.

Restraint means controlling a patient's physical activity in order to protect the patient or others from injury by seclusion, medication or mechanical devices.

§ 71056. Skilled Nursing Care Bed Classification.

"Skilled nursing care bed classification" means beds designated for patients requiring skilled nursing care on a continuous and extended basis.

§ 71057. Sterilization.

Sterilization means a process employed to destroy all living organisms.

§ 71059. Supervision.

(a) Supervision means to instruct an employee or subordinate in his duties and to oversee or direct his work but does not necessarily require the immediate presence of the supervisor.

(b) Direct supervision means that the supervisor shall be present in the same building as the person being supervised and available for consultation and/or assistance.

(c) Immediate supervision means that the supervisor shall be physically present while a task is being performed.

§ 71061. Supplemental Service.

Supplemental service means an organized inpatient or outpatient service which is not required to be provided by law or regulation.

§ 71063. Unit Dose Medication System.

Unit dose medication system means a system in which single dosage units of drugs are prepackaged and prelabeled in accordance with all applicable laws and regulations governing these practices. The system shall also comprise, but not be limited to, all equipment and appropriate records necessary and used in making the dose available to the patient accurately and safely. A pharmacist shall be in charge and responsible for the system.

Article 2. License

§ 71101. Inspection of Hospitals.

(a) The Department shall inspect and license hospitals.

(b) Any officer, employee or agent of the Department may, upon presentation of proper identification, enter and inspect any building or premise at any reasonable time to secure compliance with, or to prevent a violation of, any provision of these regulations.

(c) All hospitals for which a license has been issued shall be inspected periodically by a representative or representatives appointed by the Department. Inspections shall be conducted as frequently as necessary, but not less than once every two years, to assure that quality care is being provided. During the inspection, the representative or representatives of the Department shall offer such advice and assistance to the hospital as is appropriate. For hospitals of 100 licensed bed capacity or more, the inspection team shall include at least a physician, registered nurse and persons experienced in hospital administration and sanitary inspections.

(d) The Department may provide consulting services upon request to any hospital to assist in the identification or correction of deficiencies or the upgrading of the quality of care provided by the hospital.

(e) The Department shall notify the hospital of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the Director may take action to revoke or suspend the license.

(f) Reports on the results of each inspection of a hospital shall be prepared by the inspector or inspection team and shall be kept on file in the Department along with the plan of correction and hospital comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies and plans of correction shall be open to public inspection without regard to which body performs the inspection.

(g) The Department shall have the authority to contract for outside personnel to perform inspections of hospitals as the need arises. The Department, when feasible, shall contract with nonprofit, professional organizations which have demonstrated the ability to carry out the provisions of this section. Such organizations shall include, but not be limited to, the California Medical Association Committee on Medical Staff Surveys and participants in the Consolidated Hospital Survey Program.

§ 71103. License Required.

(a) No person, firm, partnership, association, corporation, political subdivision of the State or other governmental agency shall establish, operate or maintain a hospital, or hold out, represent or advertise by any means that it operates a hospital without first obtaining a license from the Department.

(b) The provisions of this article do not apply to any facility conducted by and for the adherents of any well recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.

§ 71105. Application Required.

(a) A verified application shall be forwarded to the Department whenever any of the following circumstances occur:

(1) Construction of a new or replacement facility or addition to an existing facility.

(2) Increase or decrease of licensed bed capacity.

(3) Added service or change from one service to another.

(4) Change of ownership.

(5) Change of name of hospital.

(6) Change of license category.

(7) Change of location of the hospital.

(8) Change of bed classification.

§ 71107. Content of Application.

(a) Any person, firm, partnership, association, corporation, political subdivision of the State, state agency or other governmental agency desiring to obtain a license shall file with the Department an application on forms furnished by the Department. The application shall contain the following:

(1) Name of applicant, and if an individual, verification that the applicant has attained the age of 18 years.

(2) Type of facility to be operated and types of services for which approval is requested.

(3) Location of the hospital.

(4) Name of person in charge of the hospital.

(5) If the applicant is an individual, satisfactory evidence that the applicant is of reputable and responsible character.

(6) If applicant is a firm, association, organization, partnership, business trust, corporation or company, satisfactory evidence that the members or shareholders thereof and the person in charge of the hospital for which application for license is made are of reputable and responsible character.

(7) If the applicant is a political subdivision of the State or other governmental agency, satisfactory evidence that the person in charge of the hospital for which application for license is made is of reputable and responsible character.

(8) If the applicant is a partnership, the name and principal business address of each partner.

(9) If the applicant is a corporation, the name and principal business address of each officer and director of the corporation; and for nonpublic corporations the name and business address of each stockholder owning five percent or more of the stock and any corporate member who has responsibility in the operation of the hospital.

(10) Copy of the current organizational chart.

(11) Certificate of Need or a Certificate of Exemption from the Department if required by Chapter 1, Division 1, Division 7 of this title.

(12) Such other information or documents as may be required by the Department for the proper administration and enforcement of the licensing law and requirements.

§ 71109. Architectural Plans.

Applications submitted for proposed construction of new hospitals or additions to licensed hospitals shall include architectural plans and specifications. Information contained in such applications shall be on file in the Department and available to interested individuals and community agencies.

§ 71110. Fee.

(a) Each application for a license shall be accompanied by the prescribed fee.

(b) The annual fee for a license to operate a hospital, the term for which commences at any time during the calendar year 1975, when the application is filed upon a change of ownership, change of location or renewal of a license shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–49	$150.00 plus 0.0185 of 1 percent of the gross operating costs for the last fiscal year ending on or before December 31, 1974
50–99 inclusive	$300.00 plus 0.0185 of 1 percent of the gross operating costs for the last fiscal year ending on or before December 31, 1974
100 and over	$425,00 plus 0.0185 of 1 percent of the gross operating costs for the last fiscal year ending on or before December 31, 1974.

(c) The annual fee for a license to operate a hospital which is being licensed for the first time, the term for which commences at any time during the calendar year 1975, shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–49 inclusive	$200.00
50–99 inclusive	$300.00
100 and over	$800.00

(d) no fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department.

(e) An additional fee of $25.00 shall be paid for processing any change of name. However, no additional fee shall be charged for any change of name, which is processed upon a renewal application or upon an application filed because of a change of ownership.

(f) Fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the number of months to be licensed divided by 12 months.

(g) Fees shall be waived for any facility conducted, maintained or operated by this state or any state department, authority, bureau, commission or officer or by the Regents of the University of California or by a local hospital district, city or county.

NOTE: Authority cited: Sections 208 (a), 1266, Health and Safety Code. Reference: Section 1266, Health and Safety Code.

§ 71111. Fee

(a) Each application for a license shall be accompanied by the prescribed fee. The license fee under this section shall be effective January 1, 1979.

(b) The fee for a license to operate a hospital which is being licensed for the first time, or upon a change of ownership or change of location shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–49 inclusive	$293.00
50–99 inclusive	$439.00
100 and over	$1,172.00

(c) The fee for a license to operate a hospital upon a renewal of a license during the year 1979 shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–49 inclusive.	$200.00 plus 0.01232 of 1 percent of gross operating costs for the last complete fiscal year of the hospital
50–99 inclusive	$399.00 plus 0.01232 of 1 percent of gross operating costs for the last complete fiscal year of the hospital
100 and over	$567.00 plus 0.01232 of 1 percent of gross operating costs for the last complete fiscal year of the hospital

(d) No fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department.

(e) Fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the total number of months to be licensed divided by 12 months.

(f) Fees shall be waived for any facility conducted, maintained or operated by this State or any state department, authority, bureau, commission or officer or by the Regents of the University of California or by a local hospital district, city or county.

NOTE: Authority cited: Sections 1275, and 1729, Health and Safety Code. Reference: Sections 1266, and 1729, Health and Safety Code.

§ 71113. Projects Requiring a Certificate of Need.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71113.1. Projects Eligible for a Certificate of Exemption.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268. Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71113.2. Projects Not Subject to Review by a Voluntary Area Health Planning Agency.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71113.3. Projects Previously Decided by a Voluntary Area Health Planning Agency.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71113.4. Exemption Requests for Remodeling and Replacement Projects.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255 and 1268, Health and Safety Cod. Reference: Chapter 854, Statutes of 1976.

§ 71115. Safety, Zoning and Building Clearance.

(a) Architectural plans shall not be approved and a license shall not be originally issued to any hospital which does not conform to: the regulations in this chapter; state requirements on seismic safety, fire and life safety and environmental impact and local fire safety, zoning and building ordinances. Evidence of such compliance shall be presented in writing to the Department.

(b) It shall be the responsibility of the licensee to maintain the hospital in a safe structural condition. If the Department determines that an evaluation of the structural condition of a hospital building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall establish a basis for eliminating or correcting the structural conditions which may be hazardous to occupants.

§ 71117. Issuance, Expiration and Renewal.

(a) Upon verification of compliance with the licensing requirements, the Department shall issue the applicant a license.

(b) If the applicant is not in compliance with the laws or regulations, the Department shall deny the applicant a license and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form.

(c) Each initial license shall expire at midnight, one year from the date of issue. A renewal license:

(1) May be issued for a period not to exceed two years if the holder of the license has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding license period.

(2) Shall reflect the number of beds that meet construction and operational requirements and shall not include beds formerly located in patient accommodation space which has been permanently converted.

(3) Shall not be issued if the hospital is liable for and has not paid the special fees required by Section 90417, Chapter 1, Division 7, of this Title.

(d) The Department shall mail an application for renewal of license form to the licensee at least 45 days prior to expiration of a license. Application for renewal, accompanied by the necessary fees, shall be filed with the Department annually not less than ten days prior to the expiration date. Failure to make a timely renewal shall result in expiration of the license.

§ 71119. Separate Licenses.

Separate licenses shall be required for hospitals which are maintained on separate premises even though they are under the same management. This does not apply to outpatient departments or clinics of hospitals designated as such which are maintained and operated on separate premises. Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds.

§ 71121. Posting.

The license, or a true copy thereof, shall be posted conspicuously in a prominent location within the licensed premises and accessible to public view.

§ 71123. Transferability.

Licenses are not transferable. The licensee shall notify the Department in writing at least 30 days prior to the effective date of any change of ownership. A new application for license shall be submitted by the prospective new owner.

§ 71124. Bed Classification.

(a) Each hospital shall notify the Department on forms supplied by the Department of bed classifications as defined in Sections 71004, 71038 and 71056 within 30 days of the effective date of this section. For hospitals not reporting within the 30–day period, the Department will classify the beds based on the latest information in the Department files.

(b) After the above notification has been received by the Department or the Department has reclassified the beds, no further reclassification of beds shall take place until on or after January 1, 1977.

NOTE: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 71125. Report of Changes.

(a) The licensee shall notify the Department in writing any time a change of stockholder owning ten percent or more of the nonpublic corporate stock occurs. Such writing shall include the name and principal mailing address of the new stockholder(s).

(b) Each licensee shall notify the Department in writing within ten days prior to any change of the mailing address of the licensee. Such writing shall include the new mailing address of the licensee.

(c) Any change in the principal officer shall be reported in writing within ten days by the licensee to the Department. Such writing shall include the name and principal business address of such officer.

§ 71127. Program Flexibility.

(a) All hospitals shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

(b) Special exceptions may be granted under this section for hospitals required to provide services and accommodations for persons who may have dangerous propensities necessitating special precautions, personnel with special qualifications, locked accommodations, special protection for windows, type and location of lighting and plumbing fixtures, signal systems, control switches, beds and other furnishing. This applies to psychiatric units and detention facilities where added protection is necessary for patients, staff members and members of the public.

(c) Any approval of the Department granted under this section, or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 71121.

§ 71129. Voluntary Suspension of License or Licensed Beds.

(a) Upon written request, a licensee may request that his license or licensed beds be put in suspense. The Department may approve the request for a period not to exceed 12 months.

(b) Any license or portion thereof which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active license, including the payment of license renewal fees, during the period of temporary suspension.

(c) Any license suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension upon receipt of an application and evidence showing compliance with licensing operational requirements in effect at the time of reinstatement. If the license is not reinstated within the 12–month period, the license shall expire automatically and shall not be subject to reinstatement.

§ 71131. Voluntary Cancellation of License.

(a) The licensee shall notify the Department in writing as soon as possible and in all cases at least 30 days prior to the desired effective date of cancellation of the license.

(b) Any license voluntarily cancelled pursuant to this section may be reinstated by the Department on receipt of an application along with evidence showing compliance with operational licensing requirements.

§ 71133. Revocation or Involuntary Suspension of License.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part I, Division 3, Title 2, Government Code, the Department may suspend or revoke any license issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds.

(1) Violation by the licensee of any of the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license is issued.

(b) The license of any hospital against which special fees are required by Section 90417, Chapter 1, Division 7, of this Title shall be revoked, after notice of hearing, if it is determined by the Department that the fees required were not paid within the time prescribed.

(c) The Director may temporarily suspend any license prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation.

(2) Upon receipt of a notice of defense by the licensee, the Director shall set the matter for hearing within 15 days. The hearing shall be held as soon as possible but no later than 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the license of such organization or may suspend the license as to any individual person within such organization who is responsible for such violation.

(d) The withdrawal of an application for a license shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground, unless the Department consents in writing to such withdrawal.

(e) The suspension, expiration, or forfeiture of a license issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking a license or otherwise taking disciplinary action against the licensee on any such ground.

NOTE: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1296, Health and Safety Code.

§ 71134. Conviction of Crime: Standards for Evaluating Rehabilitation.

When considering the denial, suspension or revocation of a license based on the conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating rehabilitation:

(1) The nature and the seriousness of the crime(s) under consideration.

(2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(3) The time which has elapsed since commission of the crime(s) or conduct referred to in subdivision (1) or (2).

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant.

(5) Any rehabilitation evidence submitted by the applicant.

NOTE: Authority cited: Sections 208(a), 1265.2 and 1275, Health and Safety Code. Reference: Sections 1265.1, 1265.2 and 1294, Health and Safety Code.

§ 71135. Bonds.

(a) Each licensee shall file or have on file with the Department a bond issued by a surety company admitted to do business in this State if the licensee is handling or will handle money in the amount of $25 or more per patient or $500 or more for all patients in any month.

(1) The amount of the bond shall be according to the following schedule:

Amount Handled	*Bond Required*
$750 or less	$1,000
$751 to $1,500	$2,000
$1,501 to $2,500	$3,000

(2) Every further increment of $1,000 or fraction thereof shall require an additional $1,000 on the bond.

(b) Each application for an original license or renewal of license shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles or will handle money of patients and the maximum amount of money to be handled for any patient and for all patients in any month.

(c) No licensee shall either handle money of a patient or handle amounts greater than those stated in the affidavit submitted by him without first notifying the Department and filing a new or revised bond if required.

Article 3. Basic Services

§ 71201. Medical Service Definition.

Medical service means those medically and professionally directed services for the diagnosis, therapeutic management and treatment of mentally disordered patients. For purposes of these regulations, “mental disorder” is defined as any psychiatric illness or disease, whether functional or of organic origin.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71203. Medical Service General Requirements.

(a) The medical service shall consist of the following organized and staffed elements:

(1) Psychiatric component.

(A) Psychiatrists or clinical psychologists within the scope of their licensure and subject to the rules of the facility, shall be responsible for the diagnostic formulation for their patients and the development and implementation of each patient's treatment plan.

(B) A psychiatrist shall be available at all times for psychiatric emergencies.

(2) General medicine component.

(A) All incidental medical services necessary for the care and support of patients shall be provided by in–house staff or through the use of outside resources in accordance with Section 71513 of these regulations.

(B) Incidental medical services include but are not limited to:

1. General medicine and surgery.
2. Dental.
3. Radiological.
4. Laboratory.
5. Anesthesia.
6. Podiatry.
7. Physical therapy.
8. Speech pathology.
9. Audiology.

(3) Psychological component.

(A) Psychological service shall be provided by clinical psychologists within the scope of his/her licensure and subject to the provisions of Section 1316.5 of the Health and Safety Code.

(B) Staff physicians shall assume responsibility for those aspects of patient care which may be provided only by physicians.

(4) Social service component.

(A) Social service shall be provided by social workers under the direction of the medical staff.

(b) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(c) The responsibility and the accountability of the medical service to the medical staff and administration shall be defined.

(d) An appropriate committee of the medical service shall:

(1) Identify and recommend to administration the equipment and supplies necessary for coping with emergency medical problems.

(2) Develop a plan for handling and/or referral of patients with emergency medical problems.

(3) Determine the circumstances under which electroconvulsive therapy may be administered.

(4) Develop guidelines for the administration of drugs when given in unusually high dosages or when given for purposes other than those for which the drug is customarily used.

(e) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

NOTE: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Sections 1276 and 1316.5, Health and Safety Code; and *CAPP v. Rank* (1990) 51 Cal. 3d 1.

§ 71205. Medical Service Staff.

(a) A physician shall have overall responsibility for the medical service.

(b) Psychiatric component.

(1) A psychiatrist shall coordinate the psychiatric services provided.

(2) There shall be sufficient psychiatrists on the staff to meet the needs of the patients.

(c) General medical component.

(1) A physician shall coordinate the general medical component.

(2) This physician shall have training and/or experience sufficient to coordinate the incidental medical services.

(d) Psychological component.

(1) One or more psychologists shall be employed on a full–time, regular part–time or consulting basis.

(e) Social service component.

(1) One or more social workers shall be employed on a full–time, regular part–time or consulting basis.

§ 71207. Medical Service Equipment and Supplies.

There shall be adequate equipment and supplies maintained related to the nature of the needs and the services offered.

§ 71209. Medical Service Space.

There shall be adequate space maintained to meet the needs of the service.

§ 71211. Psychiatric Nursing Service Definition.

Psychiatric nursing service means the performance of those services directed toward meeting the objectives of an individual planned therapeutic program supervised and coordinated by a registered nurse in conjunction with the treatment plan, nursing care and other health professional care.

§ 71213. Psychiatric Nursing Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b) The responsibility and the accountability of the nursing service to the medical staff and hospital administration shall be defined.

(c) There shall be a written organized staff education program which shall include orientation and in–service education and training.

(1) There shall be written objectives, plans for implementation and an evaluation mechanism.

(d) There shall be a written patient care plan developed for each patient in coordination with the total mental health team. This plan shall include goals, problems/needs and approach and shall be available to all members of the mental health team.

(e) There shall be a written nursing audit procedure and evidence that audit procedures are in effect.

(f) There shall be a method for determining staffing requirements based on assessment of patient needs. This assessment shall take into consideration at least the following:

(1) The ability of the patient to care for himself.

(2) His degree of illness.

(3) Requirements for special nursing activities.

(4) Skill level of personnel required in his care.

(5) Placement of the patient in the nursing unit.

(g) There shall be documentation of the methodology used in making staffing determinations. Such documentation shall be part of the records of the nursing service and be available for review.

(h) There shall be a written staffing pattern which shall show:

(1) Total numbers of staff including full–time and full–time equivalents.

(2) The available nursing care hours for each nursing unit.

(3) The categories of staff available for patient care.

(i) There shall be a record retained for six months of the written staffing pattern available for review by the Department at any given time.

§ 71215. Psychiatric Nursing Service Staff.

(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or

(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

(b) The director of nurses shall not be designated to serve as charge nurse.

(c) Sufficient registered nursing personnel shall be provided to:

(1) Assist the director of nurses for evening and night services and when necessary for day services.

(2) Give direct nursing care based on patient need.

(3) Have a registered nurse on duty at all times.

(4) Plan, supervise and coordinate care given by licensed vocational nurses, licensed psychiatric technicians and other mental health workers.

(d) Each nursing unit shall have a registered nurse, licensed vocational nurse or licensed psychiatric technician on duty at all times.

(e) Licensed vocational nurses and licensed psychiatric technicians may be utilized as needed to assist registered nurses in ratios appropriate to patient needs.

(f) Mental health workers may be utilized as needed to assist with nursing procedures.

§ 71217. Psychiatric Nursing Service Equipment and Supplies.

There shall be adequate and appropriate equipment and supplies related to the scope and nature of the needs anticipated and the services offered.

§ 71219. Psychiatric Nursing Service Space.

Office space shall be provided for the director of nurses.

§ 71221. Psychiatric Rehabilitative Activities Service Definition.

Psychiatric rehabilitative activities service means that rehabilitative service medically prescribed, professionally directed and supervised, to evaluate and treat the patient. Therapists as used in Section 71221 through 71229 may include occupational, music, art, dance and recreation therapists.

§ 71223. Psychiatric Rehabilitative Activities Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b) The policies and procedures shall include but not be limited to:

(1) Treatment goals and objectives.

(2) Scope of service.

(3) Standards of practice.

(4) Arrangements for continuity of care upon discharge.

(c) The responsibility and the accountability of the psychiatric rehabilitative activities service to the medical staff and administration shall be defined.

(d) Patients shall be evaluated and a treatment program shall be established and modified with the concurrence of the referring physician.

(e) Signed progress notes shall be entered into the patient's medical record by the therapist at least weekly. A summary note shall be written upon completion of the treatment program.

(f) Meetings and conferences with other members of the mental health team shall be held in order to plan, review and coordinate patient treatment programs.

(g) There shall be regularly scheduled in–service training for all levels of staff.

(h) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

§ 71225. Psychiatric Rehabilitative Activities Service Staff.

(a) A therapist shall have overall responsibility for the psychiatric rehabilitative activities service. This person shall have had at least two years' experience in the care of acute psychiatric patients.

(b) There shall be a sufficient number of therapists to carry out the scope of services offered. Nonprofessional assistants and volunteers shall work under the direct supervision of a therapist.

(c) A sufficient number of appropriate personnel shall be provided for the safety of the patients.

§ 71227. Psychiatric Rehabilitative Activities Service Equipment and Supplies.

(a) There shall be sufficient equipment and supplies appropriate to the needs of the psychiatric rehabilitative activities services offered. In addition, there shall be:

(1) A telephone.

(2) A handwashing sink in the treatment area.

(3) Drinking fountain.

(4) Toilet facilities.

§ 71229. Psychiatric Rehabilitative Activities Service Space.

(a) Adequate space shall be maintained for the necessary equipment to provide psychiatric rehabilitative activity services.

(b) There shall be indoor and outdoor patient areas provided.

(c) There shall be an activities room and a patient lounge separate from the patient's dining room.

(d) There shall be office space separate from the activities area.

(e) When outpatients are treated, there shall be a waiting area provided.

(f) Where children are accepted for treatment, space appropriate for children's use shall be provided.

§ 71231. Pharmaceutical Service Definition.

Pharmaceutical service means the procuring, manufacturing, compounding, dispensing, distributing, storing and administering of drugs, biologicals and chemicals by appropriate staff, which has adequate space, equipment and supplies. Pharmaceutical services also include the provision of drug information to other health professionals and patients.

§ 71233. Pharmaceutical Service General Requirements.

(a) All hospitals having 100 beds or more shall have a pharmacy on the premises licensed by the California Board of Pharmacy. Those hospitals having less than 100 beds shall have a pharmacy license issued by the Board of Pharmacy pursuant to Section 4029 or 4056 of the Business and Professions Code.

(b) The responsibility and the accountability of the pharmaceutical service to the medical staff and administration shall be defined.

(c) A pharmacy and therapeutics committee shall be established. The committee shall consist of at least one physician, one pharmacist, the director of nursing service or her representative and the administrator or his representative.

(1) The committee shall develop written policies and procedures for establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of drugs and chemicals. The pharmacist, in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(2) The committee shall be responsible for the development maintenance of a formulary of drugs for use throughout the hospital.

(d) There shall be a system maintained whereby no person other

than a pharmacist or an individual under the direct supervision of a pharmacist shall dispense medications for use beyond the immediate needs of the patient.

(e) There shall be a system assuring the availability of prescribed medications 24 hours a day.

(f) Supplies of drugs for use in medical emergencies only shall be immediately available at each nursing unit or service area as required.

(1) Written policies and procedures establishing the contents of the supply, procedures for use, restocking and sealing of the emergency drug supply shall be developed.

(2) The emergency drug supply shall be stored in a clearly marked portable container which is sealed by the pharmacist in such a manner that a seal must be broken to gain access to the drugs. The contents of the container shall be listed on the outside cover and shall include the expiration earliest date or lot number of any drugs within.

(3) The supply shall be inspected by a pharmacist at periodic intervals specified in written policies. Such inspections shall occur no less frequently than every 30 days. Records of such inspections shall be kept for at least three years.

(g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person legally authorized to prescribe. The order shall include the name of the drug, the dosage, the frequency of administration, the route of administration if other than oral, and the date, time and signature of the prescriber. Orders for drugs should be written by the prescriber. Verbal orders for drugs shall be given only to a registered nurse or licensed pharmacist by a person legally authorized to prescribe and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber shall countersign the order within 48 hours.

(h) Standing orders for drugs may be used for specified patients when authorized by a person licensed to prescribe. These standing orders shall:

(1) Specify the circumstances under which the drug is to be administered.

(2) Specify the types of medical conditions of patients for whom the standing orders are intended.

(3) Be initially approved by the pharmacy and therapeutics committee or its equivalent and be reviewed at least annually by that committee.

(4) Be specific as to the drug, dosage, route and frequency of administration.

(5) A copy of standing orders for a specific patient shall be dated, promptly signed by the physician and included in the patient's medical record.

(i) An individual prescriber may notify the hospital in writing of his own standing orders, the use of which is subject to prior approval and periodic review by the pharmacy and therapeutics committee or its equivalent.

(j) The hospital shall develop policies limiting the duration of drug therapy in the absence of the prescriber's specific indication of duration of therapy or under other circumstances recommended by the pharmacy and therapeutics committee or its equivalent and approved by the executive committee of the medical staff. The limitations shall be established for classes of drugs and/or individual drug entities.

(k) If drugs are supplied through a pharmacy, orders for drugs shall be transmitted to the pharmacy either by written prescription of the prescriber, by an order form which produces a direct copy of the order or by an electronically reproduced facsimile. When drugs are not supplied through a pharmacy, such information shall be made available to the hospital pharmacist.

(*l*) No medications shall be left at the patient's bedside.

(m) Medications brought by or with the patient to the hospital shall not be administered to the patient unless all of the following conditions are met:

(1) The drugs have been ordered by the patient's attending physician and the order entered in the patient's medical record.

(2) The medication containers are clearly and properly labeled.

(3) The contents of the containers have been examined and positively identified, after arrival at the hospital, by the patient's physician or the hospital pharmacist.

(n) The hospital shall establish a supply of medications which is accessible without entering the pharmacy during hours when the pharmacist is not available. Access to the supply shall be limited to designated registered nurses. Records of drugs taken from the supply shall be maintained and the pharmacist shall be notified of such use. The records shall include the name and strength of the drug, the amount taken, the date and time, the name of the patient to whom the drug was administered and the signature of the registered nurse. The pharmacist shall be responsible for maintenance of the supply and assuring that all drugs are properly labeled and stored. The drug supply shall contain that type and quantity of drugs necessary to meet the immediate needs of patients as determined by the pharmacy and therapeutics committee.

(o) Investigational drug use shall be in accordance with applicable state and federal laws and regulations and policies adopted by the hospital. Such drugs shall be used only under the direct supervision of the principal investigator, who shall be a member of the medical staff and be responsible for assuring that informed consent is secured from the patient. Basic information concerning the dosage form, route of administration, strength, actions, uses, side effects, adverse effects, interactions and symptoms of toxicity of investigational drugs shall be available at the nursing station where such drugs are being administered and in the pharmacy. The pharmacist shall be responsible for the proper labeling, storage and distribution of such drugs pursuant to the written order of the investigator.

(p) No drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication and the medication has been properly labeled and prepared by the pharmacist in accordance with state and federal laws, for use outside of the hospital.

(q) Labeling and storage of drugs shall be accomplished to meet the following requirements:

(1) Individual patient medications may be returned to the pharmacy provided that lot control is maintained if the drugs are to be reissued.

(2) All drug labels must be legible and in compliance with state and federal requirements.

(3) All labeling of drugs shall be performed by one legally authorized to prescribe or dispense or under the supervision of a pharmacist.

(4) Test agents, germicides, disinfectants and other household substances shall be stored separately from drugs.

(5) External use drugs in liquid, tablet, capsule or powder form shall be segregated from drugs for internal use.

(6) Drugs shall be stored at appropriate temperatures. Refrigerator temperature shall be from 2.2^{o}C (36°F) to 7.7^{o}C (46°F) and room temperature shall be between 15°C (59°F) and 30°C (86°F).

(7) Drugs shall be stored in an orderly manner in well lighted cabinets, shelves, drawers or carts of sufficient size to prevent crowding.

(8) Drugs shall be accessible only to responsible personnel designated by the hospital.

(9) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drug shall be available for use.

(10) Drugs maintained on the nursing unit shall be inspected at least monthly by a pharmacist. Any irregularities shall be reported to the director of nursing services and as required by hospital policy.

(11) Discontinued individual patient's drugs not supplied by the hospital may be sent home with the patient. Those which remain in the hospital after discharge that are not identified by a lot number shall be destroyed in the following manner:

(A) Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of two pharmacists or a pharmacist and a registered nurse employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the patient's medical record or in a separate log. Such a log shall be retained for at least three years.

(B) Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of pharmacist or registered nurse. The name of the patient, the name and strength of the drug, the prescription number if applicable, the amount destroyed, the date of destruction and the signatures of two witnesses shall be recorded in the patient's medical record or in a separate log. Such a log shall be retained for at least three years.

(r) The pharmacist shall develop and implement written quality control procedures for all drugs which are prepackaged or compounded in the hospital, including intravenous solution additives. He shall also develop and implement written quality control procedures for intravenous solution additives and shall establish a training program of physicians and registered nurses to assure compliance therewith.

(s) The pharmacist shall be consulted on proper methods for repackaging and labeling of bulk cleaning agents, solvents, chemicals and poisons used throughout the hospital.

(t) Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration

NOTE: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71235. Pharmaceutical Service Staff.

A pharmacist shall have overall responsibility for the pharmaceutical service. He shall be responsible for the procurement, storage and distribution of all drugs as well as the development, coordination, supervision and review of pharmaceutical services in the hospital. Hospitals with a limited pharmacy permit shall employ a pharmacist on at least a consulting basis. Responsibilities shall be set forth in a job description or agreement between the pharmacist and the hospital. The pharmacist shall be responsible to the administrator and shall furnish him written reports and recommendations regarding the pharmaceutical services within the hospital. Such reports shall be provided no less often than quarterly.

§ 71237. Pharmaceutical Service Equipment and Supplies.

(a) There shall be adequate equipment and supplies for the provision of pharmaceutical service within the hospital.

(b) Reference materials containing monographs on all drugs in use in the hospital shall be available in each nursing unit. Such monographs must include information concerning generic and brand names, if applicable, available strengths and dosage forms and pharmacological data including indications, side effects, adverse effects and drug interactions.

§ 71239. Pharmaceutical Service Space.

(a) Adequate space shall be available at each nursing station for the storage of drugs and preparation of medication doses.

(b) All spaces and areas used for the storage of drugs shall be lockable.

§ 71241. Dietetic Service Definition.

Dietetic service means providing safe, satisfying and nutritionally adequate food for patients with appropriate staff, space, equipment and supplies.

§ 71243. Dietetic Service General Requirements

(a) The dietetic service shall provide food of the quality and quantity to meet the patient's need in accordance with physicians' orders and, to the extent medically possible, to meet the Recommended Daily Dietary Allowance, 1974 Edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, 2107 Constitution Avenue, Washington, DC 20418, and the following:

(1) Not less than three meals shall be served daily.

(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day.

(3) Nourishment or between meal feedings shall be provided as required by the diet prescription and shall be offered to all patients unless counterordered by the physician.

(4) Patient food preferences shall be respected as much as possible and substitutes shall be offered through use of a selective menu or substitutes from appropriate food groups.

(5) Where desirable, table service should be provided for all who can and wish to eat at a table. Tables of appropriate height shall be provided for patients in wheelchairs.

(6) When food is provided by an outside commercial food service, all applicable requirements herein set forth shall be met. The hospital shall maintain adequate space, equipment and staple food supplies to provide patient food service in emergencies.

(b) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(c) The responsibility and the accountability of the dietetic service to the medical staff and hospital administration shall be defined.

(d) A current diet manual approved by the dietitian and the medical staff shall be used as the basis for diet orders and for planning modified diets. Copies of the diet manual shall be available at each nursing station and in the dietetic service area.

(e) Therapeutic diets shall be provided as prescribed by the attending physician and shall be planned, prepared and served with supervision and/or consultation from the dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary.

(f) A current profile card shall be maintained for each patient indicating diet, likes, dislikes and other pertinent information concerning the patient's dietary needs.

(g) Menus.

(1) Menus for regular and routine modified diets shall be written at least one week in advance, dated and posted in the kitchen at least three days in advance.

(2) If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen.

(3) Menus shall provide a variety of foods in adequate amounts at each meal.

(4) Menus shall be planned with consideration for cultural and religious background and the food habits of patients.

(5) A copy of the menu as served shall be kept on file for at least 30 days.

(6) Records of food purchased shall be kept available for one year.

(7) Standardized recipes, adjusted to appropriate yield, shall be maintained and used in food preparation.

(h) Food shall be prepared by methods which conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs.

(i) Nutritional Care.

(1) Nutritional care shall be integrated in the patient care plan.

(2) Observations and information pertinent to dietetic treatment shall be recorded in patient's medical records by the dietitian.

(3) Pertinent dietary records shall be included in patient's transfer discharge record to ensure continuity of nutritional care.

(j) In–service training shall be provided for all dietetic service personnel and a record of subject areas covered, date and duration of each session, and attendance lists shall be maintained.

(k) Food Storage.

(1) Food storage areas shall be clean at all times.

(2) Dry or staple items shall be stored at least 30 cm (12 inches) above the floor, in a ventilated room, not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents or vermin.

(3) All readily perishable foods or beverages capable of supporting rapid and progressive growth f microorganisms which can cause food infections or food intoxication shall be maintained at temperatures of 7ºC (45ºF) or below, or at 60ºC (140ºF) or above, at all times except during necessary periods of preparation and service. Frozen food shall be stored at –18ºC (0ºF) or below.

(4) There shall be a reliable thermometer in each refrigerator and in storerooms used for perishable food.

(5) Pesticides, other toxic substances and drugs shall not be stored in the kitchen area or in storerooms for food and/or food preparation equipment and utensils.

(6) Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storerooms or food storage areas.

(*l*) Sanitation.

(1) All kitchens and kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies or other insects.

(2) All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas.

(3) Plasticware, china and glassware that is unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded.

(4) Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner.

(5) Kitchen wastes that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers and shall be disposed of as frequently as necessary to prevent a nuisance or unsightliness.

(m) All utensils used for eating, drinking and in the preparation and serving of food and drink shall be cleaned and disinfected after each usage.

(1) Gross food particles shall be removed by scraping and prerinsing in running water.

(2) The utensils shall be thoroughly washed in hot water with a minimum temperature of 43ºC (110ºF), using soap or detergent, rinsed in hot water to remove soap or detergent and disinfected by one of the following methods or an equivalent method approved by the Department:

(A) Immersion for at least two minutes in clean water at 77ºC (170ºF).

(B) Immersion for at least 30 seconds in clean water at 82ºC (180ºF).

(C) Immersion in water containing bactericidal chemical as approved by the Department.

(3) After disinfection the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used.

(4) Results obtained with dishwashing machines shall be equal to those obtained by the methods outlined above and all dishwashing machines shall meet the requirements contained in Standard No. 3 as amended in April 1965 of the National Sanitation Foundation, P.O. Box 1468, Ann Arbor, MI 94106.

§ 71245. Dietetic Service Staff.

(a) Registered dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus and participation in development or revision of dietetic policies and procedures as in planning and conducting in-service education programs.

(b) If a registered dietitian is not employed full-time person who has completed a dietetic supervisor's training program meeting the requirements of Essentials of an Acceptable Program of Dietetic Assistant Edu–
cation, revised June, 1974, by the American Dietetic Association, 430 North Michigan Avenue, Chicago, IL 60611, shall be employed to be responsible for the operation of the food service. This program or its equivalent shall be required on and after July 1, 1977.

(c) Sufficient dietetic service personnel shall be employed, oriented, trained and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service areas. If dietetic service employees are assigned duties in other service areas, those duties shall not interfere with the sanitation, safety or time required for dietetic work assignments.

(d) Current work schedules by job titles and weekly duty schedules shall be posted in the dietetic service area.

(e) A record shall be maintained of the number of persons by job title employed full or part–time in dietetic services and the number of hours each works weekly.

(f) Hygiene of Dietetic Staff.

(1) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including a cap and/or a hair net and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

(2) Employees' street clothing stored in the kitchen shall be in a closed area.

(3) Kitchen sinks shall not be used for handwashing. Separate handwashing facilities with soap, running water and individual towels shall be provided.

(4) Persons other than dietetic personnel shall not be allowed in the kitchen area unless required to do so in the performance of their duties.

§ 71247. Dietetic Service Equipment and Supplies.

(a) Equipment of the type and in the amount necessary for the proper preparation, serving and storing of food and for proper dishwashing shall be provided and maintained in good working order.

(1) The dietetic service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes and prevent excessive condensation.

(2) Equipment necessary for preparation and maintenance of menus, records and references shall be provided.

(3) Fixed and mobile equipment in the dietetic service area shall be located to assure sanitary and safe operation and shall be of sufficient size to handle the needs of the hospital.

(b) Food Supplies.

(1) At least one week's supply of staple foods and at least two (2) days supply of perishable foods shall be maintained on the premises. Supplies shall be appropriate to meet the requirements of the menu.

(2) All food shall be of good quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food in unlabeled, rusty, leaking, dented or broken containers, or cans with side seam dents, rim dents or swells shall not be accepted or retained.

(3) Milk, milk products and products resembling milk shall be processed or manufactured in milk product plants meeting the requirements of Division 15 of the California Food and Agricultural Code.

(4) Milk may be served in individual containers, the cap or seal of which shall not be removed except in the presence of the patient. Milk may be served from a dispensing device which has been approved for such use. Milk served from an approved device shall be dispensed directly into the glass or other container from which the patient drinks.

(5) Catered foods and beverages from a source outside the hospital shall be prepared, packed, properly identified, stored and transported in compliance with these regulations and other applicable federal, state and local codes as determined by the Department.

(6) Food held in refrigerated or other storage areas shall be appropriately covered. Food which was prepared and not served shall be stored appropriately, clearly labeled and dated.

(7) Hermetically sealed foods or beverages served in the hospital shall have been processed in compliance with applicable federal, state and local codes.

§ 71249. Dietetic Service Space.

(a) Adequate space for the preparation and serving of food shall be provided. Equipment shall be placed so as to provide aisles of sufficient width to permit easy movement of personnel, mobile equipment and supplies.

(b) Well ventilated food storage areas of adequate size shall be provided.

(c) A minimum of 0.057 cubic meters (two cubic feet) of usable refrigerated space per bed shall be maintained for the storage of frozen and chilled foods.

(d) Adequate space shall be maintained to accommodate equipment, personnel and procedures necessary for proper cleaning and sanitizing of dishes and other utensils.

(e) Where employee dining space is provided, a minimum of 1.4 square meters (15 square feet) of floor area per person served, including serving area, shall be maintained.

(f) Office or other suitable space shall be provided for the dietitian or dietetic service supervisor for privacy in interviewing personnel, conducting other business related to dietetic service and for the preparation and maintenance of menus and other necessary reports and records.

Article 4. Supplemental Service Approval

§ 71301. Supplemental Service Approval Required.

(a) Any licensee desiring to establish or conduct, or who holds out, represents or advertises by any means, the provision of a supplemental service, shall obtain prior approval from the Department, or a special permit if required by Section 70401.

(b) The provisions of this Article shall apply only to any supplemental service for which a special permit is not required.

(c) Any licensee who offers a supplemental service for which approval is now required under these regulations, is authorized to continue furnishing such service without obtaining approval until the Department inspects and evaluates the quality of the service and determines whether such service meets the requirements for the service contained in these regulations. If the Department determines that the service meets such requirements, it shall notify the licensee in writing. If the Department determines that the service does not meet the requirements, it shall so notify the licensee of all deficiencies of compliance with these regulations and the hospital shall agree with the Department upon a plan of corrections which shall give the hospital a reasonable time to correct such deficiencies. If at the end of the allotted time, as revealed by repeat inspection, the hospital has failed to correct the deficiencies, the licensee shall cease and desist all holding out, advertising or otherwise representing that it furnishes such recognized service.

§ 71303. Application.

Any licensee desiring approval for a supplemental service shall file with the Department an application on forms furnished by the Department.

§ 71305. Issuance, Expiration and Renewal.

(a) The Department shall list on the hospital license each supplemental service for which approval is granted.

(b) If the applicant is not in compliance with the laws and regulations, the Department shall deny the applicant approval and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Each supplemental service approval shall expire on the date of expiration of the hospital license. A renewal of the approval may be issued for a period not to exceed two years if the holder of the approval has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding approval period.

§ 71307. Program Flexibility.

(a) All hospitals shall maintain continuous compliance with the supplemental service requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

(b) Any approval granted by the Department pursuant to this Section, or a true copy thereof, shall be posted immediately adjacent to the facility's license required to be posted by Section 71121.

§ 71309. Revocation or Involuntary Suspension of Approval.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part I, Division 3, Government Code, the Department may suspend or revoke the approval of a supplemental service issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds:

(1) Violation by the licensee of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of the supplemental service regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of any supplemental service regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of a supplemental service.

(b) The Director may temporarily suspend any supplemental service approval prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licensee with an accusation.

(2) Upon receipt of a notice of contest by the licensee, the Director shall set the matter for hearing within 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the supplemental service regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the approval of such organization or may suspend the approval as to any individual person within such organization who is responsible for such violation.

(c) The withdrawal of an application for approval shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the approval upon any group provided by law or to enter an order denying the approval upon any such ground, unless the Department consents in writing to such withdrawal.

(d) The suspension, expiration or forfeiture of an approval issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking approval or otherwise taking disciplinary action against the licensee on any such ground.

(e) A licensee whose approval has been revoked or suspended may petition the Department for reinstatement or reduction of penalty after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

Article 5. Supplemental Services

§ 71401. Requirements for Supplemental Services.

When a supplemental service is provided, the requirements for that service in Article 3 and 6, Chapter 1, Division 5, Title 22, California Administrative Code, shall be met.

§ 71403. Types of Supplemental Services.

(a) Supplemental services include but are not limited to:

(1) Anesthesia Service.

(2) Clinical Laboratory Service.

(3) Intensive Care Service.

(4) Intermediate Care Service.

(5) Outpatient Service.

(6) Radiological Service.

(7) Skilled Nursing Service.

Article 6. Administration

§ 71501. Governing Body.

(a) The governing body shall:

(1) Adopt written bylaws in accordance with legal requirements and its community responsibility which shall include but not be limited to provision for:

(A) Identification of the purposes of the hospital and the means of fulfilling them.

(B) Appointment and reappointment of members of the medical staff.

(C) Appointment and reappointment of one or more dentists, podiatrists, and/or clinical psychologists to the medical staff respectively when dental, podiatric, and/or clinical psychological services are provided.

(D) Formal organization of the medical staff with appropriate officers and bylaws.

(E) Membership on the medical staff which shall be restricted to physicians, dentists, podiatrists and clinical psychologists competent in their respective fields, worthy in character and in professional ethics. No hospital shall discriminate with respect to employment, staff privileges or the provision of professional services against a licensed clinical psychologist within the scope of his/her licensure, or against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O. or D.P.M. degree. Wherever staffing requirements for a service mandate that the physician responsible for the service be certified or eligible for certification by an appropriate American Medical Board, such position may be filled by an osteopathic physician who is certified or eligible for certification by the equivalent appropriate American Osteopathic Board.

(F) Self government by the medical staff with respect to the professional work performed in the hospital, regular and periodic meetings of the medical staff to review and analyze their clinical experience, and requirement that the medical records of the patients shall be the basis for such review and analysis.

(G) The preparation and maintenance of a complete and accurate medical record for each patient.

(2) Appoint an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. The Department shall be notified in writing whenever a change of administrator occurs.

(3) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the mental health needs of the community.

(4) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures.

(5) Provide for the control and use of the physical and financial resources of the hospital.

(6) Require that the medical staff establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices including provision that all members of the medical staff be required to demonstrate their ability to perform surgical and/or other procedures competently to the satisfaction of an appropriate committee or committees of the staff, at the time of original application for appointment to the staff and at least every two years thereafter.

(7) Assure that medical staff bylaws, rules and regulations are subject to governing body approval, which approval shall not be withheld unreasonably. These bylaws shall include an effective formal means for the medical staff, as a liaison, to participate in the development of all hospital policy.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 71503. Organized Medical Staff.

(a) Each hospital shall have an organized medical staff responsible to the governing body for the fitness, adequacy and quality of the medical care rendered to patients in the hospital.

(b) Medical staff membership.

(1) The medical staff shall be composed of physicians and, where dental or podiatric services are provided, dentists or podiatrists.

(2) When clinical psychological services are provided, clinical psychologists may be appointed to the medical staff subject to the bylaws, rules and regulations of the hospital.

(c) The medical staff, by vote of the members and with the approval of the governing body, shall adopt written bylaws which provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the medical staff and governing body deem appropriate. The medical staff shall abide by and establish a means of enforcement of its bylaws. Medical staff by–laws, rules and regulations shall not deny or restrict, within the scope of their licensure, the voting rights of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an M.D., D.O. or D.P.M. degree or clinical psychology license.

(d) The medical staff shall meet regularly. Minutes of each meeting shall be retained and filed at the hospital.

(e) The medical staff bylaws, rules, and regulations shall include, but shall not be limited to, provision for the performance of the following functions: executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting the medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. These functions may be performed by individual committees, or when appropriate, all functions or more than one function may be performed by a single committee. Reports of activities and recommendations relating to these functions shall be made to the executive committee and the governing body as frequently as necessary and at least quarterly.

(f) The medical staff shall provide in its bylaws, rules and regulations for appropriate practices and procedures to be observed in the various departments of the hospital. In this connection, the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(g) The medical staff shall provide for availability of a staff physician for emergencies among the in–hospital population in the event that the attending physician or his alternate is not available.

(h) The medical staff shall participate in a continuing program of professional education. The results of retrospective medical care evaluation shall be used to determine the continuing education needs. Evidence of participation in such programs shall be available.

(i) The medical staff shall provide at least one physician to participate as a member of the hospital infection control committee.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 71505. Medical Staff, Residents, Interns and Students.

(a) The hospital shall not permit any physician, dentist, podiatrist or clinical psychologist or any medical, dental, podiatric or clinical psychology resident, intern or student to perform any service for which a license, certificate of registration or other form of approval is required unless such person is licensed, registered, approved or is exempted therefrom under the provisions of the State Medical Practice Act, the State Dental Practice Act or the State Psychology Licensing Law and, further, unless such services are performed under the direct supervision of a licensed practitioner whenever so required by law.

(b) If patient care is provided by residents, interns and medical students, such care shall be in accordance with the provisions of a program approved by and in conformity with: the Council on Education of the American Medical Association, the American Osteopathic Association Board of Trustees through the Committee on postdoctoral training and the Bureau of Professional Education, the American Dental Association, the American Podiatry Association or the Education and Training Board of the American Psychological Association, and/or the residency training programs of the respective specialty boards.

(c) Except in an emergency, all other patient care by interns, house officers, residents or persons with equivalent titles, not provided as specified in subdivision (b) of this section, must be provided by a practitioner with a current license to practice in California.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 71507. Patients' Rights.

(a) All patients shall have rights which include, but are not limited to the following:

(1) To wear his own clothes, to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for canteen expenses and small purchases.

(2) To have access to individual storage space for his private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps, and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse psychosurgery as defined in Section 5325, Welfare and Institutions Code.

(8) To be informed of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department.

(9) All other rights as provided by law or regulation.

(b) The physician who has overall responsibility for the service or his designee, may for good cause, deny a person any of the rights specified in (a) above, except those rights specified in subsection (7) and (9) above and the rights under subsection (6) may be denied only under the conditions specified in Section 5326.7, Welfare and Institutions Code. The denial, and the reasons therefore, shall be entered in the patient's medical record.

(c) These rights, written in English and Spanish, shall be prominently posted.

(d) There shall be a procedure established whereby patient complaints are forwarded to hospital administration. Knowledge of this procedure shall be readily available to patients. The hospital administration shall, in all cases, acknowledge to the patient their receipt of his complaint. Additional follow–up of the complaint and response to the patient shall be handled as is appropriate.

§ 71508. Clinical Research.

Research projects involving human subjects shall have the prior approval of a broadly represented committee which shall assure maximum patient safety and understanding.

§ 71509. Emotional and Attitudinal Support.

Hospitals shall have a written plan for the provision of those components of total patient care that relate to the spiritual, emotional and attitudinal needs of the patient, patients' families and hospital personnel.

§ 71511. Education of Patients.

(a) Where patients of school age expected to remain in the hospital for 30 days or more, the local school district shall be contacted to arrange for education, wherever appropriate.

(b) A hospital may operate its own educational program for patients in the school age group in consultation and cooperation with the local school district.

§ 71513. Outside Resource.

If a hospital does not employ a qualified professional person to render a specific service to be provided by the hospital, there shall be arrangements for such a service through a written agreement with an outside resource which meets the standards and requirements of these regulations. The responsibilities, functions, and objectives, and the terms of agreement, including financial arrangements and charges, of each such outside resource shall be delineated in writing and signed by an authorized representative of the hospital and the person or the agency providing the service. The agreement shall specify that the hospital retains professional and administrative responsibility for the services rendered. The outside resource, when acting as a consultant, shall apprise the administrator of recommendations, plans for implementation and continuing assessment through dated, signed reports which shall be retained by the administrator for follow–up action and evaluation of performance.

§ 71515. Nondiscrimination Policies.

(a) No hospital shall discriminate against any person based on sex, race, color, religion, ancestry or national origin, except as provided herein. This provision shall apply to the appointment of the medical

staff, hiring of hospital employees and the admission, housing or treatment of patients.

(b) Any bona fide nonprofit religious, fraternal or charitable organization, which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this section, may establish admission policies limiting or giving preference to their own members or adherents. Such policies shall not be construed as a violation of the first paragraph of this section. Any admission of nonmembers or nonadher-ents shall be subject to the first paragraph of this subsection.

(c) No hospital which permits sterilization operations for contraceptive purposes nor any member of its medical staff shall require of the patient any special nonmedical qualifications which are not imposed upon individuals seeking other types of operations. Prohibited nonmedical qualifications shall include, but not be limited to, age, marital status and number of natural children. This prohibition does not affect requirements relating to the physical or mental condition of the patient, physician counseling of the patient or existing law pertaining to individuals below the age of majority.

§ 71517. Admission, Transfer and Discharge Policies.

(a) Each hospital shall have written admission, transfer and discharge policies which encompass the types of diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, policies concerning advance deposits, rates of charge for care, charges for extra services, terminations of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other related functions.

(b) Patients shall be admitted only upon the order and under the care of a member of the medical staff of the hospital who is a licensed health care practitioner acting within the scope of his or her professional licensure. The patient's condition and provisional diagnosis shall be established at time of admission by the member of the medical staff who admits the patient subject to the rules and regulations of the hospital, and the provisions of Section 71505(a).

(c) Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination and psychiatric evaluation performed by persons lawfully authorized by their respective practice acts to perform such examinations providing the condition of the patient permits. Each patient shall have a complete psychological evaluation performed by a physician and surgeon or clinical psychologist consistent with the medical staff bylaws, and providing the condition of the patient permits.

(d) No mentally competent adult shall be detained in a hospital against his will. An emancipated minor shall not be detained in a hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where law permits an unemancipated minor to contract for medical care without the consent of his parent or guardian, he shall not be detained in the hospital against his will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the hospital in his own interest, nor the temporary detention of a mentally disturbed patient for the protection of himself or others under the provisions of the Lanterman–Petris–Short Act (Welfare and Institutions Code, Section 5000 et seq.) if the hospital has been designated by the county as a treatment facility pursuant to said act, nor to prohibit a minor legally capable of contracting for medical care from assuming responsibility for his discharge. However, in no event shall a patient be detained solely for nonpayment of his hospital bill.

(e) No inpatient shall be transferred or discharged for purposes of effecting a transfer, from a hospital to another health facility, unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or attempts over a 24–hour period have been made and a responsible person cannot be reached. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician or clinical psychologist, acting within his or her scope of professional licensure, such transfer or discharge would create a physical or mental health hazard.

(f) A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct in writing. This provision shall not be construed to preclude a minor legally capable of contracting for medical care from assuming responsibility for himself upon discharge.

(g) Each patient upon admission shall be provided with a wristband identification tag or other means of identification unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient, hospital admission number and the name of the hospital.

(h) Involuntary admission to the hospital shall be in conformity with the provisions of the Lanterman–Petris–Short Act (Welfare and Institutions Code, Section 5000 et seq.).

NOTE: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code; and *CAPP v. Rank* (1990) 51 Cal. 3d 1

§ 71519. Personnel Policies.

(a) Each hospital shall adopt written personnel policies concerning qualifications, responsibilities and conditions of employment for each type of personnel, which shall be available to all personnel. Such policies shall include but not be limited to:

(1) Wage scales, hours of work and all employee benefits.

(2) A plan for orientation of all personnel to policies and objectives of the hospital and for on–the–job training where necessary.

(3) A plan for at least an annual evaluation of employee performance.

(b) Personnel policies shall require that employees and other persons working in or for the hospital familiarize themselves with these and such other regulations as are applicable to their duties.

(c) Hospitals shall furnish evidence of a plan for growth and development of the hospital staff through:

(1) Designation of a staff member qualified by training and experience who shall be responsible for staff education.

(2) Reference material, relevant to the services provided by the hospital, which shall be readily accessible to the staff.

§ 71521. Employees.

(a) The hospital shall recruit qualified personnel and provide initial orientation of new employees, a continuing in–service training program and competent supervision designed to improve patient care and employee efficiency.

(b) If language or communication barriers exist between hospital staff and a significant number of patients, arrangements shall be made for interpretors or for the use of other mechanisms to insure adequate communications between patients and personnel.

(c) The hospital shall designate a member of the staff as a patient discharge planning coordinator.

(d) All employees of the hospital, having patient contact, including students, interns and residents, shall wear an identification tag bearing their name and vocational classification.

(e) All appropriate employees shall be given training in methods of hospital infection control.

(f) Uniform rules shall be established for each classification of employees concerning the conditions of employment. A written statement of all such roles shall be provided each employee upon commencing employment.

§ 71523. Employee Health Examinations and Health Records.

(a) Personnel employed in health facilities who will have contact directly or indirectly with patients shall be free from symptoms indicating the presence of infectious diseases.

(b) A health examination performed under the direction of a physician shall be required as a requisite for employment and must be performed within one week after employment. Written examination reports signed by the physician which verify that employees are able to perform assigned duties shall be maintained. Repeat examinations

shall be performed whenever necessary to ascertain that employees are free from symptoms indicating the presence of infectious disease and are able to perform their assigned duties. Upon initial examination, and at least annually, the employee shall have a skin test for tuberculosis using Purified Protein Derivatives intermediate strength or a chest X–ray. Positive reaction to the skin test shall be followed by a 35.56 cm x 43.18 cm (14″ x 17″) chest X–ray.

(c) Employee health records shall be maintained by the hospital and shall include the records of all required health examinations. Such records shall be kept a minimum of three years following termination of employment.

(d) Employees known to have or evidencing symptoms of infectious disease shall be removed from contact with patients.

§ 71525. Employee Personnel Records.

All hospitals shall maintain personnel records of all employees. Such records shall be retained for at least three years following termination of employment. The record shall include the employee's full name, Social Security number, the license or registration number, if any, brief resume of experience, employment classification, date of beginning employment and date of termination of employment. Records of hours and dates worked by all employees during at least the most recent six–month period shall be kept on file at the place of employment.

§ 71527. Job Descriptions.

Job descriptions detailing the functions of each classification of employee shall be written and shall be available to all personnel.

§ 71529. Advertising.

No hospital shall make or disseminate any false or misleading statement, or advertise by any manner or means any false claims regarding services provided by the hospital.

§ 71531. Records and Reports.

(a) Each hospital shall maintain copies of the following applicable documents on file in the administrative offices of the hospital:

(1) Articles of incorporation or partnership agreement.

(2) Bylaws and rules and regulations of the governing body.

(3) Bylaws and rules and regulations of the medical staff.

(4) Minutes of the meetings of the governing body and the medical staff.

(5) Reports of inspections by local, state and federal agencies.

(6) All contracts, leases and other agreements required by these regulations.

(7) Patient admission roster.

(8) Reports of unusual occurrences for the preceding two years.

(9) Personnel records.

(10) Policy manuals.

(11) Procedure manuals.

(12) Minutes and reports of the hospital infection control committee.

(13) Any other records deemed necessary for the direct enforcement of these regulations by the Department.

(b) The records and reports mentioned or referred to above shall be made available for inspection by any duly authorized officer, employee or agent of the Department.

§ 71533. Annual Reports.

All hospitals shall submit annual reports to the Department, on forms supplied by the Department and by the date specified on the form.

§ 71535. Reporting.

(a) Reportable Diseases or Unusual Occurrences. All cases of reportable diseases shall be reported to the local health officer in accordance with Section 2500, Article 1, Subchapter 1, Chapter 4, Title 17, California Administrative Code. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors shall be reported as soon as reasonably practical, either by telephone or by telegraph, to the local health officer and to the Department. The hospital shall furnish such other pertinent information related to such occurrences as the local health officer of the Department may require.

(b) Testing for Phenylketonuria. If a maternity patient is admitted the hospital shall comply with the requirements governing testing for phenylketonuria (PKU) contained in Section 6500 of Title 17, California Administrative Code.

(c) Rhesus (Rh) Hemolytic Disease of the Newborn. All hospitals to which maternity patients may be admitted shall comply with the requirements for the determination and reporting of the rhesus (Rh) blood type of maternity patients and the reporting of rhesus (Rh) hemolytic disease of the newborn as contained in Section 6510 of Title 17, California Administrative Code.

(d) Child Placement. The release of children for adoption shall be in conformity with the state law regulating adoption procedure. Hospitals shall report to the Department on forms supplied by them, within 48 hours, the name and address of any person other than a parent or relative by blood or marriage, or the name and address of the organization or institution into whose custody a child is given on discharge from the hospital.

§ 71537. Infection Control Program.

(a) A written hospital infection control program shall be adopted. The program shall conform to the guidelines contained in Infection Control in the Hospital, 1974, published by the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611.

(b) A copy of the plan shall be available for review by the Department.

(c) There shall be a system of reporting of possibly acquired hospital infections to the infection control committee.

(d) The program shall be reviewed, evaluated and updated annually by the infection control committee. A report of this review shall be available to the Department.

§ 71539. Disaster and Mass Casualty Program.

(a) A written disaster and mass casualty program shall be developed and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts. The program shall be in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health. The program shall be approved by the medical staff and administration. A copy of the program shall be available on the premises for review by the Department.

(b) The program shall cover local disasters occurring in the community and widespread disasters. It shall provide for at least the following:

(1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

(2) An efficient system of notifying and assigning personnel.

(3) Unified medical command.

(4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

(5) Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.

(6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.

(7) Procedures for the prompt discharge or transfer of patients, already in the hospital who can be moved without jeopardy.

(8) Maintaining security in order to keep relatives and curious persons out of the triage area.

(9) Establishment of a public information center and assignment of

public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

(c) The program shall be brought up–to–date, at least annually, and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a reasonable time after commencement of their employment.

(d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills. The actual evacuation of patients to safe areas during the drill is optional.

§ 71541. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) The written program shall include at least the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire fighting equipment.

(6) Specification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(c) Fire and internal disaster drills shall be held at least quarterly, for each shift of hospital personnel and under varied conditions. The actual evacuation of patients to safe areas during a drill is optional.

(d) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

§ 71543. Fire Safety.

All hospitals shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic. All hospitals shall secure and maintain a clearance relative to fire safety from the State Fire Marshal.

§ 71544. Disruption of Services.

(a) Each hospital shall develop a written plan to be used when a discontinuance or disruption of services occurs.

(b) The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

§ 71545. Restraint of Patients.

(a) Restraint shall be used only when alternative methods are not sufficient to protect the patient or others from injury.

(b) Patients shall be placed in restraint only on the written order of the physician or clinical psychologist, acting within the scope of his or her professional licensure. This order shall include the reason for restraint and the type of restraint to be used. In a clear case of emergency, a patient may be placed in restraint at the discretion of a registered nurse and a verbal or written order obtained thereafter. If a verbal order is obtained it shall be recorded in the patient's medical record and be signed by the physician or clinical psychologist on his or her next visit.

(c) Patients in restraint by seclusion or mechanical means shall be observed at intervals not greater than 15 minutes.

(d) Restraints shall be easily removable in the event of fire or other emergency.

NOTE: Authority cited: Sections 1275 and 100275, Health and Safety Code. Reference: Sections 1255, 1276 and 1316.5, Health and Safety Code; and *CAPP v. Rank* (1990) 51 Cal. 3d 1.

§ 71547. Medical Records Service.

(a) The hospital shall maintain a medical record service which shall be conveniently located and adequate in size and equipment to facilitate the accurate processing, checking, indexing and filing of all medical records.

(b) The medical records service shall be under the supervision of a registered record administrator or accredited records technician. The registered record administrator or accredited records technician shall be assisted by such qualified personnel as are necessary for the conduct of the service.

(c) Policies and procedures shall be established to ensure the confidentiality of patient health information, in accordance with applicable laws and regulations.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71549. Medical Record Content.

(a) Each inpatient medical record shall consist of at least the following:

(1) Identification sheets to include but not be limited to the following:

(A) Name.

(B) Address on admission.

(C) Identification number (if applicable).

1. Hospital admission number.

2. Social Security number.

3. Medicare number.

4. Medi–Cal number.

(D) Age.

(E) Sex.

(F) Marital status.

(G) Legal status.

(H) Religion.

(I) Date of admission.

(J) Date of discharge.

(K) Name, address and telephone number of person or agency responsible for patient.

(L) Name of patient's medical staff member responsible for care.

(M) Initial diagnostic impression.

(N) Discharge or final diagnosis.

(O) Disposition.

(2) Psychiatric history and physical examination.

(3) Legal authorization for admission.

(4) Consultation reports, including neurologic examination.

(5) Order sheet including medication, treatment and diet orders.

(6) Treatment plan.

(7) Progress notes including current or working diagnosis, the complaints of others regarding the patient, as well as the patient's comments.

(8) Nurses' notes which shall include but not be limited to the following:

(A) Concise and accurate record of nursing care provided.

(B) Record of pertinent observation of the patient and the response to treatment.

(C) Name, dosage and time of administration of medications and treatment. Route of administration and site of injection shall be recorded, if other than by oral administration.

(D) Record of type of restraint, including time of application and removal.

(9) Vital sign sheet, including weight record.

(10) Reports of all laboratory tests performed.

(11) Reports of all X–ray examinations performed.

(12) Consent forms, when applicable.

(13) Anesthesia record including preoperative diagnosis, if anesthesia has been administered.

(14) Operative report including preoperative and postoperative diagnosis, description of findings, technique used, tissue removed or altered, if surgery was performed.

(15) Pathological report, if tissue or body fluid was removed.

(16) Labor record, if applicable.

(17) Delivery record, if applicable.

(18) A discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, the patient's condition on discharge and the recommendation and arrangements for future care.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1316.5, Health and Safety Code.

§ 71551. Medical Record Availability.

(a) Records shall be kept on all patients admitted or accepted for treatment. All required records, either as originals or accurate reproductions of the contents of such originals, shall be maintained in such form as to be legible and readily available upon the request of: the attending physician; the hospital or its medical staff or any authorized officer, agent or employee of either; authorized representatives of the Department; or any other person authorized by law to make such a request.

(b) The medical record, including X–ray film, is the property of the hospital and is maintained for the benefit of the patient, the medical staff and the hospital. The hospital shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient records including X–ray film or reproductions thereof shall be preserved safely for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a hospital ceases operation, the Department shall be informed within 48 hours of the arrangements made for safe preservation of patient records as above required.

(e) If ownership of a licensed hospital changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that:

(1) The new licensee will have custody of the patients' records upon transfer of the hospital, and that the records are available to both the new and former licensee and other authorized persons; or

(2) Arrangements have been made for the safe preservation of patient records, as required above, and that the records are available to both the new and former licensees and other authorized persons.

(f) Medical records shall be filed in an easily accessible manner in the hospital or in an approved medical record storage facility off the hospital premises.

(g) Medical records shall be completed promptly an authenticated or signed by a physician, dentist, podiatrist or clinical psychologist within two weeks following the patient's discharge. Medical records may be authenticated by a signature stamp or computer key, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative office to the effect that he/she is the only person who:

(1) Has possession of the stamp or key.

(2) Will use the stamp or key.

(h) Medical records shall be indexed according to patient, diagnoses and physician.

(i) By July 1, 1976 a unit medical record system shall be established and implemented with inpatient, outpatient and emergency room records combined.

(j) The medical record shall be closed and a new record initiated when a patient is transferred to a different level of care within a hospital which has a distinct part skilled nursing or intermediate care service.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71553. Transfer Summary.

A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the skilled nursing long–term unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan and shall be signed by the physician.

§ 71555. Patients' Monies and Valuables.

(a) No licensee shall use patients' monies or valuables as his own or mingle them with his own. Patients' monies and valuables shall be separate, intact and free from any liability the licensee incurs in the use of his own or the institution's funds and valuables.

(b) Each licensee shall maintain adequate safeguards and accurate records of patients' monies and valuables entrusted to his care.

(1) Records, of patients' monies which are maintained as a drawing account, shall include a control account for all receipts and expenditures, an account for each patient and supporting vouchers filed in chronological order. Each account shall be kept current with columns for debits, credits and balance.

(2) Records of patients' monies and other valuables entrusted to the licensee for safekeeping shall include a copy of the receipt furnished to the patient or to the person responsible for the patient.

(c) Patients' monies not kept in the hospital shall be deposited in a demand trust account in a local bank authorized to do business in California, the deposits of which are insured by the Federal Deposit Insurance Corporation. A county hospital may deposit such funds with the county treasurer.

(d) When the amount of money entrusted to a licensee for patients exceeds $500, all money in excess of $500 shall be deposited in a demand trust account as specified in (c), above, unless a fireproof safe is provided on the premises for the protection of monies and valuables. If a fireproof safe is kept and the licensee desires the protection accorded by Civil Code Section 1860, he shall give notice as provided by that section.

(e) Upon discharge of a patient, all refunds due and all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient or the person responsible for the patient in exchange for a signed receipt. Money and valuables kept within the hospital must be surrendered upon demand and those kept in a demand trust account or with the county treasurer shall be made available within three normal banking days.

(f) Following the death of a patient, except in a coroner or medical examiners case, all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the person responsible for the patient, the executor or the administrator of the estate in exchange for a signed receipt, within 30 days. Immediate written notice of the death of a patient without an agent or known heirs shall be given to the public administrator of the county as specified by Section 1145, of the Probate Code.

(g) Upon change of ownership of a hospital, a written verification by a public accountant of all patients' monies which are being transferred to the custody of the new owners shall be obtained by the new owner in exchange for a signed receipt.

§ 71557. First Aid and Referrals.

(a) If a hospital subject to the provisions of this chapter does not maintain an emergency medical service, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists, render necessary life saving first aid and shall direct the persons seeking emergency care to the nearest hospital which can render the needed services and shall assist the persons seeking emergency care in obtaining such services, including transportation services, in every way reasonable under the circumstances.

(b) Hospitals not providing emergency medical service shall not advertise or make any other representation to the public that may convey or connote the availability of such service. The posting of signs to designate entrances for use by outpatients and ambulances such as ambulance entrance, referred patients, outpatient service or other words of similar connotation is not prohibited. Such hospitals may represent to the public in any form or manner, and only in its entirety, the phrase first aid and referral service.

§ 71559. Medical Library.

(a) Each hospital shall maintain a medical library consistent with the needs of the hospital.

(b) The medical library shall be located in a convenient location, and its contents shall be organized, easily accessible and available through authorized personnel at all times.

(c) The library shall contain current textbooks, journals and magazines pertinent to the clinical services maintained in the hospital.

§ 71561. Medical Photography.

The hospital shall have a policy regarding the obtaining of consent for medical photography.

§ 71563. Conference Room.

A conference room shall be provided in the hospital.

Article 7. Physical Plant

§ 71601. Alterations to Existing Buildings or New Construction.

(a) Alterations to existing buildings licensed as hospitals or new construction shall be in conformance with Chapter 1, Division 17, Part 6, Title 24, California Administrative Code.

(b) Hospitals licensed and in operation prior to the effective date of changes in these regulations shall not be required to institute corrective alterations or construction to comply with such changes except where specifically required or where the Department determines that a definite hazard to health and safety exists. Any hospital for which preliminary or working drawings and specifications have been approved by the Department prior to the effective date of changes to these regulations shall not be required to comply with such changes provided substantial, actual construction is commenced within one year after the effective date of such changes.

§ 71603. Application for Plan Review.

(a) Drawings and specifications for alterations to existing buildings or new construction shall be submitted to the Department for approval and shall be accompanied by an application for plan review on forms furnished by the Department. The application shall:

(1) Identify and describe the work to be covered by the plan review for which the application is made.

(2) Describe the land on which the proposed work is to be done, by lot, block, tract or house and street address or similar description that will readily identify and definitely locate the proposed building or work.

(3) Show the present and proposed use or occupancy of all parts of the building or buildings.

(4) State the number of square meters (square feet) of floor area involved in new construction and in alterations.

(5) Give such other information as may be required by the Department for unusual design circumstances.

(6) Be signed by the person designing the work or the owner of the work.

(b) The application for plan review shall also include a written statement that a description of the proposed work has been submitted to the Area Comprehensive Health Planning Agency approved by the State Advisory Health Council pursuant to Section 437.7 of the Health and Safety Code.

§ 71605. Space Conversion.

Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department.

§ 71607. Notice to Department.

The licensee shall notify the Department in writing not later than ten days after the date when construction of a new hospital is commenced or when construction involving an increase in bed capacity or change of services of an existing hospital is commenced.

§ 71609. Patient Accommodations.

(a) No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X–ray or laboratory departments are not included in the approved licensed bed capacity.

(b) Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use.

(c) Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been granted a fire clearance by the State Fire Marshal, except as provided in paragraph (a) above.

(d) The number of licensed beds shown on a license shall not exceed the number of beds for which the facility meets applicable construction and operational requirements.

§ 71611. Patient Rooms.

(a) Patients shall be accommodated only in rooms with the following minimum floor area:

(1) Single rooms: 10.2 square meters (110 square feet) of floor area except for private rooms in pediatric units which shall have at least 9.3 square meters (100 square feet).

(2) Multipatient rooms: 7.4 square meters (80 square feet) of floor area per bed with one meter (three feet) between beds, except in specialized units.

(b) Each patient room shall be labeled with a number, letter or combination of the two for identification.

(c) Patient rooms which are approved for ambulatory patients only shall not accommodate nonambulatory patients. Before patients are accommodated in ambulatory sections, they shall demonstrate that they are ambulatory, and this shall be noted in the patient's medical record. The hospital shall transfer patients from the ambulatory section when their condition becomes nonambulatory. The ambulatory status of patients shall be demonstrated upon request of the Department.

(d) Patient rooms approved for use by ambulatory patients only shall be identified as follows: the words reserved for ambulatory patients, in letters at least one and one–half centimeters (one–half inch) high, shall be posted on the outside of the door or on the wall alongside the door where they are visible to persons entering the room.

(e) Except for rooms approved by the Department for detention of psychiatric patients, patients' rooms shall not be kept locked when occupied.

(f) The decision of maintaining locked wards shall be made by the staff, depending upon the needs of the patient(s).

(g) Where patients are kept in locked wards or rooms, adequate staff must be available to assure safe and quick egress of the patients.

(h) Where the safety of the patient and others are of appropriate concern because of the condition of the patient, windows shall either be inaccessible to the patient or glazed with unbreakable materials.

§ 71613. Patient Property Storage.

Patients shall be provided with closet or locker space for clothing, toilet articles and other personal belongings. Where appropriate, bedside tables or equivalent shall also be provided.

§ 71615. Patient Room Furnishings.

A bed with a suitable mattress and a chair shall be provided for each patient.

§ 71617. Provisions for Emptying Bedpans.

(a) Bedpans shall be cleaned in utility rooms or bedpan cleaning rooms, unless toilets adjoining patients' rooms are used for cleaning bedpans, in which case such toilets shall be equipped with bedpan flushing attachments and vacuum breakers. Bedpans shall not be cleaned in bathtubs, handwashing sinks or laundry tubs.

(b) Bedpan covers shall not be used interchangeably.

§ 71619. Provision for Privacy.

A method of assuring privacy for each patient shall be maintained in patient rooms and in tub, shower and toilet rooms.

§ 71621. Public Telephone.

A telephone shall be available for patient use.

§ 71623. Isolation Facilities.

At least one single bed special room shall be provided for the isolation of a single patient at a ratio of one special room for each 50 beds or major fraction thereof. At least one special room shall be provided.

§ 71625. Seclusion Rooms.

Where provided, seclusion rooms shall be designed and equipped to ensure the safety of the patient.

§ 71627. Patient Lounge.

Adequate space and equipment shall be provided for patient use for social activities.

§ 71629. Laundry Service.

(a) Laundry and linen.

(1) An adequate supply of clean linen shall be provided for at least three complete bed changes for the hospital's full bed capacity.

(2) There shall be written procedures developed and maintained pertaining to the handling, storage, transportation and processing of linens.

(3) If the hospital operates its own laundry, such laundry shall be:

(A) Located in such relationship to other areas that steam, odors, lint and objectionable noises do not reach patient or personnel areas.

(B) Well lighted and ventilated and adequate in size for the needs of the hospital and for the protection of employees.

(C) Maintained in a sanitary manner and in good repair.

(D) Not part of a storage area.

(4) Hospital linens shall be washed according to the following method:

All linens shall be washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71ºC (160ºF) for at least 24 minutes during the washing process, or a lower temperature of 60ºC (140ºF.) for 24 minutes may be utilized if the linens are subsequently passed through a flatwork ironer at 110–115 feet per minute at a temperature of 300ºF. or a tumbler dryer at a temperature of 180ºF.

(5) Separate rooms shall be maintained in the hospital for storage of clean linen and for storage of soiled linen. Linen storage rooms shall be adequate in size for the needs of the hospital and shall not be used for any other purpose. Storage shall not be permitted in attic spaces, corridors or plenums (air distribution chambers) of air conditioning or ventilating systems.

(6) Handwashing and toilet facilities for laundry personnel shall be provided at locations convenient to the laundry.

(7) Soiled and clean linen carts shall be so labeled and provided with covers made of washable materials which shall be laundered daily or suitably cleaned daily.

(8) If the hospital does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this section.

(b) Soiled linen.

(1) Laundry shall be handled, stored and processed in a manner that will prevent the spread of infection and will assure the maintenance of clean linen.

(2) Each of the following classes of laundry shall be separately transported, stored and washed:

(A) Linen from isolation rooms.

(B) All radioactive contaminated linen.

(C) Linen from pathology.

(3) Soiled linen shall be sorted in a separate enclosed room by a person instructed in methods of protection from contamination. This person shall not have responsibility for immediately handling clean linen.

(4) Soiled linen shall be stored and transported in a closed container which does not permit airborne contamination of corridors and areas occupied by patients, and precludes the cross–contamination of clean linen.

(5) If soiled linen is transported in wheeled containers such conveyances shall not be used for transporting clean linen. Carts or conveyances and their contents shall be covered during the transportation process.

(6) If chutes are used for transporting soiled linen, the chutes shall be maintained in a clean, sanitary state.

(c) Clean Linen.

(1) Clean linen shall be sorted, handled and transported in such a manner as to prevent cross–contamination.

(2) Clean linen carts shall be used only for the purpose of transportation or storage of clean linen.

(3) Persons processing clean linen shall be dressed in clean garments at all times while on duty and shall not handle soiled linen.

(4) Clean linen from a commercial laundry shall be delivered to the hospital completely wrapped and delivered to a designated clean area.

(5) Clean linen in patient care units shall be stored in clean, ventilated closets, rooms or alcoves, used for that purpose only. Corridors shall not be used for storage of linen.

(6) If clean linen is stored in the laundry area, it shall be stored in a room separate from the sorting room, laundry room or soiled linen room.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 71631. Housekeeping.

(a) Each hospital shall make provision for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures.

(b) There shall be written routines and procedures developed and maintained to include but not be limited to the following:

(1) Daily cleaning of patient areas, nurses' stations, work areas, halls, entrances, storage areas, restrooms, laundry, pharmacy, offices, etc.

(2) Daily cleaning of specialized areas.

(3) Daily cleaning of isolation areas.

(4) Daily cleaning of kitchen and associated areas.

(5) Weekly cleaning of such things as radiators, clocks, pictures, ventilators, curtains, draperies, etc.

(6) Monthly and as necessary cleaning of walls and ceilings.

(7) Terminal cleaning of patient unit upon discharge of patient.

(c) There shall be sufficient housekeeping cleaning supplies and equipment provided.

(1) Housekeeping cleaning supplies, other than in bulk, and equipment shall be stored in housekeeping rooms.

(2) A detergent germicide shall be used for all cleaning and dusting purposes.

(3) Mop heads shall be removable and changed at least daily.

(d) There shall be sufficient housekeeping personnel to maintain

the interior of the hospital in a safe, clean, orderly, attractive manner and free from offensive odors.

(e) A person qualified by experience and training shall be designated to be in charge of housekeeping service.

§ 71633. Morgue.

(a) Hospitals with a licensed bed capacity of 50 or more shall maintain a well ventilated morgue with autopsy facilities, unless adequate morgue and autopsy facilities are available in the local community.

(b) Hospitals with a licensed bed capacity of 200 or more shall maintain a well ventilated morgue with autopsy facilities.

(c) Refrigerated compartments shall be maintained if human remains are held unembalmed. The air temperature shall not be higher than 7ºC (45ºF).

§ 71635. Central Sterile Supply.

(a) Each hospital shall provide, prepare, sterilize and store sufficient sterile supplies and medical and surgical equipment and shall dispense them to all services in the hospital. The operation of this service shall be carried out in an area designated, equipped and staffed for this purpose.

(b) A person qualified by training and experience, recommended by the infection control committee shall be designated to be in charge of the central sterile supply. Liaison with the infection control committee shall be maintained through that person's membership on the committee.

(c) There shall be written procedures developed and maintained pertaining to the cleaning, preparation, disinfection and sterilization of utensils, instruments, solutions, dressings and other articles.

(d) There shall be effective separation of soiled or contaminated supplies and equipment from the clean and sterilized supplies and equipment.

(e) Sterile supplies and equipment shall be stored in clean cabinets, cupboards or other satisfactory spaces. An orderly system of rotation of supplies shall be used so that supplies stored first will be used first.

§ 71637. Autoclaves and Sterilizers.

(a) Autoclaves and sterilizers shall be maintained in operating condition at all times.

(b) Instructions for operating autoclaves and sterilizers shall be posted in the area where the autoclaves and sterilizers are located.

(c) Written procedures shall be developed, maintained and available to personnel responsible for sterilization of supplies and equipment that include, but are not limited to the following:

(1) Time, temperature and pressure for sterilizing the various bundles, packs, dressings, instruments, solutions, etc.

(2 Cleaning, packaging, storing and issuance of supplies and equipment.

(3) Dating and outdating of material sterilized.

(4) Loading of the sterilizer.

(5) Daily checking of recording and indicating thermometers and filing for one year of recording thermometer charts.

(6) Monthly bacteriological test, the bacterial organism used and filing for one year of the test results.

(7) Length of aeration time for materials gas sterilized.

§ 71639. Disinfecting.

(a) Each hospital shall make provision for the cleaning and disinfection of contaminated articles and surfaces which cannot be sterilized.

(b) Thermometers should be disinfected for at least ten minutes with 70 percent ethyl alcohol or 99 percent isopropyl alcohol with 0.2 percent iodine.

(c) Written procedures shall be developed and maintained for the disinfection of articles and surfaces.

§ 71641. General Safety and Maintenance.

(a) The hospital shall be clean, sanitary, and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures for the safety and well–being of patients, personnel and visitors.

(b) Hospital buildings and grounds shall be maintained free of such environmental pollutants and such nuisances as may adversely affect the health or welfare of patients to the extent that such conditions are within the reasonable control of the hospital.

(c) All hospitals shall maintain in operating condition all buildings, fixtures and spaces in the numbers and types as specified in construction requirements under which the hospital or unit was first licensed.

(d) A written manual on maintenance of heating, air conditioning and ventilation systems shall be adopted by each hospital and a maintenance log shall be maintained.

(e) Equipment provided must meet any and all applicable California Occupational Safety and Health Act requirements in effect as of the time of purchase. All portable electrical equipment using 110–120 volt 60 hertz current shall be equipped with a three–wire grounded power cord with an Underwriters Laboratories approved hospital grade three–prong plug. The cord grip shall be an integral part of the plug.

(f) All gauging and measuring equipment shall be regularly calibrated as specified by the manufacturer and records of such testing kept for at least two years.

§ 71643. Air Filters.

(a) The licensee shall be responsible for regular inspection, cleaning or replacement of all filters installed in heating, air conditioning and ventilating systems, as necessary to maintain the systems in normal operating condition. The efficiency of the replacement filters shall be equal to the efficiency rating of the replaced filters.

(b) A written record of inspection, cleaning or replacement including static pressure drop shall be regularly maintained and available for inspection. The record shall include a description of the filters originally installed, the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) atmospheric dust spot test efficiency rating and the criteria established by the manufacturer or supplier to determine when replacement or cleaning is necessary.

(c) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and bypass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and bypass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department.

(d) Where filter maintenance is performed by an equipment service company, a certification shall be provided to the licensee that the requirements listed in Section 71643 (a) and (b) have been accommodated.

(e) If filter maintenance as required in Section 71643 (a) and (b) is performed by employees of the hospital, a written record shall be maintained by the licensee.

§ 71645. Emergency Lighting and Power System.

(a) Auxiliary lighting and power facilities shall be readily available at all times.

(1) The emergency lighting and power system shall be maintained in operating condition to provide automatic restoration of power for emergency circuits within ten seconds after normal power failure.

(2) Emergency generators installed in hospitals shall be tested under load conditions for at least 30 minutes at intervals of not more than seven days.

(b) The licensee shall provide and maintain an emergency electrical system in compliance with Section E702–7 and E702–20,

Part 3, Title 24, California Administrative Code. The system shall serve all lighting, signals, alarms and equipment required to permit continued operation of all necessary functions of the hospital for a minimum of 24 hours.

(c) The Department may require the licensee to submit a report of evaluation of the emergency electrical systems by a registered electrical engineer to substantiate compliance with Subarticle E702–7, Part 3, Title 24, California Administrative Code. Essential engineering data, including load calculations, assumptions and tests, and where necessary, plans and specifications acceptable to the Department, shall be included in the report.

(d) Where alteration of the emergency electrical system is determined to be necessary, the work shall comply with Sections E702–20 and E702–24, Part 3, Title 24, California Administrative Code.

(e) A written record of inspection, performance, exercising period and repairs shall be maintained and available.

§ 71647. Storage and Disposal of Solid Wastes.

(a) Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease. These wastes shall not be a nuisance or provide a breeding place for insects or rodents nor shall it be a food source for either.

(b) Solid waste containers shall be stored and located in a manner that will protect against odors.

(c) Syringes and needles, before being discarded into waste containers, shall be rendered unusable.

§ 71649. Solid Waste Containers.

(a) All containers, except movable bins used for storage of solid wastes, shall have tight–fitting covers in good repair, external handles and be leakproof and rodent proof.

(b) Movable bins, when used for storing or transporting solid wastes from the premises, shall meet the following requirements:

(1) Have tight–fitting covers approved by the local health department and kept closed when not being loaded.

(2) Be in good repair.

(3) Be leakproof.

(4) Be rodent proof unless stored in a room or screened enclosure.

(c) All containers receiving putrescible wastes shall be emptied at least every four days, or more often if necessary.

(d) Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin may provide for suitable access and a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 208 (a) and 1254 Health and Safety Code. Reference: Sections 1250 and 25157.3, Health and Safety Code.

§ 71651. Infectious Waste.

Infectious waste, as defined in Health and Safety Code Section 25117.5, shall be handled and disposed of in accordance with the Hazardous Waste Control Law, Chapter 6.5, Division 20, Health and Safety Code (beginning with Section 25100) and the regulations adopted thereunder (beginning with Section 66100 of this Title).

NOTE: Authority cited: Sections 208, 1254, 25150 and 25157.3, Health and Safety Code. Reference: Sections 1250, 25117 and 25117.5, Health and Safety Code.

§ 71653. Gases for Medical Use.

(a) Provision shall be made for safe handling and storage of medical gas cylinders.

(b) Transfer of gas by hospital personnel from one cylinder to another is prohibited except when approved by the Department.

(c) Gases for medical use include carbon dioxide, cyclopropane, ethylene, helium, nitrous oxide, oxygen, helium–oxygen mixtures and carbon dioxide–oxygen mixtures.

(d) All anesthesia machines and related equipment shall be so constructed that connections for different gases are not interchangeable.

These requirements shall be accomplished by installing permanent fittings as indicated below:

(1) Yoke connections of anesthesia machines and flush outlet valves for small compressed gas cylinders (Style E and smaller) shall conform with the pin index and safety system contained in pamphlet B57.1, Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 Edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018.

(2) Valve outlet connections for large cylinders (Style F and larger) for oxygen and nitrous oxide shall conform with the standards contained in pamphlet B57.1, Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 Edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018. Standard connection No. 540 shall be used with oxygen cylinders and standard connection 1320 shall be used with nitrous oxide cylinders. Cylinders for medical gases, other than oxygen and nitrous oxide used with anesthesia machines, shall be limited to Style E and smaller.

(3) Removable exposed threaded connections, where employed in medical gas piping systems and equipment used in conjunction with resuscitators and oxygen therapy apparatus, shall be provided with noninterchangeable connections which conform with pamphlet V–5, Diameter–Index Safety System, May 1970 printing, by the Compressed Gas Association, Inc., 500 Fifth Avenue, New York, NY 10036.

(4) Station outlets from piped oxygen and nitrous oxide systems shall conform with the standards contained in bulletin NFPA No. 56F, Nonflammable Medical Gas Systems, 1973, by the National Fire Protection Association, 470 Atlantic Avenue, Boston, MA 02210.

(5) Removable connection hoses from station outlets or cylinders to yokes of anesthesia machines shall be fitted with permanently connected fittings to match the standards listed above in paragraphs (1), (2), (3) and (4).

(e) The piped oxygen or nitrous oxide system(s) shall be tested in accordance with the National Fire Protection Association bulletin, NFPA No. 56F, referred to above, and a written report shall be maintained in each of the following instances.

(1) Upon completion of initial installation.

(2) Whenever changes are made to a system.

(3) Whenever the integrity of a system has been breached.

(4) At least annually.

(f) Oxygen Equipment.

(1) Vaporizer bottles shall be sterilized after each use.

(2) Only sterile fluid shall be used in vaporizer bottles.

(3) Vaporizer bottles shall be changed at least every 24 hours.

§ 71655. Lighting.

(a) All rooms, attics, basements, passageways and other spaces shall be illuminated.

(b) Adequate illumination shall be maintained for the comfort of patients and personnel.

(c) All patient rooms shall have a minimum of 30 foot candles of light delivered to reading or working surfaces and not less than 10 foot candles of light in the remainder of the room.

(d) All corridors, storerooms, stairways, ramps, exits and entrances shall have a minimum of five foot candles of light measured in the darkest corner.

(e) Except in closets, storage spaces, attic spaces, equipment rooms and similar areas, lighting fixtures shall have suitable enclosures to control fixture brightness and to prevent accidental breakage. Where exposed lamp fixtures are permitted, suitable guards shall be maintained in locations where breakage could be hazardous to personnel.

(f) Emergency lighting facilities shall be maintained for use during electrical power failure. In addition, flashlights shall be available at all times. Open flame lights shall not be used.

§ 71657. Mechanical Systems.

Heating, air conditioning, and ventilating systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the hospital.

§ 71659. Screens.

To protect against flies and other insects, screens of 6 mesh per centimeter (16 mesh per inch) shall be provided on doors and openable windows. Screen doors shall be of a type approved by the State Fire Marshal.

§ 71661. Signal Systems.

(a) Where bed patients are cared for, a call system shall be maintained in operating order in all nursing units. Call systems shall be maintained to provide visible and audible signal communication between nursing personnel and patients. The minimum requirements are:

(1) A visible signal in the corridor above the door of each patient room.

(2) An audible signal and light indicating the room from which the call originates shall be located at the nurses' stations. Alternate systems must be approved in writing by the Department.

(b) The nurses' call systems shall be designed to require resetting at the calling station where the call originates unless a two–way voice communication component is included in the system.

§ 71663. Storage.

(a) All hospitals shall maintain general storage space of at least 1.9 square meters (20 square feet) per bed in addition to specialized storage space.

(b) Storage is not permitted in plenums (air distribution chambers) of air conditioning or ventilation systems.

§ 71665. Water Supply and Plumbing.

(a) Water for human consumption from an independent source shall be subjected to bacteriological analysis by the local health department, State Department of Health or a licensed commercial laboratory at least every three (3) months. A copy of the most recent laboratory report shall be available for inspection.

(b) Plumbing and drainage facilities shall be maintained in compliance with Part 5, Title 24, California Administrative Code, Basic Plumbing Requirements. Drinking water supplies shall comply with Group 4, Subchapter 1, Chapter 5, Division T17, Part 6, Title 24, California Administrative Code.

(c) Backflow preventers (vacuum breakers) shall be maintained in operating condition where required by Section T17–210 (c), Division T17, Part 6, Title 24, California Administrative Code.

(d) For hot water used by patients, there shall be temperature controls to automatically regulate the temperature between 40.5ºC. (105ºF) and 48.9ºC (120ºF).

(e) Hot water at a minimum temperature of 82.2ºC (180ºF) shall be maintained at the final rinse section of dishwashing facilities unless alternate methods are approved by the Department.

(f) Taps delivering water at 51.60ºC (125ºF) or higher shall be identified prominently by warning signs with letters 5 cm (2 inches) high.

(g) Grab bars are not required for each toilet, bathtub and shower except where both are appropriate to patient care and supervised by personnel.

(h) As a minimum, toilet, handwashing and bathing facilities shall be maintained in operating condition in the number and types specified in construction requirements in effect at the time the building or unit was constructed.

(i) Overhead pipes and ducts shall not be exposed in such manner as to endanger the patient directly or indirectly.

§ 71667. Ice.

Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Bacteriological testing shall be performed at least monthly and reports thereof shall be on file in the laboratory.

Chapter 3. Skilled Nursing Facilities

Article 4. Optional Services

§ 72443. Special Treatment Program Service Unit—General.

(a) Special treatment programs shall provide programs to serve patients who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. Special treatment program services are those therapeutic services, including prevocational preparation and prerelease planning, provided to mentally disordered persons having special needs in one or more of the following general areas: self–help skills, behavior adjustment, interpersonal relationships.

(b) To be eligible for special treatment program services, the patient's condition should be responsive to special treatment program services and prohibitive to placement in a skilled nursing facility.

(c) The facility shall not accept for care any mentally disordered patient who has an identified program need unless the Department of Mental Health has approved the facility's specific special treatment plan.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72445. Special Treatment Program Service Unit—Services.

(a) The program objective shall be to provide a program aimed at improving the adaptive functioning of chronic mentally disordered patients to enable some patients to move into a less restrictive environment and prevent other patients from regressing to a lower level of functioning.

(b) The facility shall have the capability of providing all of the following special rehabilitation program services. Individual programs shall be provided based on the specific needs identified through patient assessments.

(1) Self–Help Skills Training. This shall include but not be limited to:

(A) Personal care and use of medications
(B) Money management
(C) Use of public transportation
(D) Use of community resources
(E) Behavior control and impulse control
(F) Frustration tolerance
(G) Mental health education
(H) Physical fitness

(2) Behavioral Intervention Training. This shall include but not be limited to:

(A) Behavior modification modalities
(B) Remotivation therapy
(C) Patient government activities
(D) Group counseling
(E) Individual counseling

(3) Interpersonal Relationships. This shall include but not be limited to:

(A) Social counseling
(B) Educational and recreational therapy
(C) Social activities such as outings, dances, etc.

(4) Prevocational Preparation Services. This shall include but not be limited to:

(A) Homemaking
(B) Work activity
(C) Vocational counseling

(5) Prerelease Planning

(A) Out–of–home placement

(c) In order to qualify for special treatment program services approval, the facility shall have, initially, a minimum of 30 patients whose need for special treatment program services is reviewed and approved by the local mental health director or designee.

(d) The facility program plan shall include provisions for accomplishing the following:

(1) The facility in conjunction with the local mental health director shall make an initial, individual assessment of each patient to identify the current level of functioning and program needs of the patient. The assessment shall be standardized and recorded on forms approved by the Department.

(2) At least every 4 months, the facility, in conjunction with the local mental health director or designee, shall reassess each patient to determine the need for continued certification of the patient in the special treatment program.

(3) A minimum average of 27 hours per week of direct group or individual program service for each patient.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72447. Special Treatment Program Service Unit—Distinct Part.

(a) A special treatment program service distinct part means an identifiable and physically separate unit of a skilled nursing facility or an entire skilled nursing facility which provides therapeutic programs to an identified mentally disordered population group. The distinct part shall be indicated on the facility license.

(b) A special treatment program means a therapeutic program of services designed, staffed and implemented by the special treatment program service for the purpose of meeting the special needs of an identified population group.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72449. Special Treatment Program Service Unit—Program Approval.

(a) Annually the facility shall submit to the Department of Mental Health a written description of its Special Treatment Program which shall meet all of the requirements of Section 72461. The facility shall also specify any alternate requirements needed to implement a special program, and shall submit other documents requested by the Department of Mental Health.

(b) The facility shall comply with all requirements of its approved Special Treatment Program and also any approved, specific, alternate requirement which shall govern the operation of the program notwithstanding the provisions of any other regulation contained in this chapter.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72451. Special Treatment Program Service Unit—Program Requirements.

(a) The facility shall specify each population group that it plans to serve. The program shall be developed to meet specific needs for that group. The program shall consist of the following components:

(1) The description of the population group to be served, shall include the following:

(A) Age range

(B) Sex

(C) Physical characteristics

(D) Emotional characteristics

(E) Number of patients to be served in each population group

(F) Identification of the particular needs within the population group

(G) A written program designed to meet the identified needs of the population

(H) Method and frequency of evaluating patient progress

(b) Each patient admitted shall have an initial evaluation and assessment by facility staff of his medical, nursing dietetic, social and physical needs within 15 days of admission unless an evaluation has been done by the referring agency within 30 days prior to admission to the facility.

(c) Each patient admitted shall have a psychological evaluation and assessment by the appropriate discipline within 45 days of admission.

(d) Consultative sources shall be used in the planning and organization of appropriate programs for the mentally disordered, incorporating discharge planning services intended to enable the patient to function and gain independence.

(e) Skills training programs shall be provided but not limited to techniques of behavior modification training in self–skills, sensory training or the modalities of reality orientation and remotivation therapy, as applicable to patients' needs or as described in the treatment plan.

(f) Orientation and in–service training of staff members by a qualified person to assist them in the recognition and understanding of the emotional problems and social needs of patients and the means of taking appropriate action. Available community resources and services should be included in the orientation.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72453. Special Treatment Program Service Unit—Rights of Patients.

(a) Each patient admitted to a special treatment program in a skilled nursing facility shall have the following rights, a list of which shall be prominently posted in English and Spanish in all facilities providing such services. The rights shall also be brought to the patient's attention by additional, appropriate means:

(1) To wear their own clothes; to keep and use personal possessions including toilet articles; and to keep and be allowed to spend a reasonable sum of their own money for small purchases.

(2) To have access to individual storage space for private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse lobotomy services.

(8) Other rights as provided by law.

(b) The attending physician may, for good cause, deny or limit a patient his or her rights, except the right to refuse lobotomy or shock treatment. Any denial or limitation of a patient's rights shall be entered in the patient's health record.

(c) Information pertaining to denial of rights contained in the patient's health record shall be made available on request to the Department and to the individuals authorized by law.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code, Section 5325, Welfare and Institutions Code.

§ 72455. Special Treatment Program Service Unit—Abuse and Corporal Punishment.

Patients shall not be subjected to verbal or physical abuse of any kind. Corporal punishment of patients is prohibited. Patients shall not discipline other patients.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72457. Special Treatment Program Service Unit—Restraint and Seclusion.

(a) Restraint and seclusion shall only be used as emergency measures to protect the patient from injury to self or to others. Restraint and seclusion shall not be used as punishment or the convenience of the staff.

(1) Restraints may be used:

(A) For the protection of the patient during treatment and diagnostic procedures, including but not limited to, intravenous therapy, tube feeding and catheterization.

(B) To prevent infirm patients from falling out of bed or chairs or otherwise injuring themselves.

NOTE: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72459. Special Treatment Program Service Unit—Acceptable Forms of Restraints.

(a) Mechanical or behavior restraints are defined as any apparatus that interferes with the free movement of a patient.

(1) Physical restraint means restraint to control an acutely disturbed person to prevent the person from causing harm to self or others. The tying of hands or feet, whether or not the person is restrained in a bed, chair or wheelchair, shall be considered a physical restraint. A physical restraint shall not be confused with a postural support as defined in Section 72319(k). Only the following types of physical restraint may be used:

(A) Soft tie consisting of cloth which prevents movements of a patient.

(B) Mittens without thumbs which are securely fastened around the wrist with a small tie.

(C) Cloth vests consisting of sleeveless cloth webbing.

(D) Belts and cuffs, which are well padded, used to control a seriously disturbed, assaultive patient.

NOTE: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72461. Special Treatment Program Service Unit—Orders for Restraint and Seclusion.

(a) Restraint and seclusion shall only be used on the signed order of a physician which shall be renewed every 24 hours. In a documented case of emergency, which threatens to bring immediate injury to the patient or others, a restraint may be applied, and a physician shall give an order for application of the restraint within one hour. A physician may give the order by telephone. In such an event, the physician shall sign the order within 5 days.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered.

(c) Full documentation of the episode leading to the behavior restraint or seclusion, the type of behavior restraint or seclusion used, the length of time that the restraint or seclusion was applied or utilized, and the name of the individual applying such measures shall be entered in the patient's health record.

NOTE: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72463. Special Treatment Program Service Unit—Restrictions on Applying Restraints and Utilizing Seclusion.

(a) In applying physical restraints, each of the following requirements shall be met in addition to those set forth in Section 72319:

(1) Careful consideration shall be given to the methods by which the restraints may be speedily removed in the event of fire or other emergency.

(2) Patients placed in restraint shall be observed by qualified treatment personnel at least every half hour. This observation shall be noted and initialed in the patient's health record following each observation.

(3) Each individual program plan authorizing restraint shall specify the behavior to be modified, the method to be used, the schedule for use
of the method, the person responsible for the program and the effectiveness of the modality in attaining stated objectives.

(4) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is applied. The exercise periods shall be documented in the patient's record.

(b) In utilizing seclusion each of the following requirements shall be met:

(1) Patients placed in seclusion shall be observed by qualified treatment personnel at least every half hour. This observation shall be noted and initialed in the patient's health record.

(2) Each individual program plan authorizing seclusion shall specify the behavior to be modified, the method to be used, the schedule for use of the method, the person responsible for the program and the effectiveness of the modality in attaining stated goals.

(3) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which seclusion is applied. The exercise periods shall be documented in the patient's record.

(c) Medication shall not be used as punishment, as a substitute for a program or for the convenience of staff.

NOTE: Authority cited: Sections 208 (a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72465. Special Treatment Program Service Unit—Staff.

(a) A registered nurse, licensed vocational nurse or licensed psychiatric technician shall be employed at least 40 hours a week on the day shift and be responsible for nursing supervision of the distinct part. If the facility has a total licensed capacity of 59 beds or less the director of nursing services may also be the charge nurse for the distinct part.

(b) Nursing service charge personnel on all shifts shall have at least one year of experience or training related to the special treatment program services, or shall participate in in–service provided by the facility.

(c) If the facility is devoted entirely to the care of the mentally disordered, there shall be at least one registered nurse or licensed vocational nurse on duty on all three shifts seven days per week.

(d) A licensed psychiatric technician may:

(1) Serve as a charge nurse.

(2) Administer medications only in a special treatment program.

(e) The Department may require the licensee to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional personnel is needed to provide for the health and safety of patients. Nursing service personnel shall be on duty in the number and with the qualifications, training, and supervision necessary to meet the individual care needs of patients admitted for care.

(f) Interdisciplinary Professional Staff: The facility shall provide either through direct employment or by contractual arrangement, an interdisciplinary professional staff to develop and implement special rehabilitation programs and to provide specific expertise to the program staff, and/or provide direct patient services.

(1) The interdisciplinary professional staff shall be composed of at least two of the following disciplines:

(A) Psychologist

(B) Social Worker

(C) Occupational therapist

(D) Recreation therapist

(E) Art therapist

(F) Dance therapist

(G) Music therapist

(H) Any other related discipline approved by the Department

(2) Each member of the interdisciplinary professional staff shall have a minimum of one year of experience or training in a mental health setting.

(3) In addition to general staffing requirements in Section 72329(f) a facility which provides a special treatment program shall provide interdisciplinary staff as required in Section 72329(f) in accordance with the following schedule:

(A) For facilities having an average of 49 or fewer certified patients per week, 24 hours per week of professional staff time.

(B) For facilities having an average between 50–69 certified patients per week, 32 hours per week of professional staff time.

(C) For facilities having an average between 70–99 certified patients per week, 48 hours per week of professional staff time.

(D) For facilities having an average of more than 100 certified patients per week, 72 hours per week of professional staff time.

(E) The facility shall provide at least one hour of direct program staff time for each six program hours of long–term program rehabilitation services provided. Program staff shall include all persons who directly provide program services to mentally disordered persons and shall not include the program director.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72467. Special Treatment Program Service Unit—Program Director.

(a) The facility shall have a program director who has been approved by the Department of Mental Health. The program director shall not be the director of nursing service, charge nurse or facility administrator.

(b) The program director shall have at least two years experience or training in a mental health setting, one year of which shall include experience or training in program development for mentally disordered.

(c) The program director shall ensure that the in–service education program is provided.

(d) The program director shall be one of the following:

(1) Licensed vocational nurse.

(2) Art therapist.

(3) Dance therapist.

(4) Music therapist.

(5) Occupational therapist.

(6) Physician.

(7) Licensed psychiatric technician.

(8) Licensed psychologist.

(9) Recreation therapist.

(10) Registered nurse.

(11) Social worker.

(12) Any other related discipline approved by the Department of Mental Health.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72469. Special Treatment Program Service Unit—In–Service Education.

(a) The facility shall provide to all program staff an average of at least one hour per week of ongoing, planned academic and on–the–job in–service education. The education shall include, but not be limited to the following:

(1) Specific program techniques for the mentally disordered.

(2) Setting behavioral program objectives for patients.

(3) Evaluation and assessment procedures and criteria.

(4) Noting and documenting patient progress in the program.

(b) The facility shall maintain a record of the in–service education. This record shall include the signature of staff in attendance, the number of hours, the date and the subjects covered.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72471. Special Treatment Program Service Unit—Patient Health Records and Plans for Care.

(a) The facility shall maintain an individual health record for each patient which shall include but not be limited to the following:

(1) A list of the patient's care needs, based upon an initial and continuing individual assessment with input as appropriate from the health professionals involved in the care of the patient. Initial assessments by a licensed nurse shall commence at the time of admission of the patient and shall be completed within seven days after admission.

(2) The plan for meeting behavioral objectives. The plan shall include but not be limited to the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(3) Development and implementation of an individual, written care plan based on identified patient care needs. The plan shall indicate the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. The objectives shall be measurable, with time frames, and shall be reviewed and updated at least every 90 days.

(b) There shall be a review and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(c) The patient care plan shall be approved, signed and dated by the attending physician.

(d) There shall be at least monthly progress notes in the record for each patient which shall include notes written by all members of the staff providing program services to the patient. The notes shall be specific to the needs of the patients and the program objectives and plans.

(e) At the time of reassessment there shall be a summary of the progress of the patient in the program, the appropriateness of program objectives and the success of the plan.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72473. Special Treatment Program Service Unit—Equipment.

There shall be sufficient equipment, assistive devices and supplies available to implement the treatment program ordered or indicated for meeting the physical, mental, emotional or recreational needs of patients.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 72475. Special Treatment Program Service Unit—Space.

(a) The special treatment program service shall have accommodations, including dining, recreational and program service areas to meet the needs of the program.

(b) Indoor and outdoor areas shall be designated for special treatment programs.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

Chapter 4. Intermediate Care Facilities

Article 1. Definitions

§ 73001. Activity Leader.

"Activity leader" means a person qualified by training and/or experience to develop and implement an activity program.

§ 73003. Administrator.

"Administrator" means a person licensed as a nursing home administrator by the California Board of Examiners of Nursing Home Administrators.

§ 73005. Alteration.

"Alteration" means any work other than maintenance in an existing building and which does not increase the floor or roof area or the volume of enclosed space.

§ 73007. Art Therapist.

"Art therapist" means a person who has a masters degree in art therapy or in art with emphasis in art therapy, including an approved

clinical internship from an accredited college or university; or a person who is registered or eligible for registration with the American Art Therapy Association.

§ 73009. Audiologist.

"Audiologist" means a person licensed as an audiologist by the California Board of Medical Examiners.

§ 73011. Autoclaving.

"Autoclaving" means the process of sterilization by steam under pressure.

§ 73012. Certificate of Exemption.

Certificate of Exemption means a document containing Department approval for the exemption of a specified project from Certificate of Need review.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73012.1. Certificate of Need.

Certificate of Need means a document containing Department approval for a specified project.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73012.2. Chemical Restraint.

Chemical restraint means a drug used to control behavior and used in a manner not required to treat the patient's medical symptoms.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73013. Cleaning.

"Cleaning" means the process employed to free a surface from dirt or other extraneous material.

§ 73014. Consent.

Consent means the voluntary agreement by a patient or a representative of an incapacitated patient to receive an identified treatment or procedure.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73015. Conservator.

"Conservator" means a person appointed by a court to take care of the person, the property, or both of the conservatee under Section 5350 et seq., of the Welfare and Institutions Code or under Section 1701 et seq., of the Probate Code.

§ 73017. Consultant.

"Consultant" means a qualified person who gives professional advice or service, with or without remuneration.

§ 73019. Dance Therapist.

"Dance therapist" means a person who is registered or eligible for registration as a dance therapist registered by the American Dance Therapy Association.

§ 73021. Defined.

As used in these regulations, the word defined means defined in writing.

§ 73023. Dentist.

"Dentist" means a person licensed as a dentist by the California Board of Dental Examiners.

§ 73025. Department.

"Department" means the State Department of Health Services.

NOTE: Authority cited: Sections 208, 1255, 1266, 1275, 1402 and 1426, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 1222, 1229, 1250, 1251, 1251.5, 1252, 1253–1257, 1265, 1265.5, 1265.7, 1265.8, 1266–1270, 1275–1280, 1282, 1294–1298, 1300, 1315–1318, 1400–1405, 1410–1412, 1417.1, 1418–1432, 1437, 1439, 1729, 1734, 38254 and 38255, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Specific reference: Chapter 1252, Statutes of 1977.

§ 73027. Developmentally Disabled.

"Developmentally disabled" means a person with a disability attributable to mental retardation, cerebral palsy, epilepsy or other neurologically handicapping condition found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded children. Such disability originates before an individual attains age 18, continues, or can be expected to continue, indefinitely and constitutes a substantial handicap for such individual.

§ 73029. Developmental Specialist.

"Developmental specialist" means a psychiatric technician who is trained to maximize the capabilities of the developmentally disabled in the areas of sensory–motor and cognitive development, adaptive behavior and problem–solving. The program consists of a full year's training based at a state hospital for the developmentally disabled.

§ 73031. Dietitian.

"Dietitian" means a person who is registered or eligible for registration as a registered dietitian by the American Dietetic Association.

§ 73033. Director.

Director means the Director of the State Department of Health Services.

NOTE: Authority cited: Sections 208, 1255, 1266, 1275, 1402, 1426, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 1222, 1229, 1250, 1251, 1251.5, 1252, 1253–1257, 1265, 1265.5, 1265.7, 1265.8, 1266–1270, 1275–1280, 1282, 1294–1298, 1300, 1315–1318, 1400–1405, 1410–1412, 1417.1, 1418–1432, 1437, 1439, 1729, 1734, 38254 and 38255, Health and Safety Code; Sections 7354, 14105 and 14124.5, Welfare and Institutions Code. Specific reference: Chapter 1252, Statutes of 1977.

§ 73035. Disinfection.

"Disinfection" means the process employed to destroy harmful microorganisms, but ordinarily not viruses and bacterial spores.

§ 73037. Distinct Part.

"Distinct part" means an identifiable unit accommodating beds and related facilities including but not limited to contiguous rooms, a wing, floor or building that is approved by the Department for a specific purpose.

§ 73039. Drug Administration.

"Drug administration" means the act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed properly labeled container (including a unit dose container), verifying the dose with the prescriber's orders, giving the individual dose to the proper patient and promptly recording the time and dose given.

§ 73041. Drug Dispensing.

"Drug dispensing" means the act entailing the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, packaging, labeling, and issuance of the drug or biological for a patient or for a service unit of the facility.

§ 73043. Existing Facility.

"Existing facility" means a facility currently licensed as an intermediate care facility.

§ 73045. Guardian.

"Guardian" means a person appointed by the court to take care of the person or property, or both of a ward under Section 1400 et seq., of the Probate Code.

§ 73047. Health Facility.

"Health facility" means any facility, place or building which is organized, maintained and operated for the diagnosis, care and treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which such persons are admitted for a 24–hour stay or longer.

§ 73049. Infirmary.

NOTE: Authority cited: Section 1250.1(d), Health and Safety Code. Reference: Section 1250(d), Health and Safety Code.

§ 73049.1. Informed Consent.

Informed consent means the voluntary agreement of a patient or a representative of an incapacitated patient to accept a treatment or procedure after receiving information in accordance with Sections 73523(a)(5) and 73524.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

§ 73050. Intermediate Care Bed Classification.

"Intermediate care bed classification" means beds designated for patients requiring skilled nursing and supportive care on less than a continuous basis.

NOTE: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73051. Intermediate Care Facility.

"Intermediate Care Facility" means a health facility, or a distinct part of a hospital or skilled nursing facility, which provides the following basic services: Inpatient care to patients who have need for skilled nursing supervision and need supportive care, but who do not require continuous nursing care.

§ 73053. License.

"License" means the basic document issued by the Department permitting the operation of an intermediate care facility. This document constitutes the authority to receive patients and to perform the services included within the scope of these regulations and as specified on the intermediate care facility license.

§ 73054. License Category.

(a) License category means any of the following categories:

(1) General acute care hospital.

(2) Acute psychiatric hospital.

(3) Skilled nursing facility.

(4) Intermediate care facility.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73055. Licensee.

"Licensee" means the person, persons, firm, partnership, corporation, association, political subdivision of the state, or other governmental agency to whom a license has been issued.

§ 73057. Licensed Psychiatric Technician.

"Licensed psychiatric technician" means a person licensed as a licensed psychiatric technician by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

§ 73059. Licensed Vocational Nurse.

"Licensed vocational nurse" means a person licensed as a licensed vocational nurse by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

§ 73061. Long–Term Health Care Facility.

"Long–term health care facility" means any facility licensed pursuant to Chapter 2 (commencing with Section 1250) which (1) maintains and operates 24–hour skilled nursing services for the care and treatment of chronically ill or convalescent patients, including mental, emotional or behavioral problems, mental retardation or alcoholism; or (2) provides supportive, restorative and preventive health services in conjunction with a socially oriented program to its residents and which maintains and operates 24–hour services including board, room, personal care and intermittent nursing care.

§ 73063. Maintenance.

"Maintenance" means the upkeep of a building and equipment to preserve the original functional and operational state.

§ 73064. Modernization.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73065. Music Therapist.

"Music therapist" means a person who is registered or eligible for registration as a registered music therapist by the National Association for Music Therapy.

§ 73067. New Construction.

"New construction" means any of the following:

(a) New facilities.

(b) Additions to existing buildings.

(c) Conversions of existing building or portions thereof not currently licensed as a health facility.

§ 73069. New Facility.

"New facility" means a newly constructed intermediate care facility or one that has not been previously licensed as an intermediate care facility or one that has not operated as an intermediate care facility for one year or more.

§ 73071. Nursing Unit.

"Nursing unit" means a designated patient care area of the facility which is planned, organized, operated and maintained to function as a unit. It includes patient rooms with adequate support facilities, services and personnel providing nursing care and necessary management of patients.

§ 73073. Occupational Therapist.

"Occupational therapist" means a person who is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or is eligible for registration by the American Occupational Therapy Association; or has two years of appropriate experience as an occupational therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary of the federal Department of Health, Education and Welfare.

§ 73075. Occupational Therapy Assistant.

"Occupational therapy assistant" means a person who is certified or eligible for certification by the American Occupational Therapy Association, as a certified occupational therapy assistant.

§ 73077. Patient.

(a) "Patient" means a person accommodated in an intermediate care facility who because of a physical or mental condition, or both, requires supervision and nursing care, but does not in the opinion of the attending physician have an illness, injury or disability for which continuous skilled nursing care is required.

(b) Ambulatory Patient. "Ambulatory Patient" means a patient who is capable of demonstrating the mental competence and physical ability to leave a building without assistance or supervision of any person under emergency conditions.

(c) Nonambulatory Patient. "Nonambulatory patient" means a patient who is unable to leave a building unassisted under emergency conditions. It includes, but is not limited to, those persons who depend upon mechanical aids such as crutches, walkers, or wheelchairs, profoundly or severely mentally retarded persons and shall include totally deaf persons.

§ 73078. Permanently Converted.

Permanently converted means space which is not available for patient accommodation because the facility has converted the patient accommodation space to some other use and such space could not be reconverted to patient accommodation within 24 hours.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73079. Pharmacist.

"Pharmacist" means a person licensed as a registered pharmacist by the California Board of Pharmacy.

§ 73080. Physical Restraint.

For purposes of informed consent, physical restraint means any physical or mechanical device or material, attached or adjacent to a patient's body, that the patient cannot remove easily, which has the effect of restricting the patient's freedom of movement. Physical restraint does not include the use of the least restrictive immobilization reasonably necessary to administer necessary treatment of a therapeutic, non–continuous nature, such as a single injection of antibiotics, and where the immobilization is removed upon the administration of such treatment. This exception shall not include immobilizations for continuously administered treatments such as intravenous therapy.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73081. Physical Therapist.

"Physical therapist" means a person licensed as a registered physical therapist by the California Board of Medical Examiners.

§ 73083. Physical Therapist Assistant.

"Physical therapist assistant" means a person who is approved as a physical therapist assistant by the Physical Therapy Examining Committee of the California Board of Medical Examiners.

§ 73085. Physician.

(a) "Physician" means a person licensed as a physician and surgeon by the California Board of Medical Examiners or by the California Board of Osteopathic Examiners.

(b) Attending Physician. "Attending physician" means the physician responsible for the medical treatment of the patient in the facility.

(c) Advisory Physician. "Advisory physician" means the physician who assumes responsibility for the medical guidance of the licensed facility.

(d) Psychiatrist. "Psychiatrist" means a physician who has specialized training and/or experience in psychiatry.

§ 73087. Podiatrist.

"Podiatrist" means a person licensed as a podiatrist by the California Board of Medical Examiners.

§ 73089. Psychologist.

"Psychologist" means a person licensed as a psychologist by the California Board of Medical Examiners.

§ 73090. Psychotherapeutic Drug.

Psychotherapeutic drug means a medication to control behavior or to treat thought disorder processes.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73091. Recreation Therapist.

"Recreation therapist" means a person who is certified or eligible for certification as a registered recreator with specialization in therapeutic recreation by the California Board of Park and Recreation Personnel or the National Therapeutic Recreation Society.

§ 73093. Registered Nurse.

"Registered nurse" means a person licensed as a registered nurse by the California Board of Registered Nursing.

§ 73095. Restraint.

"Restraint" means controlling a patient's physical activity in order to protect the patient or others from injury.

§ 73097. Skilled Nursing Facility.

"Skilled nursing facility" means a health facility which provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. It provides 24–hour inpatient care and, as a minimum, includes medical, nursing, dietary, pharmaceutical services and an activity program. The facility shall have effective arrangements, confirmed in writing, through which services required by the patients, but not regularly provided within the facility, can be obtained promptly when needed.

§ 73099. Social Work Aide.

"Social work aide" means a staff person with orientation, on–the–job training and supervision from a social worker or a social work assistant.

§ 73101. Social Work Assistant.

"Social work assistant" means a person with a baccalaureate degree in the social sciences or related fields and who receives supervision, consultation and in–service training from a social worker.

§ 73103. Social Worker.

"Social worker" means a person who is a graduate of a school of social work accredited or approved by the Council on Social Work Education and has one year of social work experience in a health care setting or is licensed as a clinical social worker by the Board of Behavioral Science Examiners.

§ 73105. Special Disability Professional.

"Special disability professional" means a physician, a psychiatrist, a clinical psychologist, a social worker, a special education teacher, or a person with an academic degree in learning disabilities, who has at least one year experience or training in the care of the mentally disordered, developmentally disabled or substance abusers.

§ 73107. Special Disability Worker.

"Special disability worker" means a person, who through experience, vocational training, formal education or licensure has developed expertise in special disability work. They may function under different job titles such as but not limited to: social worker, psychiatric technician, recreation therapist, occupational therapy aide, program therapist or an activity therapist.

§ 73109. Speech Pathologist.

"Speech pathologist" means a person licensed as a speech pathologist by the California Board of Medical Examiners.

§ 73111. Sterilization.

"Sterilization" means the process employed to destroy all living organisms.

§ 73113. Supervision.

(a) "Supervision" means to instruct an employee or subordinate in

his duties and to oversee or direct his work, but does not necessarily require the immediate presence of the supervisor.

(b) Direct Supervision. "Direct supervision" means that the supervisor shall be present in the same building as the person being supervised and available for consultation and/or assistance.

(c) Immediate Supervision. "Immediate supervision" means that the supervisor shall be physically present while a task is being performed.

§ 73115. Unit Dose Medication System.

"Unit dose medication system" means a system in which single dosage units of drugs are prepackaged and prelabeled in accordance with all applicable laws and regulations governing these practices and are made available separated by patient and by dosage time. The system shall also comprise, but not be limited to, all equipment and appropriate records deemed necessary and used in making the dose available to the patient in an accurate and safe manner. A pharmacist shall be in charge and responsible for the system.

Article 2. License

§ 73201. License Required.

(a) No person, firm, partnership, association, corporation, political subdivision of the State or other governmental agency within the State, shall operate, establish, manage, conduct or maintain an intermediate care facility in this State or claim to operate an intermediate care facility, without first obtaining a license from the Department.

(b) The provisions of this article do not apply to the following institutions:

(1) Any facility conducted by and for the adherents of any well–recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.

(2) Hotels or other similar places that furnish only board and room, or either, to their guests.

(3) Any house or institutions supplying board and room only, or room only, or board only; provided, that no resident thereof requires any element of medical care as determined by the Department.

§ 73203. Application Required.

(a) A verified application shall be submitted to the Department whenever any of the following circumstances occur:

(1) Construction of a new or replacement facility.

(2) Increase or decrease of licensed bed capacity.

(3) Addition of or deletion of any optional service units listed in Section 73445 (b).

(4) Change of ownership.

(5) Change of name of facility category.

(6) Change of license category.

(7) Change of location of facility.

(8) Change of bed classification.

(9) If a person wishes to acquire a beneficial interest of 10 percent or more in any corporation or partnership licensed to operate an intermediate care facility, or to become an officer or director of, or general partner in, such a corporation or partnership, such a person shall obtain prior written approval of the Department. Each application for approval shall include the information specified in Section 73205 (a) (8) as regards the person for whom the application is made.

(A) The provisions of this subsection shall not apply to any institution or person exempted by Section 1267.5 (f) or 1267.5(h) of the Health and Safety Code.

(B) If the Department fails to approve or disapprove such an application for approval within 30 days after receipt thereof, the application shall be deemed approved.

NOTE: Authority cited: Sections 208 and 1275, Health and Safety Code. Reference: Section 1267.5, Health and Safety Code.

§ 73205. Content of Application.

(a) Any person, firm, partnership, association, corporation, political subdivision of the State or other governmental agency, desiring to obtain a license shall file with the Department an application on forms furnished by the Department. The application shall contain the following:

(1) Name of applicant and, if an individual, verification that the applicant has attained the age of 18 years.

(2) Type of facility to be operated and types of services for which approval is requested.

(3) The location of the intermediate care facility.

(4) Name and license number of the administrator in charge of the intermediate care facility.

(5) If the applicant is an individual, satisfactory evidence that the applicant and the person in charge of the intermediate care facility for which application for license is made are of reputable and responsible character.

(6) If applicant is a firm, association, organization, partnership, business trust, corporation or company, satisfactory evidence that the members or shareholders holding five percent or more stock, officers, any member having responsibility in the operation of the facility and the person in charge of the intermediate care facility for which application for license is made are of reputable and responsible character.

(7) If the applicant is a political subdivision of the State or other government agency, satisfactory evidence that the person in charge of the intermediate care facility, for which application for license is made, is of reputable and responsible character.

(8) The name, title, principal business address and the percentage of ownership interest of all officers, directors and stockholders having a beneficial interest of 10 percent or more in the applicant corporation or partnership. If any such person has served or currently serves as an administrator, general partner, or corporate officer or director of, or has held a beneficial ownership interest of 10 percent or more in any other skilled nursing facility or intermediate care facility, or in any community care facility licensed pursuant to Community Care Facility Act, Chapter 3 (commencing with Section 1500) of the Health and Safety Code, the applicant shall disclose to the Department the person's relationship to the facility, including the name and current or last address of the health facility or community care facility and the date such relationship commenced, and if applicable, the date it was terminated. Each such person shall also disclose whether he or she was an officer, director, general partner or owner of a 10 percent or greater interest in a licensee of a skilled nursing facility, intermediate care facility or community care facility at a time when one or more violations of law were committed therein which resulted in suspension or revocation of its license.

(A) The provisions of Section 73205 (a) (8) shall not apply to the directors of a nonprofit corporation, which is exempt from taxation under Section 23701 (d) of the Revenue and Taxation Code, and which operates an intermediate care facility in conjunction with a licensed residential facility, where such directors serve without financial compensation and are not compensated by the nonprofit corporation in any other capacity. For purposes of this Section, a person owning a 10 percent or greater beneficial interest in, or holding any compensated position in any corporation, partnership, association, or trust which is compensated by the nonprofit corporation in any capacity relating to the facility shall be deemed to be compensated by the nonprofit corporation.

(B) The provisions of Section 73205 (a) (8) shall not apply to a bank, trust company, financial institutions, title insurer, controlled escrow company or underwritten title company to which a license is issued in a fiduciary capacity.

(9) Copy of the current organizational chart.

(10) Certificate of Need or a Certificate of Exemption from the Department if required by Chapter 1, Division 7 of this title.

(11) Such other information or documents (such as fingerprint cards and qualification information forms) as may be required by the Department for the proper administration and enforcement of the licensing statutes and regulations.

NOTE: Authority cited: Sections 208 and 1275, Health and Safety Code. Reference: Section 1267.5, Health and Safety Code.

§ 73207. Architectural Plans.

Applications submitted for proposed construction of new facilities, remodeling or additions to facilities shall include architectural plans and specifications. Information contained in such applications shall be on file in the Department and available to interested individuals and community agencies.

§ 73208. Fee.

(a) Each application for a license shall be accompanied by the following prescribed fee.

(1) The annual fee for a license to operate an intermediate care facility, the term for which commences at any time during the calendar year 1975, when the application is filed upon a change of ownership, change of location, renewal of license or a new license, shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–49 inclusive	$ 800.00 plus $10.00 per licensed bed.
50–99 inclusive	$1,000.00 plus $10.00 per licensed bed.
100 and over	$1,300.00 plus $10.00 per licensed bed.

(2) No fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department.

(3) An additional fee of $25.00 shall be paid for processing any change of name. However, no additional fee shall be charged for any change of name which is processed upon a renewal application or upon application filed because of a change of ownership.

(b) Application fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the total number of months. (Example: 18 months divided by 12 equal 1.5 times the application fee specified in the fee schedule.)

(c) Provisional license fee credit. Applications for provisional licenses (for six–month periods) shall be subject to the full amount of the fee specified in the fee schedule. If upon the expiration of the provisional license a second provisional (six–month period) license is to be issued, the licensee shall receive credit for the unused portion of the fee collected and no additional fee will be required of the licensee.

If a regular license is issued upon the expiration of the first provisional license, the unused portion of the fee collected for the provisional license shall be credited against the annual fee required for the regular license. If neither a second provisional nor a regular license is to be issued to the applicant, there will be no refund of any portion of the fee paid for the provisional license.

(d) Fees shall be waived for any facility conducted, maintained or operated by this state or any state department, authority, bureau, commission or officer, or by the Regents of the University of California or by a local hospital district, city or county.

NOTE: Authority cited: Sections 208 (a), 1266, Health and Safety Code. Reference: Section 1266, Health and Safety Code.

§ 73209. Fee.

(a) Each application for a license shall be accompanied by the prescribed fee. The license fee under this section shall be effective January 1, 1979.

(1) The fee for a license to operate an intermediate care facility which is being licensed for the first time or upon a change of ownership or change of location or renewal of license shall be that specified in the following schedule:

Capacity Requested	*Fee*
1–59 inclusive	$ 948.00 plus $13.00 per licensed bed
60–99 inclusive	$1,186.00 plus $13.00 per licensed bed
100 and over	$1,540.00 plus $13.00 per licensed bed

(2) No fee shall be refunded to the applicant if the application is withdrawn or if the application is denied by the Department.

(b) Application fees for licenses which cover periods in excess of 12 months shall be prorated on the basis of the total number of months to be licensed divided by 12 months. (Example: 18 months divided by 12 equals 1.5 times the application fee specified in the fee schedule.)

(c) Provisional License Fee Credit. Applications for provisional licenses (for six–month periods) shall be subject to the full amount of the fee specified in the fee schedule. If upon the expiration of the provisional license a second provisional (six–month period) license is to be issued, the licensee shall receive credit for the unused portion of the fee collected and no additional fee will be required of the licensee.

If a regular license is issued upon the expiration of the first provisional license, the unused portion of the fee collected for the provisional license shall be credited against the annual fee required for the regular license. If neither a second provisional nor a regular license is to be issued to the applicant, there will be no refund of any portion of the fee paid for the provisional license.

(d) Fees shall be waived for any facility conducted, maintained or operated by this State or any state department, authority, bureau, commission or officer or by the Regents of the University of California or by a local hospital district, city or county.

NOTE: Authority cited: Sections 1275, and 1729, Health and Safety Code. Reference: Sections 1266, and 1729, Health and Safety Code.

§ 73211. Projects Requiring a Certificate of Need.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73211.1. Projects Eligible for a Certificate of Exemption.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73211.2. Projects Not Subject to Review by a Voluntary Area Health Planning Agency.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73211.3. Projects Previously Decided by a Voluntary Area Health Planning Agency.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73211.4. Exemption Requests for Remodeling and Replacement Projects.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73213. Safety, Zoning and Building Clearance.

(a) Architectural plans shall not be approved and a license shall not be originally issued to any intermediate care facility which does not conform to these requirements or other state requirements on seismic safety, fire and life safety, and environmental impact, and to local fire safety, zoning and building ordinances, evidence of which shall be presented in writing to the Department.

(b) It shall be the responsibility of the licensee to maintain the intermediate care facility in a safe structural condition. If the Department determines in a written report submitted to the licensee that an evaluation of the structural condition of an intermediate care facility building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall establish a basis

for eliminating or correcting the structural conditions which may be hazardous to occupants.

(c) The facility shall meet the seismic safety requirements, if any, prescribed by Section 15001 of the Health and Safety Code.

§ 73214. Bed Classification.

(a) Each facility shall notify the Department on forms supplied by the Department of bed classifications as defined in Section 73050 within 30 days of the effective date of this section. For facilities not reporting within the 30–day period, the Department will classify the beds based on the latest information in the Department files.

(b) After the above notification has been received by the Department or the Department has classified the beds, no further reclassification of beds shall take place until on or after January 1, 1977.

NOTE: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

§ 73215. Issuance, Expiration and Renewal.

(a) Upon verification of compliance with the licensing requirements the Department shall issue the license to the applicant.

(b) If the applicant is not in compliance with the laws or regulations, the Department shall deny the applicant a license. Immediately upon the denial of any application for a license, the Department shall notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written notice of appeal for a hearing to the Department. Upon receipt by the Department of the appeal in proper form, such appeal shall be set for hearing. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code.

(c) The Department may deny the application of any prospective licensee if the applicant or any of the general partners, directors, officers or persons having a beneficial ownership interest of 10 percent or more in the facility, has failed to comply with the reporting requirements or to obtain approvals required in Health and Safety Code Section 1267.5 (a) and (b).

(d) The Department may deny the application of any prospective licensee if any of the general partners, directors, officers or persons having a beneficial ownership interest of 10 percent or more in the facility, was an officer, director, general partner or owner of a 10 percent or more beneficial interest in a skilled nursing facility, intermediate care facility or community care facility at a time when one or more violations of law were committed therein which resulted in suspension or revocation of its license. However, such prior suspension or revocation of a license shall not be grounds for denial of the application if the applicant shows to the satisfaction of the Department that the person in question took every reasonably available action to prevent the violation or violations which resulted in the disciplinary action and that he or she took every reasonably available action to correct such violation or violations once he or she knew, or with the exercise of reasonable diligence should have known, of the violation or violations.

(e) No application shall be denied pursuant to subsection (d) until the Department provides the applicant with notice in writing of grounds for the proposed denial of application, and affords the applicant an opportunity to submit additional documentary evidence within 30 days in opposition to the proposed denial.

(f) The Department shall immediately notify, in writing, the applicant for a license if a license has been denied under Section 73215 (b), (c) or (d). If the applicant wishes to appeal the denial, the applicant must present a written notice of appeal for a hearing to the Department within 20 days of receipt of the denial notice. Upon receipt by the Department of the petition in proper form, such petition shall be set for hearing. Hearing procedures shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code.

(g) Each initial license shall expire at midnight, one year from the date of issuance. A renewal license:

(1) May be issued for a period not to exceed two years if the holder of the license has been found in substantial compliance with statutory requirements, regulations or standards during the preceding license period.

(2) Shall reflect the number of beds that meet constructional and operational requirements and shall not include beds formerly located in patient accommodation space which has been permanently converted.

(3) Shall not be issued if the intermediate care facility is liable for and has not paid the special fees required by Section 90417, Chapter 1, Division 7, of this Title.

(h) At least 45 days prior to expiration of a license, the Department shall mail an application for renewal of license form to each licensee. Application for renewal accompanied by the necessary fees shall be filed with the Department not less than 30 days prior to the expiration date. Failure to make a timely renewal shall result in expiration of the license.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, 1268, and 1275, Health and Safety Code. Reference: Chapter 854, Statutes of 1976 and Section 1267.5, Health and Safety Code.

§ 73217. Provisional License.

(a) The Department may issue a provisional license for the operation of an intermediate care facility not previously licensed as an intermediate care facility pursuant to Chapter 2, commencing with Section 1250, of the Health and Safety Code, or to any applicant for an intermediate care facility license upon a change of ownership of an existing facility, if that applicant has not previously held an intermediate care facility license pursuant to Chapter 2, commencing with Section 1250, of the Health and Safety Code.

(b) A provisional license issued pursuant to Section 73217 (a) shall terminate six months from the date of issuance. Within 30 days prior to the termination of a provisional license issued pursuant to Section 73217 (a), the Department shall give such facility a full and complete inspection, and if the facility meets all applicable requirements for licensure, a regular license shall be issued. If the facility does not meet the requirements for licensure but has made substantial progress toward meeting such requirements as determined by the Department, the initial provisional license shall be renewed for six months. If the Department determines that there has not been substantial progress toward meeting licensure requirements at the time of the first full inspection provided by this Section, or if the Department determines upon its inspection made within 30 days of the termination of a renewed provisional license that there is lack of full compliance with such requirements, no further license shall be issued.

(c) The Department may issue a provisional license upon a change of ownership of an intermediate care facility to an applicant who has previously held an intermediate care facility license pursuant to Chapter 2, commencing with Section 1250, of the Health and Safety Code if the initial relicensure inspection reveals the following:

(1) The facility and the applicant for licensure are in substantial compliance with licensing requirements.

(2) No violation of such laws or regulations exists in the facility which jeopardizes the health or safety of patients.

(3) The applicant has adopted a plan for correction of any existing violation which is satisfactory to the Department.

(d) A provisional license issued under Section 73217 (c) shall terminate six months after the date of issuance, or at such earlier time as determined by the Department at the time of issuance. Within 30 days of the termination of the provisional license issued pursuant to Section 73217 (c), the Department shall give such facility a full and complete inspection, and if the facility meets all the requirements for licensure, a regular license shall be issued. A provisional license issued under Section 73217 (c) may not be renewed.

(e) If an applicant for a provisional license, pursuant to Section

73217 (a) and (b), or (c) and (d) has been denied provisional licensing by the Department, that applicant may contest such denial by filing a notice of appeal. The proceedings to review such denial shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2, of the Government Code.

NOTE: Authority cited: Section 208 (a), Health and Safety Code. Reference: Section 1268.5, Health and Safety Code.

§ 73219. Separate Licenses.

Separate licenses shall be required for intermediate care facilities which are maintained on separate premises even though they are under the same management. Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds.

§ 73221. Posting.

The license or a true copy thereof shall be conspicuously posted in a prominent location accessible to public view.

§ 73223. Transferability.

Licenses are not transferable. The licensee shall notify the Department in writing prior to any change of ownership and an application for license shall be submitted by the new owner.

§ 73225. Report of Changes.

(a) The licensee shall notify the Department within 10 days in writing any time a change of stockholder owning 10 percent or more of the nonpublic corporate stock occurs. Such writing shall include the name and principal mailing addresses of the new stockholder(s).

(b) When a change of administrator occurs, the Department shall be notified within 10 days in writing by the licensee. Such writing shall include the name and license number of the new administrator.

(c) Each licensee shall notify the Department within 10 days in writing of any change of the mailing address of the licensee. Such writing shall include the new mailing address of the licensee.

(d) When a change in the principal officer of a corporate licensee (chairman, president or general manager) occurs, the Department shall be notified within 10 days in writing by the licensee. Such writing shall include the name and principal business address of such officer.

§ 73227. Program Flexibility.

(a) All intermediate care facilities shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualification or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this section, or a true copy thereof, shall be posted immediately adjacent to the facility's license that is required to be posted by Section 73221.

§ 73229. Voluntary Suspension of License, Service or Licensed Beds.

(a) Upon written request a licensee may request that a license, service or beds be put in suspense. The Department may approve the request for a period not to exceed 12 months.

(b) Any license or portion thereof which has been temporarily suspended by the Department pursuant to this section shall remain subject to all renewal requirements of an active license, including the payment of license renewal fees, during the period of temporary suspension.

(c) Any license suspended pursuant to this section may be reinstated by the Department within 12 months of the date of suspension, upon receipt of an application and evidence showing compliance with licensing operational requirements in effect at the time of reinstatement. If license is not reinstated within the 12–month period, the license shall expire automatically and shall not be subject to reinstatement.

§ 73231. Voluntary Cancellation of License.

(a) Any licensee desiring to voluntarily surrender his license for cancellation shall notify the Department in writing as soon as possible and in all cases at least 30 days prior to the effective date of cancellation of the license.

(b) Any license voluntarily cancelled pursuant to this section may be reinstated by the Department within 12 months of date of cancellation on receipt of an application and evidence showing compliance with licensing operational requirements.

§ 73233. Revocation or Involuntary Suspension of License.

(a) Pursuant to proceedings conducted under the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, the Department may suspend or revoke the license of any facility upon any of the following grounds:

(1) Violation by the licensee of any of the provisions of Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code or of any of the regulations promulgated by the Department contained in this chapter.

(2) Failure of a licensee or any of the general partners, directors, officers or persons having a beneficial ownership interest of 10 percent or more in the licensed facility, to comply with the reporting requirements or to obtain approvals required in Health and Safety Code Section 1267.5 (a) and (b) and Section 73205 (a) (8) of Division 5 of Title 22 of the California Administrative Code, except that this subsection shall not apply to the directors of a nonprofit corporation as described in Section 1267.5 (h) of the Health and Safety Code, or to a bank or other institution exempted under Section 1267.5 (f) of the Health and Safety Code.

(3) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code or of any of the regulations promulgated by the Department contained in this chapter.

(4) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises for which a license is issued.

(b) The license of any intermediate care facility against which special fees are required by Section 90417, Chapter 1, Division 7, of this Title shall be revoked, after notice of hearing, if it is determined by the Department that the fees required were not paid within the time prescribed.

NOTE: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, 1268, and 1275, Health and Safety Code. Reference: Chapter 854, Statutes of 1976 and Section 1267.5, Health and Safety Code.

§ 73235. Temporary Suspension of License.

(a) The Director may temporarily suspend any license prior to any hearing, when in his or her opinion such action is necessary to protect the public welfare, in the following manner:

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licen-see with an accusation.

(2) Upon receipt of a notice of defense by the licensee, the Director shall set the matter for hearing within 15 days. The hearing shall be held as soon as possible but no later than 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination on the merits.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code or regulations promulgated by the Director are violated by a licensee which is a

group, corporation or other association, the Director may suspend the licensee of such organization or may suspend the license as to any individual person within such organization who is responsible for such violation.

NOTE: Authority cited: Section 208(a), Health and Safety Code. Reference: Section 1296, Health and Safety Code.

§ 73237. Pursuing Disciplinary Action to Completion.

(a) The withdrawal of an application for a license after it has been filed with the Department shall not, unless the Department consents in writing to such withdrawal, deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

(b) The suspension, expiration or forfeiture by operation of law of a license issued by the Department, or its suspension, forfeiture or cancellation by order of the Department or by order of a court of law, or its surrender without the written consent of the Department, shall not deprive the Department of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

§ 73239. Reinstatement of Revoked or Suspended License.

A person whose license has been revoked or suspended may petition the Department for reinstatement or reduction of the disciplinary action imposed after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

§ 73240. Conviction of Crime: Standards for Evaluating Rehabilitation.

When considering the denial, suspension or revocation of a license based on the conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating rehabilitation:

(1) The nature and the seriousness of the crime(s) under consideration.

(2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(3) The time which has elapsed since commission of the crime(s) or conduct referred to in subdivision (1) or (2).

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanction lawfully imposed against the applicant.

(5) Any rehabilitation evidence submitted by the applicant.

NOTE: Authority cited: Sections 208(a), 1265.2 and 1275, Health and Safety Code. Reference: Sections 1265.1, 1265.2 and 1294, Health and Safety Code.

§ 73241. Bonds.

(a) Each licensee shall file or have on file with the Department a bond issued by a surety company authorized to do business in California if the licensee is handling or will handle money in the amount of $25 or more per patient or $500 or more for all patients in any month. The amount of the bond shall be according to the following schedule:

(1) *Amount Handled*	*Bond Required*
$750 or less.	$1,000
$751 to $1,500.	$2,000
$1,501 to $2,500	$3,000

(2) Every further increments of $1,000 or fraction thereof shall require an additional $1,000 on the bond.

(b) Each application for an original license or renewal of license shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles or will handle money of patients and the maximum amount of money to be handled for:

(1) Any patient.

(2) All patients in any month.

(c) No licensee shall either handle money of a patient or handle amounts greater than those stated in the affidavit submitted by him without first notifying the Department and filing a new or revised bond if requested.

Article 3. Services

§ 73301. Required Services.

(a) Intermediate care facilities shall provide as a minimum, but shall not be limited to, the following required services: Physician, intermittent nursing, dietary, pharmaceutical and an activity program.

(b) Intermediate care facilities caring for patients who are mentally disordered, developmentally disabled or substance abusers and who have identified program needs as described in Section 73391 shall meet also the requirements for a special disability service.

(c) Intermediate care facilities caring for day care patients shall meet all the requirements for inpatients and shall not exceed their licensed bed capacity.

(d) Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist or clinical psychologist subject to the scope of licensure and the policies of the facility. If the service cannot be brought into the facility, the facility shall assist the patient, if necessary, in arranging for transportation to and from the service location.

(e) Provision shall be made for dental examinations and dental treatments by a dentist as indicated by the needs of the patient.

(f) Arrangements shall be made for one or more physicians to be called in an emergency.

§ 73303. Physician Services—General.

(a) Physician services are services provided by physicians responsible for the care of individual patients in the facility. All persons admitted or accepted for care by the intermediate care facility shall be under the care of a physician. Physician services shall include but are not limited to:

(1) Patient examinations.

(2) Patient diagnosis.

(3) Advice, treatment and treatment plan, and determination of appropriate level of patient care needed for each patient.

(4) Written and signed orders for care, diagnostic tests and treatment of patients by others. Orders for restraints must specify the duration and circumstances under which the restraints are to be used and must comply with the following:

(A) Orders must be specific to individual patients.

(B) In accordance with Section 73355 there shall be no standing orders.

(C) There shall be no P.R.N. orders for physical restraints.

(5) Health record progress notes and other appropriate entries in the patient's health records.

(6) Periodic reevaluation of the patient's condition and the review and updating of treatment orders and care program at least every 60 days unless otherwise approved by the Department.

(7) Provision of emergency medical services in the facility when indicated.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code; and *Valdivia, et al. v. Coye*, U.S. District Court for the Eastern District of California, Case No. CIV S–90–1226.

§ 73305. Physician Services—Policies and Procedures.

There shall be available to attending physicians a list of the services provided in or available through the facility and a listing of the types of patients who may be admitted for care. Information pertinent to the orientation of new physicians to the facility or changes in services or policy shall be made available by the facility. Patient care policies, manuals or other patient care instruction or reference materials shall

be available for review or reference by individual physicians when requested or indicated.

§ 73307. Physician Services—Equipment and Supplies.

Equipment for physical examinations and emergency treatment of patients shall be available in the facility and shall include at least:

stethoscope
sphygmomanometer
flashlight
gloves (sterile and unsterile)
tongue depressors
examination spotlight
suction apparatus
emergency oxygen supply and equipment for administration
scales for weighing patients
vaginal speculum
rectal speculum
appropriate record forms
sterile dressing
suture tray
suture removal equipment
airway

§ 73309. Nursing Service—Defined.

"Nursing service" means a service organized, staffed and equipped to provide nursing care to patients.

§ 73311. Nursing Service—General.

Nursing service shall include, but not be limited to, the following:

(a) Identification of problems and development of an individual plan of care for each patient based upon initial and continuing assessment of the patient's needs by the nursing staff and other health care professionals. The plan shall be reviewed and revised as needed but not less often than quarterly.

(b) Notification of the attending physician immediately of any patient exhibiting unusual signs or behavior.

(c) Ensuring that patients are served the diets as prescribed by attending physicians, and that patients are provided with the necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed.

(d) Any marked or sudden change in weight shall be reported promptly to the attending physician.

§ 73313. Nursing Service—Drug Administration.

Nursing service shall include but not be limited to the following, with respect to the administration of drugs:

(a) Medications and treatments shall be administered as prescribed and shall be recorded in patient's health records.

(b) Preparation of doses for more than one scheduled administration time shall not be permitted.

(c) Medications shall only be administered by personnel who have completed a state–approved training program in medication administration.

(d) Medications shall be administered as soon as possible after doses are prepared and shall be administered by the same person who prepared the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(e) Patients shall be identified prior to administration of a drug.

(f) The time and dose of drug administered to the patient shall be properly recorded in each patient's medication record by the person who administered the drug.

(g) No medication or treatment shall be given except on the order of a person lawfully authorized to give such order.

(h) Telephone orders shall be received only by a licensed nurse or pharmacist and shall be recorded immediately in the patient's health record and shall be signed by the prescriber within 48 hours.

(i) Medications brought by or with the patient to the facility shall not be used unless all of the conditions specified in Section 73363 are met.

(j) A registered nurse or a pharmacist shall review each patient's medications monthly and if appropriate, request a review from the patient's attending physician.

§ 73315. Nursing Service—Patient Care.

(a) No patient shall be admitted or accepted for care by an intermediate care facility except upon the order of a physician.

(b) Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.

(c) Each patient, upon admission, shall be given proper orientation to the intermediate care facility and the facility's services and staff.

(d) Each patient shall show evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails and shall be free of offensive odors.

(e) Each patient shall be encouraged and/or assisted to achieve and maintain his highest level of self–care and independence. Every effort shall be made to keep patients active except when contraindicated by physician's orders.

(f) Such supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided.

(g) Treatment for minor illness or routine treatments for minor disorders when ordered by the physician shall be administered by nursing personnel.

(h) Bedside nursing care may be provided on a temporary basis when the attending physician determines the illness to be temporary and minor.

(i) When a patient requires services which are not considered to be intermediate care services, the physician shall be notified and arrangements made to transfer the patient from the intermediate care facility.

§ 73317. Nursing Service—Policies and Procedures.

(a) Written policies and procedures developed by the supervisor of health services and approved by the Patient Care Policy Committee shall be available to all nursing personnel. Such policies and procedures shall include:

(1) An organization chart of the nursing service showing staff positions, lines of authority and communication.

(2) Specific instruction on the preparation, review and updating of individual patient care plans.

(3) Orientation procedures and programs for new employees.

(4) An ongoing education program planned and conducted for the development and improvement of skills of all facility's personnel including training related to problems and needs of the aged, ill and disabled.

(5) A current nursing procedure manual.

§ 73318. Nursing Service—Nurse Assistant Training and Certification.

NOTE: Authority cited: Section 1137.7, Health and Safety Code. Reference: Chapter 351/1978 (AB 2567).

§ 73319. Nursing Service—Staff.

(a) Nursing service personnel shall be employed in the number and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care. The Department may require a facility to provide additional staff whenever the Department determines through a written evaluation of patients and patient care in the facility that such additional staff are needed to provide adequate nursing care and treatment or to provide for the safety of the patients.

(b) Facilities shall employ a registered nurse or licensed vocational nurse eight hours per day on the day shift, seven days per week. In case of facilities where a licensed vocational nurse serves as supervisor of health services, consultation shall be provided by a registered nurse, through formal contract, at regular intervals, but not less than four hours weekly.

(c) Facilities with 100 or more beds shall employ a registered nurse eight hours per day, on the day shift, seven days per week. In addition,

a registered nurse or licensed vocational nurse employed four hours per day, seven days per week, during the day for each 50 beds or portion thereof in excess of 100.

(d) Nursing stations shall be staffed by nursing personnel day and night when patients are housed in the nursing unit.

(e) Each facility shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(1) Facilities which provide care for mentally disordered or developmentally disabled patients and in which licensed psychiatric technicians provide patient care shall meet the following standards:

(A) If patients are not certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(B) For patients certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 0.7 nursing hour per patient day for each patient certified to the special treatment program, exclusive of additional staff required to meet the staffing standards of the special treatment program.

NOTE: Authority cited: Sections 208(a), 1275 and 1276.5, Health and Safety Code. Reference: Sections 1276 and 1276.5, Health and Safety Code; and Section 14110.7(c), Welfare and Institutions Code.

§ 73321. Nursing Service—Equipment and Supplies.

(a) Equipment and supplies of the quality and in the quantity necessary for care to patients, as ordered or indicated, shall be provided and shall include but not be limited to:

(1) Water pitchers, emesis basins, denture cups, ice caps, urinals, bedpans, thermometers, stethoscope, sphygmomanometer, ear syringe, hypodermic syringes and needles and scales for weighing patients.

(2) A sufficient supply of wheelchairs and walkers to meet the intermittent needs of patients and maintained in clean and operable condition.

(3) Supplies necessary to perform urine sugar and acetone testing.

(4) Current and authoritative nursing reference material.

(5) First aid equipment and supplies, as determined by the patient care policy committee, readily available at all times.

§ 73347. Pharmaceutical Service—General.

(a) Arrangements shall be made to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) If a pharmacy is located on the premises, the pharmacy shall be licensed by the California State Board of Pharmacy and approved by the Department. The pharmacy shall not serve the general public unless a separate public entrance or a separate public serving window is utilized. Pharmacies located on the licensed premises of intermediate care facilities shall be opened for inspection upon the request of an authorized Department representative.

§ 73349. Pharmaceutical Service Requirements.

(a) Pharmaceutical service shall include, but not be limited to, the following:

(1) Obtaining necessary drugs on a prompt and timely basis, including the availability of 24–hour emergency prescription service.

(2) Preparation for administration of drugs and biologicals.

(3) Monitoring the drug distribution system which includes ordering, dispensing and administration of medications.

(4) Provision of consultative and other services furnished by pharmacists which assist in the development, coordination, supervision and review of the pharmaceutical services within the facility.

§ 73351. Pharmaceutical Service—Policies and Procedures.

There shall be written policies and procedures for safe and effective distribution, control, use and disposition of drugs developed by the patient care policy committee. The committee shall monitor implementation of the policies and procedures and make recommendations for improvement.

§ 73353. Pharmaceutical Service—Orders for Drugs.

No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness. All such orders shall be in writing and signed by the person giving the order. The name, quantity or duration of therapy, dosage and time of administration of the drug, the route of administration if other than oral and the site of injection when indicated shall be specified. Telephone orders may be given only to a licensed pharmacist or licensed nurse and shall be immediately recorded in the patient's health record and shall be signed by the prescriber within 48 hours. The signing of orders shall be by signature or a personal computer key.

§ 73355. Pharmaceutical Service—Standing Orders.

No facility shall use any standing order for medications or treatments.

§ 73357. Pharmaceutical Service—Stop Orders.

Written policies shall be established limiting the duration of drug therapy, in the absence of a prescriber's specific indication of duration of therapy. The prescriber shall be contacted for new orders prior to the termination time established by the policy.

§ 73359. Pharmaceutical Service—Drug Order Processing.

Written orders for drugs shall be transmitted to the issuing pharmacy as directly as possible, either by written prescription of the prescriber by an order form which produces a direct copy of the order or by an electronically reproduced facsimile.

§ 73361. Pharmaceutical Service—Drug Order Records.

Facilities shall maintain a record which includes, for each drug ordered by prescription, the drug name, strength and quantity, the name of the patient, the date ordered, the date received and the name of the issuing pharmacy. The records shall be kept at least one year.

§ 73363. Pharmaceutical Service—Personal Medications.

(a) Medications brought by or with the patient to the facility shall not be used, unless all of the following conditions are met:

(1) The drugs have been ordered by the patient's physician and the order entered in the patient's health record.

(2) The medication containers are clearly and properly labeled.

(3) The contents of the containers have been examined and positively identified after admission by the patient's physician or a pharmacist retained by the facility.

§ 73365. Pharmaceutical Service—Labeling and Storage of Drugs.

(a) Containers which are cracked, soiled or without secure closures shall not be used. Drug labels shall be legible.

(b) All drugs obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing. No person other than the pharmacist shall alter any prescription label.

(c) Nonlegend drugs shall be labeled in conformance with state and federal food and drug laws.

(d) Test reagents, germicides, disinfectants and other household substances shall be stored separately from drugs.

(e) External use drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use.

(f) Drugs shall be stored at appropriate temperatures. Drugs required to be stored at room temperature shall be stored at a temperature between 15ºC (59ºF) and 30ºC (86ºF). Drugs requiring refrigeration shall be stored in a refrigerator between 2ºC (36ºF) and 8ºC (46ºF). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed properly labeled container, clearly labeled "drugs."

(g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.

(h) Dose preparation and administration areas shall be well lighted. If medication carts are used, a light shall be available on the cart.

(i) Drugs shall be accessible only to licensed nursing personnel.

(j) Bedside storage of medications shall be limited to sublingual or inhalation forms of emergency drugs.

(k) All bedside storage of medications shall be specifically ordered by the physician.

(*l*) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

(m) The drugs of each patient shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

(n) Discontinued drug containers shall be marked to indicate that the drug has been discontinued. Discontinued drugs shall be disposed of within 90 days of the date the drug order was discontinued, unless the drug is reordered within that time.

§ 73367. Pharmaceutical Service—Controlled Drugs.

(a) Drugs listed in Schedules II, III and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the facility. The supervisor of health services shall be designated by the licensee to be responsible for the control of such drugs. Drugs listed in Schedule II of the above Act shall be stored in a locked cabinet or a locked drawer separate from noncontrolled drugs.

(b) Separate records of use shall be maintained on all Schedule II drugs. Such records shall be maintained accurately and shall include the name of the patient and the prescriber, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug. Such records shall be reconciled at least daily and shall be retained at least one year. If such drugs are supplied on a scheduled basis as part of a unit dose medication system, such records need not be separate from patient medication records.

(c) Drug records shall be maintained for drugs listed in Schedules III and IV of the above Act in such a way that the receipt and disposition of any such drug may be readily traced. Such records need not be separate from other medication records.

§ 73369. Pharmaceutical Service—Disposal of Drugs.

(a) Drugs may be sent with the patient upon discharge if so ordered by the discharging physician. Such drugs shall be dispensed in compliance with the California Pharmacy Laws and Regulations. A record of the drugs sent with the patient shall be made in the patient's health record.

(b) Discontinued individual patient's drugs supplied by prescription or those which remain in the facility after discharge shall be destroyed by the facility in the following manner:

(1) Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the facility in the presence of a pharmacist and a registered nurse employed by the facility. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(2) Drugs not listed under Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the facility in the presence of a pharmacist or registered nurse. The name of the patient, the name and strength of the drug, the prescription number, if applicable, the amount destroyed, the date of destruction and the signatures of two witnesses shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(c) Unless otherwise prohibited under applicable federal or state laws, individual patient drugs supplied in sealed containers may be returned, if unopened, to the issuing pharmacy for disposition provided that:

(1) No drugs covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 are returned.

(2) All such drugs are identified as to lot or control number.

(3) The signatures of the receiving pharmacist and a registered nurse employed by the facility are recorded in a separate log which lists the name of the patient, the name, strength, prescription number (if applicable), the amount returned of the drug and the date of return. The log must be retained for at least three years.

§ 73371. Pharmaceutical Service—Unit Dose Medication System.

There shall be at least a 24–hour supply of all patient medications on hand at all times, excepting those drugs which are to be discontinued within the 24–hour period. Drugs that are part of the system shall not exceed a 48–hour supply.

§ 73373. Pharmaceutical Service—Staff.

Facilities shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals.

§ 73375. Pharmaceutical Service—Equipment and Supplies.

(a) There shall be adequate equipment and supplies necessary for the provision of pharmaceutical services within the facility. This includes:

(1) Refrigerator with thermometer.

(2) Lockable drug cabinets, drawers, or closets or rooms.

(3) Drug service trays and/or carts.

(4) Drug preparation counter area and convenient water source.

(5) Syringes, needles, rubber tubing, clamps, droppers, medicine glasses, cups or other small containers which are accurately calibrated.

(6) Reference materials containing drug monographs on all drugs in use in the facility. Such monographs shall include information concerning generic and brand names if applicable, available strengths and dosage forms and pharmacological data including indications and side effects.

(b) Emergency drug supplies as determined by patient care policy committee shall be available. Facilities shall store a supply of emergency legend drugs on at least one nursing station and:

(1) Such drugs shall be limited to a maximum of three single doses in either sealed ampules or vials of any one emergency drug. If an emergency drug is not available in parenteral form, a supply of the drug in inhalation or sublingual form may be maintained in the smallest sealed manufacturer's package. No other oral legend drugs may be so stored.

(2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper–proof seal must be broken to gain access to the drugs. The supply shall be opened only in the presence of a physician, pharmacist or licensed nurse. The supervisor of health service shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist.

(3) The contents of the supply shall be listed on the outside of the container.

(4) The supply shall be checked at least monthly by the pharmacist.

(5) Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the patient, the date and time of administration and the signature of the person administering the dose.

§ 73377. Activity Program—Defined.

An activity program means a program which is staffed and equipped to meet the needs and interests of patients. Patients shall be encouraged to participate in activities suited to their individual needs. An activity program shall have a written planned schedule of social

and other purposeful independent or group activities for each patient designed to make his life more meaningful, to stimulate and support his desire to use his physical and mental capabilities to their fullest extent, to enable him to maintain his highest attainable social, physical and emotional functioning, his usefulness and self–respect but not necessarily to correct or remedy a disability.

§ 73379. Activity Program—Scope.

(a) The scope of the activity program shall include:

(1) Social activities which involve group participation and are designed to promote group relationships.

(2) Recreational activities, both indoor and outdoor.

(3) Opportunity to participate in activities outside the facility.

(4) Religious programs, including the right of each patient to attend the church or religious program of his choice.

(5) Creative and expressive activities.

(6) Educational activities.

(7) Exercises.

§ 73381. Activity Program—Policies and Procedures.

(a) Written policies and procedures governing the conduct of the activity program shall be available for use by the activity leader and other personnel assisting in the program. The policies and procedures shall be developed by the patient care policy committee with the assistance of the activity leader.

(b) The primary objectives of activity programs shall be to encourage the patient toward restoration of self–care and the resumption of normal activities, or for those who cannot realistically resume normal activities, to prevent further mental or physical deterioration.

(c) Opportunities should be provided for patient involvement, both individual and group, in the planning and implementation of the activity program.

(d) The program shall be designed so as to offer patients the opportunity for choice among a variety of activities such as discussion and study groups, reading, gardening, games, simple homemaking tasks, exercise classes, musical and other creative activities and religious programs. Attendance at religious services shall be voluntary.

(e) The facility shall be responsible for encouraging participation by each patient in social and recreational activities at least 10 hours per week unless this is documented to the contrary in the patient's health record.

§ 73383. Activity Program—Activity Record.

The record of each patient shall contain an activity plan. Each plan shall be reviewed at least quarterly and changed according to need. Progress notes shall be recorded at least quarterly in the patient's health record.

§ 73385. Activity Program—Staff.

(a) Activity program personnel with appropriate training and experience shall be provided to meet the needs of patients.

(b) Each facility shall designate an activity leader who, under the direction of the administrator, shall:

(1) Develop, implement and supervise the activity program.

(2) Obtain from the supervisor of health services a list of those patients who can participate in each activity program.

(3) Conduct or participate in in–service training of the staff of the facility and where appropriate and permissible, recruit, train and supervise volunteers to assist with or augment the regular program.

(4) Coordinate the activities schedule with other patient services.

(5) Provide the administrator with a current schedule of planned activities.

(6) Post the current activity schedule conspicuously for the information of patients and staff.

(7) Request and maintain equipment and supplies.

(8) Maintain a current record of the type and frequency of activities provided and the names of patients participating in each activity.

(9) Develop and maintain an appropriate schedule of activities for patients unable to leave their rooms.

(10) Develop appropriate contacts with community agencies and organizations.

(c) As a minimum, facilities shall provide an activity leader as follows:

(1) Any facility with 50 or more intermediate care beds shall have a full–time employee whose sole responsibility shall be the development, implementation and supervision of the social, recreational and rehabilitative programs of the facility.

(2) Any facility with 25 or more, but less than 50 intermediate care beds shall have an employee who shall devote a minimum of 20 hours per week to the development, implementation and supervision of the social, recreational and rehabilitative programs of the facility.

(3) Any facility with less than 25 intermediate care beds shall have an employee or consultant who shall devote a minimum of 10 hours per week to the development, implementation and supervision of the social, recreational and rehabilitative programs of the facility.

(d) The activity leader shall:

(1) Have two years experience in a social or recreational program within the past five years, one year of which was full–time in a patient activities program in a health care setting; or

(2) Be an occupational therapist, art therapist, music therapist, dance therapist, recreation therapist or occupational therapy assistant; or

(3) Have completed at least 36 hours training in a course designated specifically for this position and approved by the Department.

§ 73387. Activity Program–Equipment and Supplies.

There shall be equipment and supplies necessary for the program, including special equipment and supplies necessary for patients having special needs and for both independent and group activities.

§ 73389. Activity Program–Space.

(a) Designated indoor and outdoor activity areas appropriate to independent and group needs of patients shall be maintained. Such areas shall be as follows:

(1) Accessible to wheelchair and ambulatory patients.

(2) Of sufficient size to accommodate necessary equipment and permit unobstructed movement of wheelchair and ambulatory patients or personnel responsible for instruction and supervision.

(3) Have adequate space to store equipment and supplies.

§ 73391. Special Disability Services.

(a) Each special disability service shall provide a therapeutic milieu facilitating the individual's ability to cope with social, emotional and physical disabilities to reestablish independence and to attain optimal potential. Each patient shall participate in a special disability service specific to his identified program needs. A facility shall not accept or care for any of the following types of patients who have an identified program need unless a specific special disability program, approved by the Department, is provided:

Group I. Developmentally Disabled
Group II. Substance Abuser
A. Alcohol Substance Abuser
B. Drug Substance Abuser
Group III. Mentally Disordered

(b) Facilities to be eligible for additional reimbursement for special rehabilitation program services for the mentally disordered shall meet the requirements of Sections 73391 through 73423.

(c) Facilities to be eligible for additional reimbursement for special subacute psychiatric program services for the mentally disordered shall meet the requirements of Sections 73391 through 73415 and shall also meet the requirements of Sections 73425 through 73431.

(d) Facilities to be eligible for additional reimbursement for special program requirements for the developmentally disabled shall meet the requirements of Sections 73391 through 73415 and shall also meet the requirements of Sections 73433 through 73441.

§ 73393. Special Disability Services—"Distinct Part"—"Program."

(a) A "Special Disability Service Distinct Part" means a licensed intermediate care facility with a separate identifiably and physically independent unit or an entire intermediate care facility that provides therapeutic programs to patients and which is licensed by the Department to provide treatment to an identified special disability population group.

(b) A "Special Disability Program" means a therapeutic program of services and/or functions designed, staffed and implemented by the Special Disability Service Distinct Part for the purpose of meeting the specific needs of an identified population group.

(c) Facilities having multiple programs shall have appropriately designated areas to provide for adequate segregation of patients by program where required by the Department. No facility shall admit or care for patients of a program other than that for which the facility is approved.

§ 73395. Special Disability Services—Program Approval.

(a) The facility shall submit to the Department a written description of its Special Disability Program which shall meet all of the requirements of Section 73397. The facility shall also specify any alternate requirements needed to implement a specific program. The Department shall review the program and, if it determines that the program and the proposed specific alternate requirements meet the specific needs of the population group to be served, the Department shall issue its written approval of the program and shall designate the specific alternate requirements that shall govern the operation of the program. These specific alternate requirements shall take precedence over the regulations contained in this chapter. The Department may waive any requirement if the implementation of that requirement would be detrimental to the program. Written justification for a waiver request would be required.

(b) A facility shall comply with all requirements of its approved Special Disability Program and also any approved specific alternate requirement which shall govern the operation of the program notwithstanding the provisions of any other regulation contained in this chapter.

§ 73397. Special Disability Services—Program Requirements.

(a) The facility shall specify each population group that it plans to serve. For each group there shall be a separate special disability program developed to meet specific needs of the particular group. The program shall consist of the following components:

(1) Description of population group to be served shall include the following:

(A) Age (chronologic and developmental when applicable)

(B) Sex

(C) Physical characteristics

(D) Developmental characteristics

(E) Emotional characteristics

(2) Number of patients to be served in each population group.

(3) Identification of the particular needs within the population group.

(4) A written program designed to meet the identified needs.

(5) Method and frequency of evaluating patient progress.

(b) Combining of population groups shall be subject to approval by the Department.

(c) Programs which include the commingling of population groups shall be appropriate to the group needs and subject to approval by the Department.

(d) Each person admitted shall have an initial evaluation and assessment by facility staff of his medical, nursing, dietetic, social and physical needs within 15 days of admission unless an evaluation has been done by the referring agency within 30 days prior to admission to the facility.

(e) Each person admitted shall have a psychological and educational evaluation and assessment by the appropriate discipline within 45 days of admission.

(f) The patient's plan of care shall emphasize social interaction, educational needs, physical and recreational activity.

(g) The multidisciplinary notes shall describe the physical behavior and social growth of the individual.

(h) Consultative sources shall be used in the planning and organization of appropriate programs for the mentally disordered, developmentally disabled and substance abusers, incorporating post planning services intended to enable the patient to function and gain independence.

(i) Remedial educational programs consistent with patients' needs and plan of care shall be available under the direction of qualified teachers with a valid California teaching credential or persons with an academic degree in learning disabilities. Appropriate community school facilities may be used.

(j) Skill training programs shall be provided but not limited to techniques of behavior modification training in self–skills, sensory training or the modalities of reality orientation and remotivation therapy.

(k) If patients attend schools in the community, transportation and supervision to and from school shall be arranged in accordance with the needs and conditions of the patients.

(*l*) If the program in a facility is not appropriate to the patient needs, the patient shall be moved to a facility providing the appropriate program.

(m) Orientation and in–service training of staff members by a qualified person to assist them in the recognition and understanding of the emotional problems and social needs of patients and the means of taking appropriate action in relation to such needs. Available community resources and services should be included in the orientation.

§ 73399. Special Disability Services—Rights of Patients.

(a) Each patient admitted to a special disability program in an intermediate care facility shall have the following rights, a list of which shall be prominently posted in English and Spanish in all facilities providing such services, and otherwise brought to his attention by such additional means as is appropriate:

(1) To wear his own clothes; to keep and use his own personal possessions including his toilet articles; and to keep and be allowed to spend a reasonable sum of his own money for small purchases.

(2) To have access to individual storage space for his private use.

(3) To see visitors each day.

(4) To have reasonable access to telephones, both to make and receive confidential calls.

(5) To have ready access to letter writing materials, including stamps and to mail and receive unopened correspondence.

(6) To refuse shock treatment.

(7) To refuse lobotomy.

(8) Other rights as provided by law.

(b) The attending physician may, for good cause, deny a patient his rights under this section, except the right to refuse lobotomy or shock treatment. Any denial of a patient's rights shall be entered in the patient's health record.

(c) Information pertaining to denial of rights contained in the patient's health record shall be made available, on request, to the patient, his attorney, his conservator or guardian, or the Department, members of the State Legislature or a member of a county board of supervisors.

§ 73401. Special Disability Services—Abuse and Corporal Punishment.

Patients shall not be subjected to verbal or physical abuse of any kind. Corporal punishment of patients is prohibited.

§ 73403. Special Disability Services—Restraint and Seclusion.

(a) Restraint and seclusion shall only be used as emergency

measures to protect the patient from injury to himself or others. Restraint and seclusion shall not be used as punishment or as a substitute for more effective medical and nursing care program. Restraints may be used for:

(1) The protection of the patient during treatment and diagnostic procedures, as intravenous therapy, tube feeding and catheterization.

(2) To prevent infirm patients from falling out of bed or chairs or otherwise injuring themselves.

(3) To protect the aggressive, assaultive, acutely disturbed or severely confused patient from injuring himself or others.

§ 73405. Special Disability Services—Acceptable Forms of Restraint.

(a) Mechanical or behavior restraint consists of any apparatus that interferes with the free movement of a patient. Only the following types of restraint may be used:

(1) Soft tie consisting of cloth which prevents movement of a patient.

(2) Mittens without thumbs which are securely fastened around the wrist with a small tie.

(3) Tie jackets consisting of sleeveless cloth.

(4) Restraining sheet consisting of a wide piece of muslin placed over the body of the patient.

(5) Belts and cuffs, which are well–padded, used to control a seriously disturbed, assaultive patient.

§ 73407. Special Disability Services—Restrictions on Applying Restraints.

(a) In applying restraints each of the following requirements shall be met:

(1) Careful consideration shall be given to the methods by which the restraints may be speedily removed in the event of fire or other emergency.

(2) Except in rooms approved by the Department for seclusion, patients' rooms shall not be locked when occupied.

(3) Patients placed in restraint shall be observed by qualified treatment personnel at least every half hour. This observation shall be noted and initialed in the patient's health record.

(4) Patients placed in seclusion shall be observed by qualified treatment personnel at least every hour. This observation shall be noted and initialed in the patient's health record.

§ 73409. Special Disability Services—Orders for Restraint and Seclusion.

(a) Restraint and seclusion shall only be used on the signed order of a physician which shall be renewed every 24 hours. In a clear case of medical emergency, a physician may give the order by telephone. In such an event, the physician shall sign the order within 48 hours.

(b) A daily log shall be maintained in each facility exercising behavior restraint and seclusion indicating the name of the patient for whom behavior restraint or seclusion is ordered, full documentation of the episode leading to the behavior restraint or seclusion, the type of the behavior restraint or seclusion used, the length of time and the name of the individual applying such measures.

§ 73411. Special Disability Services—Staff.

(a) Professional staff shall include as a minimum a Special Disability Professional on a full–time, part–time or consultant basis.

(b) A registered nurse, licensed vocational nurse or licensed psychiatric technician shall be employed at least 40 hours a week on the day shift and be responsible for nursing supervision of the distinct part under the direction of the facility's supervisor of health services. This person shall have at least one year of experience or training related to the special disability service offered.

(c) If the facility is devoted entirely to the care of the mentally disordered or the developmentally disabled or substance abusers, the director of nursing service shall meet the requirements set forth in Section 72323 (b) of this article and in addition shall have at least one year of experience or training related to the special disability service offered. If the facility is devoted entirely to the care of any combination of the foregoing types of patients, the director of nursing service shall have at least one year of experience or training in one of the special disability services offered.

(d) Charge personnel on all shifts shall have at least one year of experience or training related to the special disability service offered.

(e) If the facility is devoted entirely to the care of the mentally disordered or developmentally disabled or substance abusers, there shall be at least one registered nurse or licensed vocational nurse or licensed psychiatric technician on duty on all three shifts seven days per week.

(f) A licensed psychiatric technician may serve as a charge nurse only in a special disability unit and only under the supervision of a registered nurse or licensed vocational nurse.

(g) Additional personnel shall be employed on all shifts to provide an appropriate level of care as determined by the Department.

(h) A special disability worker may be in charge of a specific program within the distinct part.

(i) A licensed psychiatric technician may administer medications only in a special disability unit.

§ 73413. Special Disability Services—Equipment.

There shall be sufficient equipment, assistive devices and supplies available to implement the treatment and program as ordered or indicated or necessary for meeting other physical, mental, emotional or recreational needs of patients.

§ 73415. Special Disability Services—Space.

(a) The distinct part shall have sufficient accommodations, including dining, recreational and program areas to meet the needs of the program.

(b) Indoor and outdoor areas shall be designated for programs with appropriate equipment, apparatus and adequate supplies which will meet the needs of the patient.

§ 73417. Special Rehabilitation Program Services—Mentally Disordered.

(a) Mentally disordered rehabilitation programs are designed to serve patients who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. These patients require continuous supervision and can be expected to benefit from an active rehabilitation program effort designed to improve their adaptive functioning and develop a potential for placement in a less protected living environment. A facility may, but is not required to, provide special rehabilitation program services for the mentally disordered. If the facility meets all of the requirements of this section, it shall be entitled to a supplemental special program rate under the Medi–Cal program (Title 22, California Administrative Code, Section 51335 (k)) such special program services are those therapeutic services provided to mentally disordered persons having special needs or deficits in one or more of the following general areas: Self–Help Skills, Behavior Adjustment, Interpersonal Relationships, Prevocational Preparation and Prerelease Planning.

(b) To be approved by the Department to furnish such special rehabilitation services to the mentally disordered, a facility shall have:

(1) A minimum initially of 30 patients in the facility who have been certified by the local mental health director as eligible for special program services. Eligibility for special program services shall be redetermined every four months by the local mental health director. At any time that the number of eligible patients receiving special program services drops below 27, total program reimbursement shall be terminated unless otherwise agreed to by the Department.

(2) An approved facility plan.

(A) To participate in this program, a facility shall submit to the Department's headquarters review and approval team for approval an application and a facility plan which meets all the requirements of Section 73417 (c).

(B) When the Department through the headquarters review and approval team determines that the facility plan meets the specified needs of the patient population, it shall provide its written approval of the plan to the facility.

(C) Where the headquarters review and approval team disapproves a facility plan, it shall submit a written report to the facility which specifies components of the plan which need to be improved or corrected. The facility may submit a revised facility plan and a new application to the headquarters review and approval team at any time.

(3) Within 45 days after written approval of the facility by the headquarters review and approval team an on–site visit by the Department to evaluate the appropriateness of the implementation of the facility plan. Upon the recommendation of the on–site visit team, the Department shall certify the facility's Special Rehabilitation Program Services—Mentally Disordered. Eligibility for Medi–Cal reimbursement shall commence on the first day that the on–site visit team determined that full implementation of the approved plan actually occurred; provided, however, that the first day of payment shall not be prior to the actual date of written approval of the plan.

(4) Executed an approved Medi–Cal provider participation agreement.

(5) Maintained compliance with the approved facility plan. Failure to comply with special program requirements of the plan shall cause the termination of eligibility for reimbursement for special program services, unless otherwise excused in writing by the Department.

(c) The following requirements shall be met if the facility is to receive approval for providing special rehabilitation program services to mentally disordered individuals with identified program needs.

(1) A facility plan for providing special rehabilitation program services shall be developed and submitted to the Department for approval initially and annually thereafter. The facility plan shall include:

(A) A description of the population group to be served.

(B) Names and number of patients to be served.

(C) An identification of special patient needs and grouping criteria.

(D) A description of the program design to meet the identified patient's needs.

(E) A description of the method and frequency of evaluating patient progress.

(F) Facility program staffing pattern which includes:

1. An organization chart for special program services staff.

2. A description of staffing ratios for program staff.

3. A description of interdisciplinary professional staff by discipline and hours provided per week.

(G) A description of program space provisions.

(H) Description of equipment utilized for program services.

(I) A plan for use of community resources.

(J) Sample patient program days.

(K) In–service training program in effect or planned.

(L) Provisions for accomplishing the following:

1. The facility in conjunction with the local mental health director shall make an initial individual assessment on each patient from which to identify the current level of functioning and program needs of its patients. The assessment shall be standardized on forms approved by the Department.

2. At least every four months, the facility in conjunction with the local mental health director shall make a written reassessment of each patient's program needs to evaluate patient progress and reassess program needs.

3. A minimum average of 27 hours of direct group or individual program service for each patient per week.

4. The facility shall have the capability of providing all of the following special rehabilitation program services. Actual programs shall be provided based on the specific needs identified through the patient assessments.

a. Self–Help Skills Training. This shall include but not be limited to:

(i) Personal care—use of medications

(ii) Money management

(iii) Use of public transportation

(iv) Use of community resources

(v) Behavior control, impulse control

(vi) Frustration tolerance

(vii) Mental health education

(viii) Physical fitness

b. Behavioral Intervention Training. This shall include but not be limited to:

(i) Behavior modification modalities

(ii) Remotivation therapy

(iii) Patient government activities

(iv) Group counseling

(v) Individual counseling

c. Interpersonal Relationships. This shall include but not be limited to:

(i) Social counseling

(ii) Educational and recreational therapy

(iii) Socialization activities such as outings, dances, etc.

d. Prevocational Preparation Services. This shall include but not be limited to:

(i) Homemaking

(ii) Work activity

(iii) Vocational counseling

e. Prerelease Planning.

(i) Out–of–home placement

§ 73419. Special Rehabilitation Program Services—Staffing.

(a) At the time of program approval, the facility shall have employed a program director who has been approved by the Department. The program director shall be on duty at least 40 hours per week and shall have the responsibility for the supervision and coordination of the special program staff and implementation of the in–service training program. The program director shall not be the supervisor of health services, charge nurse or facility administrator.

(b) The program director shall be either a social worker, an occupational therapist, a psychologist, a physician, a psychiatric technician, a registered nurse, an art therapist, a dance therapist, a music therapist or a member of another profession approved by the Department. The program director shall have the following minimum qualifications:

(1) At least two years' experience or training in a mental health setting, and

(2) At least one year of experience or training in program development for the mentally disordered.

(c) Interdisciplinary Professional Staff. In addition to the requirement for a program director, the facility shall provide, either through direct employment or on a contractual arrangement, an interdisciplinary professional staff to develop and implement special rehabilitation programs and to provide specific expertise to the program staff and/or provide direct patient services.

(1) The interdisciplinary professional staff shall be composed of at least two of the following disciplines:

(A) Psychologist.

(B) Social worker.

(C) Occupational therapist.

(D) Recreation therapist.

(E) Art therapist.

(F) Dance therapist.

(G) Music therapist.

(H) Any other related discipline approved by the Department.

(2) The interdisciplinary professional staff shall have a minimum of one year of experience or training in a mental health setting.

(3) A facility which implements a rehabilitation program shall

provide interdisciplinary professional staff in accordance with the following schedule:

(A) For facilities having an average of 49 or fewer certified patients per week, 24 hours per week of professional staff time are required.

(B) For facilities having an average of between 50–69 certified patients per week, 32 hours per week of professional staff time are required.

(C) For facilities having an average of between 70–99 certified patients per week, 48 hours per week of professional staff time are required.

(D) For facilities having an average of more than 100 certified patients per week, 72 hours per week of professional staff time are required.

(d) Program Staff. The facility shall provide a minimum of one hour of direct program staff for each six patient hours of special program services provided. Program staff shall include all persons who directly provide program services to the mentally disordered and shall not include the program director.

§ 73421. Special Rehabilitation Program Services—In–Service Training.

(a) The facility shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 60 days of employment. Initial training shall include, but not be limited to the following:

(1) Orientation to special needs of the mentally disordered.

(2) Orientation to overall concepts of programs to meet the special needs of the mentally disordered.

(3) Orientation and training in specific program techniques being used in the facility to meet the identified program needs of the patients.

(b) The facility shall provide all program staff an average of at least one hour per week of ongoing planned academic and on–the–job in–service training. The training shall include, but not be limited to the following:

(1) Specific program techniques for the mentally disordered.

(2) Setting behavioral program objectives for patients.

(3) Evaluation and assessment procedures and criteria.

(4) Noting and documenting patient progress in the program.

(c) The facility shall maintain a record of in–service training. This record shall include names of staff receiving training, number of hours, date and subjects covered in training.

§ 73423. Special Rehabilitation Program Services—Patient Health Records.

(a) The facility shall insure that every patient receiving special program services shall have an individual record which includes all of the following:

(1) A list of the patient's problems or needs, as identified from the individual assessment.

(2) The behavioral objectives for resolving problems or meeting needs of the patient. These objectives shall be measurable, observable, within time frames and subject to frequent review and updating.

(3) A statement of the plan for how the behavioral objectives will be met. The statement shall include, but not be limited to all of the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(4) The progress notes written by all members of the staff providing program services to the patient. The notes shall be:

(A) Specific to the needs or problems of the patients.

(B) Specific to the patient's program objectives and plans.

(5) A summary of the progress of the patient in the program, the appropriateness of program objectives, the success or failure of the plan and any other pertinent information regarding the patient's program shall be available at the time of the patient's reassessment.

§ 73425. Special Subacute Psychiatric Program Services—Mentally Disordered.

(a) Mentally disordered subacute psychiatric programs are designed to serve patients who have a chronic psychiatric impairment and whose adaptive functioning is severely impaired. These patients require continuous and intensive supervision and can be expected to benefit from an active subacute psychiatric program effort designed to improve their adaptive functioning to the point of entry into a rehabilitation program. A facility may, but is not required to, provide special subacute psychiatric program services. If the facility meets all of the requirements of this section, it shall be entitled to a supplemental special program rate under the Medi–Cal program (Title 22, California Administrative Code, Section 51335 (k)). Such special program services are those therapeutic services provided to mentally disordered persons having special needs or deficits in one or more of the following general areas: Self–Help Skills, Behavior Adjustment, Interpersonal Relationships, Prevocational Preparation and Prerelease Planning.

(b) To be approved by the Department to furnish such special subacute psychiatric programs to the mentally disordered, a facility shall have:

(1) A minimum initially of 30 patients in the facility who have been certified by the local mental health director as eligible for special subacute psychiatric program services. Eligibility for special subacute psychiatric services shall be redetermined every 30 days by the local mental health director. Patient eligibility for the special subacute psychiatric program shall be limited to a maximum of 90 days. The Department may authorize exceptions to this provision in writing to the local mental health director on an individual patient basis. At any time that the number of eligible patients receiving special program services drops below 27, total program reimbursement shall be terminated unless otherwise agreed to by the Department.

(2) An approved facility plan.

(A) To participate in this program, a facility shall submit to the Department's headquarters review and approval team for approval, an application and a facility plan which meets all the requirements of Section 73425 (c).

(B) When the Department through the headquarters review and approval team determines that the facility plan meets the specified needs of the patient population, it shall provide its written approval of the plan to the facility.

(C) Where the headquarters review and approval team disapproves a facility plan, it shall submit a written report to the facility which specifies components of the plan which need to be improved or corrected. The facility may submit a revised facility plan and a new application to the headquarters review and approval team at any time.

(3) Within 45 days after written approval of the facility plan, by the headquarters review and approval team an on–site visit by the Department to evaluate the appropriateness of the implementation of the facility plan. Upon the recommendation of the on–site visit team, the Department shall certify the facility's Special Subacute Psychiatric Program Services—Mentally Disordered. Eligibility for Medi–Cal reimbursement shall commence on the first day that the on–site visit team determined that full implementation of the approved plan actually occurred; provided, however, that the first day of payment shall not be prior to the actual date of written approval of the plan.

(4) Executed an approved Medi–Cal provider participation agreement.

(5) Maintained compliance with the approved facility plan. Failure to comply with special program requirements of the plan shall cause the termination of eligibility for reimbursement for special program services, unless otherwise excused in writing by the Department.

(c) The following requirements shall be met if the facility is to receive approval for providing special subacute program services to mentally disordered individuals with identified program needs.

(1) A facility plan for providing special subacute psychiatric program services shall be developed and submitted to the Department for approval initially and annually thereafter. The facility plan shall include:

(A) A description of the population group to be served.

(B) Names and number of patients to be served.

(C) An identification of special patient needs and grouping criteria.

(D) A description of the program design to meet the identified patient's needs.

(E) A description of the method and frequency of evaluating patient progress.

(F) Facility program staffing pattern which includes:

1. An organization chart for special program services staff.

2. A description of staffing ratios for program staff.

3. A description of interdisciplinary professional staff by discipline and hours provided per week.

(G) A description of program space provisions.

(H) Description of equipment utilized for program services.

(I) A plan for use of community resources.

(J) Sample patient program days.

(K) In–service training program in effect or planned.

(L) Provisions for accomplishing the following:

1. The facility in conjunction with the local mental health director shall make an initial individual assessment on each patient from which to identify the current level of functioning and program needs of its patients. The assessment shall be standardized on forms approved by the Department.

2. At least every 30 days, the facility in conjunction with the local mental health director shall make a written reassessment of each patient's program needs to evaluate patient progress and reassess program needs.

3. A minimum average of 30 hours of direct group or individual program service for each patient per week.

4. The facility shall have the capability of providing all of the following subacute psychiatric program services. Actual programs shall be provided based on the specific needs identified through the patient assessments.

a. Self–Help Skills Training. This shall include but not be limited to:

(i) Personal care—use of medications

(ii) Money management

(iii) Use of public transportation

(iv) Use of community resources

(v) Behavior control, impulse control

(vi) Frustration tolerance

(vii) Mental health education

(viii) Physical fitness

b. Behavioral Intervention Training. This shall include but not be limited to:

(i) Behavior modification modalities

(ii) Remotivation therapy

(iii) Patient government activities

(iv) Group counseling

(v) Individual counseling

c. Interpersonal Relationships. This shall include but not be limited to:

(i) Social counseling

(ii) Educational and recreational therapy

(iii) Socialization activities such as outings, dances, parties, etc.

d. Prevocational Preparation Services. This shall include but not be limited to:

(i) Homemaking

(ii) Work activity

(iii) Vocational counseling

e. Prerelease Planning.

(i) Out–of–home placement

§ 73427. Special Subacute Psychiatric Program Services—Staffing.

(a) At the time of program approval, the facility shall have employed a program director who has been approved by the Department. The program director shall be on duty at least 40 hours per week and shall have the responsibility for the supervision and coordination of the special program staff and implementation of the in–service training program. The program director shall not be the supervisor of health services, charge nurse or facility administrator.

(b) The program director shall be either a social worker, an occupational therapist, a psychologist, a physician, a psychiatric technician, a registered nurse, an art therapist, a dance therapist, a music therapist, a recreation therapist or a member of another profession approved by the Department. The program director shall have the following minimum qualifications:

(1) At least two years' experience or training in a mental health setting, and

(2) At least one year of experience or training in program development for the mentally disordered.

(c) Interdisciplinary Professional Staff. In addition to the requirement for a program director, the facility shall provide, either through direct employment or on a contractual arrangement, an interdisciplinary professional staff to develop and implement special rehabilitation programs and to provide specific expertise to the program staff and/or provide direct patient services.

(1) The interdisciplinary professional staff shall be composed of at least two of the following disciplines:

(A) Psychologist

(B) Social worker

(C) Occupational therapist

(D) Recreation therapist

(E) Art therapist

(F) Music therapist

(G) Dance therapist

(H) Any other related discipline approved by the Department.

(2) Each member of the interdisciplinary professional staff shall have a minimum of one year of experience or training in a mental health setting.

(3) A facility which implements a subacute psychiatric program shall provide interdisciplinary professional staff in accordance with the following schedule:

(A) For facilities having an average of 49 or fewer certified patients per week, 48 hours per week of interdisciplinary professional staff time are required.

(B) For facilities having an average of between 50–69 certified patients per week, 64 hours per week of professional staff time are required.

(C) For facilities having an average of between 70–99 certified patients per week, 96 hours per week of professional staff time are required.

(D) For facilities having an average of more than 100 certified patients per week, 144 hours per week of professional staff time are required.

(d) Program Staff. The facility shall provide a minimum of one hour of direct program staff for each six patient hours of special subacute program services provided. Program staff shall include all persons who directly provide program services to the mentally disordered and shall not include the program director.

§ 73429. Special Subacute Psychiatric Program Services—In–Service Training.

(a) The facility shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training

within 60 days of employment. Initial training shall include, but not be limited to the following:

(1) Orientation to special needs of the mentally disordered.

(2) Orientation to overall concepts of programs to meet the special needs of the mentally disordered.

(3) Orientation and training in specific program techniques being used in the facility to meet the identified program needs of the patients.

(b) The facility shall provide all program staff an average of at least one hour per week of ongoing planned academic and on–the–job in–service training. The training shall include but not be limited to the following:

(1) Specific program techniques for the mentally disordered.

(2) Setting behavioral program objectives for patients.

(3) Evaluation and assessment procedures and criteria.

(4) Noting and documenting patient progress in the program.

(c) The facility shall maintain a record of in–service training, number of hours, date and subjects covered in training.

§ 73431. Special Subacute Psychiatric Program Services—Patient Health Records.

(a) The facility shall insure that every patient receiving special program services shall have an individual record which includes all of the following:

(1) A list of the patient's problems or needs, as identified from the individual assessment.

(2) The behavioral objectives for resolving problems or meeting needs of the patient. These objectives shall be measurable, observable, within time frames and subject to frequent review and updating.

(3) A statement of the plan for how the behavioral objectives will be met. The statement shall include, but not be limited to all of the following:

(A) Resources to be used.

(B) Frequency of plan review and updating.

(C) Persons responsible for carrying out plans.

(4) The progress notes written by all members of the staff providing program services to the patient. The notes shall be:

(A) Specific to the needs or problems of the patients.

(B) Specific to the patient's program objectives and plans.

(5) A summary of the progress of the patient in the program, the appropriateness of program objectives, the success or failure of the plan and any other pertinent information regarding the patient's program shall be available at the time of the patient's reassessment.

§ 73433. Special Program Requirements—Developmentally Disabled.

(a) A facility may, but is not required to, provide special program services to the developmentally disabled. If a facility meets all of the requirements of this section, it shall be entitled to a supplemental program rate under the Medi–Cal program (Title 22, California Administrative Code, Section 51335(j)) or by a regional center for the developmentally disabled (Title 17, California Administrative Code, Section 50125(c)). Such special program services are those therapeutic services provided to developmentally disabled persons having specifically identified needs in one or more of the following general areas:

(1) Sensory–motor development

(2) Self–help skills

(3) Behavior adjustment

(4) Rehabilitation

(5) Sensory development for the sensory deprived

(b) To be approved by the Department to furnish such special program services to the developmentally disabled, a facility shall have:

(1) A minimum initially of 25 patients in the facility who have been certified by the regional center director in the region in which the facility is located, as eligible for special program services. Eligibility for special program services shall be redetermined every six months by the regional center director. At any time that the number of eligible patients receiving special program services drops below 23, total program reimbursement shall be terminated, unless otherwise agreed to by the Department.

(2) An approved facility plan.

(A) To participate in the program, a facility shall submit to the Department's headquarters review and approval team for approval, an application and a facility plan which meets all the requirements of Section 73433(c).

(B) When the Department through the headquarters review and approval team determines that the facility plan meets the specified needs of the patient population, it shall provide its written approval of the plan to the facility.

(C) Where the headquarters review and approval team disapproves a facility plan, it shall submit a written report to the facility which specifies components of the plan which need to be improved or corrected. The facility may submit a revised facility plan and a new application to the headquarters review and approval team at any time.

(3) Within 45 days after written approval of the facility plan, by the headquarters review and approval team, an on–site visit by the Department to evaluate the appropriateness of the implementation of the facility plan. Upon the recommendation of the on–site visit team, the Department shall certify the facility's Special Program Requirements—Developmentally Disabled. Eligibility for Medi–Cal reimbursement shall commence on the first day that the on–site visit team determined that full implementation of the approved plan actually occurred; provided, however, that the first day of payment shall not be prior to the actual date of written approval of the plan.

(4) Executed an approved Medi–Cal provider participation agreement.

(5) Maintained compliance with the approved facility plan.

(A) Failure to comply with special program requirements of this plan shall cause the termination of eligibility for reimbursement for special program services unless otherwise excused in writing by the Department.

(c) The following requirements shall be met if the facility is to receive approval for providing special program services to developmentally disabled individuals with identified program needs.

(1) A facility plan for providing special program services shall be developed and submitted to the Department for approval initially and annually thereafter. The facility plan shall include:

(A) Names and number of eligible patients.

(B) A profile of the patient population.

(C) A summary of specifically identified patient needs and grouping criteria.

(D) Individualized descriptions of specific programs in effect or to be implemented.

(E) Sample patient program days.

(F) The facility program staffing pattern, including:

1. Organizational chart of program staff.

2. Staffing ratios of patients to program staff.

3. Interdisciplinary professional staff utilized or to be utilized by discipline and hours per week.

(G) Description of program space provisions.

(H) Description of equipment obtained or to be obtained for program use.

(I) In–service training program in effect or planned.

(J) Plan for utilization of community resources.

(K) Such other documentation as the Department may require.

(L) Provisions for accomplishing the following:

1. The facility in conjunction with the regional center shall make an initial individual assessment on each patient from which to identify the current level of functioning and program needs of its patients. The assessment shall be standardized on forms approved by the Department.

2. At least every six months the facility, in conjunction with the regional center, shall make a written reassessment of each patient's program needs to evaluate patient progress and reassess program needs.

3. The facility shall provide daily, seven days a week, a minimum average of five hours of direct group or individual program services for each patient.

4. The facility shall have the capability of providing all of the following special program services. Actual programs shall be provided based on the specific needs identified through the patient assessments.

a. A sensory motor development training program which shall include but not be limited to:

(i) Visual stimulation

(ii) Auditory stimulation

(iii) Tactile stimulation

(iv) Kinesthetic stimulation

(v) Physical therapy

(vi) Laterality and directionality training

(vii) Large and small muscle stimulation

(viii) Balance and postural training

(ix) Training in the developmental skills which precede ambulation

b. A self–help skills training program shall include an intensive habilitation program in the following specific areas:

(i) Bladder and bowel control

(ii) Dressing

(iii) Bathing

(iv) Feeding

(v) Grooming

c. A behavioral intervention program which shall include the elimination of maladaptive behaviors, both destructive and stereotypic through the use of behavior modification techniques, counseling, and other appropriate techniques. The program shall also focus on the introduction, shaping and strengthening of adaptive behaviors through the use of such techniques as positive reinforcement and token economics. Such programs may either be separate or integrated with other program activity throughout the program day.

d. A rehabilitation program which shall include educational and recreational therapy components as well as advanced socialization skills. Such a program shall place emphasis on advanced manipulative skills and on activities with a purely recreational intent. Included are speech therapy, cooking classes, art classes, traditional educational activities and socialization activities such as outings, dances and parties. The program may also include the development of workshops and/or activity centers for those patients capable of benefiting from them.

e. A sensory development program for the sensory deprived which shall include intensive training in the area of communication, mobility, and orientation, environmental and tactile awareness, self–care, and socialization skills for patients with sensory handicaps. The goal shall be to help each patient attain as high a level of independent functioning as can be achieved. (The program for each patient shall be individually prescribed by an interdisciplinary review team.) For the deaf, the program shall include a total communication approach, using both oral and manual language. For the blind, the program shall include mobility training orientation and environmental awareness.

§ 73435. Special Program Requirements—Staffing.

(a) At the time of program approval, the facility shall have employed a program director who has been approved by the Department. The program director shall be on duty at least 40 hours per week. The program director shall have the responsibility for the supervision and coordination of the special program staff and implementation of the in–service training program. The program director shall not be the supervisor of health services, a charge nurse or the administrator of the facility.

(1) The program director shall be either a physician, a clinical or educational psychologist, a social worker, a special education teacher, a psychiatric technician, art therapist, dance therapist, music therapist or a member of another related profession approved by the Department.

(2) The program director shall have the following qualifications:

(A) At least two years of experience or training in the care of the developmentally disabled.

(B) At least one year of experience or training in program development for the developmentally disabled.

(b) In addition to the program director, the facility shall provide either through direct employment or on a contractual arrangement, an interdisciplinary professional staff to develop and implement special programs and to provide specific expertise to the program staff.

(1) The interdisciplinary professional staff shall be composed of at least one person from any three of the following disciplines:

(A) Clinical or educational psychologist.

(B) Recreation therapist.

(C) Occupational therapist.

(D) Physical therapist.

(E) Social worker.

(F) Speech pathologist.

(G) Special education teacher.

(H) Art therapist.

(I) Dance therapist.

(J) Music therapist.

(K) Any other related discipline approved by the Department.

(2) A facility with 49 or fewer eligible patients, which is approved to provide special program services, shall provide a minimum of 24 hours weekly of professional staff time.

(3) A facility with 50 to 69 eligible patients, which is approved to provide special program services, shall provide a minimum of 32 hours weekly of professional staff time.

(4) A facility with 70 to 99 eligible patients, which is approved to provide special program services, shall provide a minimum of 48 hours weekly of professional staff time.

(5) A facility with 100 or more eligible patients, which is approved to provide special program services, shall provide a minimum of 72 hours weekly of professional staff time.

(c) The facility shall provide a direct patient/staff program ratio of at least one staff member, with direct patient contact excluding the program director, for each five patients during all program hours.

§ 73437. Special Program Requirements—In–Service Training.

(a) The facility shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 60 days of employment. Initial training shall include, but not be limited to the following:

(1) Orientation to special needs of the developmentally disabled.

(2) Orientation to overall concepts of programs to meet the special needs of the developmentally disabled.

(3) Orientation and training in specific program techniques being used in the facility to meet the identified program needs of the patients.

(b) The facility shall provide all program staff an average of at least one hour per week of ongoing planned academic and on–the–job in–service training. The training shall include, but not be limited to the following:

(1) Specific program techniques for the developmentally disabled.

(2) Setting behavioral program objectives for patients.

(3) Evaluation and assessment procedures and criteria.

(4) Noting and documenting patient progress in the program.

(c) The facility shall maintain a record of in–service training. This record shall include names of staff receiving training, number of hours, date and subjects covered in training.

§ 73439. Special Program Requirements—Patient Health Records.

(a) The facility shall assure that every patient receiving special program services shall have an individual record which includes all of the following:

(1) A list of the patients' problems or needs, as identified from the individual assessment.

(2) The behavioral objectives for resolving problems or meeting needs of the patient. These objectives shall be measurable, observable, within time frames and subject to frequent review and updating.

(3) A statement of the plans for how the behavioral objectives will be met. The plans shall include, but not be limited to, all of the following:

(A) Resources to be used

(B) Frequency of plan review and updating

(C) Persons responsible for carrying out plans

(4) Progress notes written by all members of the staff providing program services to the patient. The notes shall be:

(A) Specific to the needs or problems of the patients

(B) Specific to the patient's program objectives and plans.

(5) A summary of the progress of the patient in the project, appropriateness of program objectives, the success or failure of the plans, and any other pertinent information regarding the patient's program shall be available at the time of the patient's reassessment.

§ 73441. Application, Issuance, Expiration and Renewal.

(a) Any facility desiring approval for a special disability service or program, special rehabilitation program service for the mentally disordered, special subacute psychiatric program service for the mentally disordered or a special program service for the developmentally disabled, shall file with the Department an application on forms furnished by the Department.

(b) The Department shall list on the facility license each such program or service for which approval is granted.

(c) If the applicant is not in compliance with the laws and regulations, the Department shall deny the applicant approval and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Each such program or service approval shall expire on the date of expiration of the facility's Provider Participation Agreement.

§ 73445. Optional Service Unit.

(a) Optional service unit means a functional unit of a intermediate care facility which is organized, staffed and equipped to provide a specific type or types of patient care. A facility is not required to operate an optional service unit.

(b) Only the following types of optional service units may be operated in an intermediate care facility: physical therapy, occupational therapy, speech pathology and/or audiology, social work services and rehabilitation services.

(c) If outpatient services are to be provided, the following conditions shall be met:

(1) Outpatient service units shall be located or constructed in a manner that will minimize noise, odors, hazards and unsightliness to the facility's inpatients.

(2) Outpatient access to optional service units shall not traverse a nursing unit.

(3) Separate toilets for men and women outpatients shall be provided.

(4) Drinking water facilities of a type approved by the Department shall be available for outpatients and personnel.

(5) Handwashing facilities with hot and cold water supply shall be provided in the optional service units accommodating outpatients.

(6) Waiting areas shall be provided with sufficient floor space to seat the maximum number of persons who are expected to be accommodated at any one time.

(d) Each optional service unit within the facility shall be approved by the Department. Any facility desiring approval for an optional service unit shall file with the Department an application on forms furnished by the Department.

(e) The Department shall list on the facility's license each optional service for which approval is granted.

(f) If the applicant is not in compliance with the laws and regulations, the Department shall deny the applicant approval and shall immediately notify the applicant in writing. Within 20 days of receipt of the Department's notice, the applicant may present his written petition for a hearing to the Department. The Department shall set the matter for hearing within 30 days after receipt of the petition in proper form. The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(g) Each optional service approval shall expire on the date of expiration of the intermediate care facility license. A renewal of the approval may be issued for a period not to exceed two years if the holder of the approval has been found not to have been in violation of any statutory requirements, regulations or standards during the preceding approval period.

(h) No facility shall make or disseminate any statement or advertise by any means or hold out or represent by any means, that the facility has or operates any optional service unit unless said optional service unit meets all of the requirements of this article pertaining to said optional service unit and said optional service unit has been approved by the Department.

(i) All optional service units in existence on the effective date of implementation of this article shall comply with the provisions of the regulations governing the particular type of optional service unit within one year following the effective date thereof.

(j) A facility may offer and charge for physical therapy, occupational therapy, speech pathology and/or audiology, social work services and rehabilitation services, if such services are provided through arrangements with a person or an outside agency that will render direct service to patients or act as a consultant or employee, providing that the facility does not advertise or otherwise represent to the public that the facility has or operates an optional service unit for the particular type of service.

§ 73447. Optional Services—Revocation or Involuntary Suspension of Approval.

(a) Pursuant to provisions of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Government Code, the Department may suspend or revoke the approval of an optional service issued under the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, upon any of the following grounds:

(1) Violation by the licensee of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of the optional service regulations promulgated by the Department.

(2) Aiding, abetting or permitting the violation of any provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or of any optional service regulations promulgated by the Department.

(3) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of an optional service.

(b) The Director may temporarily suspend any optional service approval prior to any hearing when, in his opinion, such action is necessary to protect the public welfare.

(1) The Director shall notify the licensee of the temporary suspension and the effective date thereof and at the same time shall serve such licen-see with an accusation.

(2) Upon receipt of a notice of defense by the licensee, the Director shall set the matter for hearing within 30 days after receipt of such notice.

(3) The temporary suspension shall remain in effect until such time as the hearing is completed and the Director has made a final determination.

(4) If the Director fails to make a final determination within 60 days after the original hearing has been completed, the temporary suspension shall be deemed vacated.

(5) If the provisions of Chapter 2 (commencing with Section 1250), Division 2, Health and Safety Code, or the optional service regulations promulgated by the Director are violated by a licensee which is a group, corporation or other association, the Director may suspend the approval of such organization or may suspend the approval as to any individual person within such organization who is responsible for such violation.

(c) The withdrawal of an application for approval shall not deprive the Department of its authority to institute or continue a proceeding against the applicant for the denial of the approval upon any ground provided by law or to enter an order denying the approval upon any such ground, unless the Department consents in writing to such withdrawal.

(d) The suspension, expiration or forfeiture of an approval issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking approval or otherwise taking disciplinary action against the licensee on any such ground.

(e) A licensee whose approval has been revoked or suspended may petition the Department for reinstatement or reduction of penalty after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

§ 73449. Social Work Service Unit.

(a) Social work services are those services which assist staff, patients and patients' families to understand and cope with patient's personal, emotional and related health and environmental problems.

(b) A social work service unit shall meet the following requirements:

(1) The social worker, social work assistant or social work aide shall develop a plan, including goals and treatment, for social work services for each patient who needs them, with participation of the patient, the family, the patient's physician, the supervisor of health services and other appropriate staff.

(2) Each patient within five days after admission shall be interviewed and a social work assessment completed. When indicated, a social work treatment plan reviewed and approved by the social worker shall be carried out, as appropriate, by the social worker, social work assistant or social work aide.

(3) Signed and dated progress reports shall be written at least monthly in the health record of each patient receiving social services, by the social worker, social work assistant or social work aide.

(4) The social worker, social work assistant or social work aide shall participate in regular staff conferences with the attending physician, the director of nursing service and other appropriate personnel.

(5) There shall be discharge planning and implementation through liaison with local health and welfare agencies, other community personnel and the patient's family or authorized representative.

(6) Orientation and in–service training of other staff members on all shifts shall be conducted at least monthly by the social worker in charge of the social work service, to assist in the recognition and understanding of the emotional problems and social needs of patients and families and to learn how to implement appropriate action to meet such identified needs. Orientation and training shall include informing the staff about available community resources and services.

§ 73451. Social Work Service Unit—Policies and Procedures.

(a) There shall be written patient care policies, procedures and job descriptions developed and maintained governing the provision of social service within the intermediate care facility, including all of the requirements of Section 73449, and the relating of these services to other patient care services. Such policies, procedures and job descriptions shall be developed whether provided by (1) an organized social service within the intermediate care facility or (2) a social worker employed on a part–time basis or (3) consultant services from a community agency.

(b) The policies, procedures and job description shall be developed by the social worker in consultation with the Patient Care Policy Committee.

§ 73453. Social Work Service Unit—Staff.

(a) There shall be a social work staff employed a sufficient number of hours in the facility to meet the social work needs of the patient.

(b) The social work service unit shall be organized, directed and supervised by the social worker, who has responsibility for supervision of other social work staff, including social work assistants and social work aides.

(c) Social work service staff may include the social work assistant and/or the social work aide. Assigned functions and tasks shall be supervised by the social worker. Under conditions specified in the written patient care policies, procedures and job descriptions, the social work aide may be under the supervision of the social work assistant.

(d) Adequate clerical support services shall be provided for social work staff, including those employed on a contractual basis.

§ 73455. Social Work Service Unit—Equipment and Supplies.

(a) Office equipment and supplies necessary for the social work service unit shall be available. These include, but are not limited to:

(1) Appropriate professional literature and references on subjects including psychosocial problems and needs of the patient population in the facility.

(2) Directories, listing and other reference materials on available community resources.

(3) Necessary clerical equipment and supplies.

§ 73457. Social Work Service Unit—Space.

Adequate office or other accessible space for privacy in interviewing, telephoning and conferences shall be provided.

§ 73459. Physical Therapy Service Unit.

(a) Physical therapy services are those services ordered by a physician or upon a physician's referral and provided to a patient by or under the supervision of a physical therapist to achieve and maintain the highest level of functional ability.

(b) Physical therapy services, include but are not limited to, the following:

(1) Assisting the physician in an evaluation of the patient's rehabilitation potential.

(2) Applying muscle, nerve, joint and functional ability tests.

(3) Treating patients to relieve pain, develop or restore function.

(4) Assisting patients to achieve and maintain maximum performance using physical means such as exercise, massage, heat, sound, water, light and electricity.

(c) A physical therapy service unit shall meet the following requirements:

(1) Evaluation by the physical therapist and a treatment program shall be established and modified as needed based upon subsequent reevaluations.

(2) Health records shall contain pertinent information on the patient and a procedure for obtaining signed medical orders.

(3) Notes indicating physical therapy services performed shall be entered into the patient's health record each day that the service is rendered and signed by the appropriate qualified person.

(4) Initial evaluation and discharge summary shall be written and signed by the physical therapist and posted on each patient's health record.

(5) Progress notes shall be written and signed at least weekly by the physical therapist.

(6) When hydrotherapy is offered, there shall be written cleaning and culturing techniques posted near the equipment.

(7) Personnel policies shall define the responsibilities of the physical therapy director and the duties assigned to the auxiliary personnel.

§ 73461. Physical Therapy Service Unit—Policies and Procedures.

There shall be written policies and procedures governing the physical therapy service unit, including all of the requirements of Section 73459 and the relating of these services to other patient care services. The patient care policy committee shall be responsible for the development and implementation of physical therapy policies, procedures and job descriptions, with the assistance of the physical therapist.

§ 73463. Physical Therapy Service Unit—Staff.

(a) The physical therapy service unit shall be under the direction of a physical therapist.

(b) A physical therapist assistant shall treat patients only under the supervision of a physical therapist in accordance with the Physical Therapy Practice Act, Article 4.5 (beginning with Section 2655) of the Business and Professions Code.

(c) A physical therapy aide shall work only under the direct supervision of a physical therapist.

(d) The physical therapist, physical therapist assistant and physical therapy aide shall work the hours necessary to accomplish those tasks listed in Section 73459.

§ 73465. Physical Therapy Service Unit—Equipment.

(a) Physical therapy equipment shall be sufficient to provide an adequate physical therapy service. This shall include, but not be limited to:

(1) Parallel bars

(2) Full view mirror

(3) Overhead pulley and weights

(4) Set of training stairs

(5) Treatment table enclosed by cubicle curtains for privacy

(6) Availability of wheelchairs, walkers, canes, crutches and other ambulation aids.

§ 73467. Physical Therapy Service Unit—Space.

(a) Adequate space shall be maintained for the necessary equipment needed to provide physical therapy service. The minimum floor area for physical therapy service shall be 28 square meters (300 square feet), no dimension of which shall be less than 3.7 meters (12 feet).

(b) A sink shall be provided in the treatment area and shall have controls other than hand controls.

(c) The toilet facilities shall be located nearby and equipped with grab bars on both sides of the commode and the space shall be of sufficient size to allow for patient transfer activities.

§ 73469. Occupational Therapy Service Unit.

(a) Occupational therapy is a medically prescribed service in which selected purposeful activity is used as treatment in the rehabilitation of persons with a physical or emotional disability.

(b) Occupational therapy service includes:

(1) Assisting the physician in his evaluation of a patient's level of function by applying diagnostic and prognostic tests.

(2) Reevaluating the patient as his condition changes and modifying treatment goals consistent with these changes.

(3) Decreasing or eliminating disability during patient's initial phase of recovery following injury or illness.

(4) Increasing or maintaining a patient's capability for independence.

(5) Enhancing a patient's physical, emotional and social well–being.

(6) Developing function to a maximum level so that early testing can be applied for future job training and employment.

(7) Guiding patients in their use of therapeutic, creative and self–care activities for improving function.

(c) An occupational therapy service unit shall meet the following requirements:

(1) Health records shall contain pertinent information on the patient and procedures for obtaining signed medical orders.

(2) Notes shall indicate procedures performed and be signed by the occupational therapist.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted in each patient's health record.

(4) Progress notes shall be written and signed on each visit by the occupational therapist.

(5) Personnel policies shall define the occupational therapy director's responsibilities and the duties assigned to the occupational therapy assistant.

§ 73471. Occupational Therapy Service Unit—Policies and Procedures.

There shall be written policies and procedures governing the occupational therapy service unit, including all of the requirements of Section 73469 and the relating of these services to other patient care services. The patient care policy committee shall be responsible for the development and implementation of occupational therapy policies, procedures, and job descriptions, with the assistance of the occupational therapist.

§ 73473. Occupational Therapy Service Unit—Staff.

(a) The occupational therapy service unit shall be under the direction of an occupational therapist.

(b) An occupational therapy assistant shall work only under direct supervision of an occupational therapist.

(c) The occupational therapist and occupational therapy assistant shall work the hours necessary to accomplish those tasks listed in Section 73469.

§ 73475. Occupational Therapy Service Unit—Equipment.

(a) Equipment necessary to enable patients to increase their functional capacity or capability shall be provided. This shall include, but not be limited to:

(1) Supportive slings, supportive and/or assistive hand splints and the materials from which to fabricate these and other assistive devices.

(2) Adapted devices to aid in the performance of daily living skills such as eating, dressing, grooming, writing, with instruction for their use.

(3) Equipment and supplies for creative skills to include but not be limited to leatherwork, weaving, needlework, ceramics, woodworking, painting and graphic arts.

(4) Means and supplies for adapting equipment for reeducation in activities of daily living.

§ 73477. Occupational Therapy Service Unit—Space.

Adequate space shall be provided for the necessary equipment

needed to provide occupational therapy. The minimum floor area shall be 28 square meters (300 square feet), no dimension of which shall be less than 3.7 meters (12 feet).

§ 73479. Speech Pathology and/or Audiology Service Unit.

(a) Speech pathology and/or audiology services are physician referred services which provide diagnostic screening, preventive and corrective therapy for individuals with speech, hearing and/or language disorders.

(b) Speech pathology and/or audiology services include:

(1) Evaluation of patients to determine the type of speech, language and/or hearing disorder.

(2) Determination and recommendation of the appropriate speech, language and hearing therapy.

(3) Instruction of other health team personnel and family members in methods of assisting the patient to improve and/or correct speech or hearing disorders.

(c) A speech pathology and/or audiology service unit shall meet the following requirements:

(1) Health records shall include all pertinent information of patient history and background and a signed medical order for the service.

(2) Progress notes, including the patient's reaction to treatment and any change in condition, shall be written at least monthly and be signed by the speech pathologist and/or audiologist.

(3) Personnel policies shall define the duties of the speech pathology and audiology director and allied personnel in the speech and audiology service unit.

§ 73481. Speech Pathology and/or Audiology Service Unit—Policies and Procedures.

There shall be written policies and procedures governing the speech pathology and audiology service unit, including all of the requirements of Section 73479, and the relating of these services to other patient care services. The patient care policy committee shall be responsible for the development and implementation of policies, procedures and job descriptions in conjunction with the speech pathologist and/or audiologist.

§ 73483. Speech Pathology and/or Audiology Service Unit—Staff.

(a) There shall be a speech pathologist and/or audiologist employed a sufficient number of hours to accomplish those tasks listed in Section 73479.

(b) There may be at least one speech pathology and/or audiology aide to assist in the testing and implementation of the service. The aides shall be registered as speech pathology and/or audiology aides with the Board of Medical Examiners and shall work only under the supervision of a speech pathologist and/or audiologist.

§ 73485. Speech Pathology and/or Audiology Service Unit—Equipment.

(a) There shall be sufficient equipment, tests, materials and supplies to implement the treatment and program required by each patient seen by the speech pathologist and/or audiologist.

(b) The following equipment shall be provided:

(1) An appropriate diagnostic clinical audiometer.

(2) Diagnostic tests and materials.

(3) Other equipment and materials deemed necessary by the speech pathologist and/or audiologist to meet the needs of patients being seen.

§ 73487. Speech Pathology and/or Audiology Service Unit—Space.

Space shall be adequately free of ambient noise to produce valid test results.

§ 73489. Rehabilitation Service Unit.

(a) Rehabilitation service is a service prescribed by a physician for the purpose of maximum reduction of physical disability and restoration of the patient to the highest possible functional level.

(b) A rehabilitation service unit shall include all of the following services:

(1) Physical Therapy.

(2) Occupational Therapy.

(3) Speech Pathology and/or Audiology.

(4) Social Work Services.

(5) Rehabilitation Nursing Services.

(c) A rehabilitation service unit shall meet the following requirements:

(1) Health records shall contain pertinent information of the patient's history and background and shall contain signed medical orders for the prescribed services needed.

(2) Daily notes shall indicate procedures performed and be signed by the appropriate discipline member.

(3) Initial evaluation, treatment plan and discharge summary shall be written and posted on each record.

(4) Progress notes shall be written and signed on each visit by the appropriate discipline member.

(5) Personnel policies shall define the duties of the director of rehabilitation service and auxiliary personnel.

§ 73491. Rehabilitation Service Unit—Policies and Procedures.

There shall be written policies and procedures governing the rehabilitation service unit, including all of the requirements of Section 73489 and the relating of these services to other patient care services. The patient care policy committee shall be responsible for the development and implementation of the rehabilitation service policies, procedures and job descriptions with the assistance of the director of the rehabilitation services unit, the registered nurse, the physical therapist, the occupational therapist, the speech pathologist and/or audiologist and the social worker.

§ 73493. Rehabilitation Service Unit—Staff.

(a) The director of the rehabilitation service unit shall be a physician, physical therapist or occupational therapist who has at least three years of active practice in rehabilitation.

(b) Physical therapy shall meet all the standards set forth in Section 73463.

(c) Occupational therapy shall meet all the standards set forth in Section 73473.

(d) Speech pathology and audiology shall meet all the standards set forth in Section 73483.

(e) Social work services shall meet all the standards set forth in Section 73453.

(f) Rehabilitation nursing shall include at least a full–time (40 hours per week) registered nurse, in addition to the director of nursing service of the facility, who has had two years of rehabilitative nursing practice or has completed a recognized program in rehabilitative nursing within the past five years.

(g) Additional personnel shall be employed to carry out the functions of the rehabilitation service.

§ 73495. Rehabilitation Service Unit—Equipment.

Equipment of the quality and in the quantity necessary for care of patients as ordered or indicated shall be provided to include but not limited to that which meets the standards set forth in Section 73455, Section 73465, Section 73475 and Section 73485.

§ 73497. Rehabilitation Service Unit—Space.

(a) There shall be sufficient space to meet all standards set forth in Section 73467, Section 73477, Section 73487 and Section 73457.

(b) There shall be toilet facilities equipped with grab bars and of sufficient size to accommodate wheelchair patients.

Article 4. Administration

§ 73501. Licensee—General Duties.

(a) The licensee shall be responsible for compliance with licensing requirements and for the organization, management, operation and control of the licensed facility.

(b) The licensee, if a licensed administrator, may act as the administrator or shall appoint a licensed administrator to carry out the policies of the licensee. A responsible adult shall be appointed, in writing, to carry out the policies of the licensee in the absence of the administrator. If the licensed administrator is to be absent for more than 30 consecutive days, the licensee shall appoint another licensed administrator to carry out the day–to–day functions of the intermediate care facility.

(c) The licensee shall delegate to the designated licensed administrator in writing authority to organize and carry out the day–to–day functions of the intermediate care facility through appropriate delegation of duties.

(d) Except where provided for in approved continuing care agreements, no intermediate care facility, owner, administrator, employee or representative thereof shall act as guardian, or conservator of the patient or the estate or both of such intermediate care facility.

(e) The licensee shall employ an adequate number of qualified personnel to carry out all the functions of the facility and shall provide for initial orientation of all new employees, a continuing in–service training program and competent supervision.

(f) If language or communication barriers exist between intermediate care facility staff and a significant number of patients, arrangements shall be made for interpreters or for the use of other mechanisms to insure adequate communication between patients and personnel.

§ 73502. Consumer Information to Be Posted.

(a) The following consumer information shall be conspicuously posted in a prominent location accessible to public view:

(1) Name, license number and date of employment of the current facility's administrator.

(2) A listing of all services and special programs provided in the facility and those provided through written contracts.

(3) A notice that the facility's written admission and discharge policies are available upon request.

(4) Most recent licensing visit report supported by the related follow–up plan of correction visit reports.

(5) The names and addresses of all previous owners.

(6) A listing of all other skilled nursing and intermediate care facilities owned by the same person, firm, partnership, association, corporation or parent or subsidiary corporation, or a subsidiary of the parent corporation.

(7) Any revocation and/or suspension actions instituted against the facility during the current or prior licensing period.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 73503. Transfer Agreements.

The licensee shall maintain, where appropriate, written transfer agreements with other nearby health facilities to make the services of the other facilities more readily accessible and to facilitate the easy transfer of patients and essential patient information along with the patient.

§ 73504. Bed Hold.

(a) If a patient of an intermediate care facility is transferred to a general acute care hospital as defined in Section 1250(a) of the Health and Safety Code, the intermediate care facility shall afford the patient a bed hold of seven (7) days, which may be exercised by the patient or the patient's representative.

(1) Upon transfer to a general acute care hospital, the patient or the patient's representative shall notify the intermediate care facility within twenty–four (24) hours after being informed of the right to have the bed held, if the patient desires the bed hold.

(2) Except as provided in Section 51535.1, Title 22, California Administrative Code, any patient who exercises the bed hold option shall be liable to pay reasonable charges, not to exceed the patient's daily rate for care in the facility, for bed hold days.

(3) If the patient's attending physician notifies the intermediate care facility in writing that the patient's stay in the general acute care hospital is expected to exceed seven (7) days, the intermediate care facility shall not be required to maintain the bed hold.

(b) Upon admission of the patient to the intermediate care facility and upon transfer of the patient of an intermediate care facility to a general acute care hospital, the intermediate care facility shall inform the patient, or the patient's representative, in writing of the right to exercise this bed hold provision. No later than June 1, 1985, every intermediate care facility shall inform each current patient or patient's representative in writing of the right to exercise the bed hold provision. Each notice shall include information that a non–Medi–Cal eligible patient will be liable for the cost of the bed hold days, and that insurance may or may not cover such costs.

(c) A licensee who fails to meet these requirements shall offer to the patient the next available bed appropriate for the patient's needs. This requirement shall be in addition to any other remedies provided by law.

NOTE: Authority cited: Sections 213(a), 1275 and 1276, Health and Safety Code. Reference: Sections 1275 and1276, Health and Safety Code.

§ 73505. Affiliations.

Copies of affiliation agreements, contract or written arrangements for advice, consultation, services, training or transportation, with other facilities, organizations or individuals, public or private agencies, shall be on file in the facility's administrative office. These shall be readily available for inspection and review by the Department. The agreement and/or contracts shall include, but not be limited to, the description of the services to be provided, the financial arrangements, the methods by which the services are to be provided to the particular patient, the conditions upon which the agreement or contract can be terminated.

§ 73507. Fire Safety.

The licensee shall conform to the regulations adopted by the State Fire Marshal establishing minimum standards for the prevention of fire and for the protection of life and property against fire and panic. A copy of the State Fire Marshal's current fire clearance shall be on the premises.

§ 73509. Smoking.

(a) Patients shall not be permitted to smoke in bed except under observation.

(b) Patients shall be permitted to smoke only in areas so designated. Such areas shall be under periodic observation when patients are smoking.

(c) Smoking or open flame is prohibited in all rooms or spaces where oxygen is being administered or stored.

(d) No smoking signs shall be prominently posted in any room where oxygen cylinders are in use or stored.

§ 73511. Administrator.

(a) Each intermediate care facility shall employ or otherwise provide a licensed administrator to carry out the policies of the licensee. Such administrator shall not be responsible for the administration and management of more than one intermediate care facility unless other intermediate care facilities for which he is

responsible are operated by the same governing body, are in the same vicinity and within reasonable travel time. If an administrator is responsible for more than one facility, he shall not be responsible for more than three facilities or more than 200 beds total and shall designate an individual in each facility to be responsible for carrying out the policies of the licensee.

(b) The administrator shall have sufficient freedom from other responsibilities and shall be on the premises of the intermediate care facility a sufficient number of hours to permit adequate attention to the management and administration of the facility. The Department may require that the administrator spend additional hours in the facility whenever the Department determines through a written evaluation that such additional hours are needed to provide adequate administrative management.

(c) A copy of the current intermediate care facility regulations contained in this chapter shall be maintained by the administrator and shall be available to all personnel.

(d) The administrator shall be responsible for informing appropriate staff of applicable additions, deletions and changes to intermediate care facility regulations.

(e) The administrator shall be responsible for informing the Department, via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage, or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

§ 73513. Advertising.

(a) No intermediate care facility shall make or disseminate false or misleading statements or advertise by any other manner or means, false claims regarding facilities or services provided.

(b) No intermediate care facility shall use the words "Approved by the California Department of Health" or any other words conveying the same idea in any advertising material.

(c) The name or title "hospital" shall not be used by any intermediate care facility.

§ 73515. Inspection Reports.

The latest report of inspection by state or local health authorities shall be kept on file in the facility with notations made of the action taken to comply with any recommendations.

§ 73517. Admission of Patients

(a) The licensee shall:

(1) Admit a patient only on physician's orders.

(2) Accept and retain only those patients for whom it can provide adequate care.

(3) Admit each patient only after a preadmission personal interview according to the written policies of the facility, with the patient's physician, referring health practitioner, the patient, the patient's next of kin and/or sponsor, as appropriate. A telephone interview may be substituted when a personal interview is not feasible.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 73518. Standard Admission Agreement.

(a) The licensee shall use the California Standard Admission Agreement for Skilled Nursing and Intermediate Care Facilities, form number HS 327 (02/05), which is incorporated by reference herein, as the sole contract of admission between residents and the licensee.

(b) Except to enter information specific to the facility or the resident in blank spaces provided in the Standard Admission Agreement form or its attachments, the licensee shall not alter the Standard Admission Agreement without the prior written authorization of the Department.

(c) No resident or his or her legal representative shall be required to sign any other document at the time of, or as a condition of, admission to the licensee's facility, or as a condition of continued stay in the facility.

(d) The licensee shall not present any arbitration agreement to a prospective resident as a part of the Standard Admission Agreement. Any arbitration agreement shall be separate from the Standard Admission Agreement and shall contain the following advisory in a prominent place at the top of the proposed arbitration agreement, in bold–face font of not less than 12 point type: **"Residents shall not be required to sign this arbitration agreement as a condition of admission to this facility, and cannot waive the ability to sue for violation of the Resident Bill of Rights."**

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1276, 1430, 1599.60, 1599.61, 1599.81 and 123222.1, Health and Safety Code.

§ 73519. Administrative Policies and Procedures.

(a)Written administrative policies shall be reviewed and revised at least annually and shall include the following:

(1) Written management and personnel policies to govern the administration of the intermediate care facility shall be established and implemented. Job descriptions detailing the functions of each classification of employee shall be written and available to all personnel.

(2) All intermediate care facilities shall have written admission and discharge policies which shall include rate of charge for care, charges for extra services, limitation of services, cause for termination of services and refund policies applying to termination of services. These policies shall be made available to patients or their agents upon admission and upon request and shall be made available to the public upon request.

(b) The following types of patients shall not be admitted, nor cared for, in an intermediate care facility:

(1) Persons with a communicable disease.

(2) Mentally disturbed persons who require special services not available in the intermediate care facility.

(3) Mentally retarded persons requiring special services not available in the intermediate care facility.

(4) Persons requiring skilled nursing care and observation on a 24–hour basis.

(5) Those requiring daily care by a physician.

(c) All patients shall have a tuberculosis screening procedure done upon admission. These procedures shall be determined by the patient care policy committee. Subsequent tuberculosis screening procedures shall be determined by attending physicians. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the intermediate care facility.

(d) Nondiscrimination Policies. No intermediate care facility shall deny admission to a patient on account of race, color, religion, ancestry or national origin except as provided in this section. Admission policies shall state that, except as provided herein, patients will be accepted for care and cared for without discrimination on the basis of race, color, religion, ancestry or national origin.

Any bona fide nonprofit religious, fraternal or charitable organization which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this section may establish admission policies limiting or giving preference to its own members or adherents and such policies shall not be construed as a violation of the first paragraph of this subdivision. Any admission of nonmembers or nonadherents shall be subject to the first paragraph of this subdivision.

(e) Written policies and procedures governing patient health records shall be developed with the assistance of a person skilled in record maintenance and preservation. Health records shall be stored and systematically organized to facilitate retrieving of information.

(f) The Patient Care Policy Committee shall implement the provisions of the Health and Safety Code, Sections 1315 and 1316.5, by means of written policies and procedures.

(1) Facilities which choose to allow clinical psychologists to refer patients for admissions shall do so only if there are physicians who will provide the necessary medical care for the referred patients.

(2) Only physicians shall assume overall care of patients including performing the admitting history and physical examinations.

(3) Facilities which choose to allow dentists to refer patients for admission shall do so only if there are physicians who will provide the necessary medical care for the referred patients. Dentists shall perform only those duties lawfully authorized by their practice act.

(g) The Patient Care Policy Committee shall implement the provisions of Health and Safety Code, Section 1316, by means of written policies.

(1) Facilities which choose to allow podiatrists to refer patients for admission shall do so only if a physician provides necessary medical care for the referred patient.

(2) Only physicians shall assume overall care of patients, including performing admitting history and physical examinations.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 73521. Patient Care Policy Committee.

Written patient care policies shall be established and followed in the care of patients governing the following services: physician, dental, nursing, dietetic, pharmaceutical and an activity program and such diagnostic, social, psychological and therapy services as may be provided. Such policies shall be developed by a committee whose membership shall consist of at least one physician, the administrator, the supervisor of health services and such other professional personnel as may be appropriate. These policies shall be reviewed and revised by the committee at least annually and minutes of the committee meetings shall be maintained on file indicating the names of members present, the subject matter discussed and action taken.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315 and 1316.5, Health and Safety Code.

§ 73523. Patients' Rights.

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facilities' basic per diem rate or not covered under Title XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing, and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 73524(c).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept his written delegation of this responsibility subject to the provisions of Section 73557.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of the patient's financial and health records and to approve or refuse their release, by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive his personal mail unopened.

(14) To meet with and participate in activities of social, religious and community groups at the patient's discretion.

(15) To retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's his/her spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones both to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic and/or physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 73012, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code Sections 5325 and 5325.1 for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code, Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights as set forth above may only be denied or

limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker, designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, informed consent must be obtained from a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of the patient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify, consistent with current statutory and case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599 and 1599.1, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 299.

§ 73524. Informed Consent Requirements.

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and the probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient has given informed consent to the proposed treatment or procedure. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.

(f) Notwithstanding Sections 73523(a)(5) and 73524(c)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that unless inappropriate a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 73524(c)(1) through (6) or that is determined by the physician not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physical because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code; and *Cobbs* v. *Grant* (1972) 8 Cal.3d 229.

§ 73525. Employees' Health Examinations and Health Records.

(a) All employees working in the facility, including the licensee, shall have a health examination by a physician prior to employment or within seven days after employment and at least annually thereafter. Each such examination shall include a medical history,

physical evaluation and laboratory work as indicated. The examination shall be in sufficient detail to indicate that the employee is sufficiently free of disease to perform his assigned duties and that he does not have any health condition that would create a hazard for himself, fellow employees or patients. A report shall be made of each examination, signed by the examining physician.

(b) The initial health examination and subsequent annual examination shall include a purified protein derivative intermediate strength intradermal skin test for tuberculosis or a chest X–ray. Positive reaction to the skin test shall be followed by a 35.56cm x 43.18cm (14″ x 17″) chest X–ray.

(c) The facility shall maintain a health record for each employee, including reports of all employment–related health examinations. Such records shall be kept a minimum of three years following termination of employment.

§ 73527. Employee Personnel Records.

(a) All facilities shall maintain employee records of all personnel. The record shall include the employee's full name, social security number, professional license or registration number, if any, employment classification, information as to past employment and/or qualifications, date of beginning employment and date of termination of employment. Such records shall be retained for at least three years following termination of employment.

(b) Records of hours and dates worked by all employees during at least the most recent six–month period shall be kept on file at the place of employment or at a central location within the State of California. Such records shall be made available to the Department upon request.

§ 73529. Employee Name Badges.

All personnel serving patients or the public shall wear name and title badges unless contraindicated.

§ 73531. Patients with Communicable Disease.

(a) Patients acquiring a communicable disease while in the facility shall be transferred to an appropriate facility as soon as possible. While awaiting transfer, the following requirements shall be met:

(1) Any patient diagnosed as having a reportable communicable disease or being in a carrier state who the attending physician determines is a potential danger to other patients or personnel, shall be accommodated in a room provided with a separate toilet, handwashing facility, soap dispenser and individual towels.

(2) The intermediate care facility shall adopt and observe written procedures approved by the local health officer. Such procedures shall be posted at the nurses' station or other appropriate location. The procedures shall outline the technique to be used in the care of patients with a communicable disease and shall include:

(A) Handwashing upon entering and leaving patient's room.

(B) Proper handling and disposal of infectious material.

(C) Procedures for medical and nursing personnel providing for proper isolation techniques.

(D) Health education provided to the patient.

(E) Proper handling of dishes.

(F) Proper handling of patient care equipment.

§ 73533. Reporting of Communicable Disease.

Each facility shall report to the local health officer each case of reportable communicable disease.

§ 73535. Reporting of Outbreaks.

Each facility having knowledge of any outbreak or undue prevalence of infectious or parasitic disease or infestation shall report the facts promptly to the local health officer.

§ 73537. Occurrence of Unusual Disease.

Each facility having knowledge of a case of an unusual disease shall convey the facts promptly to the local health officer.

§ 73539. Unusual Occurrences.

Occurrences such as epidemic outbreaks, poisoning, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health office and the Department. An incident report shall be retained on file in the facility. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premise shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

§ 73541. Annual Reports.

Each facility on or before the 15th day of February of each year shall file with the Department upon forms furnished by the Department a report for the preceding calendar year upon all matters requested by the Department.

§ 73543. Patients' Health Records.

(a) Records shall be permanent, either typewritten or legibly written with pen and ink and shall be kept on all patients admitted or accepted for treatment. All health and social records of discharged patients shall be completed and filed within 30 days and such records shall be kept for a minimum of seven years, except for minors whose records shall be kept at least until one year after the minor has reached the age of 18 but in no case less than seven years. If a facility operates an X–ray unit, all exposed X–ray film shall be retained for seven years. All required records, either originals or faithful and accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon request of the attending physician, he facility or any authorized officer, agent or employee of either or any other person authorized by law to make such request.

(b) Information contained in the records shall be treated as confidential and disclosed only to authorized persons.

(c) If a facility ceases operation, the Department shall be informed immediately of the arrangements made for the safe preservation of the patients' records.

(d) The Department shall be informed in writing immediately whenever patients' health records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the facility changes, both the licensee and the new applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation, stating:

(1) That the new licensee will have custody of the patients' records and these records will be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the current licensee for the safe preservation and location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or

(3) The reasons for the unavailability of such patients' health records.

(f) Patients' health records shall be current and kept in detail consistent with acceptable professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department.

(g) Patients' health records shall be filed and stored so as to be protected against loss, destruction or unauthorized use.

§ 73545. Admission Records.

(a) A facility shall complete for each patient an admission record which shall include the following:

(1) Name and Social Security number.

(2) Current address.

(3) Age and date of birth.

(4) Sex.

(5) Date of admission.

(6) Date of discharge.

(7) Name, address and telephone number of person or agency responsible for patient and next of kin.

(8) Name, address and telephone number of attending physician and of the podiatrist, dentist or clinical psychologist if such practitioner is primarily responsible for the treatment of the patient.

(9) Name, address and telephone number of the designated alternate physician.

(10) Admission diagnosis, known allergies and final diagnosis.

(11) Medicare and Medi–Cal numbers when appropriate.

(12) An inventory including but not limited to:

(A) Items of jewelry.

(B) Items of furniture.

(C) Radios, television and other appliances.

(D) Prosthetic devices.

(E) Other valuable items, so identified by the patient, family or authorized representative.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1315, 1316 and 1316.5, Health and Safety Code.

§ 73547. Content of Health Records.

(a) A facility shall maintain for each patient a health record which shall include the following:

(1) Diagnoses (current).

(2) Drug and treatment orders.

(3) Diet orders.

(4) Progress notes written at the time of visit by professional personnel in attendance to the patient.

(5) Nurses' notes which shall include:

(A) Narrative notes made by nurses' aides when appropriate, and after such aides have been properly instructed. They shall include:

1. Care and treatment done with and for the patient.

2. Patients' reactions to care and treatment.

3. Daily observation of how patient looks, feels, reacts, interacts, degree of dependency and motivation towards improved health.

(B) Meaningful and informative nurses' progress notes written by licensed nurses as often as the patient's condition warrants. However, weekly nurses' progress notes shall be written by licensed personnel on each patient and shall be specific to the psychological, emotional, social, spiritual, recreational needs and related to the patient care plans.

Progress notes reflecting observations of the patient's response to his environment, physical limitations, independent activities, dependency status, behavioral changes, skin problems, dietary problems and restorative measures to characterize the functional status of progression and/or regression.

(C) Name, dosage and time of administration of drugs, the route of administration if other than oral and site of injection. If the scheduled time is indicated on the record the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both his initials and the time of administration.

(D) Justification for and the results of the administration of all P.R.N. medications and the withholding of scheduled medications.

(E) Record of type of restraint and time of application and removal. The time of application and removal shall not be required for soft tie restraints prescribed by the physician for the support and protection of the patient.

(F) Medications and treatments administered and recorded as prescribed.

(6) Current history and physical examination or appropriate health evaluation.

(7) Temperature, pulse and respiration where indicated.

(8) Laboratory reports of all tests prescribed and completed.

(9) Reports of all X–rays prescribed and taken.

(10) Condition and diagnosis of patient at time of discharge and final disposition.

(11) Physician orders, including drug, treatment and diet orders signed on each visit. Physician orders recapitulated as appropriate.

(12) Observation and information pertinent to the dietetic treatment recorded in the patient's health record by the dietitian or nurse. Pertinent dietary records shall be included in patient's transfer records to ensure continuity of nutritional care.

(13) Consent forms for prescribed treatment and medication.

(14) An inventory of all patients' personal effects and valuables made upon admission and discharge. The inventory list shall be signed by a representative of the facility and the patient or his authorized representative with one copy to be retained by each.

§ 73549. Disaster and Mass Casualty Program.

(a) A written disaster and mass casualty program shall be adopted. The program shall be developed with the advice and assistance of qualified fire and safety experts and shall be in conformity with the California Emergency Plan of October 10, 1972, developed by the state office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974, developed by the office of Emergency Services, Department of Health. A copy of the Program shall be available on the premises for review by the Department.

(b) The program shall provide plans for local disasters occurring in the community and widespread disasters. The written program shall include at least the following:

(1) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

(2) An efficient system of notifying and assigning personnel.

(3) Unified medical command.

(4) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.

(5) Prompt transfer of casualties when necessary and after preliminary medical or surgical services have been rendered to the facility most appropriate for administering definitive care.

(6) Arrangements for provision of transportation of patients including emergency housing where indicated.

(7) Arrangements for care of patients during transporting and while occupying emergency housing.

(8) Disposition and care of patients after evacuation of facility.

(9) A special disaster medical record, such as an appropriately designed tag that accompanies the casualty as he is moved.

(10) Procedures for the prompt discharge or transfer of inpatients at the time of the disaster who can be moved without jeopardy.

(11) Maintaining security in order to keep relatives and curious persons out of the triage area.

(12) Establishment of a public information center and assignment of public relations liaison duties to a responsible individual.

(c) The program shall be brought up–to–date at least annually and all personnel shall be instructed in its requirements. There shall be evidence in the personnel files, e.g., orientation checklist or elsewhere indicating that all new employees have been oriented to the program and procedures at the beginning of their employment.

(d) The disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills.

§ 73551. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of qualified fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) Program Coverage. The written program shall include at least the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire–fighting equipment.

(6) Specification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(8) List of persons and telephone numbers to call in the event of fire or disaster.

(c) Fire and internal disaster drills shall be held at least quarterly for each individual shift of intermediate care facility personnel and under varied conditions. The actual evacuation of patients to safe areas during a drill is optional.

(1) A dated written report and evaluation of each drill and rehearsal shall be maintained.

(d) The evacuation plan shall be posted throughout the facility and shall include at least the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

(4) Emergency phone number of the local fire department.

§ 73553. Disruption of Services.

Each intermediate care facility shall develop a written plan to be used when a discontinuance or disruption of service occurs.

§ 73555. Patient Identification.

Each patient shall be provided with a wristband identification tag or other means of identification at all times unless the attending physician notes in the health record that the patient's condition would not permit such identification. Minimum information shall include the name of the patient and the name of the facility.

§ 73557. Safeguards for Patients' Monies and Valuables.

(a) Each facility to whom a patient's money or valuables have been entrusted shall comply with the following:

(1) No licensee shall use patients' monies or valuables as his own or mingle them with his own. Patients' monies and valuables shall be separate, intact and free from any liability that the licensee incurs in the use of his own or the institution's funds and valuables.

(2) Each licensee shall maintain adequate safeguards and accurate records of patients' monies and valuables entrusted to his care.

(A) Records of patients' monies which are maintained as a drawing account shall include a control account for all receipts and expenditures, an account for each patient and supporting vouchers filed in chronological order. Each account shall be kept current with columns for debits, credits and balance.

(B) Records of patients' monies and other valuables entrusted to the licensee for safekeeping shall include a copy of the receipt furnished to the patient or to the person responsible for the patient.

(3) Patients' monies not kept in the facility shall be deposited in a demand trust account in a local bank authorized to do business in California, the deposits of which are insured by the Federal Deposit Insurance Corporation, except that a facility operated by a county may deposit such funds with the County Treasurer.

(4) A person, firm, partnership, association or corporation which is licensed to operate more than one health facility shall maintain a separate demand trust account for each such facility and shall not commingle patient funds from one facility with another.

(5) When the amount of patients' money entrusted to a licensee exceeds $500, all money in excess of $500 shall be deposited in a demand trust account as specified in (3) and (4) above unless a fireproof safe is provided for protection of monies and valuables. If a fireproof safe is kept and the licensee desires the protection accorded by Section 1860 of the Civil Code, he shall give notice as provided by that section.

(6) Upon discharge of a patient, all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the patient in exchange for a signed receipt. Money and valuables kept within the facility shall be surrendered upon demand and those kept in a demand trust account or with the County Treasurer shall be made available within three normal banking days.

(7) Within 30 days following the death of a patient, except in a coroner or medical examiner case, all money and valuables of that patient which have been entrusted to the licensee shall be surrendered to the person responsible for the patient, or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient without a representative or known heirs dies, immediate written notice thereof shall be given by the facility to the Public Administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be filed with the Department.

(8) Upon change of ownership of a facility, a written verification by a public accountant of all patients' monies which are being transferred to the custody of the new owners shall be obtained by the new owner in exchange for a signed receipt.

§ 73558. Liability for Rent and Return of Rental Advance.

(a) This section shall apply to all hiring agreements executed on or after January 1, 1979.

(b) Whenever accommodations in an intermediate care facility are rented by or for a patient on a month to month basis, the renter or his heir, legatee or personal representative shall not be liable for any rent due under the rental agreement for accommodations beyond the date on which the patient died.

(c) Any advance payment of rent by the renter shall be returned to the heir, legatee or personal representative of the patient no later than two weeks after the death of the patient.

(d) The rights described in subsections (b) and (c) of this section shall not be modified or waived in the rental agreement.

NOTE: Authority cited: Sections 208 and 1275, Health and Safety Code. Reference: Section 1934.5, Civil Code.

Article 5. Physical Plant

§ 73601. Alterations to Existing Buildings or New Construction.

(a) Alterations to existing buildings licensed as intermediate care facilities or new construction shall be in conformance with Chapter 1, Division T17, Part 6, Title 24, California Administrative Code.

(b) Intermediate care facilities licensed and in operation prior to the effective date of changes in construction regulations shall not be required to institute corrective alterations or construction to comply with such new requirements except where specifically required or where the Department determines that a definite hazard to health and safety exists. Any intermediate care facility for which preliminary or working drawings and specifications have been approved by the Department prior to the effective date of changes to construction regulations shall not be required to comply with such new requirements provided substantial actual construction is commenced within one year of the effective date of such new requirements.

(c) All intermediate care facilities shall maintain in operating condition all buildings, fixtures and spaces in the numbers and types as specified in the construction requirements under which the intermediate care facility or unit was first licensed.

§ 73603. Application for Plan Review.

(a) Drawings and specifications for alterations to existing buildings or new construction shall be submitted to the Department for approval and shall be accompanied by an application for plan review on forms furnished by the Department. The application shall:

(1) Identify and describe the work to be covered by the plan review for which the application is made.

(2) Describe the land on which the proposed work is to be done, by lot, block, tract or house and street address or similar description that

will readily identify and definitely locate the proposed building or work.

(3) Show the present and proposed use or occupancy of all parts of the building or buildings.

(4) State the number of square meters (square feet) of floor area involved in new construction and in alterations.

(5) Give such other information as may be required by the Department for unusual design circumstances.

(6) Be signed by the person designing the work or the owner of the work.

(b) The application for plan review shall also include a written statement that a description of the proposed work has been submitted to the Area Comprehensive Health Planning Agency approved by the State Advisory Health Council pursuant to Section 437.7 of the Health and Safety Code.

§ 73605. Space Conversion.

Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the approval of the Department.

§ 73607. Notice to Department.

The Department shall be notified, in writing, by the owner or licensee of the intermediate care facility, within five days of the commencement of any construction, remodeling or alterations to such facility.

§ 73609. Patient Capacity.

(a) An intermediate care facility shall not have more patients or beds set up for use than the number for which it is licensed except in case of emergency when temporary permission may be granted by the Director or his designee.

(b) Five percent of a facility's total licensed bed capacity may be used for a classification other than that designated on the license. Upon application to the Director and a showing that seasonal fluctuations justify, the Director may grant the use of an additional five percent of the beds for other than the classified use.

(c) Patients shall not be housed in areas which have not been approved by the Department for patient housing and which have not been given a fire clearance by the State Fire Marshal except as provided in paragraph (a) above.

(d) The number of licensed beds shown on a license shall not exceed the number of beds for which the facility meets applicable construction and operational requirements.

§ 73611. Patient Rooms.

(a) Each patient room shall be labeled with a number, letter or combination of the two for identification.

(b) Each resident shall be provided clean, comfortable and reasonably private living accommodations with no more than four residents occupying a room.

(c) Residents shall be accommodated only in rooms approved by the Department with the following minimum floor area:

(1) Single rooms: 10 square meters (110 square feet)

(2) Multibed rooms: 7.5 square meters (80 square feet per bed)

(d) Except in rooms approved by the Department for seclusion of psychiatric patients, patients' rooms shall not be kept locked when occupied.

(e) Only upon the written approval of the Department may any exit door, corridor door, yard enclosures or perimeter fences be locked to egress.

(f) Patients' rooms which are approved for ambulatory patients only shall not accommodate nonambulatory patients. Before a patient is accommodated in an ambulatory only section, he shall demonstrate his ambulation ability and this shall be noted in the patient's health record. The intermediate care facility shall transfer any patient from the ambulatory section when his condition becomes nonambulatory. The ambulatory ability of any patient in an ambulatory only section shall be demonstrated upon the request of the Department.

(g) Patient rooms approved for use by ambulatory patients only shall be identified as follows: The words "Reserved for Ambulatory Patient," in letters at least 1.25 centimeters (one–half inch) high shall be posted on the outside of the door or on the wall alongside the door where they are visible to persons entering the room.

§ 73613. Patients' Property Storage.

Patients shall be provided with closet or locker space for clothing, toilet articles and other personal belongings. Bedside tables or the equivalent shall be provided for each patient.

§ 73615. Patients' Room Furnishings.

A clean and comfortable bed with an adequate mattress, pillow, blankets, bed linen, night stand, a comfortable arm chair and reading lamp shall be provided for each bed licensed.

§ 73617. Recreation and Dining Areas.

Lounge, recreation and dining areas shall be provided apart from sleeping quarters.

§ 73619. Provision for Privacy.

Visual privacy for each patient shall be provided in patient rooms, tub, shower and toilet rooms. Doors providing access to the corridor shall not be considered as meeting this requirement.

§ 73621. Public Telephone.

(a) A telephone shall be installed on each floor accommodating patients. This may not be required in separate buildings having six beds or less which are restricted to occupancy by ambulatory patients.

(b) The telephone shall be at appropriate height for use by patients in wheelchairs.

§ 73623. Special Rooms.

Special rooms shall be maintained for the isolation of a single patient in the ratio of one room for each 35 beds or major fraction thereof. These rooms shall be used for isolation of patients with infectious disease, acute or terminal illness or those who become agitated and create a disturbance. At least one special room shall be maintained with adjoining toilet and handwashing facilities which are not shared with other patients.

§ 73625. Nursing Stations.

(a) Nursing stations shall be maintained in each nursing unit or building.

(b) Nursing stations shall be maintained with a cabinet, a desk, space for records, a bulletin board, a telephone and a specifically designated and well–illuminated medicine storage compartment with a lockable door. If a separate medicine room is maintained, it shall have a lockable door and a medicine sink with water connections. If a nourishment refrigerator is used, the following standards shall apply:

(1) Be located in a clean area not subject to contamination by human waste and subject to the same conditions specified in Section 73337 (c).

(2) Maintain temperatures at or below 7ºC (45ºF) for chilling.

(3) Maintain freezer at or below minus 7ºC (20ºF).

(4) Have a reliable thermometer in refrigerator at all times.

(5) Food in the refrigerator subject to the same conditions as specified in Section 73345(b)(6).

§ 73627. Central Supply and Sterilizing.

(a) Intermediate care facilities having a licensed bed capacity of 60 or more beds shall maintain a central supply and sterilizing area which shall be adequate to maintain the following services, spaces and equipment as a minimum:

(1) Work space.

(2) Sterilizing space.

(3) Storage space for sterile supplies.

(4) Storage space for unsterile supplies.

(5) Equipment for clean–up and sterilization of dressings, utensils, supplies and solutions.

(b) Autoclaves shall be equipped with recording thermometers in addition to the standard mercury thermometers.

§ 73629. Utility Rooms.

(a) Utility rooms shall be maintained in each nursing unit and shall be designed for separation of clean and dirty work areas. The following spaces and equipment shall be maintained as a minimum:

(1) Work counters.

(2) Cabinets.

(3) Rim–flush clinic sink with an integral 7.6 centimeters (3–inch) trap and waste–line flushometer valve and hot and cold water supply.

§ 73631. Special Systems.

(a) A nurses' call system shall be maintained in operating order in all nursing units. Nurses' call systems shall be maintained in a manner that will provide visible and audible signal communication between nursing personnel and patients. The minimum requirements are:

(1) A call station or stations providing detachable extension cords to each patient's bed in the patients' rooms. These extension cords shall be readily accessible to patients at all times unless attending physician orders otherwise.

(2) A visible signal in the corridor above the corridor door of each patient's bedroom, visible from all parts of the corridor.

(3) An audible signal and a nurses' call annunciator indicating the room from which the call originates or an alternate system, approved in writing by the Department, shall be located at the nurses' station. The sounding of the audible signal shall be continuous or intermittent until answered.

(b) A nurses' call system shall be provided in each patient's toilet rooms, bathroom and shower room in locations easily accessible to the patients. Electric shock hazard shall be eliminated by grounding or by an equally effective method.

(c) The nurses' call systems shall be so designed as to require resetting at the station where the call originates unless a two–way voice communication component is included in the system.

§ 73633. Handrails.

Corridors shall be equipped with handrails on each side properly secured.

§ 73635. General Maintenance.

(a) The facility shall be clean, sanitary and in good repair at all times. Maintenance shall include provision and surveillance of services and procedures assuring safety and well–being of patients, staff and visitors.

(b) Buildings ad grounds shall be free of environmental pollutants and such nuisances as may adversely affect the health or welfare of patients to the extent that such conditions are within the reasonable control of the facility.

(c) All buildings, fixtures, equipment and spaces shall be maintained in operable condition.

(d) There shall be appropriate personnel for preventive maintenance and to carry out the required maintenance program.

(e) Equipment provided must meet any and all applicable California Occupational Safety and Health Act requirements in effect as of the time of purchase. All portable electrical equipment designed for 110–120 volts, 60 hertz current shall be equipped with a three wire grounded power cord with a hospital grade three prong plug. The cord shall be an integral part of the plug.

§ 73637. Air Filters.

(a) The licensee shall be responsible for regular inspection, cleaning or replacement of all filters installed in heating, air conditioning and ventilating systems, as necessary to maintain the systems in normal operating condition.

(b) A written record of inspection, cleaning or replacement, including static pressure drop, shall be maintained and available for inspection. The record shall include a description of the filters originally installed, the American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE) efficiency rating and the criteria established by the manufacturer or supplier to determine when replacement or cleaning is necessary.

(c) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and bypass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and bypass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department.

(d) Where filter maintenance is performed by an equipment service company, a certification shall be provided to the licensee that the requirements listed in this section have been accommodated.

§ 73639. Emergency Lighting and Power System.

(a) Auxiliary lighting and power facilities shall be readily available in case of necessity. Flashlights shall be in readiness for use at all times. Open–flame type of light shall not be used.

(b) The licensee shall provide and maintain an emergency electrical system in safe operating condition and in compliance with subdivisions (d), (e) and (f). The system shall serve all lighting, signals, alarms and equipment required to permit continued operation of all necessary functions of the facility for a minimum of six hours.

(c) If the Department determines that an evaluation of the emergency electrical system of a facility or portion thereof, is necessary, the Department may require the licensee to submit a report by a registered electrical engineer which shall establish a basis for alteration of the system to provide reasonable compliance with Subarticle E702–B, Part 3, Title 24, California Administrative Code (Emergency Electrical Systems For Existing Nursing Homes). Essential engineering data, including load calculations, assumptions and tests, and where necessary, plans and specifications, acceptable to the Department, shall be submitted in substantiation of the report. When corrective action is determined to be necessary, the work shall be initiated and completed within an acceptable time limit.

(d) The emergency lighting and power system shall be maintained in operating condition to provide automatic restoration of power for emergency circuits within 10 seconds after normal power failure.

(e) Emergency generators installed in intermediate care facilities shall be tested under load conditions for at least 30 minutes at intervals of not less than 14 days.

(f) A written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection.

§ 73641. Storage and Disposal of Solid Waste.

(a) Solid wastes shall be stored and eliminated in a manner to preclude the transmission of communicable disease. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either.

(b) Solid waste containers shall be stored and located in a manner that will protect against odors.

(c) Syringes and needles, before being discarded into waste containers, shall be rendered unusable.

§ 73643. Solid Waste Containers.

(a) All containers, except movable bins used for storage of solid wastes, shall have tight–fitting covers in good repair, external handles and be leakproof and rodent proof.

(b) Movable bins when used for storing or transporting solid wastes from the premises shall have approval of the local health department and meet the following requirements:

(1) Have tight–fitting covers, closed when not being loaded.

(2) Be in good repair.

(3) Be leakproof.

(4) Be rodent proof unless stored in a room or screened enclosure.

(c) All containers receiving putrescible wastes shall be emptied at least every four days or more often if necessary.

(d) Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin should provide for suitable access and a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 208(a) and 1254, Health and Safety Code. Reference: Sections 1250, 1276 and 25157.3, Health and Safety Code.

§ 73645. Infectious Waste.

Infectious waste, as defined in Health and Safety Code Section 25117.5, shall be handled and disposed of in accordance with the Hazardous Waste Control Law, Chapter 6.5, Division 20, Health and Safety Code (beginning with Section 25100) and the regulations adopted thereunder (beginning with Section 66100 of this Title).

NOTE: Authority cited: Sections 208, 1254, 25150 and 25157.3, Health and Safety Code. Reference: Sections 1250, 25117 and 25117.5, Health and Safety Code.

§ 73647. Gases for Medical Use.

(a) Gases for medical use covered by this section are: carbon dioxide, cyclopropane, ethylene, helium, nitrous oxide, oxygen, helium–oxygen mixtures and carbon dioxide–oxygen mixtures.

(b) Provision shall be made for safe handling and storage of medical gas cylinders.

(c) Transfer of gas by facility personnel from one cylinder to another shall be prohibited.

(d) All medical gas cylinders, pressure regulators, wall outlets from piping systems and external removable connection hoses used therewith shall, by physical design, be so constructed that connections for different gases are not interchangeable. This standardization shall be accomplished by installing permanent fittings as indicated in this section:

(1) Outlet valves for small compressed gas cylinders (Style E and smaller) shall conform with the Pin Index and Safety Systems contained in Pamphlet B57.1 Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018.

(2) Valve outlet connections for large cylinders (Style F and larger) for oxygen and nitrous oxide shall conform with the standards contained in Pamphlet B57.1, Compressed Gas Cylinder Valve Outlet and Inlet Connections, 1965 edition, by the American National Standards Institute, Inc., 1430 Broadway, New York, NY 10018. Standard Connection No. 240 shall be used with oxygen cylinders and Standard Connection 1320 shall be used with nitrous oxide cylinders.

(3) Removable exposed threaded connections, where employed in medical gas piping systems and equipment used in conjunction with resuscitators and oxygen therapy apparatus, shall be provided with noninterchangeable connections which conform with Pamphlet V–5, Diameter–Index Safety System, May 1970 printing, by the Compressed Gas Association, Inc., 500 Fifth Avenue, New York, NY 10036.

(4) Station outlets from piped oxygen and nitrous oxide systems shall conform with the standards contained in Bulletin NFPA No. 56F, Nonflammable Medical Gas Systems, 1973, by the National Fire Protection Association, 470 Atlantic Avenue, Boston, MASS 02210.

(5) Removable connection hoses from outlets shall be fitted with permanently connected fittings to match the standards listed above in subsections (1), (2), (3) and (4).

(e) The piped oxygen or nitrous oxide system(s) shall be tested in accordance with the National Fire Protection Association Bulletin, NFPH No. 56F, referred to above, and a written report shall be maintained in each of the following instances:

(1) Upon completion of initial installation.

(2) Whenever changes are made to a system.

(3) Whenever the integrity of a system has been breached.

(4) At least annually.

(f) Oxygen Equipment.

(1) Vaporizer bottles on oxygen equipment shall be sterilized after each use.

(2) Only sterile distilled water shall be used in vaporizer bottles.

(3) Vaporizer bottles shall be changed at least every 24 hours.

§ 73649. Water Supply and Plumbing.

(a) Where water for human consumption is from an independent source, it shall be subjected to bacteriological analysis by the local health department, the State Department or a licensed commercial laboratory at least every three months. A copy of the most recent laboratory report shall be available for inspection.

(b) Plumbing and drainage facilities shall be maintained in compliance with Part 5, Title 24, California Administrative Code, Basic Plumbing Requirements. Drinking water supplies shall comply with Group 4, Subchapter 1, Chapter 5, Division T17, Part 6, of Title 24, California Administrative Code.

(c) Vacuum breakers shall be maintained in operating condition where required by Section T17–210 (c), Division T17, Part 6, Title 24, California Administrative Code.

(d) Hot water temperature controls shall be maintained to automatically regulate temperature of hot water delivered to plumbing fixtures used by patients to attain a hot water temperature not less than 40.5ºC (105ºF) and not more than 48.9ºC (120ºF).

(e) Hot water at a minimum temperature of 83ºC (180ºF) shall be maintained at the final rinse section of dishwashing facilities unless alternate methods are approved by the Department.

(f) Taps delivering water at 51.6ºC (125ºF) or above shall be prominently identified by warning signs in letters at least five centimeters (two inches) high. Special precautions shall be taken to prevent the scalding of patients.

(g) Grab bars readily accessible to patients shall be maintained at each toilet, bathtub and shower used by patients, where required by Section T17–212 (b), Division T17, Part 6, of Title 24, California Administrative Code.

(h) Toilet, handwashing and bathing facilities shall be maintained in operating condition and in the number and types specified in construction requirements in effect at the time the building or unit was constructed. Those handwashing facilities listed in Section T17–208, Division T17, Part 6, Title 24, California Administrative Code, shall not be equipped with aerators.

§ 73651. Lighting.

(a) All rooms, attics, basements, passageways and other spaces shall be provided with artificial illumination.

(b) Adequate illumination shall be provided for the comfort of patients, operating functions in work areas and for the safety of patients and personnel.

(c) All patient rooms shall have a minimum of 30 lumens of light delivered to reading or working surfaces and not less than 10 lumens of light in the rest of the room.

(d) All corridors, storerooms, stairways, ramps, exits and entrances shall have a minimum of five lumens of light measured in the darkest corner.

(e) Lighting fixtures shall have suitable enclosures to control fixture brightness and to prevent accidental lamp breakage. Where exposed lamp fixtures are permitted, such as, closets, storage spaces, equipment rooms and similar areas, suitable guards shall be installed in locations where accidental lamp breakage could be hazardous to personnel.

§ 73653. Maintenance Manual.

(a) A written manual on maintenance of heating, air conditioning and ventilation systems shall be adopted by each facility.

(b) A maintenance log shall be maintained.

(c) Where maintenance is performed by an equipment service

company, a certification shall be provided to the licensee that the required work has been performed in accordance with acceptable standards. This certification shall be retained on file in the facility.

§ 73655. Mechanical Systems.

Air conditioning and ventilating systems shall be maintained in normal operating conditions to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility.

§ 73657. Screens.

Where necessary to protect against flies and other insects, screens of six mesh per centimeter (16 mesh per inch) shall be provided on doors and windows. Screen doors shall be of a type or installed as approved by the State Fire Marshal.

§ 73659. Storage.

(a) General and specialized storage space shall be maintained adequate to meet the needs of patients, for efficient operation of the facility and as required at the time of licensure. Storage shall not be permitted in air distribution chambers of heating, air conditioning or ventilating systems.

(b) Intermediate care facilities shall maintain combined general and specialized storage in accordance with the following schedule:

1–10 bed	11 square meters (120 square feet) minimum
11–100 beds	1.1 square meters (12 square feet) per bed
over 100 beds	111 square meters plus 0.5 square meters (1200 square feet plus five square feet) per bed for each bed over 100

§ 73661. Space.

All spaces located in the facility or internally connected to a licensed facility shall be considered a part of the facility and subject to licensing regulations.

§ 73663. Linen.

(a) A supply of linen shall be provided sufficient for not less than three complete bed changes for the facility's licensed capacity. Particular attention shall be given to assuring a supply of clean linen during and after weekends, holidays and other periods when laundry service is not available.

(b) There shall be written procedures posted pertaining to the handling, storage, transportation and processing of linens.

§ 73665. Laundry

(a) When a facility operates it own laundry such laundry shall be:

(1) Located in relationship to other areas that steam, odors, lint and objectionable noises do not reach patient or personnel areas.

(2) Adequate in size, well–lighted and ventilated to meet the needs of the facility.

(3) Laundry equipment shall be of a suitable capacity, kept in good repair and maintained in a sanitary condition.

(4) The laundry space shall be maintained in a clean and sanitary condition.

(b) If the facility does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this section.

§ 73667. Laundry Areas.

(a) Clean linen and soiled linen shall each be stored in separate rooms maintained for that purpose.

(b) Handwashing and toilet facilities shall be provided at locations convenient to the laundry for personnel.

(c) Linen carts shall be labeled "soiled" or "clean linen" made of washable materials and laundered or suitably cleaned daily.

§ 73669. Clean Linen.

(a) Clean linen shall be stored, handled and transported in a way that precludes cross contamination.

(b) Clean linen shall be stored in clean, ventilated closets, rooms, or alcoves used only for that purpose.

(c) Clean linen from a commercial laundry shall be delivered to a designated clean area.

(d) Linens shall be maintained in good repair.

§ 73671. Soiled Linen.

(a) Soiled linen shall be handled, stored and processed in a manner that will prevent the spread of infection.

(b) Soiled linen shall be sorted in a separate room by methods affording protection from contamination.

(c) Soiled linen shall be stored and transported in a closed container which does not permit airborne contamination of corridors and areas occupied by patients and precludes cross contamination of clean linen.

(d) When laundry chutes are used to transport soiled linen, they shall be maintained in a clean, sanitary state.

§ 73673. Wash Cloths and Towels.

An adequate supply of clean wash cloths and towels shall be provided for each patient.

§ 73675. Housekeeping.

(a) Each facility shall make provisions for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures.

(b) There shall be routines and procedures posted indicating daily, weekly and monthly cleaning schedules, for all areas of the facility.

(c) There shall be sufficient cleaning supplies and equipment available to housekeeping staff.

(1) Cleaning supplies and equipment shall be stored in rooms for housekeeping use only.

(2) A commercial detergent germicide shall be used for all cleaning.

(3) Mop heads shall be removable and changed at least daily.

(d) There shall be sufficient housekeeping personnel to maintain the interior of the facility in a safe, clean, orderly and attractive manner free from offensive odors.

(e) A person qualified by experience and training shall be in charge of housekeeping department.

(f) An adequate number of janitors' closets, service sinks and storage areas shall be maintained to meet the needs of the facility.

§ 73677. Autoclaving, Sterilizing and Disinfecting.

(a) All facilities shall make provision within the facility, or by acceptable arrangements for outside service, for proper sterilization of dressings, utensils, instruments and solutions used in the facility.

(b) All sterilization of supplies and equipment in the facility shall be under the supervision of a person qualified by experience and training.

(1) Autoclaves and sterilizers where provided shall be maintained in operating condition at all times.

(2) Instructions for operating autoclaves and sterilizers shall be posted.

(3) Written instructions for preparing supplies for autoclaving and for the operation of autoclaves shall be available to personnel. This shall include the method of packaging, loading the autoclave, temperature and pressure to be applied and the period of exposure.

(4) Autoclaves shall be checked at least weekly to verify that recording thermometers and indicating thermometers reasonably coincide.

Records of recording thermometers shall be checked for each load to verify that the performance of the autoclave is in accordance with established standards for sterilization. Records of recording thermometers shall be preserved for one year. Recording thermometers are not required on portable sterilizers and autoclaves.

(5) Autoclaving results shall be checked at least monthly by bacteriological tests. Records of results of such tests shall be preserved at least one year.

(6) Sterilized supplies and equipment shall be dated.

§ 73679. Disinfecting and Sterilizing.

(a) All facilities shall make provision for disinfection of contaminated articles or surfaces such as mattresses, linen, thermometers and oxygen tents.

(b) Equipment such as washbasins and bedpans shall be sanitized by one of the following methods:

(1) Submersion in boiling water for a minimum of 30 minutes.

(2) Autoclaving at 15 pounds pressure and 121ºC (250ºF) for 20 minutes.

(3) Gas sterilization.

The use of chemicals is not approved as a substitute for the above methods.

§ 73681. Provisions for Emptying Bedpans.

(a) Bedpans shall be cleaned in utility or hopper rooms unless toilets adjoining patients' rooms are equipped with flushing attachments and vacuum breakers. Bathtubs, lavatories or laundry trays shall not be used for cleaning bedpans.

(b) Bedpan covers shall not be used interchangeably.

§ 73683. Cleaning, Disinfecting and Sterilizing Manual.

A written manual on cleaning, disinfecting and sterilizing procedures shall be adopted, and all such procedures shall be in accordance with the manual. This manual shall include procedures used in the care of utensils, instruments, solutions, dressings, articles and surfaces.

§ 73685. Centralized Services Shared by Several Facilities.

Nothing in these requirements shall prohibit the provision of required services from a centralized service facility serving two or more licensed facilities when approved in writing by the Department.

Article 6. Violations and Civil Penalties

§ 73701. Definitions.

(a) The following definitions shall apply to this Article:

(1) "Substantial probability" means that the more likely consequence of a violation is death or serious physical harm to a patient.

(2) "Serious physical harm" means that type of bodily injury in which:

(A) A part of the body would be permanently removed, rendered functionally useless, or substantially reduced in capacity, either temporarily or permanently or

(B) A part of an internal function of the body would be inhibited in its normal performance to such a degree as to shorten life or cause reduction in physical or mental capacity.

§ 73702. Class "A" Violations.

A Class "A" violation is any violation of a statute or regulation relating to the operation or maintenance of any intermediate care facility which presents an imminent danger to the patients of the intermediate care facility or a substantial probability that death or serious physical harm would result therefrom. A physical condition or one or more practices, means, methods or operations in use in an intermediate care facility may constitute such a violation.

§ 73703. Class "A" Violations—Examples.

NOTE: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73705. Class "B" Violations.

A class "B" violation is any violation of a statute or regulation relating to the operation or maintenance of any intermediate care facility which has a direct or immediate relationship to the health, safety or security of the patients of the intermediate care facility, other than class "A" violations.

§ 73707. Class "B" Violations—Examples.

NOTE: Authority cited: Sections 100275(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 73709. Class "C" Violations.

A class "C" violation is any violation of a statute or regulation relating to the operation or maintenance of any intermediate care facility which the Department determines has only a minimal relationship to the health or safety of intermediate care facility patients.

§ 73711. Filing of Names and Addresses.

(a) The licensee of each intermediate care facility shall file with the Department the address of the licensee to which all citations and notices concerning any class "A" or class "B" violations shall be mailed by the Department.

(b) Each such licensee shall also designate one or more persons who is authorized to accept on the licensee's behalf, any citations to be served by any representative of the Department.

(c) Each such licensee shall file with the Department the names or titles of those persons who are such designees of the licensee.

(d) Each such licensee shall also file with the Department a written notice of any change in address or of any change of designee. The Department shall mail all citations or notices to the latest address on file with the Department.

§ 73713. Complaints.

(a) Any person may request an inspection of any intermediate care facility by giving notice to the Department of an alleged violation of applicable requirements of law or regulations.

(b) Any such notice shall be in writing, signed by the complainant and shall set forth with reasonable particularity the matters complained of. The substance of the complaint shall be provided to the licensee no earlier than at the commencement of the inspection. Neither the name of the individual complainant nor other person mentioned in the complaint shall be disclosed by the Department, unless the complainant specifically requests the release of such name or names or the matter results in a judicial proceeding.

(c) Upon the request of either the complainant or the Department, the complainant or his representative, or both, may be allowed to accompany the inspector to the site of the alleged violations during his tour of the facility, unless the inspector determines that the privacy of any patient would be violated.

§ 73715. Issuance of Citations.

(a) When a routine visit, survey or investigation of a complaint is conducted and the representative of the Department determines that an intermediate care facility is in violation of any statutory provision or regulation relating to the operation or maintenance of such facility, except with respect to violations determined to have only a minimal relationship to safety or health, he shall promptly, but not later than one day after the date of inspection, issue a citation to the licensee.

(b) The citation shall be served personally upon the licensee or his designee by the representative of the Department. If the licensee is not served personally, a copy of the citation shall be sent by registered or certified mail to the licensee.

(c) The District Administrator, Facilities Licensing Section, in which the facility is located, or his designee, shall review the alleged violation and shall fix the amount, if any, of the civil penalty to be imposed by the Department. The Department shall serve the licensee personally or by registered or certified mail, within four business days of the date of the issuance of the citation, with a written notice of the amount, if any, of the proposed civil penalty. The person who issued the citation shall not serve at any time as the designee of the District Administrator under any provision of this article.

(d) Each citation shall be in writing and shall include at least the following:

(1) A description of the nature of the violation fully stating the manner in which the licensee violated a specified statutory provision or regulation, and the particular place or area of the facility in which it occurred. The name of any patient jeopardized by the violation shall not be specified in the citation in order to protect the privacy of the patient. However, at the time the licensee is served with the citation, the licensee shall also be served with a written list of each of the names of the patients alleged to have been jeopardized by the violation. If the violation jeopardized all of the patients of the entire facility or all patients in any particular portion, wing, or ward of the facility, such fact shall be specified in the citation, and a written list of the names of the patients involved is not required to be furnished to the licensee.

(2) The earliest feasible time for the elimination of the condition constituting the violation. Such time shall be the shortest possible time within which the licensee reasonably can be expected to correct the alleged violation. In prescribing such time, the Department shall consider the following factors:

(A) The seriousness of the alleged violation.

(B) The number of patients affected.

(C) The availability of required equipment or personnel.

(D) The estimated time required for delivery, and any installation, of required equipment.

(E) Any other relevant circumstances.

(3) The name, address and telephone number of the district administrator of the district in which the facility is located.

(e) If a citation is issued as the result of the investigation of a signed, written complaint to the Department, a copy of the citation shall be sent to each person or organization who filed the written complaint.

(f) No licensee shall be cited for any violation caused by any person licensed pursuant to the State Medical Practice Act (Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code if such person is independent of and not connected with the licensee and the licensee shows that he has exercised reasonable care and diligence in notifying such persons of their duty to the patients in the licensee's intermediate care facility.

§ 73717. Penalties.

(a) The condition or practice constituting a class "A" violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the Department, is required for correction. A class "A" violation is subject to a civil penalty in an amount not less than one thousand dollars ($1,000) and not exceeding five thousand dollars ($5,000) for each and every violation. In fixing the amount of the civil penalty to be imposed for a class "A" violation, the district administrator, or his designee, shall consider:

(1) The gravity of the violation, which shall include:

(A) The degree of substantial probability that death or serious physical harm to a patient will result, and if applicable, did result, from the violation.

(B) The severity of serious physical harm most likely to result, and if applicable, that did result, from the violation.

(C) The extent to which the provisions of the applicable statutes or regulations were violated.

(2) The "Good Faith" exercised by the licensee. Indications of good faith include awareness of the applicable statutes and regulations, and reasonable diligence in complying with such requirements, prior accomplishments manifesting the licensee's desire to comply with such requirements, and any other mitigating factors in favor of the licensee.

(3) Any previous violations committed by the licensee.

(b) A class "B" violation is subject to a civil penalty in an amount not less than fifty dollars ($50) and not exceeding two hundred fifty dollars ($250) for each and every violation. A citation for a class "B" violation shall specify the time within which the violation is required to be corrected. If a class "B" violation is corrected within the time specified, no civil penalty shall be imposed.

(c) A class "C" violation is not subject to any monetary civil penalty. A notice of all such violations shall be issued and an appropriate plan of correction obtained at the time of completion of inspection.

(d) Where a licensee has failed to correct a class "A" or a class "B" violation within the time specified in the citation, the Department shall assess the licensee a separate civil penalty in the amount of fifty dollars ($50) for each day that the particular violation continues beyond the date specified for correction.

(e) The civil penalties authorized shall be trebled for a second or subsequent violation of the same regulation occurring within any 12–month period if a citation was issued for the previous violation occurring within such period and a civil penalty was assessed.

§ 73719. Review Procedures.

(a) If a licensee does not wish to contest a citation, he may transmit to the Department, within four business days, after the issuance of the citation the sum of $1,000 for each class "A" violation and the sum of $50 for each class "B" violation.

(b) If a licensee desires to contest a citation, the assessment of a proposed civil penalty, or the date specified for correction of a violation, he shall, within four business days after service of the citation or assessment of the proposed civil penalty, as the case may be, serve upon the district administrator, or his designee, either personally or by registered or certified mail, the licensee's written notice that:

(1) An informal conference be scheduled to review the matter with the district administrator or his designee; or

(2) The case be presented to the Superior Court for appropriate action.

§ 73721. Informal Conference.

(a) The district administrator or his designee shall hold, within four business days from the receipt of the licensee's request, an informal conference.

(1) The licensee shall have the right to be represented by legal counsel, to present oral and written evidence or other information on its behalf, and to explain any mitigating circumstances.

(2) The representatives of the Department who issued the citation should attend the conference and present whatever evidence or information, oral or written, in substantiation of the alleged violation.

(3) The conference shall be a simple informal proceeding, and shall not be conducted in the manner of a judicial hearing or as a hearing under the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), and need not be conducted according to technical rules relating to evidence and witnesses.

(4) Neither the licensee nor the Department shall have the right to subpoena any witness to attend the conference, nor to formally cross–examine any person testifying at the conference. However, both the licensee and the Department may present any witness on its behalf at the conference.

(5) At the conclusion of the informal conference, the district administrator or the designee conducting the conference, may affirm, modify or dismiss the citation, the proposed assessment of a civil penalty, or the date of correction of a violation.

(b) If the district administrator or his designee modifies or dismisses the citation or proposed assessment of a civil penalty, he shall state with particularity, in writing, his reasons for such action and shall immediately transmit a copy to each party to the original complaint, if any.

(c) If the licensee desires to contest the decision made after the informal conference, he shall inform the district administrator in writing by registered or certified mail within four business days after he receives the decision of the informal conference.

(d) If the licensee fails to so notify the district administrator in writing that he further intends to contest the citation or the proposed

assessment of a civil penalty or the decision made by the district administrator or his designee after an informal conference within the time specified, the citation or the proposed assessment of a civil penalty or the decision by the district administrator or his designee shall be deemed a final order of the Department and shall not be subject to further administrative review.

(e) If a licensee notifies the district administrator, or his designee, in writing by registered or certified mail that he intends to contest a citation or the assessment of a proposed civil penalty, after an informal conference has been held, the department shall refer the matter immediately to the Attorney General for appropriate action in the Superior Court of the county in which the facility is located.

§ 73723. Posting of Citations.

(a) Each citation for a class "A" violation which has become final, or copy or copies thereof, shall be prominently posted by the licensee until the violation is corrected to the satisfaction of the Department, up to a maximum of 120 days. The citation or copy shall be posted in a place or places in plain view of the patients in the intermediate care facility, persons visiting those patients and persons who inquire about placement in the facility.

(b) Each citation for class "A" or class "B" violations which has become final, or a copy or copies thereof, shall be retained by the licensee at the facility cited until the violation is corrected to the satisfaction of the Department. Each such citation shall be made promptly available by the licensee for inspection or examination by any member of the public who so requests. In addition, every licensee shall post in a place or places in plain view of the patient in the intermediate care facility, persons visiting those patients and persons who inquire about placement in the facility, a prominent notice informing such persons that copies of all final uncorrected violations issued by the Department to the facility will be made promptly available by the licensee for inspection by any person who so requests.

§ 73725. Interference with Official Duties.

(a) Any duly authorized officer, employee or agent of the Department may enter and inspect any facility, including, but not limited to, interviewing patients and reviewing records at any time. Inspections conducted pursuant to complaints filed with the Department shall be conducted in such a manner as to ensure maximum effectiveness. No advance notice shall be given of any inspection unless previously and specifically authorized by the Director or required by federal law.

(b) No licensee or employee of any intermediate care facility shall:

(1) Willfully prevent, interfere with or attempt to impede in any way the work of any duly authorized representative of the department in the lawful enforcement of his inspection duties.

(2) Willfully prevent or attempt to prevent any such representative from examining any relevant books or records in the conduct of his inspection duties.

(3) Willfully prevent or interfere with any such representative in the preserving of evidence of any violation of these regulations.

§ 73727. Discrimination or Retaliation.

(a) No licensee shall discriminate or retaliate in any manner against a patient or employee in its intermediate care facility on the basis or for the reason that such patient or employee or any other person has initiated or participated in any proceeding specified in these regulations. A licensee who violates this provision is also subject under Section 1432 of the Health and Safety Code to a civil penalty of no more than five hundred dollars ($500).

(b) Any attempt to expel a patient from an intermediate care facility or any type of discriminatory treatment of a patient by whom, or upon whose behalf, a complaint has been submitted to the Department or any proceeding instituted under or related to this article within 120 days of the filing of the complaint or the institution of such action, shall raise a rebuttable presumption that such action was taken by the licensee in retaliation for the filing of the complaint.

Chapter 7.2. Psychology Clinics

Article 1. Definitions

§ 75301. Accredited Record Technician.

Accredited record technician means a person accredited as such by the American Medical Record Association.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Section 1226, Health and Safety Code.

§ 75303. Clinic.

Clinic means psychology clinic when used in this chapter.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75305. Psychologist.

Psychologist means a person licensed as such by the California Board of Medical Quality Assurance.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75307. Registered Record Administrator.

Registered record administrator means a person who is registered as such by the American Medical Record Association.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Section 1226, Health and Safety Code.

Article 2. License

§ 75309. Application Required.

(a) A signed application shall be submitted to the Department for prior approval in any of the following circumstances:

(1) Establishment of a psychology clinic.

(2) Change of ownership.

(3) Change of license classification.

(4) Operation of a psychology clinic at a new location.

(b) Within 30 days of receipt of an application the Department shall inform the applicant, in writing, that the application is complete and accepted for filing or that the application is deficient and what specific information is required.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1, 1205 and 1226, Health and Safety Code and Section 15376(a) Government Code.

§ 75311. Content of Application.

(a) In addition to the contents of an application as required by Section 1212, Health and Safety Code, an application shall contain the following:

(1) The applicant's principal place of business.

(2) The date and state of incorporation for all incorporated applicants, corporation number and, if a foreign corporation, evidence of authority to do business in the State of California.

(3) A copy of the Internal Revenue Service determination letter, pursuant to Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, which is required for all nonprofit corporations.

(4) Name of the administrator and a description of the administrator's experience and background and, where the same person is the administrator of more than one clinic, the name of, and the number of hours spent in each clinic per week.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1, 1212 and 1226, Health and Safety Code.

§ 75313. Fees.

(a) The application fee for licensure shall not be refunded to the applicant if the application is withdrawn by the applicant or denied by the Department.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1214.5, Health and Safety Code.

§ 75315. Posting.

The license shall be conspicuously posted in a location accessible to public view.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1205, Health and Safety Code.

§ 75317. Report of Changes.

(a) Any change in the principal officer such as chairperson, president, or general manager of the governing board shall be immediately reported in writing to the Department, but in no case later than 10 days following such change. Such written notice shall include the name and principal business address of each new principal officer.

(b) When a change in administrator occurs, the Department shall be immediately notified in writing, but in no case later than 10 days following such change. Such notification shall include the name of the new administrator, the mailing address, the date of assuming office and a brief description of his or her background and qualifications.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1, 1212 and 1226, Health and Safety Code.

Article 3. Basic Services

§ 75321. Basic Services—General Requirements.

(a) All advice, diagnosis, and treatment shall be provided only by persons authorized by law to provide such services.

(b) Diagnostic and therapeutic services for the care and treatment of patients for whom the clinic accepts responsibility shall be provided in the clinic, or arranged for by the clinic with other licensed, certified, or registered providers.

(c) A psychology clinic shall provide reference materials and written patient care policies and procedures as described in Section 75325, which are approved by the Governing Body and are readily available to clinic personnel.

(d) The clinic may be required by the Department to obtain consultation where necessary to meet the patient care standards specified in these regulations.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75323. Basic Services—Psychology Staff.

(a) Every psychology clinic shall have a clinical psychologist as defined in Section 1316.5(c), Health and Safety Code, designated as the professional director.

(b) The professional director's responsibilities, acting alone or through an organized staff, shall include:

(1) Establishing, reviewing, and maintaining psychological policies and standards, which shall be reviewed at least annually.

(2) Assuring the quality of psychological services provided to all patients treated by the clinic.

(3) Establishing and implementing a system of peer review, pursuant to written procedures.

(4) Ensuring that all personnel are qualified by training and experience to perform those services they are assigned to provide.

(5) Reviewing credentials of the psychologists providing service in the clinic.

(c) At least one staff member of the clinic shall have admitting privileges to a hospital to ensure the availability of needed hospital services or a written plan, approved by the Department, to ensure that needed hospital services are available.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75325. Basic Services—Policies and Procedures.

(a) Written policies and procedures which the clinic shall implement shall include, but not be limited to:

(1) Description of the type and scope of services which the clinic will provide.

(2) Policies relating to patient care.

(3) Provisions for the education of patients in preventive, therapeutic and mental health maintenance care.

(4) Plans for follow–up of patients treated in the clinic which may include home care consistent with Section 1200.1, Health and Safety Code.

(5) Referral of patients to other agencies or health facilities.

(6) Provisions for handling emergencies and unusual occurrences.

(7) Procedures ensuring compliance with the legal requirements relative to the treatment of minors and persons who are under guardianship or conservatorship.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health an Safety Code.

Article 4. Administration

§ 75327. Governing Body.

(a) The governing body shall have full legal authority and responsibility for the operation of the psychology clinic including compliance with all applicable federal, state and local laws and regulations.

(b) The governing body shall operate pursuant to articles of incorporation and by–laws.

(c) Written records of all proceedings of the governing body shall be maintained and made available to the Department upon request.

(d) The governing body shall appoint an administrator by governing body resolution.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75329. Administrator.

(a) The governing body shall delegate to the administrator authority to carry out the day–to–day functions of the psychology clinic and the responsibility for ensuring that the psychology clinic conforms to all applicable federal, state and local laws and regulations.

(b) The qualifications, authority, and duties of the administrator shall be defined in a job description approved by the governing body.

(c) The administrator shall devote sufficient time to administrative responsibilities to ensure the proper administration and management of the psychology clinic. The administrator may be responsible for more than one psychology clinic only if all clinics are operated by the same governing body.

(d) The administrator shall designate in writing an individual to act in his or her absence, in order to provide the clinic with administrative direction at all times.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75331. Written Administrative Policies.

(a) Written administrative policies shall be established and implemented and shall be reviewed at least annually and revised as necessary.

(b) The policies shall include but not limited to the following:

(1) Management and personnel policies which include job descriptions detailing the functions of each classification of employee or volunteer.

(2) Policies for acceptance of a patient and termination of services shall include rate of charge for care, charges for outside services, limitation of services, cause for termination of services and refund policies applying to termination of services. These policies shall be made available to patients or their agents upon admission and upon request and shall be made available to the public upon request.

(3) Policies and procedures governing patient treatment records.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75333. Employees.

(a) The psychology clinic shall recruit qualified personnel and provide initial orientation of new employees, a continuing in–service training program, and supervision designed to improve patient services and employee efficiency.

(b) The clinic shall provide a copy of the appropriate job description to each person employed or volunteering to work in the clinic.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75335. Employee Health Examinations and Health Records.

(a) A health examination, performed by a person lawfully authorized to perform such an examination shall be performed as a prerequisite for employment within six months prior to employment or within one week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties and do not have any health condition that would create a hazard for the employee, fellow employees, patients or visitors. The initial health examination shall include a tuberculosis screening test consisting of a purified protein derivative intermediate strength intradermal skin test and a chest X–ray if the skin test is positive. The psychology clinic shall establish a policy regarding subsequent health examinations and tuberculosis screening tests based on an assessment of the following:

(1) The risk of a previously infected person developing tuberculosis and then possibly infecting others.

(2) The risk of a non–infected person becoming infected and developing a disease.

(b) The facility shall develop policies which ensure that reasonable precautions are taken to prevent the spread of infectious disease between persons within the clinic.

(c) Employee health records shall be maintained by the clinic and shall include the records of all required health examinations. Such records shall be kept a minimum of three years following termination of employment.

NOTE: Authority cited: Sections 208(a) ad 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75337. Employee Records.

(a) All psychology clinics shall maintain current and accurate personnel records for all persons working for the clinic. The record shall include the person's full name, social security number, license, registration or certification number, if any, and date of expiration, employment classification, date of beginning employment, date of termination of employment and performance evaluations. Such records shall be retained for at least three years following termination of employment.

(b) Employee personnel records shall be maintained in a confidential manner and shall be made available to representatives of the Department upon request in order to ensure compliance with the requirements of these regulations.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75339. Unusual Occurrences.

Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural cause or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or, in areas not having an organized fire service, to the State Fire Marshal.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75341. Patient Treatment Record Service.

(a) Each psychology clinic shall establish and maintain a patient treatment record service which is systematically organized to provide a complete accurate, correlated, and current treatment record for each patient which, is filed in a centrally located area.

(b) The treatment record service shall be located to facilitate immediate retrieval of required information.

(c) A person working in the clinic shall be responsible for the direction and supervision of the treatment record service to ensure that all patient records are accurately documented, completed, indexed, and filed in the unit system. When the Department finds the treatment record service does not meet the standards set forth in these regulations, the clinic may be required to obtain the services of either an accredited records technician or registered record administrator to assist in establishing and maintaining the treatment record service.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75343. Unit Patient Treatment Records.

(a) Records shall be permanent, either typewritten or legibly written in ink, and shall be kept on all patients accepted for treatment. All treatment records of discharged patients shall be completed and filed within 30 days after termination of each episode of treatment and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until one (1) year after the minor has reached the age of 18, but in no case less than seven (7) years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending psychologist, the clinic or any authorized officer, agency or employee of either, or any other person authorized by law to make such request.

(b) Information contained in the treatment records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state or local laws.

(c) If a psychology clinic ceases operation, arrangements shall be made for the safe preservation of the patients' treatment records. The Department shall be informed by the clinic of these arrangements prior to the 48 hours before cessation of operations.

(d) The Department shall be informed within 48 hours, in writing, by the licensee whenever patient treatment records are defaced or destroyed before termination of the required retention period.

(e) If the ownership of the clinic changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the Department with written documentation stating:

(1) That the licensee shall have custody of the patients' treatment records and these records shall be available to the former licensee, the new licensee and other authorized persons; or

(2) That other arrangements have been made by the current licensee for the safe preservation and the location of the patients' treatment records and they are available to both the new and former licensees and other authorized persons.

(f) Patients' treatment records shall be current and kept in detail consistent with good professional practice and shall describe the services provided to each patient. All entries shall be dated and be authenticated with the name and professional title of the person making the entry.

(g) Patients' treatment records shall be stored so as to be protected against loss, destruction or unauthorized use.

(h) Patient treatment records shall be filed in an easily accessible manner in the clinic. Storage of records shall provide for prompt retrieval when needed for continuity of care. Prior approval of the Department is required for storage of inactive treatment records away from the facility premises.

(i) The patient treatment record shall be the property of the facility and shall be maintained for the benefit of the patient, treatment team

and clinic and shall not be removed from the psychology clinic, except for storage purposes after termination of services or as required by law.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75345. Admission Records.

(a) The clinic shall complete an admission record for each patient which shall include the following:

(1) Name.

(2) Current address.

(3) Age and date of birth.

(4) Sex.

(5) Diagnosis.

(6) Date services began.

(7) Last date of services.

(8) If the patient is under guardianship or conservatorship, the name, address and telephone number of guardian or conservator.

(9) Consent for treatment authorizations.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75347. Disaster Program.

(a) Each clinic shall adopt a written disaster program and all personnel shall be instructed in its requirements. A copy of the program shall be available in the clinic for review by the Department.

(b) The program shall provide plans for disaster occurring within the facility. The written program shall include at least the following:

(1) Administrative procedures, including designated authority, and personnel duty assignments. There shall be provisions for simulated fire drills at least semi–annually and records to verify that such drills were conducted.

(2) Plans for evacuation of patients when necessary, including means of egress, methods of handling and transporting patients, and disposition and care of patients after removal from the clinic.

(c) The program shall be reviewed annually, and updated as needed.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75349. Posting of Clinic Schedule.

A schedule of the hours and days during which the clinic is open shall be conspicuously posted in the clinic for public view and information. The clinic shall be open and service available during the posted times. Changes in such schedules shall be posted in advance of the change.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75351. Quality Assurance Evaluation Program.

The clinic shall have a system for annual evaluation of its operation and the services it provides. This system shall include written procedures for evaluating the efficiency and effectiveness of the psychological services provided, and written procedures for he evaluation of utilization of services.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

Article 5. Physical Plant

§ 75353. Alterations and New Construction.

Alterations to existing buildings, or new construction, shall be in conformance with the applicable provisions of Chapter 1, Division T17, Part 6, Title 24, California Administrative Code.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75355. Fire Safety.

Each clinic shall maintain compliance with the rules and regulations of the State Fire Marshal as verified by an initial fire clearance issued by the State Fire Marshal.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75357. Maintenance and Operation.

(a) The clinic shall be clean, sanitary and in good repair at all times. Maintenance shall include provision and surveillance of maintenance services and procedures for the safety and well–being of patients, personnel and visitors.

(b) Flashlights shall be in readiness for use at all times. Open flame light shall not be used.

(c) A clinic shall be required to submit a report by a licensed structural engineer when the Department has determined that a structural condition of the clinic exists that may present a danger to the health and safety of occupants of the clinic. Such report shall provide a basis for a plan of correction.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Section 1226, Health and Safety Code.

§ 75359. Water Supply and Plumbing.

(a) Where water for human consumption is obtained from an independent source, it shall be subjected to bacteriological analysis by the local health department, the Department or a licensed commercial laboratory at least every three months. A copy of the most recent laboratory report shall be available for inspections.

(b) Plumbing and drainage facilities shall be maintained in compliance with Chapter 1, Division T17, Part 6, Title 24, California Administrative Code.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75361. Cleaning Equipment and Fixtures.

Each clinic shall provide for the cleaning of articles, equipment and surfaces such as furniture, walls, exhaust grills and light and plumbing fixtures.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75365. Solid Waste Containers.

(a) All containers, except movable bins, used for storage of solid wastes shall have tight–fitting covers in good repair, external handles, and shall be leakproof and rodent–proof.

(b) Movable bins, when used for storing or transporting solid waste from the premises, shall have tight–fitting covers and shall be rodent–proof, unless stored in an enclosed area.

(c) All containers receiving putrescrible wastes shall be emptied daily and more often if necessary.

(d) Solid waste containers, including movable bins, shall be thoroughly washed and cleaned each time they are emptied, unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each removable bin shall be accessible and shall have a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75367. Electrical Systems.

All electrical and other equipment used in the clinic shall be maintained free of defect which could be a potential hazard to patients or personnel and shall be included in a regular program of preventive maintenance.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 124.1 and 1226, Health and Safety Code.

§ 75369. Illumination.

Each clinic shall provide sufficient illumination for the comfort and safety of patients and personnel.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

§ 75371. Space Conversion.

Spaces approved for specific use at the time of licensure shall not be converted to other uses without the written approval of the Department. All areas, rooms, fixtures and equipment required by Chapter 1, Division T17, Part 6, Title 24, California Administrative Code, shall be maintained. Any request for Department approval of a proposed space conversion shall either be granted or denied, in writing, within 30 days of receipt by the Department.

NOTE: Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Sections 1204.1 and 1226, Health and Safety Code.

Chapter 9. Psychiatric Health Facilities

Article 1. Definitions

§ 77001. Accredited Record Technician.

Accredited Record Technician means a person who is accredited or eligible for accreditation as such by the American Medical Records Association.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77003. Authorized Representative.

Authorized representative means a person authorized to act on behalf of the patient by law, by court order or by written statement signed by the patient, unless the patient has been judicially declared incompetent. Except in State operated facilities, an authorized representative shall not be an owner, administrator, employee, representative or agent of the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77004. Clinical Psychologist.

Clinical psychologist means a psychologist licensed by this State and (1) who possesses an earned doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another State or by the United States to provide health care, or, is listed in the latest edition of the National Register of Health Service Providers in Psychology, as adopted by the Council for the National Register of Health Service Providers in Psychology.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77004.1. Communicable Disease.

Communicable disease means an illness due to a specific disease producing agent (virus, bacteria, etc.) or its toxic products which arises through transmission of that agent or its products from an infected person, animal or other reservoir to a susceptible host—either directly as from an infected person or animal, or indirectly through the agency of an intermediate plant or animal host, vector or the inanimate environment.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77005. Department.

Department means the State Department of Mental Health.

NOTE: Authority cited: Section 4080(f), Welfare and Institutions Code. Reference: Section 1275.1, Health and Safety Code.

§ 77007. Dietitian.

Dietitian means a person who is registered or eligible for registration as a Registered Dietitian by the American Dietetic Association.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77009. Director.

Director means the Director of the State Department of Mental Health.

NOTE: Authority cited: Section 4080(f), Welfare and Institutions Code. Reference: Section 1275.1, Health and Safety Code.

§ 77010. Exclusion Timeout.

Exclusion timeout means removing a patient from an activity to another area in the same room or vicinity for a period of time contingent on a specific maladaptive behavior.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77011. Governing Body.

Governing body means the person, persons, board of trustees, directors or other body in whom the authority and responsibility is vested for conduct of the facility. In the case of a facility operated by a governmental agency, the governing body may be the County Board of Supervisors, the City Council or any committee or individual so designated by such Board or Council.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77011.1. Infectious Disease.

Infectious disease means any disease caused by growth of pathogenic microorganisms in the body. May or may not be contagious.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77011.2. Licensed Clinical Social Worker.

Licensed clinical social worker means a person who possesses a master's degree from an accredited school of social work and two years of post master's experience in a mental health setting; and shall have obtained a license as a clinical social worker by the California Board of Behavioral Science Examiners.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77012. Licensed Mental Health Professional.

Licensed mental health professional means any of the following:

(a) A licensed psychologist who qualifies as a clinical psychologist as defined in these regulations.

(b) A psychiatrist as defined in these regulations.

(c) A licensed clinical social worker, as defined in these regulations.

(d) A licensed marriage, family and child counselor as defined in these regulations.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.)

§ 77012.1. Licensed Psychiatric Technician.

Licensed psychiatric technician means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77012.2. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as such by the California Board of Vocational Nurse and Psychiatric Technician Examiners.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77013. Local Bank.

Local bank means any bank which is in the vicinity of the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77014. Marriage, Family and Child Counselor.

Marriage, family and child counselor means a person licensed as

such by the Board of Behavioral Examiners pursuant to Business and Professions Code Section 4980 *et seq.*

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77017. Mental Health Worker.

Mental health worker means a person who does not qualify as a licensed health professional but who through experience, inservice training or formal education, is qualified to participate in the care of the psychiatric patient.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77018. On–Call.

On–call means immediately available for consultation by telephone and available to be in the facility within thirty (30) minutes if requested to do so.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code

§ 77019. Permanently Converted.

Permanently converted means space which is not available for patient accommodation because the facility has converted the space to some other use and such space could not be reconverted to patient accommodation within 24 hours.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1268 and 1275.1, Health and Safety Code.

§ 77021. Postural Support.

Postural support means a method other than orthopedic braces used to assist patients to achieve proper body position and balance.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77023. Psychiatrist.

Psychiatrist means a person who is licensed as a physician and surgeon in California and shows evidence of having completed three years graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77027. Registered Record Administrator.

Registered record administrator means a person who is registered or eligible for registration as such by the American Medical Record Association.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77028. Sanction.

Sanction means a penalty imposed against a psychiatric health facility for noncompliance with regulations and laws pertaining to psychiatric health facilities. Sanctions may include:

(a) Cease and desist orders.

(b) Monetary penalties.

(c) License suspension.

(d) License revocation.

NOTE: Authority cited: Section 4080(j)(2), Welfare and Institutions Code; and Section 1275, Health and Safety Code. Reference: Section 4080(j), Welfare and Institutions Code.

§ 77029. Seclusion.

Seclusion means the isolation of a patient in a locked area, for the purpose of modifying a behavior.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77030. Structured Outpatient Services.

Structured Outpatient Services (SOPS) are services provided on a less than 24–hour basis by a psychiatric health facility with special permit from the Department.

NOTE: Authority cited: Sections 1254(e) and 1275, Health and Safety Code. Reference: Sections 1250.2(b) and 1266.1(f), Health and Safety Code.

§ 77031. Supervision.

(a) Supervision means the instruction of employees or subordinates in the manner of carrying out their duties and overseeing or directing of their work.

(b) Direct supervision means that the supervisor shall be present in the same building as the person being supervised and available for consultation and/or assistance.

(c) Immediate supervision means that the supervisor shall be physically present while a task is being performed.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77033. Treatment Restraint.

Treatment restraint means the use of a restraining device during medically prescribed treatment or diagnostic procedures such as, but not limited to, intravenous therapy, tube feeding or catheterization.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77035. Unit Patient Health Record.

Unit patient health record means a patient's health record that contains, in one file, all records of inpatient and outpatient care and treatment rendered to a patient by the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77036. Unusual Occurrences.

An unusual occurrence means any condition or event which has jeopardized or could jeopardize the health, safety, security or well–being of any patient, employee or any other person while in the facility and shall include, but not be limited to:

(1) An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such communicable disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors.

(2) Poisonings.

(3) Fires.

(4) Physical injury to any person which, consistent with good medical and professional practice, would require treatment by a physician.

(5) Death of a patient, employee or visitor from unnatural causes.

(6) Sexual acts involving patients who are nonconsenting.

(7) Physical assaults on patients, employees or visitors.

(8) All instances of patient abuse.

(9) Actual or threatened walkout, or other curtailment of services or interruption of essential services provided by the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

Article 2. Licensing and Inspection

§ 77037. Application Required.

(a) A signed application for a new license shall be submitted to the State Department of Mental Health whenever any of the following circumstances occur:

(1) Establishment of a facility.

(2) Change in the entity that operates, conducts, maintains, or manages the facility.

(b) The licensee shall submit a signed application for a corrected license to the Department whenever any of the following occur:

(1) Construction of a new or replacement facility.

(2) Increase in licensed bed capacity.

(3) Change of license category.

(4) Change of name of facility.

(5) Change of location of facility.

(6) Change in bed classification.

(7) Decrease in licensed bed capacity.

NOTE: Authority cited: Section 1254, Health and Safety Code; and Section 4080(f), Welfare and Institutions Code. Reference: Sections 1253, 1254.1 and 1275.1, Health and Safety Code.

§ 77038. Application Procedure for Obtaining a License.

(a) Whenever an application is submitted pursuant to Sections 77037 or 77070:

(1) The Department shall inform the applicant, within 30 calendar days of receipt of an application for a license or special permit, that the application is complete and accepted for filing, or that the application is deficient and what specific information, documentation, or fee is required to complete the application.

(2) It is considered complete when all documents, information or fees required to be submitted on or with an application have been received by the Department.

(b) If the applicant fails to respond within 30 calendar days to the Department's request pursuant to (a)(1) above for additional information, documentation, or fees, the application shall be deemed to have been withdrawn by the applicant.

(c) Any applicant deemed to have withdrawn an application pursuant to subsection (b) above may re–apply by submitting a new application.

(d) The Department, within 60 calendar days of submission of a completed application, shall notify the applicant in writing, of the agency's decision regarding the application.

(e) If the Department fails to notify an applicant within the time period specified in (d) above, the applicant may appeal in writing directly to the Director. The written appeal shall include:

(1) An identification of the applicant and the application;

(2) The date upon which the application was submitted;

(3) A copy of any correspondence between the Department and the applicant regarding the application; and

(4) Any other information which the applicant wishes to submit regarding the timeliness of the Department's consideration of the application.

(f) Nothing in this section shall be construed to require the Department issue a license as a psychiatric health facility.

NOTE: Authority cited: Section 15376, Government Code; and Section 1275, Health and Safety Code. Reference: Sections 15376 and 15378, Government Code and Sections 1253, 1265, 1266.1(f), 1275.1 and 1276, Health and Safety Code.

§ 77039. Safety, Zoning and Building Clearance.

(a) A license shall not be issued to any psychiatric health facility which does not conform to the State Fire Marshal's requirement for fire and life safety, the State requirements for environmental impact, and local fire safety, zoning and building ordinances. The following evidence of such compliance shall be presented in writing to the Department:

(1) The facility must obtain a fire clearance consistent with State Fire Marshal standards for psychiatric health facilities.

(2) The evidence of compliance must contain approval for the facility to use restraint and seclusion as required in Section 77101(a) and (b).

(b) It shall be the responsibility of the licensee to maintain the psychiatric health facility in a safe structural condition. If the Department determines that an evaluation of the structural condition of a psychiatric health facility building is necessary, the licensee may be required to submit a report by a licensed structural engineer which shall establish a basis for eliminating or correcting the structural conditions which are found to be hazardous to occupants.

(c) Hot water temperature controls shall be maintained to automatically regulate the temperature of hot water delivered to plumbing fixtures used by patients in compliance with Sections 611.0–611.9, Part 5, Title 24, California Code of Regulations.

NOTE: Authority cited: Sections 1254 and 1275, Health and Safety Code. Reference: Sections 1253, 1265, 1275.1 and 1276, Health and Safety Code.

§ 77041. Issuance, Expiration and Renewal.

(a) Each initial license shall be issued in accordance with Section 1267, Health and Safety Code, and shall expire at midnight, one year from the date of issue.

(b) Each renewal license shall be issued in accordance with Section 1267, Health and Safety Code.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1267 and 1275.1, Health and Safety Code.

§ 77043. Separate License.

(a) A separate license shall be required for each psychiatric health facility that is maintained on separate premises even though they are under the same management.

(b) Separate licenses shall not be required for separate buildings on the same grounds or adjacent grounds provided that they operate as one psychiatric health facility.

(c) A licensed psychiatric health facility shall not provide services other than those provided in these regulations, or hold any other license or certificate to provide services, without the written permission of the Department.

(d) A psychiatric health facility shall not be dependent upon any other facility for its staff, facility or program.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2, 1253 and 1275.1, Health and Safety Code.

§ 77045. Posting of License and Consumer Information.

(a) The license, or a true copy thereof, shall be posted in a prominent location within the licensed premises and accessible to public view.

(b) Any approval of the Department granted under program flexibility shall be posted immediately adjacent to the facility's license.

(c) The following consumer information shall be posted in a prominent location accessible to public view.

(1) Name of the current administrator of the facility.

(2) A notice that the facility's written admission and discharge policies are available upon request.

(3) Most recent licensing visit report supported by the related follow–up plan of correction visit reports or a posted statement that such documents are available upon request for public review at the facility.

(4) A notice of the name, address and telephone number of the Department of Mental Health division having jurisdiction over the facility.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77047. Report of Changes.

The licensee shall notify the Department within 10 days, in writing, of any of the following:

(a) Any change of clinical director or administrator of business and support services.

(b) Any change of the principal officers of the corporation if other than a public entity.

(c) Any change of the mailing address of the licensee.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1265 and 1275.1, Health and Safety Code.

§ 77049. Program Flexibility.

All facilities shall maintain continuous compliance with the licensing requirements. Such requirements, however, do not prohibit the use of alternate concepts, pursuant to Section 1276(b) of the Health and Safety Code.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1268, 1275.1 and 1276(b), Health and Safety Code.

§ 77051. Voluntary Suspension of Licensure or Licensed Beds.

(a) Any license or portion thereof, which has been suspended for a period of time approved by the Department shall remain subject to all renewal requirements of an active license, including the payment of license renewal fees during the period of suspension.

(b) If the license is not reinstated during the period of approved suspension, the license shall expire automatically and shall not qualify for reinstatement; however, an application may be submitted for a new license.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1300, Health and Safety Code.

§ 77052. Imposition of Sanctions.

The suspension and revocation of a license shall be initiated in accordance with Health and Safety Code, Section 1294. The Director may impose sanctions when a facility demonstrates a failure to comply with the laws and regulations that govern psychiatric health facilities.

(a) The Department shall issue a cease and desist order if, in the opinion of the Department, an immediate danger to the health, welfare and safety of the facility's patients exists.

(b) Monetary penalties levied against a facility shall be in accordance with Welfare and Institutions Code, Section 4080(j)(1)(B).

NOTE: Authority cited: Section 1275, Health and Safety Code; and Section 4080(f) and (j), Welfare and Institutions Code. Reference: Sections 1275.1 and 1294, Health and Safety Code; and Section 4080(j), Welfare and Institutions Code.

§ 77052.5. Appeal of Sanctions.

(a) All appeals of denial of licensure or imposition of a sanction, imposed in accordance with Section 77028, shall be made pursuant to this section and shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The Director shall notify in writing an applicant of a denial of licensure and a licensee of an imposed sanction.

(c) All notifications and all accompanying information may be served personally or by registered mail to the applicant's/licensee's latest address on file with the agency.

(d) The notice shall contain the following:

(1) The effective date of the denial or sanction, written delineation of the bases for the denial/sanction, and a copy of this section, governing the procedure for an appeal of a denial/sanction.

(2) A written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the applicant/licensee is charged, in a manner that the applicant/licensee will be able to prepare his defense.

(3) Specificity regarding the statutes and regulations which the applicant/licensee is alleged to have violated, but shall not consist merely of charges phrased in the language of such statutes and regulations.

(e) The Department may include with the notice any information which it deems appropriate, but it shall include a notice of defense which, when signed by or on behalf of the applicant/licensee and returned to the Department, will acknowledge service of the notice and constitute a notice of defense under Section 11506 of the Government Code.

(f) The copy of the notice of defense shall include or be accompanied by (1) a statement that the applicant/licensee may request a hearing by mailing a notice of defense as provided in Section 11506 of the Government Code within 15 days after service upon the applicant/licensee of the notice, and that failure to do so will constitute a waiver of the applicant/licensee's right to a hearing, and (2) copies of Sections 11507.5, 11507.6, and 11507.7 of the Government Code.

(g) Unless a written request for a hearing signed by or on behalf of the applicant/licensee in the accompanying notice is delivered or mailed to the Department within 15 days after the notice was personally served on the applicant/licensee or mailed to the applicant/licensee, the Department of Mental Health may proceed upon the notice without a hearing.

(h) The request for a hearing may be made by delivering or mailing the notice of defense, or by delivering or mailing a notice of defense as provided by Section 11506 of the Government Code to: the Department of Mental Health, Licensing and Certification, 1600 9th Street, Sacramento, California 95814. The applicant/licensee may, but is not required to, be represented by counsel at any or all stages of these proceedings. If the applicant/licensee desires the names and addresses of witnesses or an opportunity to inspect and copy the items mentioned in Section 11507.6 of the Government Code in the possession, custody or control of the Department, the applicant/licensee may contact: the Department of Mental Health, Licensing and Certification, 1600 9th Street, Sacramento, California 95814.

(i) The suspension, expiration, or forfeiture of a license issued by the Department shall not deprive the Department of its authority to institute or continue a proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking a license or otherwise taking disciplinary action against the licensee on any such ground.

NOTE: Authority cited: Section 1275, Health and Safety Code; and Section 4080(j)(2), Welfare and Institutions Code. Reference: Section 4080(f) and (j), Welfare and Institutions Code.

§ 77053. Bonds.

(a) Psychiatric health facilities with the exception of psychiatric health facilities operated by public entities, which handle $25.00 or more per patient or $500.00 or more for all patients within any one month, shall post a bond in accordance with the following schedule:

Amount Handled	*Bond Required*
$25 or more per patient or $500 or over and up to $750 for all patients within one month	$1,000
$751 to $1,500	$2,000
$1,501 to $2,500	$3,000
$2,500.01 and above	additional $1,000 bond for each $1,000 or fraction thereof of patients funds handled in excess of $2,500

(b) Each application for an original license or renewal of license, with the exception of psychiatric health facilities operated by public entities, shall be accompanied by an affidavit on a form provided by the Department. The affidavit shall state whether the licensee handles or will handle money of patients and the maximum amount of money to be handled for any patient and for all patients in any month.

(c) No licensee shall handle amounts greater than those stated in the affidavit submitted by the licensee without first notifying the Department and filing a new or revised bond if required.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1318, Health and Safety Code.

§ 77055. Convictions of Crime: Standards for Evaluating Rehabilitation.

(a) When considering the denial, suspension or revocation of a license based on the conviction of a crime in accordance with Section 1265.1 or 1294 of the Health and Safety Code, the following criteria shall be considered in evaluating rehabilitation.

(1) The nature and the seriousness of the crime(s) under consideration.

(2) Evidence of conduct subsequent to the crime which suggests responsible or irresponsible character.

(3) The time which has elapsed since commission of the crime or conduct referred to in subsection (1) or (2) above.

(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.

(5) Any rehabilitation evidence submitted by the applicant.

NOTE: Authority cited: Sections 208(a), 1265.2 and 1275, Health and Safety Code. Reference: Sections 1265, 1265.1, 1265.2, 1277 and 1294, Health and Safety Code.

Article 3. Services

§ 77059. Basic Services.

The facility may provide services to patients either directly or by written agreement with outside resources as specified in Section 77109.

NOTE: Authority cited: Section 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77061. Staffing.

(a) The facility shall have a clinical director who shall be a licensed mental health professional and qualified in accordance with Section 77093 of these regulations.

(b) The clinical director may also serve as the administrator.

(c) The clinical director shall designate a clinical psychologist or psychiatrist to review and approve interdisciplinary treatment plans.

(d) A physician shall be on–call at all times for the provision of physical health care and those services which can only be provided by a physician. The person in charge of patient care services on each shift shall be provided with the name(s) and means of locating and contacting the available physician. Patients requiring general acute physical health care shall be diverted from admission or transferred to a general acute care hospital. An individual patient may be admitted to a psychiatric health facility if the individual's physical health care could otherwise be managed on an outpatient basis.

(e) If the clinical director is not a physician, responsibility for those aspects of an individual treatment plan which may only be performed by a physician, shall be assumed by a physician.

(f) During the absence of any staff required in subsection (h)(1) below there shall be a substitute person with the required qualifications to provide the number of hours of services required.

(g) Community practitioners who are approved to admit and/or attend patients in the facility may be calculated as part of the staffing pattern only if they are retained by written contract to provide services for a specified number of hours to the patients at the facility.

(h) Each facility shall meet the following full–time equivalent staff to census ratio, in a 24 hour period:

(1) Inpatient Census:	1–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–90	91–100
Staff										
Psychiatrist or Clinical Psychologist or Clinical Social Worker or Marriage, Family and Child Counselor	1	2	3	4	5	6	7	8	9	10
Registered Nurse or Licensed Vocational Nurse or Psychiatric Technician	4	5	6	8	10	12	14	16	18	20
Mental Health Worker	3	5	8	10	13	15	18	20	23	25
Totals:	8	12	17	22	28	33	39	44	50	55

(2) For facilities in excess of 100 beds, staffing shall be provided in the ratios as in (1) above.

(3) A registered nurse shall be employed 40 hours per week.

(4) There shall be a registered nurse, a licensed vocational nurse, or a psychiatric technician awake and on duty in the facility at all times.

(i) The required staffing ratio shall be calculated based upon the inpatient census and shall provide services only to psychiatric health facility patients.

(j) Regardless of the minimum staffing required in subsection (h)(1) above, the facility shall employ professional and other staff on all shifts in the number and with the qualifications to provide the necessary services for those patients admitted for care.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code

§ 77063. Psychiatric, Psychological and Counseling Services.

(a) Psychiatric services shall be provided by licensed physicians with training and/or experience in psychiatry.

(b) Psychological services shall be provided by clinical psychologists in accordance with Business and Professions Code, Section 2903 and Health and Safety Code, Section 1316.5.

(c) Counseling services shall be provided by licensed clinical social workers in accordance with Business and Professions Code, Sections 4996 and 4996.9, or licensed marriage, family and child counselors in accordance with Business and Professions Code, Sections 4980 and 4980.02.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77065. Psychiatric Nursing Services.

(a) Psychiatric nursing services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan.

(b) Policies and procedures for the administration of medications shall be implemented by the psychiatric nursing service.

(c) Nursing services shall include the development of a nursing care plan based upon an initial written and continuing assessment with input from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within 72 hours after admission. Nursing care plans shall either be included as a part of the interdisciplinary treatment plan or occupy a unique section of the patient record.

(d) Written nursing services policies and procedures shall be developed which include:

(1) A current nursing procedure manual appropriate to the patients served by the facility.

(2) Provision for the inventory and identification of patients' personal possessions, equipment and valuables.

(3) Screening of all patients for tuberculosis upon admission. A tuberculosis screening procedure may not be required if there is satisfactory written evidence available that a tuberculosis screening procedure has been completed within 90 days of the date of admission to the facility. Subsequent tuberculosis screening procedures shall be determined by a physician.

(4) Notification of practitioner regarding sudden or marked adverse change in a patient's condition.

(5) Conditions under which restraints are used, the application of restraints, and the mechanism used for monitoring and controlling their use.

(6) A planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care and for resolving identified problems.

(e) Psychiatric nursing policies and procedures shall either be integrated into a separate section of a general manual or contained in

a policy and procedure manual dedicated to nursing policies and procedures.

(f) There shall be a written staffing pattern which shall show:

(1) Total numbers of staff including full–time and full–time equivalents.

(2) The available nursing care hours for each nursing unit.

(3) The categories of staff available for patient care.

(g) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualification:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or

(3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

(h) Psychiatric health facility policies and procedures shall specify how a registered nurse will exercise authority and carry out the responsibility of supervising nursing activities such as, but not limited to:

(1) Dispensing, and recording of medication(s).

(2) Documenting patients' nursing care needs in the interdisciplinary treatment plan.

(3) Implementing nursing procedures.

(4) Providing inservice education related to nursing activities.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77067. Social Services.

(a) Social services shall be designed to meet the objectives of each patient's interdisciplinary treatment plan in accordance with established policies and procedures.

(b) Social services shall be organized, directed and supervised by a licensed clinical social worker.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77069. Rehabilitation Services.

(a) Rehabilitation services mean those activities provided by occupational therapists, physical therapists or recreation therapists under the general direction of the clinical director to restore, establish and maintain optimum levels of social, vocational and physical functioning and to minimize residual disabilities of patients. Rehabilitation services provided in a psychiatric health facility are to be designed to meet the needs of acute psychiatric inpatients.

(b) In accordance with established policies and procedures, the scope of these activities shall include at least the following:

(1) Social activities which involve group participation.

(2) Recreational activities, both indoor and outdoor.

(3) Opportunity to participate in activities outside of the facility if appropriate.

(4) Exercises.

(c) A physician shall prescribe in the health record the level of physical activity in which a patient may engage.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77070. Structured Outpatient Services Program.

(a) An application for a special permit for structured outpatient services shall include all of the following:

(1) The identification of a structured outpatient services coordinator.

(2) A written policy that the facility will have staffing based on census consistent with Section 77061(h), for the services to be provided under the special permit.

(b) The Department may require the applicant to provide verification and clarification of information submitted in an application.

(c) Structured outpatient services shall be an alternative to admission to inpatient services, aftercare services following discharge from inpatient care, or both.

(1) Structured outpatient services are not to exceed 10 daytime hours.

(2) The charge for patients in both a morning and an afternoon program on the same day shall not exceed 60 percent of the facility's authorized per diem charge for inpatient services.

(3) The charge for patients in either a morning or afternoon program shall not exceed 30 percent of the facility's authorized per diem charge for inpatient services.

(d) The facility shall have staffing for the services to be provided under the special permit in addition to that required by Section 77061.

(1) Staff shall meet the same professional standards as required under these regulations.

(2) The facility shall appoint a coordinator of structured outpatient services.

(e) When a facility is issued a permit, structured outpatient services are to be provided as one of the program aspects of the psychiatric health facility.

NOTE: Authority cited: Sections 1254(e) and 1275, Health and Safety Code. Reference: Sections 1250.2(b) and 1266.1(f), Health and Safety Code.

§ 77071. Aftercare Services.

(a) Prior to or at the time of discharge, each patient shall be evaluated concerning the patient's need for aftercare services with the result of that evaluation noted in the patient's health record.

(b) Aftercare services are those services to, and on behalf of, a patient following discharge from the psychiatric health facility for the purpose of enabling the patient to achieve an optimum level of functioning.

(c) Aftercare services shall include but not be limited to the following:

(1) Arranging for out–of–home placement if necessary.

(2) Arranging for medication supervision if indicated.

(3) Obtaining community social, vocational and educational services if appropriate.

(d) If a licensed psychiatric health facility does not provide its own aftercare service through its employed staff, it shall affiliate or have an agreement with a recognized aftercare agency in the facility's service area to provide aftercare services to patients who could benefit from such services upon discharge from the facility.

(e) A member of the interdisciplinary team designated by the clinical director, shall be responsible for ensuring that the referral of the patient to the appropriate aftercare service has been completed and documented in the patient's health record.

(f) In accordance with Health and Safety Code, Section 1284 and Welfare and Institutions Code, Section 5622, aftercare plans shall be transmitted to the local director of mental health services in the county of residence for any patient placed in the facility under a county Short–Doyle plan.

(g) The content of the aftercare plan shall conform to the requirements of Health and Safety Code, Section 1284.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2, 1275.1 and 1284, Health and Safety Code.

§ 77073. Interdisciplinary Treatment Plan.

(a) A written interdisciplinary treatment plan shall be developed and implemented by the interdisciplinary treatment team for each patient as soon as possible after admission but no longer than 72 hours following the patient's admission, Saturdays, Sundays and holidays excepted.

(b) The interdisciplinary treatment plan shall include as a minimum:

(1) A statement of the patient's physical and mental condition, including all diagnoses.

(2) Specific goals of treatment with interventions and actions, and observable, measurable objectives.

(3) Methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(c) The interdisciplinary treatment plan shall be reviewed and modified as frequently as the patient's condition warrants, but at least weekly.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77075. Transfer Summary.

A transfer summary shall accompany the patient upon transfer to another health facility. The transfer summary shall include information relative to the patient's diagnosis, known residual behaviors or symptoms of mental disorder, medications, treatments, dietary requirements, rehabilitation potential, and known allergies and shall be signed by the clinical director or the clinical director's designee as specified in Section 77061(c).

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77077. Dietetic Services.

(a) The total daily diet for patients shall be of the quality and in the quantity necessary to meet the needs of the patients and shall meet the "Recommended Dietary Allowances," 9th edition, 1980, or most current edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Science, adjusted to the age, activity and environment of the group involved. All food shall be of good quality and be selected, stored, prepared and served in a safe and healthful manner. The following shall apply:

(1) Arrangements shall be made so that each patient has available at least three meals per day. Not more than fourteen (14) hours shall elapse between the third and first meal.

(2) A facility may choose to purchase, store and prepare the required food for its patients, or it may choose to purchase prepared meals from other appropriate sources, through a written contract.

(3) When a non–inpatient program exceeds four hours, nourishment or snacks shall be available.

(4) A person shall be designated by the administrator to be responsible for the management and operation of the food service. This may be provided by a full–time or part–time employee with the facility, or through a written contract with an outside supplier or food service. If this person is not a dietitian, provision shall be made for consultation from a person so qualified, who shall provide this consultation at least 4 hours every three months. If total food service is by contract, a staff member will be designated to monitor the operation of the food service within the facility.

(5) If patients participate in food preparation and/or service to inpatients as part of their interdisciplinary treatment plan, they shall comply with the same policies and procedures as those required for food service employees.

(6) Pesticides and other toxic substances shall not be stored in the food store rooms, kitchen areas, or where kitchen equipment or utensils are stored, or accessible to patients.

(7) Supplies of staple foods for a minimum of two days shall be maintained on the premises.

(8) All kitchen equipment, fixed or mobile, and dishes, shall be kept clean and maintained in good repair and free of breaks, open seams, cracks or chips.

(9) All utensils used for eating and drinking and in the preparation of food and drink shall be cleaned and sanitized after each usage.

(10) The facility shall maintain a written plan to provide patients' food service in emergencies.

(b) Provisions shall be made to provide patients with access to beverages and nourishments at times when the main dietary service is not in operation.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250.2 and 1275.1, Health and Safety Code.

§ 77079.1. Pharmaceutical Services—General.

(a) Arrangements shall be made with pharmacists licensed by the California Board of Pharmacy to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage, disposal and administration of drugs and biologicals shall be in conformance with state and federal laws.

(c) If a pharmacy is located on the premises, the pharmacy shall be approved by the Department. The pharmacy shall not serve the general public unless a separate public entrance or a separate public serving window is utilized. Pharmacies located on the licensed premises of the facility shall be opened for inspection upon the request of an authorized Department representative.

(d) The facility shall not accept money, goods or services free or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.2. Pharmaceutical Services—Requirements.

(a) Pharmaceutical service shall include, but not be limited to, the following:

(1) Obtaining necessary drugs including the availability of 24–hour prescription service on a prompt and timely basis as follows:

(A) Drugs ordered "Stat" that are not available in the facility emergency drug supply shall be available and administered within one hour of the time ordered during normal pharmacy hours. For those hours during which the pharmacy is closed, drugs ordered "Stat" shall be available and administered within two hours of the time ordered. Drugs ordered "Stat" which are available in the emergency drug supply shall be administered immediately.

(B) Anti–infectives and drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within four hours of the time ordered.

(C) Except as indicated above, all new drug orders shall be available on the same day ordered unless the drug would not normally be started until the next day.

(D) Refill of prescription drugs shall be available when needed.

(2) Dispensing of drugs and biologicals.

(3) Monitoring the drug distribution system which includes ordering, dispensing and administering of medication.

(4) Provision of consultative and other services furnished by pharmacists which assist in the development, coordination, supervision and review of the pharmaceutical services within the facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.3. Pharmaceutical Services—Labeling and Storage of Drugs.

(a) Containers which are cracked, soiled or without secure closures shall not be used. Drug labels shall be legible.

(b) All drugs obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing. No person other than the dispenser or prescriber of the drug shall alter any prescription label.

(c) Nonlegend drugs shall be labeled in conformance with state and federal food and drug laws.

(d) Test reagents, germicides, disinfectants and other household

substances shall be stored separately from drugs and shall not be accessible to patients.

(e) External use drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use.

(f) Drugs shall be stored at appropriate temperatures. Drugs required to be stored at room temperature shall be stored at a temperature between 15ºC (59ºF) and 30ºC (86ºF). Drugs requiring refrigeration shall be stored in a refrigerator between 2ºC (36ºF) and 8ºC (46ºF). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed container clearly labeled "drugs."

(g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.

(h) Dose preparation and administration areas shall be well–lighted.

(i) Drugs shall be accessible only to personnel designated in writing by the licensee.

(j) Medication shall not be kept at the patient's bedside.

(k) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

(*l*) The drugs of each patient shall be kept and stored in their originally received containers. No drug shall be transferred between containers.

(m) Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within 90 days of the date the drug order was discontinued, unless the drug is reordered within that time.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.4. Pharmaceutical Services—Stop Orders.

Written policies shall be established and implemented limiting the duration of new drug orders in the absence of a prescriber's specific indication for duration of therapy. the prescriber shall be contacted for new orders prior to the termination time established by the policy. Such policies shall include all categories of drugs.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.5. Pharmaceutical Services—Orders for Drugs.

(a) No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.

(b) All drug orders shall be written, dated, timed and signed by the person lawfully authorized to give such an order. The name, quantity or specific duration of therapy, dosage and time or frequency of administration of the drug and route of administration if other than oral shall be specified. "P.R.N." orders shall also include the indication for the use of the drug.

(c) Verbal orders for drugs and treatment shall be received only by licensed nurses, psychiatric technicians, pharmacists, physicians and physician's assistants from their supervising physicians only. Such orders shall be recorded immediately in the patient's health record by the person receiving the order and shall include the date and time of the order. The order shall be signed by the prescriber within 24 hours excluding weekends and holidays.

(d) The signing of orders shall be by signature or a personal computer key. Signature stamps shall not be used.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.6. Pharmaceutical Services—Drug Order Processing.

Signed orders for drugs shall be transmitted to the issuing pharmacy within 48 hours, either by written prescription of the prescriber or by an order form which produces a direct copy of the order or by an electronically reproduced facsimile.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.7. Pharmaceutical Services—Drug Order Records.

Facilities shall maintain a record which includes, for each drug ordered by prescription, the name of the patient, the drug name, and strength, the date ordered, the date and amount received and the name of the issuing pharmacy. The records shall be kept at least one year.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.8. Pharmaceutical Services—Personal Medications.

(a) Medications brought by or with the patient on admission to the facility shall not be used unless the contents of the containers have been examined and positively identified after admission by the patient's physician or a pharmacist retained by the facility.

(b) The facility may use drugs transferred from other licensed health facilities or those drugs dispensed or obtained after admission from any licensed or governmental pharmacy and may accept the delivery of those drugs by any agent of the patient or pharmacy without the necessity of identification by a physician or pharmacist.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.9. Pharmaceutical Services—Controlled Drugs.

(a) Drugs listed in Schedules II, III and IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 *et seq.* shall not be accessible to other than licensed nursing, pharmacy and medical personnel designated by the licensee. Drugs listed in Schedule II of the above Act shall be stored in a locked cabinet or a locked drawer separate from noncontrolled drugs unless they are supplied on a scheduled basis as part of a unit dose medication system.

(b) Separate records of use shall be maintained on all Schedule II drugs. Such records shall be maintained accurately and shall include the name of the patient, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug. Such records shall be reconciled at least daily and shall be retained at least one year. If such drugs are supplied on a scheduled basis as part of a unit dose medication system, such records need not be maintained separately.

(c) Drug records shall be maintained for drugs listed in Schedules III and IV of the above Act in such a way that the receipt and disposition of each dose of any such drug may be readily traced. Such records need not be separate from other medication records.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.10. Pharmaceutical Services—Disposition of Drugs.

(a) Drugs which have been dispensed for individual patient use and are labeled in conformance with state and federal law for outpatient use shall be furnished to patients on discharge on the order of a physician. If the discharge orders do not include provisions for drug disposition, drugs shall be furnished to patients unless:

(1) A physician's order specifies otherwise or,

(2) The patient leaves or is discharged without a physician's order or approval or,

(3) The patient is discharged to a general acute care hospital or acute psychiatric hospital, or

(4) The drug was discontinued prior to discharge or,

(5) The labeled directions for use are not substantially the same as most current orders for the drug in the patient's health record.

(b) A record of the drugs sent with the patient shall be made in the patient's health record.

(c) Patient's drugs supplied by prescription which have been

discontinued and those which remain in the facility after discharge of the patient shall be destroyed by the facility in the following manner:

(1) Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 *et seq.* shall be destroyed by the facility in the presence of a pharmacist and a registered nurse employed by the facility. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signature of the witnesses required above shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(2) Drugs not listed under Schedules II, III or IV of the above Act shall be destroyed by the facility in the presence of a pharmacist or licensed nursing personnel. The name of the patient, the name and strength of the drug, the prescription number (if applicable), the amount destroyed, the date of destruction and the signature of the person named above and one other person shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(d) Unless otherwise prohibited under applicable federal or state laws, individual patient drugs supplied in sealed containers may be returned, if unopened, to the issuing pharmacy for disposition provided that;

(1) No drugs covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 are returned.

(2) All such drugs are identified as to lot or control number.

(3) The signatures of the receiving pharmacist and a licensed nurse employed by the facility are recorded in a separate log which lists the name of the patient, the name, strength, prescription number (if applicable), the amount of the drug returned and the date of return. The log shall be retained for at least three years.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.11. Pharmaceutical Services—Medication Distribution System.

(a) In facilities utilizing a unit dose medication system, there shall be at least a 24–hour supply of all patient medications on hand at all times, except those drugs which are to be discontinued within the 24–hour period. Drugs that are a part of a unit dose medication system shall not exceed a 48–hour supply.

(b) Facilities may utilize a floor stock medication system in lieu of a unit dose medication system.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.12. Pharmaceutical Services—Staff.

(a) Facilities shall retain a consulting pharmacist who devotes a sufficient number of hours during a regularly scheduled visit, for the purpose of coordinating, supervising and reviewing the pharmaceutical service at least quarterly. The report shall include a log or record of time spent in the facility. There shall be a written agreement between the pharmacist and the facility which includes the duties and responsibilities of both.

(b) A pharmacist shall review the drug regimen of each patient at least monthly and prepare appropriate reports. The review of the drug regimen of each patient shall include all drugs currently ordered, information concerning the patient's condition relating to drug therapy, medication administration records, and where appropriate, physician's progress notes, nurse's notes, and laboratory test results. The pharmacist shall be responsible for reporting, in writing, irregularities in the dispensing and administration of drugs and other matters relating to the review of the drug regimen to the clinical director and the director of nursing service.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

§ 77079.13. Pharmaceutical Services—Equipment and Supplies.

(a) There shall be adequate equipment and supplies necessary for the provision of pharmaceutical services within the facility including at least the following:

(1) Refrigerator with an accurate thermometer.

(2) Lockable drug cabinets, drawers, closets or rooms.

(3) Drug service trays and/or carts.

(4) Drug preparation counter area and convenient water source.

(5) Reference materials containing drug monographs on all drugs in use in the facility. Such monographs shall include information concerning generic and brand names, if applicable, available strengths, and dosage forms and pharmacological data including indications and side effects.

(b) Emergency supplies shall be readily available at each facility. Emergency drug supplies shall meet the following requirements:

(1) Legend drugs shall not be stored in the emergency supply, except under the following conditions;

(A) Injectable supplies of legend drugs shall be limited to a maximum of three single doses in ampules or vials or one container of the smallest available multi–dose vial and shall be in sealed, unused containers.

(B) Sublingual or inhalation emergency drugs shall be limited to single sealed containers of the smallest available size.

(C) Not more than six emergency drugs in solid, oral dosage form or suppository dosage form for anti–infective, anti–diarrheal, anti–nausea, or analgesic use may be stored if in sealed containers. Not more than four doses of any one drug may be so stored.

(2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper–proof seal must be broken to gain access to the drugs. The registered nurse or charge nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within 72 hours and the supply resealed by the pharmacist.

(3) The contents of the supply shall be listed on the outside of the container.

(4) The supply shall be checked at least once monthly by the pharmacist.

(5) Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the patient, the date and time of administration and the signature of the person administering the dose.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code; Sections 650 and 651, Business and Professions Code.

Article 4. Administration

§ 77081. Governing Body.

The governing body shall:

(a) Assure that all services including care and treatment provided to patients, is adequate and safe at all times.

(b) Establish and implement written bylaws in accordance with legal requirements and its responsibility to the community and to the patients served which shall include, but not be limited to, provisions for:

(1) Identification of the purposes of the facility and the means of fulfilling them.

(2) Ensuring the fitness, adequacy and quality of the clinical and medical care rendered.

(3) The appointment and reappointment of clinical staff who provide treatment, care and consultation to patients in the facility.

(4) Approval of policies and procedures for appropriate practices

to be observed in the facility. In this connection, the practice of division of fees, under any guise whatsoever, shall be prohibited and any such division of fees shall be cause for exclusion from the staff.

(5) Identification of the requirements for health and treatment records.

(6) Requiring the interdisciplinary staff to establish controls that are designed to ensure the achievement and maintenance of high standards of professional ethical practices.

(c) Appoint a clinical director and administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

(d) Provide for the control and use of appropriate physical and financial resources and personnel required to meet the needs of the patients.

(e) Assure that the facility and its operation conforms to all applicable federal, state and local laws and regulations, including those relating to licensure and fire inspection.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1277, Health and Safety Code.

§ 77083. Organized Clinical Staff.

(a) The organized clinical staff shall be composed of all licensed mental health professionals as included in Section 77012 or other licensed practitioners who have admitting and/or treatment privileges in the facility and shall be responsible for the following:

(1) A formal peer review process which, in order to improve the quality of care, will review and evaluate the adequacy, appropriateness, and effectiveness of the care and treatment planned for, or provided to, facility patients.

(2) In conjunction with the pharmacist's monthly drug regimen review, a medication monitoring system that will assess the prescribing practices of the professional staff of the facility with respect to appropriateness and cost effectiveness of the medications ordered for the patients of the facility. The medication monitoring requirements specified in this subsection shall include findings of the pharmacist's monthly drug regimen review.

(3) A utilization review program which shall be a system of policies and procedures designed to ascertain and assure the clinical necessity of acute inpatient psychiatric services for patients using the facility.

(b) The clinical staff shall meet at least monthly. Minutes of each meeting shall be maintained for at least 1 year and shall be available for review by the Department.

(c) Patients shall be admitted only upon the order and under the care of a member of the clinical staff who is lawfully authorized to diagnose, prescribe and treat patients. The patient's condition and provisional diagnosis shall be established at time of admission by the admitting practitioner subject to the provisions of Section 77073.

(d) In order to carry out the functions as specified in this section, professionals who are not members of the organized clinical staff may be utilized. These professionals include, but are not limited to, pharmacists, dietitians, occupational therapists, physical therapists, recreation therapists, registered record administrators or licensed nursing staff.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77089. Affiliation with General Acute Care Hospitals.

(a) All facilities shall have a current written agreement for medical services with one or more general acute care hospitals and shall maintain a current copy of such agreements for review by the Department. The agreements shall include, but not be limited to:

(1) Whether the general acute care hospital agrees to medically screen and conduct physical examinations of patients for admission to the psychiatric health facility and the procedure by which such screening and examination will be provided.

(2) The procedure for patient transfer from the psychiatric health facility to the hospital for inpatient medical or psychiatric care.

(3) The availability of medical services for patients of the psychiatric health facility, and the procedure by which such service will be provided.

(4) The specific means by which patients who require such medical services will be transported to the hospital or medical facility.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1, Health and Safety Code.

§ 77091. Administrator of Business and Support Services.

(a) Each facility shall have an administrator who has primary responsibility for business and support services for the clinical program.

(b) The administrator shall have direct access to the clinical director for the purpose of communicating the status of business and support services of the psychiatric health facility.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77093. Clinical Director.

(a) Each facility shall have a clinical director who shall direct the clinical program, provide general direction to professional and non–professional staff, and be responsible for the quality of clinical services performed in the facility. The clinical director shall be a licensed mental health professional. The clinical director shall have at least three years of post–graduate direct clinical experience with the mentally disordered.

(b) When the clinical director is part of the overall structure of a county mental health program, the county organization chart must show a line of reportability to the director of mental health.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1275.1 and 1276.1, Health and Safety Code.

§ 77097. Interdisciplinary Treatment Team.

(a) The interdisciplinary treatment team shall be composed of those persons who work directly with the patient in each of the professions, disciplines or service areas that provide service to the patient, including direct treatment staff, the patient's attending or consulting psychiatrist, the clinical psychologist, the licensed nurse or the psychiatric technician, the clinical director, or the clinical director's designee and any other persons whose participation is relevant to the treatment and care of the patient. The interdisciplinary treatment team shall be chaired by the admitting practitioner for each patient.

(b) The interdisciplinary treatment team shall be responsible for the development and implementation of the patient's individual treatment plan in consultation with the patient and members of the patient's family pursuant to Welfare and Institutions Code, Section 5328.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77099. Patients' Rights.

(a) The governing body shall adopt and implement written policies regarding patients' rights to ensure compliance with Sections 5325, 5325.1, 5326, 5326.1, 5326.9, 5326.95 and 5520 through 5550 of the Welfare and Institutions Code.

(b) A list of these patients' rights shall be posted in English and in the predominant language of the community, if other than English, in appropriate places within the psychiatric health facility so that such rights may be read by patients.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77101. Types of Restraints and Seclusion.

(a) No physical restraints with locking devices shall be used or be available for use in the facility unless approved by the State Fire Marshal.

(b) Seclusion as defined in Section 77029 is considered to be a physical restraint.

(c) Exclusion timeout as defined in Section 77010 is considered to be a physical restraint.

(d) Treatment restraint, as defined in Section 77033, shall be accomplished by a soft tie only, so as not to cause harm to the patient and shall only be used during medically prescribed treatment or diagnostic procedures.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77103. Behavioral Restraint and Seclusion.

(a) Behavioral restraint and seclusion shall only be used as a measure to protect the patient from injury to self or others.

(b) Behavioral restraint and seclusion shall only be used upon a physician's or clinical psychologist's written or verbal order, except under emergency circumstances. Under emergency circumstances behavioral restraint may be applied and then an order obtained as soon as possible, but at least within one hour of application. Telephone orders shall be received only by authorized professional staff, shall be recorded immediately in the patient's health record and, within twenty–four (24) hours, weekends and holidays excepted, signed by the prescriber.

(c) Behavioral restraint and seclusion shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff.

(d) Orders for behavioral restraint and seclusion shall be in force for not longer than 24 hours.

(e) There shall be no PRN orders (as needed orders) for behavioral restraint and seclusion.

(f) Patients in restraint shall remain in staffs' line of vision and shall be afforded protection from other patients who may be in the area.

(g) A patient placed in behavioral restraint or seclusion shall be checked at least every 15 minutes by professional staff to assure that the restraint remains properly applied or that the patient has not harmed him/herself. A written record shall be kept of these checks and maintained in the individual patient's health record.

(h) Regular range of motion exercise of at least ten (10) minutes every two (2) hours shall be provided to restrained patients. When range of motion is contraindicated, a physician or a psychologist shall document the reason in the patient's record.

(i) Behavioral and treatment restraints shall be utilized only with patients being treated pursuant to Sections 5150 et seq. of the Welfare and Institutions Code or who are judicially committed.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77104. Postural Supports.

(a) Facilities shall have written policies and procedures concerning the use of postural supports.

(b) Postural supports shall be designed and applied for speedy removal in case of emergency.

(c) Postural supports shall be designed and applied:

(1) Under the supervision of a physical or occupational therapist.

(2) In accordance with principles of proper body alignment, with concern for circulation and allowance for change of position.

(3) To improve a patient's mobility and independent functioning.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1275.1 and 1277, Health and Safety Code.

§ 77105. Clinical Research.

Prior to implementing any research projects involving human subjects that were not approved with the initial program plan, a supplemental patient care program plan shall be submitted to the Department of Mental Health for approval or denial. All research projects involving human subjects shall meet the requirements of all applicable state and federal laws and regulations.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77107. Education of Patients.

When patients of school age, between the ages of 6 to 18, are expected to remain in the facility for 30 days or more, the facility shall arrange for appropriate educational services pursuant to Sections 48200 and 48400 of the Education Code and the applicable federal regulations.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code

§ 77109. Use of Outside Resources.

(a) If a facility does not employ qualified personnel to render a specific service to be provided by the facility, there shall be arrangements through a written agreement and/or contract with outside resources. Outside resources shall meet the standards and requirements of these and all other applicable regulations before an agreement and/or contract may be entered into and shall continue to meet these and all other applicable regulations during the term of the agreement and/or contract. Outside resources may include other facilities, organizations, individuals or public or private agencies.

(b) Signed and dated copies of agreements, contracts or written arrangements for advice, consultation, services, training or transportation, with outside resources shall be on file in the facility. These agreements and/or contracts shall be readily available for inspection and review by the Department. The agreements and/or contracts shall include, but not be limited to, a description of the services to be provided, the financial arrangements, the methods by which the services are to be provided, and the conditions upon which the agreement or contract can be terminated.

(c) The governing body shall be responsible and accountable for all services provided by agreements and/or contracts.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77111. Nondiscrimination Policies.

(a) No facility that receives any financial assistance from the State of California shall discriminate against or deny admission to any person, otherwise qualified, based on sex, age, race, color, religion, ancestry or national origin, or physical or mental handicap. Facility policies shall so state and apply to the appointment of the treatment staff, hiring of facility employees and the admission, housing and treatment of patients. While a facility may not discriminate against any group identified in this section, the facility may not admit a minor for whom it cannot provide protection from adult patients, appropriate treatment and educational services when applicable. No facility may admit a minor into the same treatment ward with adults as defined in Section 5751.7, Welfare and Institutions Code.

(b) Any bona fide nonprofit religious, fraternal or charitable organization, which can demonstrate to the satisfaction of the Department that its primary or substantial purpose is not to evade this section, may establish admission policies limiting or giving preference to its own members or adherents. Such policies shall not be construed as a violation of (a) above. Any admission of nonmembers or nonadherents shall be subject to (a) above.

(c) Facilities shall comply with the Americans with Disabilities Act (ADA), Public Law 101–336 of 1990 (42 U.S.C. §12101 et seq.) which guarantees equal opportunity for persons with disabilities.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Sections 1270 and 1275.1, Health and Safety Code; and Section 5751.7, Welfare and Institutions Code.

§ 77113. Admission Policies.

(a) Each facility shall have and implement written admission and discharge policies encompassing which licensed health professionals may admit patients, the types of diagnoses for which patients may be admitted, limitations imposed by law or licensure, staffing limitations, rules governing emergency admissions, policies

concerning advance deposits, rates of charge for care, charges for extra services, limitations of services, termination of services, refund policies, insurance agreements and other financial considerations, discharge of patients and other relevant functions. These policies shall be made available to patients or their agents upon admission and upon request, and shall be made available to the public upon request.

(1) Only persons diagnosed with major mental disorders are to be treated in psychiatric health facilities.

(2) Psychiatric health facilities shall not admit and treat patients with the primary diagnosis of an eating disorder as defined in Section 1254.5(b) of the California Health and Safety Code.

(3) Psychiatric health facilities shall not admit and treat patients when the primary diagnosis is chemical dependency, chemical intoxication or chemical withdrawal.

(4) Individuals with major mental disorders shall not be admitted to a psychiatric health facility if their treatment requires medical interventions beyond the level appropriate to a psychiatric health facility, including:

(A) detoxification from substance abuse,

(B) treatment for substance induced delirium.

(b) A facility shall accept and retain only those patients for whom it can provide adequate care, including but not limited to the provisions of Section 77135.

(c) A minor shall not be detained in a facility against the will of his or her parent or legal guardian. In those cases where law permits minors to contract for or consent to the type of medical care provided by the facility, without the consent of their parent or guardian, they shall not be detained in the facility against their will. This provision shall not be construed to preclude or prohibit attempts to persuade patients to remain in the facility in their own interest, nor the temporary detention of patients for the protection of themselves or others under the provisions of the Lanterman–Petris–Short Act (Welfare and Institutions Code, Section 5000 *et seq.*), if the facility has been designated by the county as a treatment facility pursuant to said act, nor to prohibit minors legally capable of contracting for or consenting to medical care from assuming responsibility for their discharge.

(d) Within 24 hours after admission or immediately before admission, every patient shall have a complete history and physical examination unless a history and physical examination has been completed within the previous 30 days and is determined by the attending physician to be current.

(e) No inpatient shall be transferred or discharged for purposes of effecting a transfer, from a facility to another facility, unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or, in the case of an emergency, documented attempts to contact such person have been made and a responsible person cannot be reached. A transfer or discharge shall not be carried out if in the opinion of the clinical director such transfer or discharge would be contraindicated, unless there exists no legal basis to do so. This section shall not be construed to prohibit the transfer or discharge of a patient pursuant to court orders.

(f) There shall be a method of prompt and accurate identification of each patient admitted to the facility.

NOTE: Authority cited: Section 1275, Health and Safety Code; and Section 4080(f)(1), Welfare and Institutions Code. Reference: Section 1275.1, Health and Safety Code; and Section 4080(f)(1), Welfare and Institutions Code.

§ 77115. Written Administrative Policies.

(a) Written administrative policies and procedures for services provided shall be developed and implemented by appropriate staff members. These policies and procedures shall be reviewed and approved at least annually by the clinical director and administrator.

(b) The facility shall have policies and procedures for the provision of first aid and life saving measures that shall be implemented in emergency situations.

(c) The facility shall have a policy which shall ensure the obtaining of the patient's written consent prior to photographing that patient.

(d) Each facility shall adopt and implement written policies and procedures to properly manage outbreaks or prevalence of infectious and communicable disease whether or not such disease is required to be reported by Title 17, California Administrative Code, Section 2500.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77117. Personnel Policies.

(a) Each facility shall adopt and implement written personnel policies concerning qualifications, responsibilities and conditions of employment for each classification employed which shall be available to all personnel. Such policies shall include but not be limited to:

(1) Hours of work.

(2) A plan for orientation for all new staff members that shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 60 days of employment. Staff attendance shall be documented. Initial training shall include, but not be limited to, the following:

(A) Orientation to all policies, procedures and objectives of the facility.

(B) Orientation to special needs of the mentally disordered.

(C) Orientation to overall concepts of programs to meet the special needs of the mentally disordered.

(D) Orientation and training in specific program techniques being used in the facility to meet the identified program needs of the patients.

(3) A plan for at least annual evaluation of employee performance.

(4) A plan to conduct a background investigation, including previous employment and criminal background information, on prospective employees.

(b) The facility shall provide for a continuing inservice education program designed to improve patient care and employee efficiency. This training shall include, but not be limited to, suicide prevention techniques, management of assaultive behavior techniques and cardiopulmonary resuscitation (CPR). All staff members shall attend and attendance shall be documented. Continuing inservice education shall be provided by the facility or obtained by the staff at an annual rate of 48–hours for full time staff. Part time staff accrual rates shall be prorated to be consistent with their part–time status.

(c) Personnel policies shall require that employees and other persons working in or for the facility familiarize themselves with these regulations and such other regulations as are applicable to their duties.

(d) The facility shall recruit qualified personnel. Mental health workers shall work under the direct supervision of qualified mental health professionals.

(e) If language or communication barriers exist between facility staff and patients, arrangements shall be made for interpreters or for the use of other means to ensure adequate communications between patients and personnel.

(f) All personnel shall wash their hands before and after coming in direct contact with any linen or food.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77119. Employee Personnel Records.

(a) All facilities shall maintain personnel records of all employees. Such records shall be retained for at least three years following termination of employment.

(b) The record shall include the employee's full name, Social Security number, the license of registration number, if any, brief

resume of experience, employment classification, date of beginning employment and date of termination of employment.

(c) Records of hours and dates worked by all employees during at least the most recent six–month period shall be kept on file at the place of employment.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77121. Employee Health Examinations and Health Records.

(a) A health examination, performed by a person lawfully authorized to perform such an examination shall be performed as a prerequisite for employment within six months prior to employment or within one week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties and do not have any health condition that would create a hazard for the employee, fellow employees, patients or visitors.

(b) The initial health examination shall include a tuberculosis screening test consisting of a purified protein derivative intermediate strength intradermal skin test and a chest X–ray if the skin test is positive. The facility shall establish a policy regarding subsequent health examinations and tuberculosis screening test based on an assessment of the following:

(1) The risk of a previously infected person developing tuberculosis and then possibly infecting others.

(2) The risk of a non–infected person becoming infected and developing a disease.

(c) The facility shall develop policies which ensure that reasonable precautions are taken to prevent the spread of infectious disease between persons within the facility.

(d) Employee health records shall be maintained by the facility and shall include the records of all required health examinations. Such records shall be kept a minimum of three years following terminations of employment.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77123. Equipment and Supplies.

Equipment and supplies adequate in quality and quantity shall be available as necessary to provide patient services related to the scope and nature of the services offered.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77125. Advertising.

(a) No facility shall make or disseminate any false or misleading statement, or advertise by any manner or means any false or misleading claims regarding services provided by the facility.

(b) No facility shall allow false or misleading claims regarding services provided by the facility to be made by a third party or entity on behalf of the facility.

(c) No facility shall allow the use of its name or logo to be used in advertising by third parties.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77127. Records and Reports.

(a) Each facility shall maintain copies of the following applicable documents on file in the facility.

(1) Articles of incorporation or partnership agreement.

(2) Bylaws and rules and regulations of the governing body.

(3) Bylaws and rules and regulations of all staff including medical, professional and other staff.

(4) Minutes of the meetings of the governing body, medical and professional staff.

(5) Reports of inspections by local, state and federal agencies.

(6) All contracts, leases and other agreements required by these regulations.

(7) Patient admission roster.

(8) Reports of unusual occurrences for the preceding three years.

(9) Personnel records, including credential files.

(10) Policy manuals.

(11) Procedure manuals.

(12) Any other records deemed necessary by the Department for the direct enforcement of these regulations.

(b) The records and reports specified above shall be made available for inspecting by any duly authorized officer, employee or agent of the Department.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77129. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of local fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) The written program shall be implemented in the event of a fire or internal disaster and shall include but not be limited to the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire fighting equipment.

(6) Identification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(c) Fire and internal disaster drills shall be held at least quarterly for each shift of facility personnel and under various conditions. Actual evacuation of patients during a drill is optional.

(d) The evacuation plan shall be posted throughout the facility and shall include but not be limited to the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77131. Fire Safety.

All facilities shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic. All facilities shall secure and maintain a clearance relative to fire safety from the State Fire Marshal.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77133. Disruption of Services.

(a) Each facility shall develop a written plan to be implemented when a discontinuance or disruption of service occurs.

(b) The clinical director shall be responsible for informing the Department, via telephone, telegraph or emergency radio network, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or upon occurrence of earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77135. Patients with Reportable Communicable Disease, Physical Illness or Physical Injury.

(a) Reportable communicable diseases:

(1) Persons with a communicable disease that is required to be reported by Title 17, California Code of Regulations, Section 2500, shall not be admitted to the facility.

(2) A patient who after admission is diagnosed as having a reportable communicable disease or being a carrier shall be promptly transferred to a facility capable of accommodating such patients.

(b) Non–reportable disease or injury:

(1) Psychiatric health facilities shall arrange alternative treatment settings for patients with injuries or diseases that require inpatient medical care. When a patient's particular injury or disease would ordinarily be treated on an outpatient basis absent the mental disorder, the facility may admit the patient only if the facility has appropriate policies, procedures and resources to ensure the safety of other patients and staff.

(2) A patient, who after admission is diagnosed as having a disease or injury, may be treated in the facility if the patient's particular injury or disease would ordinarily be treated on an outpatient basis. The facility may treat the patient for the injury or disease only if the facility has appropriate policies, procedures and resources to ensure the safety of other patients and staff.

NOTE: Authority cited: Section 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77137. Unusual Occurrences.

(a) Unusual occurrences shall be reported by the facility, within 24 hours, either by telephone with written confirmation, or by telegraph to the county mental health director and the Department.

(b) An unusual occurrence report shall be retained on file by the facility for three years.

(c) The facility shall furnish other pertinent information related to such occurrences as the county mental health director or the Department may require.

(d) A facility admitting a patient exhibiting a physical injury or presenting a condition caused by neglect shall immediately notify a physician and request a physical examination of the patient. If, in the opinion of the examining physician, the injury or condition appears to be the result of neglect or abuse, the facility shall report such fact by telephone, and in writing, within 24 hours of the patient's admission, to the Department, the local police authority having jurisdiction, and the county mental health department. Written reports in the patient's health record shall state the character and extent of the physical injury or condition.

(e) Every fire or explosion which occurs in or on the premises shall be reported immediately to the local fire authority, or in areas not having an organized fire service to the State Fire Marshal.

(f) All suspected criminal acts in or on the premises by or against patients, employees or visitors shall be reported to the local police authority and the Department within 24 hours.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77139. Health Record Service.

(a) The facility shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities and equipment and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.

(b) The health record service shall be under the direction of a staff member who has training and experience in records administration. This designated staff member shall be assisted by such qualified personnel as are necessary to conduct the service. A registered record administrator or accredited records technician shall provide consultation as necessary to designated staff members responsible for record administration.

(c) If a facility, in addition to inpatient services, is providing structured outpatient services or crisis intervention, a unit health record system shall be established.

(d) The facility shall have a continuing system of collecting and recording data that describe patients served in such form as to provide for continuity of care, programming services, and data retrieval for program, patient care evaluation, and research. Health records shall be stored and systematically organized to facilitate retrieving of information.

(e) Policies and procedures shall be established and implemented to ensure the confidentiality of an authorized access to patient health information, in accordance with federal, state, and local laws and acceptable standards of practice.

NOTE: Authority cited: Sections 1254(e) and 1275, Health and Safety Code. Reference: Sections 1250.2(b), 1266.1(f) and 1275.1, Health and Safety Code.

§ 77141. Health Record Content.

(a) Each patient's health record shall consist of at least the following:

(1) Admission and discharge record identification data including, but not limited to, the following:

(A) Name.

(B) Address on admission.

(C) Patient identification number.

(D) Social Security number.

(E) Date of birth.

(F) Sex.

(G) Marital status.

(H) Legal status.

(I) Religion (optional on part of patient).

(J) Date of admission.

(K) Date of discharge.

(L) Name, address and telephone number of person or agency responsible for patient.

(M) Initial diagnostic impression.

(N) Discharge or final diagnosis.

(O) Disposition, including aftercare arrangements, plus a copy of the aftercare plan prepared pursuant to section 1284, Health and Safety Code, if the patient was placed in the facility under a county Short–Doyle plan.

(2) Mental status.

(3) Medical history and physical examination.

(4) Dated and signed observations and progress notes recorded as often as the patient's condition warrants by the person responsible for the care of the patient.

(5) Any necessary legal authorization for admission.

(6) Consultation reports.

(7) Medication treatment and diet orders.

(8) Social service evaluation, if applicable.

(9) Psychological evaluations, if applicable.

(10) Dated and signed patient care notes including, but not limited to, the following:

(A) Concise and accurate records of nursing care provided.

(B) Records of pertinent nursing observations of the patient and the patient's response to treatment.

(C) The reasons for the use of and the response of the patient to PRN medication administered and justification for withholding scheduled medications.

(D) Record of type of restraint, including time of application and removal as outlined in section 77103.

(11) Rehabilitation evaluation, if applicable.

(12) Interdisciplinary treatment plan.

(13) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient.

(14) Medication records including name, dosage and time of administration of medications and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration.

(15) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided.

(16) Vital sign sheet.

(17) Consent forms as required, signed by patient or person responsible for patient.

(18) All dental records, if applicable.

(19) Reports of all laboratory tests ordered.

(20) Reports of all cardiographic or encephalographic tests performed.

(21) Reports of all X–ray examinations ordered.

(22) All reports of special studies ordered.

(23) Acknowledgement in writing of patient's rights, as required in section 77099, signed by patient or person responsible for the patient.

(24) Denial of patient rights documentation.

(25) A discharge summary prepared by the admitting practitioner which shall briefly recapitulate the significant findings and events of the patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77143. Health Record Availability.

(a) Records shall be kept on all patients admitted or accepted for treatment. All required records, either as originals or as accurate reproductions of the contents of such originals, shall be maintained in a confidential manner, legible and readily accessible upon request of persons authorized by law to have access to such records including, but not limited to, persons authorized pursuant to Health and Safety Code, Section 25250 *et seq.*, those professional persons who are providing services to the patient and authorized representatives of the Department and the Department of Mental Health.

(b) The facility shall safeguard the information in the record against loss, defacement, tampering or use by unauthorized persons.

(c) Patient health records or reproductions thereof, shall be safely preserved for a minimum of seven years following discharge of the patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a facility ceases operation, the Department shall be informed, within 48 hours prior to cessation, of the arrangements made for safe preservation of patient health records.

(e) If ownership of a licensed facility changes, both the previous licensee and the new licensee shall, prior to the change of ownership, provide the Department with written documentation that arrangements have been made for the retention and preservation of all patient records.

(f) Patient records shall be filed in an easily accessible manner in the facility or in an approved health record storage facility off the facility premises.

(g) Patient records shall be completed within 14 days following the patient's discharge.

(h) All information and records obtained in the course of providing services under Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7000) of the Welfare and Institutions Code to either voluntary or involuntary recipients of services shall be confidential and may be disclosed only in accordance with Sections 5328 through 5330 of the Welfare and Institutions Code.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77145. Patients' Monies and Valuables.

(a) No licensee shall use patients' monies or valuables as its own or mingle them with its own. Patients' monies and valuables shall be separate, intact and free from any liability the licensee incurs in the use of the licensee's or the facility's funds and valuables.

(b) Each licensee shall maintain accurate records of patients' monies and valuables entrusted to its care. Such records shall include but not be limited to:

(1) A control account for all recipients and expenditures kept current with columns for debits, credits and balances.

(2) An account for each patient with supporting vouchers filed in chronological order and kept current with columns for debits, credits and balances.

(c) Records of patients' monies and other valuables entrusted to the licensee for safe keeping shall include a copy of the receipt furnished to the patient or to the person responsible for the patient.

(d) Patients' monies entrusted to the psychiatric health facility shall be kept in a fireproof safe on the premises of the psychiatric health facility or deposited in a demand trust account in a local bank authorized to do business in California and whose deposits are insured by the Federal Deposit Insurance Corporation. A county psychiatric health facility may deposit such funds with the county treasurer.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

Article 5. Physical Plant

§ 77147. Space Conversion.

Spaces approved for specific use at the time of licensure shall not be converted to other use without the prior approval of the Department.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77151. General Maintenance.

The psychiatric health facility shall be clean, safe and sanitary and in good repair at all times.

NOTE: Authority cited: Section 208 (a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77153. Housekeeping.

(a) There shall be sufficient supplies and equipment available for housekeeping, to include but not be limited to:

(1) Cleaning supplies and equipment which shall be stored in rooms for housekeeping use only.

(2) A commercial grade detergent germicide which shall be used for all cleaning.

(3) Mop heads which shall be removable and washed when needed.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

§ 77155. Maintenance Manual.

(a) A written manual on maintenance of heating, air conditioning and ventilation systems shall be implemented by each facility.

(b) A record of maintenance shall be maintained.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1275.1, Health and Safety Code.

Chapter 12. Correctional Treatment Centers

Article 1. Definitions

§ 79501. Accredited Record Technician.

Accredited record technician means a person who is accredited or eligible for accreditation by the American Medical Records Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79503. Audiologist.

Audiologist means a person licensed as an audiologist by the Medical Board of California.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79507. Biological.

Biological means a product, virus, serum, toxin, antitoxin, or

analogous product derived from living matter applicable to prevention, treatment or cure of disease or injury in humans.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79509. Clinical Psychologist.

Clinical psychologist means a person licensed as a psychologist by the Board of Psychology and (1) who possesses an earned doctorate degree in psychology from an educational institution meeting the criteria for subdivision (c) of Section 2914 of the Business and Professions Code and (2) has not less than two years clinical experience in a multidisciplinary facility licensed or operated by this or another State or by the United States to provide health care, or (3) is currently listed in the National Register of Health Service Providers in Psychology, as adopted by the council for the National Register of Health Service Providers in Psychology. On the effective date of this regulation, a licensed psychologist employed in a correctional setting providing inpatient mental health care for at least two years shall be deemed to meet the requirements of the regulation.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1316.5(c), Health and Safety Code; and Sections 2902 and 2903, Business and Professions Code.

§ 79511. Clinical Restraint.

Clinical restraint means the use of a physical restraining device, during a period of mental health treatment, as a measure to protect the inmate–patient from injury to self or others when alternative methods are not sufficient.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79513. Clinical Seclusion.

Clinical seclusion means the isolation during the period of mental health treatment of an inmate–patient in a separate, locked area, including a padded room, for the purpose of preventing injury to self or others.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79515. Communicable Disease.

Communicable disease means an illness due to a specific disease producing agent (virus, bacteria, etc.) or its toxic products which arises through transmission of that agent, or its products, from an infected person, animal, or other reservoir to a susceptible host—either directly as from an infected person or animal, or indirectly through the agency of an intermediate plant or animal host, vector or the inanimate environment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79516. Correctional Treatment Center.

A correctional treatment center is a health facility with a specified number of beds within a state prison, county jail or California Youth Authority facility designated to provide health care to that portion of the inmate population who do not require general acute care level of services but are in need of professionally supervised health care beyond that normally provided in the community on an outpatient basis. Outpatient housing is not under the jurisdiction of this Chapter.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79517. Decubitus Ulcer.

(a) A decubitus ulcer is a lesion of the skin, which is caused by pressure.

(b) The stages of decubitus ulcers are described as follows:

(1) Stage I—Not a decubitus ulcer of itself but, rather, the precursor phase of a decubitus ulcer which is characterized by redness of the skin which is not relieved by local circulatory stimulation and/or relief of pressure.

(2) Stage II—Superficial circulatory and tissue damage which involves abrasion or skin break.

(3) Stage III—Full thickness loss of skin which may or may not include the second level and which produces drainage.

(4) Stage IV—Full thickness loss of skin with invasion of deeper tissues and/or structures such as connective tissue, muscle or bone.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79519. Dentist.

Dentist means a person licensed as such by the Board of Dental Examiners of California, pursuant to Business and Professions Code Section 1600 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 1600, Business and Professions Code.

§ 79521. Department.

Department means the State Department of Health Services or its delegatee, pursuant to Section 1257, Health and Safety Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1257, Health and Safety Code.

§ 79523. Dietitian.

Dietitian means a person who is registered or is eligible for registration as a Registered Dietitian by the American Dietetic Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79525. Director.

Director means the Director of the State Department of Health Services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79527. Drug Administration.

Drug administration means the act in which a single dose of a prescribed drug or biological is given to a patient. The complete act of administration entails removing an individual dose from a container (including a unit dose container), verifying the dose with the prescriber's orders, identifying the patient, giving the individual dose to the patient, and promptly recording the time, method of administration, and dose given.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79529. Drug Dispensing.

Drug dispensing means the interpretation of an order for a drug or biological and, pursuant to that order, the proper selection, measuring, packaging, labeling, and issuance of the drug or biological for a patient or for a service unit of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79531. Governing Body.

Governing body means the person, persons, board of trustees, directors, or other body in whom the authority and responsibility is vested for conduct of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79533. Infectious Disease.

Infectious disease means any disease caused by the growth of pathogenic microorganisms in the body. It may or may not be contagious.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79534. Informed Consent.

Informed consent means the voluntary agreement of an inmate–patient or a representative, in accordance with state law, of an incapacitated inmate–patient to accept a treatment or procedure after receiving material information concerning the treatment or procedure.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and *Cobb v. Grant* (1972) 8 Cal.3d. 229.

§ 79535. Inmate.

Inmate, as used in the correctional treatment center regulations, means a detainee or offender who is under sentence to, or confined in, a prison, jail, or other correctional institution operated by the Department of Corrections, the Department of the Youth Authority, a county, city, or city and county law enforcement agency.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79537. Inmate–Patient.

Inmate–patient means an inmate who is receiving care and supervision in a correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79539. Licensed Clinical Social Worker.

Licensed clinical social worker means a person who possesses a master's degree from an accredited school of social work and two years of post master's experience in a mental health setting, and possesses a license as a clinical social worker from the Board of Behavioral Science Examiners, pursuant to Business and Professions Code Section 4996, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 4996, Business and Professions Code.

§ 79541. Licensed Vocational Nurse.

Licensed vocational nurse means a person licensed as such by the Board of Vocational Nurse and Psychiatric Technician Examiners, pursuant to Business and Professions Code Section 2840, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 2840, Business and Professions Code.

§ 79543. Licensed Marriage, Family, and Child Counselor.

Licensed marriage, family and child counselor means a person who possesses a master's degree from a school meeting the requirements of Sections 4980.37, 4980.40 and 4980.41 of the Business and Professions Code and 3000 hours of supervised experience in a mental health setting, who possesses a license as a marriage, family and child counselor by the Board of Behavioral Science Examiners, pursuant to Business and Professions Code Section 4980, et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; Section 5751.3, Welfare and Institutions Code; and Sections 4980, 4980.37, 4980.40 and 4980.41, Business and Professions Code.

§ 79547. Mental Health Worker.

Mental health worker means a person who does not necessarily qualify as a mental health professional, but who, through experience, in–service training, or formal education, is qualified to participate in the care of the psychiatric patient.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79549. Nursing Unit.

Nursing unit means a designated inmate–patient care area of a correctional treatment center which is planned, organized, operated and maintained to function as a unit. It includes patients' rooms with adequate support accommodations, services and personnel providing nursing care and necessary management of inmate–patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79551. Occupational Therapist.

Occupational therapist means a person who is certified or eligible for certification as an occupational therapist registered by the American Occupational Therapy Association. The occupational therapist shall be a graduate of a curriculum in occupational therapy approved by the Council on Education of the American Medical Association in collaboration with the American Occupational Therapy Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79553. On–Call.

On–call means immediately available for consultation by telephone and available to be in the facility within sixty minutes if requested to do so.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79555. Outpatient Housing Unit.

An outpatient housing unit means a housing unit of a city, county or city and county law enforcement facility established to retain inmates who require special housing for security or protection. Typically, these are inmates whose health condition would not normally warrant admission to a licensed heath care facility and for whom housing in the general population may place them at personal or security risk. Outpatient housing unit residents may receive outpatient health services and assistance with the activities of daily living. Outpatient housing unit beds are not licensed correctional treatment center beds.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79557. Pharmacist.

Pharmacist means a person licensed as such by the California State Board of Pharmacy pursuant to the Business and Professions Code Sections 4000 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79559. Physical Therapist.

(a) Physical therapist means a person licensed as such by the Medical Board of California.

(b) Physical therapist assistant means a person who is approved as such the Physical Therapy Examining Committee of the Medical Board of California.

(c) Physical therapist aide means a person who, under the direct supervision of a licensed physical therapist, assists with physical therapy care.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79561. Physician.

(a) Physician means a person licensed as a physician and surgeon

by the Medical Board of California or by the Osteopathic Medical Board.

(b) Attending physician means the physician responsible for the medical treatment of the patient in the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79563. Podiatrist.

Podiatrist means a person licensed as such by the Board of Podiatric Medicine of the Medical Board of California pursuant to Business and Professions Code Sections 2460 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2460 through 2499.6 (inclusive), Business and Professions Code.

§ 79564. Psychiatric Mental Health Nurse.

Psychiatric mental health nurse means a registered nurse who possesses a Master's Degree in Psychiatric Mental Health Nursing and at least two years of experience in providing psychiatric mental health counseling services under the supervision of a psychiatric mental health nurse, a licensed clinical psychologist, a licensed clinical social worker, a licensed marriage, family and child counselor, or a psychiatrist.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79565. Psychiatric Technician.

Psychiatric technician means a person who is licensed as a psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners pursuant to Business and Professions Code Sections 4500 et seq.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 4500, Business and Professions Code.

§ 79567. Psychiatrist.

Psychiatrist means a person who is a licensed physician and surgeon in the State of California except as allowed under Section 2072 of the Business and Professions Code and who is certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry or has completed a residency program in psychiatry approved by the American Medical Association or the American Osteopathic Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 2072, Business and Professions Code.

§ 79569. Recreation Therapist.

Recreation therapist means a person with specialization in therapeutic recreation and who is registered or eligible for registration as such by the Board of Park and Recreation Personnel or the National Therapeutic Recreation Society.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79571. Registered Nurse.

Registered nurse means a person licensed as such by the Board of Registered Nursing pursuant to Business and Professions Code Sections 2700 through 2837, inclusive.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2700 through 2837, Business and Professions Code.

§ 79573. Registered Record Administrator.

Registered record administrator means a person who is registered or eligible for registration as such by the American Medical Record Association.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79575. Supervision.

(a) Supervision means the instruction of employees or subordinates in the manner of carrying out their duties and overseeing or directing their work.

(b) Direct supervision means that the supervisor is in the same building as the person being supervised and available for consultation and/or assistance.

(c) Immediate supervision means that the supervisor is physically present while a task is being performed by the employee or subordinate.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79577. Treatment Restraint.

Treatment restraint means the use of a restraining device during medically prescribed treatment or diagnostic procedures including, but not limited to, intravenous therapy, tube feeding or catheterization.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79579. Unit Health Records.

Unit health records means a patient's health record that includes all records of care and treatment rendered to an inmate–patient.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

Article 2. Licensing and Inspection

§ 79581. Application Required.

(a) An application shall be submitted to the Department for a license to operate a correctional treatment center.

(b) The licensee shall submit an application for a corrected license to the Department when any of the following occur:

(1) Construction of a new or replacement correctional treatment center.

(2) Increase or decrease in licensed bed capacity.

(3) Change of license category.

(4) Change of name of correctional institution or detention facility within whose administration the correctional treatment center is established and licensed.

(5) Change of location of correctional treatment center.

(6) Change in bed classification.

(c) All applicants for an initial or renewal license shall provide to the Department, as part of the application, a detailed written list of the services to be offered or provided by the correctional treatment center. In the case of application for renewal license, the list shall include all proposed modifications to existing approved treatment services.

(d) If the Department denies the initial application for a license or a renewal of a license, the Department shall notify the applicant in writing, specifying the reasons for the denial.

(e) Within twenty (20) days of receipt of the Department's notice of denial, the licensee or applicant may present to the Department a written request for an informal hearing to decide the issue of whether or not the Department properly denied the applicant's initial or renewal application. The informal hearing shall be held by the Department as soon as possible, but not later than thirty (30) calendar days after the Department's receipt of the applicant's or licensee's written request. The licensee or applicant may request a formal administrative adjudication pursuant to Health and Safety Code Section 1269.

(f) The provisions of this article do not apply to any facility in which the services provided consist only of emergency stabilization

pending transfer to another licensed health facility, or limited health care services that would normally be provided in the home under the care of a physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79583. Safety, Zoning, and Building Clearance.

(a) A license shall not be issued to any correctional treatment center that does not conform to the State Fire Marshal's requirements for fire and life safety, California Code of Regulations, Title 19, Division 1, commencing with Section 1.03 and the California Code of Regulations, Title 24, Parts 2, 3, 4, 5, 9 and 12, and local fire safety, zoning and building ordinances. Evidence of compliance with these requirements shall be presented to the Department in writing.

(b) It shall be the responsibility of the licensee to maintain the correctional treatment center in a safe structural condition. If the Department determines that an evaluation of the structural condition of a correctional treatment center is necessary, the licensee may be required to submit a report, prepared by a licensed structural engineer, establishing a basis for eliminating or correcting the structural conditions which are found to be hazardous to occupants.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79585. Issuance, Expiration, and Renewal.

(a) Each license shall expire at 11:59 p.m. on the date of expiration.

(b) Each initial license issued pursuant to this chapter shall expire twelve (12) months from the date of its issuance and shall expire on the expiration date of the license. Application for renewal of a license or special permit fee shall be filed with the Department not less than thirty (30) days prior to the expiration date. Failure to make a timely renewal shall result in expiration of the license or special permit.

(c) A renewal license may be issued for a period not to exceed two years if the holder of the license or special permit has been found in substantial compliance with all statutory requirements, regulations or standards during the preceding license period.

NOTE: Authority cited: Sections 208(a), 1267 and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 1267, Health and Safety Code.

§ 79587. Separate License.

(a) Separate licenses shall be required for each correctional treatment center except for the California Medical Facility, the California Men's Colony, and the California Institution for Men, which are exempted by Section 1250(j)(5) of the Health and Safety Code.

(b) Separate licenses shall not be required for separate buildings on the grounds of the correctional treatment center, provided that they operate as one correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79589. Posting of License and Patient Information.

(a) The license, or a true copy thereof, shall be posted in a prominent location within the licensed premises and be accessible to view.

(b) Any approval of program flexibility, granted and written by the Department, shall be available for inspection within the correctional treatment center.

(c) The following information shall be available within the correctional treatment center.

(1) The name of the current administrator of the facility.

(2) The most recent licensing survey report and the facility's plans of correction, and if applicable, any subsequent licensing visit reports.

(3) The name, address, and telephone number of the district office of Licensing and Certification, State Department of Health Services, having jurisdiction over the facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79591. Report of Changes.

The licensee shall notify the Department within ten (10) days, in writing, of any of the following:

(a) Any change of clinical director, nursing director, or administrator of the correctional treatment center.

(b) Any change in the mailing address of the licensee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79593. Program Flexibility.

(a) All correctional treatment centers shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.

(b) Any approval of the Department granted under this Section, or a true copy thereof, shall be posted immediately adjacent to the facility's license.

NOTE: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

§ 79595. Suspension and Revocation.

The Department may suspend or revoke any license issued under the provisions of this Chapter upon any of the following grounds:

(a) Violation by the licensee of any of the rules and regulations promulgated under this Chapter of the California Code of Regulations, Title 22.

(b) Aiding, abetting, or permitting the violation of any of the rules and regulations promulgated under this Chapter.

(c) Conduct inimical to the public health, morals, welfare or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license is issued.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254, 1265.2 and 1294, Health and Safety Code.

Article 3. Required Services

§ 79597. Required Services.

(a) Correctional treatment centers shall provide, but not be limited to, the following required services:

(1) Physician.

(2) Psychiatrist.

(3) Psychologist.

(4) Nursing.

(5) Pharmaceutical Services.

(6) Dental.

(7) Dietary.

(b) Correctional treatment centers shall maintain written service agreements with general acute care hospitals to provide for those inmate physical health needs that cannot be met by the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79599. Physician Services.

Physician services are services provided by licensed physicians responsible for the care of individual inmate–patients in the correctional treatment center. All inmates admitted to or accepted for medical care by the correctional treatment center shall be under the care of a physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79601. Physician Services—General Requirements.

(a) Physician services shall include, but not be limited to:

(1) Inmate–patient evaluation, including an admission history and physical within 24 hours for immediate care planning. A complete written history and physical examination shall be in the record within 72 hours unless done within 5 days prior to admission.

(2) Reevaluation of the inmate–patient's condition, including the review and updating of orders for care at least every thirty (30) days, upon change of attending physician and upon transfer.

(3) Inmate–patient diagnosis.

(4) Advice, treatment and the determination of appropriate level of care needed for each inmate–patient.

(5) Written and signed orders for diet, care, diagnostic tests and treatment of inmate–patients by others.

(6) Health record progress notes at least every three days or more often as the inmate–patient's condition requires. A progress note will be documented on each visit by the attending physician.

(7) Provision for alternative physician coverage in the event the attending physician is not available.

(8) Provision for nonphysician practitioners to be permitted to render those medical services that they are legally authorized to perform. There shall be written policies addressing the granting of clinical privileges and the role of nonphysician providers. Nonphysician practitioner includes, but is not limited to the following:

(A) Physician's assistants who work under the responsibility and supervision of a physician approved as a supervisor by the Medical Board of California and perform only those selected diagnostic and therapeutic tasks identified in the California Code of Regulations, Title 16, Division 13.8, Section 1399.541.

(B) Nurse practitioners who have been certified as a nurse practitioner by the Board of Registered Nursing.

(C) Other registered nurses may perform medical services utilizing "Standardized Procedures" developed pursuant to Section 2725(d), Business and Professions Code, and approved by the medical director of the correctional treatment center.

(D) Certified nurse anesthetists who have completed an accredited program for the education of nurse anesthetists and have received certification as a nurse anesthetist from the Board of Registered Nursing.

(E) Certified nurse midwives who have been certified by the Board of Registered Nursing.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2725, 2834 and 3502, Business and Professions Code.

§ 79603. Physician Services—Policies and Procedures.

(a) Written policies and procedures shall be maintained and implemented by the correctional treatment center and shall include, but not be limited to:

(1) A description of the types and scope of physician services that the correctional treatment center will provide.

(2) Policies relating to inmate–patient care and the types of inmate–patients who may be admitted for care.

(3) Policies for the follow–up care of inmate–patients treated in the correctional treatment center.

(4) Referral of inmate–patients to other agencies or health care facilities.

(5) Provision for handling emergencies and unusual occurrences.

(6) Medical record requirements, including the frequency of documentation and time periods for completion.

(7) Information pertinent to the orientation of new physicians.

(b) Inmate–patient care policy and procedure manuals and other necessary reference materials shall be readily available for review by individual physicians.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79605. Physician Service Staff.

A physician shall have overall responsibility for the physician service. The medical director may serve as the responsible physician.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79607. Physician Service Space.

Sufficient space shall be maintained to meet the needs of the service and shall include at least:

(a) Physical examination and treatment room.

(b) Office space.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79609. Psychiatrist/Psychologist Service.

(a) Psychiatrist/psychologist services means consultative services to inmate–patients of a correctional treatment center including diagnostic psychological assessment and treatment. Primary services may also be provided to inmates not requiring admission to a licensed bed.

(b) Inmate–patients requiring 24–hour treatment for a mental disorder shall be admitted to a correctional treatment center only if the facility meets the requirements for a mental health treatment program or has policies, procedures and sufficient staff to handle the emergency, pending transfer to a licensed psychiatric facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79611. Psychiatrist/Psychologist Service General Requirements.

(a) There shall be a sufficient number of psychiatrists and psychologists on the staff to meet the needs of the patients.

(b) A psychiatrist or psychologist shall be responsible for examining, diagnosing, classifying and prescribing treatment for patients. The psychiatrist or psychologist shall also record progress notes, review and update treatment orders and make other appropriate entries in the patient record.

(c) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director. These shall include, but not be limited to:

(1) Description of the type and scope of services to be provided.

(2) Policies relating to patient care.

(3) Planning for follow–up care of patients treated.

(4) Arrangements for referral to other agencies or health facilities.

(5) Documentation requirements for each evaluation and treatment encounter.

(d) Medical examination shall be performed by a physician as often as indicated by the medical needs of the inmate–patient.

(e) The responsibility and accountability of the psychiatrist/psychologist service to the medical staff, administration and governing body shall be defined.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79613. Psychiatrist/Psychologist Service Staff.

(a) A clinical director shall have overall responsibility for the psychiatrist/psychologist service.

(b) The clinical director responsible for the service, acting alone or through an organized staff, shall have the following responsibilities:

(1) Establishing, reviewing and maintaining policies and procedures for the psychiatrist/psychologist service. Policies and procedures shall include, but not be limited to, policies related to patient care, type and scope of services available, follow–up care and consultation and referral. These shall be reviewed at least annually.

(2) Assuring the quality of psychiatrist/psychologist services provided to inmate–patients in the correctional treatment center.

(3) Reviewing credentials and specifying clinical privileges for psychiatrist/psychologist staff, including other mental health professionals.

(c) Psychiatric and psychological postgraduate trainees, interns, residents, postdoctoral fellows or instructors may provide psychiatric and psychological services under the provisions of Sections 2065 and 2911 of the Business and Professions Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Sections 2065 and 2911, Business and Professions Code.

§ 79615. Psychiatrist/Psychologist Service Space.

(a) There shall be sufficient space for conducting the service, including:

(1) Suitable space for interviewing.

(2) Office space.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79625. Nursing Service.

Nursing service means a service organized, staffed and equipped to provide skilled nursing care to inmate–patients on a continuous basis.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79627. Nursing Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director when required by governing body bylaws.

(b) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which specifies the care to be given, the objectives to be accomplished, and the professional discipline responsible for each element of care. Objectives shall be measurable and time–limited. Each inmate–patient's care shall be based on this plan.

(C) Reviewing, evaluating and updating of the patient care plan, as necessary, by the nursing staff and other professional personnel involved in the care of the patient, at least monthly, and more often as the patient's condition warrants.

(2) Notifying the attending physician or the attending clinician promptly of:

(A) The admission of a patient.

(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.

(C) An unusual occurrence involving a patient.

(D) Any untoward response or reaction by a patient to a medication or treatment.

(E) Any error in the administration of a medication or treatment to a patient.

(F) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed when this presents a risk to the health, safety, or security of the patient.

(G) The inmate–patient's refusal to accept a prescribed medication, treatment, or diagnostic procedure.

(c) All attempts to notify physicians or the attending clinician shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any.

(d) Licensed nursing personnel shall verify that patients are served the diets as prescribed.

(e) Nursing staff shall maintain timely and accurate patient record documentation including:

(1) Signed, dated, nursing notes reflecting implementation of the patient care plan, the patient's response to care, and changes in patients' symptoms or behavior.

(2) A record of all medications and treatments administered.

(3) A record of all personal patient care including dietary intake and patient activity.

(4) A record of patient vital signs, weight and other appropriate measurements.

(5) An admission patient assessment and discharge summary.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79629. Nursing Service—Director of Nursing Service.

(a) The director of nursing service shall be a registered nurse and shall be employed eight hours a day, on the day shift, five days a week, except when supervision and training are required during other shifts.

(b) The director of nursing service shall have at least one year of experience in nursing supervision within the last five years.

(c) The director of nursing service shall have, in writing, administrative authority, responsibility, and accountability for the nursing services within the correctional treatment center and shall serve only one correctional treatment center in this capacity at any one time, except as provided in (d).

(d) The director of nursing service may be responsible for more than one facility if the facilities are in the same geographic region, are operated by the same governing body, and a designated registered nurse is available on–site to perform the function of the director of nursing service.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79631. Nursing Service—Staff.

(a) Nursing service personnel shall be employed and on duty in at least the number and with the qualifications to provide the necessary nursing services for patients admitted to the correctional treatment center for care.

(b) Licensed correctional treatment centers shall have at least one registered nurse, awake and on duty in the facility at all times, day and night.

(c) Facilities licensed for fifteen (15) or more beds shall have at least one registered nurse, awake and on duty, in the facility at all times, day and night, in addition to a director of nursing service. The director of nursing service shall not have charge nurse responsibilities in facilities of more than 15 beds.

(d) Nursing stations shall be staffed with nursing personnel when patients are housed in the nursing unit.

(e) Each facility shall employ licensed and certified nursing staff sufficient to provide 2.5 nursing hours per patient day.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79633. Nursing Service—Staff Development.

(a) Each correctional treatment center shall have an ongoing educational program, planned and conducted for the development and improvement of necessary skills and knowledge, for all facility personnel. Each program shall include, but not be limited to:

(1) Orientation to the facility, specific duties, and pertinent policies and procedures.

(2) In–service training including at least an annual review of:

(A) Care of acutely or chronically ill or disabled patients.

(B) Prevention and control of infections.

(C) Emergency care, including cardiac arrest and choking.

(b) Intravenous fluid administration certification or training shall be required for all licensed nursing staff administering intravenous fluids.

(c) All nursing staff shall attend at least six hours of nursing in–service training annually.

(d) Records shall be maintained for each staff orientation and in–service training including name and title of presenter, date, description of content and signatures of those attending.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79635. Nursing Service—Administration of Medications and Treatments.

(a) Medications and treatments shall be administered as follows:

(1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such an order.

(2) Medications and treatments shall be administered as prescribed.

(3) Tests and measurement of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded.

(4) Preparation of doses for more than one scheduled administration time shall not be permitted.

(5) All medications and treatments shall be administered only by licensed medical or licensed nursing personnel with the following exceptions:

(6) Unlicensed employees may, under the direct supervision of licensed nursing or licensed medical personnel, during training or after completion of training and demonstrated evidence of competence, administer the following:

(A) Medical shampoos and baths.

(B) Laxative suppositories and laxative enemas.

(C) Nonlegend topical ointments, creams, lotions, and solutions.

(7) Medications shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(8) Patients shall be identified by wristband or other established means of identification prior to administration of a drug or treatment.

(9) Drugs may be administered in the absence of a specific duration of therapy on a licensed prescriber's new drug order if the facility implements its stop order policy for such drugs. The prescriber shall be contacted prior to discontinuing therapy as established by stop order policy.

(b) No medication shall be used for any patient other than the patient for whom it was prescribed.

(c) The time and dose of the drug or treatment administered to the patient shall be recorded in the patient's individual medication record by the person who administers the drug or treatment. Recording shall include the date, the time, and the dosage, and route of administration or injection site of the medication or type of the treatment. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.

(d) Oxygen equipment shall be maintained as follows:

(1) Humidifier bottles on oxygen equipment shall be changed and sterilized or replaced at least every 24 hours or, if a closed system, in accordance with the manufacturer's directions.

(2) Only sterile distilled, demineralized or deionized water shall be used in humidifier bottles.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79637. Nursing Service—Patient Care.

(a) No patient shall be admitted or accepted for care by a correctional treatment center except on the order of a physician.

(b) Each patient shall be treated as an individual with dignity and respect, and shall not be subjected to verbal or physical abuse of any kind from employees or independent contractors of the licensee.

(c) Each patient, upon admission, shall be given orientation to the unit, emergency call system, patients' rights and rules of behavior.

(d) Each patient shall be provided care which shows evidence of good personal hygiene, except where staff safety may be compromised, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming (except where contraindicated due to criminal identification purposes), cleaning and cutting of fingernails and toenails. The patient shall be kept free of offensive odors.

(e) Patients, when indicated, shall be given care to prevent formation and progression of decubiti, contractures, and deformities. Such care shall include:

(1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.

(2) Encouraging, assisting and training in self–care and activities of daily living.

(3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.

(4) Using pressure–reducing devices where indicated.

(5) Providing care to maintain clean, dry skin free from feces and urine.

(6) Changing of linens and other items in contract with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.

(7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification.

(f) Each inmate–patient who requires help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.

(g) Each inmate–patient shall be provided with good nutrition and with necessary fluids for hydration.

(h) Fluid intake and output shall be recorded for each inmate–patient as follows:

(1) If ordered by the physician.

(2) For each inmate–physician with an indwelling catheter or receiving intravenous or tube feedings.

(i) The weight and length of each inmate–patient shall be taken and recorded in the inmate–patient's health record upon admission. The weight shall be taken and recorded once a month thereafter.

(j) Each inmate–patient shall be provided visual privacy during medical treatments and personal care, unless contraindicated due to security considerations.

(k) Inmate–patient call signals shall be answered promptly.

(*l*) The following shall be easily accessible at each nurse's station:

(1) The correctional treatment center's infection control policies and procedures.

(2) Names, addresses and telephone numbers of local health officers.

(3) The correctional treatment center's current diet manual.

(4) The correctional treatment center's current drug formulary.

(5) The correctional treatment center's current nursing policy and procedure manual.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79639. Nursing Service—Patients with Infectious Diseases.

(a) Patients with infectious diseases shall not be admitted to, or cared for, in the facility unless the following requirements are met:

(1) A patient suspected of, or diagnosed as having an airborne infectious or reportable communicable disease, or being in a carrier state, who the attending medical staff determines is a potential danger, shall be accommodated in a room, vented to the outside if airborne, and provided with a separate toilet, hand washing facility, soap dispenser and individual towels.

(2) There shall be:

(A) Separate provisions for handling contaminated linens.

(B) Separate provisions for handling contaminated dishes.

(C) Separate provisions for handling any object, article, substance or material capable of transmission of a communicable disease.

(b) The correctional treatment center shall adopt and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as necessary.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code; and Sections 2500, 2502, 2503 and 2504, Title 17, California Code of Regulations. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79641. Nursing Service—Cleaning, Disinfecting, and Sterilizing.

(a) Each correctional treatment center shall adopt a written manual on cleaning, disinfecting and sterilizing procedures. The manual shall include procedures to be used in the care of utensils, instruments, solutions, dressings, articles and surfaces and shall be available for use by facility personnel. All procedures shall be carried out in accordance with the manual.

(b) Each facility shall make provisions for the cleaning and disinfecting of contaminated articles and surfaces which cannot be sterilized.

(c) Bedside equipment including, but not limited to washbasins, emesis basins, bedpans and urinals shall be sanitized only by one of the following methods:

(1) Submersion in boiling waster for a minimum of 30 minutes.

(2) Autoclaving at 15 pounds pressure and 121^0C (250^0F) for 20 minutes.

(3) Gas sterilization.

(d) Chemicals shall not be used as a substitute for the methods specified in (c) above.

(e) Electronic thermometers shall be cleaned and disinfected according to the manufacturer's instructions. Glass thermometers shall be cleaned and disinfected for at least 10 minutes with 70 percent ethyl alcohol or 90 percent isopropyl alcohol with 0.2 percent iodine. Oral and rectal thermometers shall be stored separately in clean labeled containers with fitted lids.

(f) Individual patient care supply items designed and identified by the manufacturer to be disposable shall not be reused.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79643. Nursing Service—Space.

(a) An office or other suitable space shall be provided for the director of nursing service.

(b) A nursing station shall be maintained in each nursing unit.

(c) Each nursing station shall have a cabinet, a desk, space for records, a bulletin board, a telephone and a specifically designated and well illuminated medication storage compartment with a lockable door. If a separate medication room is maintained, it shall have a lockable door and a sink with water connections for care of equipment and for hand washing.

(d) If a refrigerator is provided in a nursing station, the refrigerator shall meet the following standards:

(1) Be located in a clean area not subject to contamination by human waste.

(2) Maintain temperatures at or below 7^0C (45^0F) for chilling.

(3) Maintain the freezer at minus 18^0C (0^0F).

(4) Contain an accurate thermometer at all times.

(5) If foods are retained in the refrigerator, they shall be covered and clearly identified as to contents and date initially covered. Drugs shall be kept in a separate, closed container in a separate area of the refrigerator.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79645. Pharmaceutical Service.

Pharmaceutical service means the procuring, manufacturing, compounding, dispensing, distributing, and storing, of drugs, biologicals, and chemicals by appropriate staff and having space, equipment, and supplies to perform that service. Pharmaceutical services also include the provision of drug information to other health professionals and to inmate–patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79647. Pharmaceutical Service—General Requirements.

(a) Arrangements shall be made with pharmacists licensed by the California State Board of Pharmacy to assure that pharmaceutical services are available to provide patients with prescribed drugs and biologicals.

(b) Dispensing, labeling, storage, and disposal of drugs and biologicals shall be in conformance with state and federal laws.

(c) If a pharmacy is located on the correctional treatment center premises, the pharmacy shall have a limited permit or license issued by the California State Board of Pharmacy. Pharmacies located on the licensed premises of the facility shall be opened for inspection upon the request of an authorized Department representative.

(d) The facility shall not accept money, goods, or services free, or below cost from any pharmacist or pharmacy as compensation or inducement for referral of business to any pharmacy.

(e) Written policies and procedures shall be developed for establishment of safe and effective systems for procurement, storage, distribution, dispensing, and use of drugs and chemicals. The pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff.

(f) There shall be a system maintained whereby no person other than a pharmacist or a legally qualified individual under the immediate supervision of a pharmacist shall dispense medications.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79649. Pharmaceutical Services—Other Requirements.

(a) Pharmaceutical service shall include, but not be limited to, the following:

(1) Obtaining necessary drugs including the availability of 24–hour prescription service on a prompt and timely basis as follows:

(A) Drugs ordered "STAT" that are not available in the facility emergency drug supply shall be available and administered within one hour of the time ordered during normal pharmacy hours. For those hours during which the pharmacy is closed, drugs ordered "STAT" shall be available and administered within two hours of the time ordered. Drugs ordered "STAT" which are available in the emergency drug supply shall be administered immediately.

(B) Institutional formulary anti–infectives and institutional formulary drugs used to treat severe pain, nausea, agitation, diarrhea or other severe discomfort shall be available and administered within one hour of the time ordered, unless ordered "STAT".

(C) Refills of prescription drugs shall be available within 24 hours.

(2) Dispensing of drugs and biologicals.

(3) Monitoring the drug distribution system which includes ordering, dispensing and disposal of medication.

(4) Provision of consultative and other services furnished by pharmacists which assist in the development, coordination, supervision and review of the pharmaceutical services within the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79651. Pharmaceutical Service—Labeling and Storage of Drugs.

(a) Containers which are cracked, soiled or without secure closures shall not be used. Drug labels shall be legible. No medication shall be dispensed by prescription except in a new container.

(b) All drugs obtained by prescription shall be labeled in compliance with state and federal laws governing prescription dispensing.

(c) Nonlegend drugs shall be labeled in conformance with state and federal food and drug laws.

(d) Test reagents, germicides, disinfectants and other household substances shall be stored separately from drugs and shall not be accessible to patients.

(e) External use drugs in liquid, tablet, capsule or powder form shall be stored separately from drugs for internal use.

(f) Drugs shall be stored at appropriate temperatures. Drugs required to be stored at room temperature shall be stored at a temperature between 15^0C (59^0F) and 30^0C (86^0F). Drugs requiring refrigeration shall be stored in a refrigerator between 2^0C (36^0F) and 8^0 (46^0F). When drugs are stored in the same refrigerator with food, the drugs shall be kept in a closed container clearly labeled "drugs".

(g) Drugs shall be stored in an orderly manner in cabinets, drawers or carts of sufficient size to prevent crowding.

(h) Dose preparation and administration areas shall be well lighted.

(i) Drugs shall be accessible only to licensed health professionals designated in writing by the licensee.

(j) Medication shall not be kept at the patient's bedside, with the exception of prescribed sublingual or inhalation forms of drugs.

(k) Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

(*l*) The drugs of each inmate–patient shall be kept and stored in their originally received containers. No drugs shall be transferred between containers.

(m) Discontinued drug containers shall be marked, or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. Discontinued drugs shall be disposed of within ninety (90) days of the date the drug order was discontinued, unless the drug is reordered within that time.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79653. Pharmaceutical Service—Stop Orders.

Written policies shall be established and implemented limiting the duration of new drug orders in the absence of a prescriber's specific indication for duration of therapy. The prescriber shall be contacted for new orders prior to the termination time established by the policy. Such policies shall include all categories of drugs.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79655. Pharmaceutical Service—Orders for Drugs.

(a) No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness.

(b) All drug orders shall be written, dated, and signed by the person lawfully authorized to give such an order. The name, quantity or specific duration of therapy, dosage and time or frequency of administration of the drug and route of administration if other than oral shall be specified. "P.R.N." orders shall also include the indication for the use of the drug.

(c) Verbal orders for drugs and treatment shall be received only by licensed nurses, psychiatric technicians, pharmacists, physicians and physician's assistants from their supervising physicians and others consistent with their practice acts. Such orders shall be recorded immediately in the patient's health record by the person receiving the order, and shall include the date and time of the order and the signature of the person receiving the order. The order shall be signed by the prescriber within forty–eight (48) hours, excluding weekends and holidays.

(d) The signing of orders shall be by signature or a personal computer key. Signature stamps shall not be used.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79657. Pharmaceutical Service—Drug Order Processing.

Signed orders for drugs shall be transmitted to the issuing pharmacy within twenty–four (24) hours, either by written prescription of the prescriber, or by an order form which produces a direct copy of the order.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79659. Pharmaceutical Service—Drug Order Records.

(a) Correctional treatment centers shall maintain a record which includes, for each drug ordered by prescription, the name of the inmate–patient, the drug name, and strength, the date ordered, the date and amount received and the name of the issuing pharmacy.

(b) The record shall be maintained in the correctional treatment center, or in the pharmacy with which the correctional treatment center contracts for pharmaceutical services, for at least three years following the date of the last entry to the record so that the record may be accessible to the correctional treatment center.

NOTE: Authority cited: Sections 208(a), 1250.1(*l*) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79661. Pharmaceutical Service—Personal Medications.

(a) Medications brought by or with the patient on admission to the correctional treatment center shall not be used unless the contents of the containers have been examined and positively identified after admission by the inmate–patient's physician or a pharmacist retained by the licensed correctional treatment center.

(b) The licensed correctional treatment center may use drugs from other licensed health care facilities or those drugs dispensed or obtained after admission from any licensed or governmental pharmacy and may accept the delivery of those drugs if identified and approved by a physician or pharmacist.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79663. Pharmaceutical Service—Controlled Drugs.

(a) Drugs listed in Schedules II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 et seq., shall not be accessible to other than licensed nursing, pharmacy and medical

personnel designated by the licensee. Drugs listed in Schedule II of the above Act shall be stored in a locked cabinet or a locked drawer, separate from noncontrolled drugs, unless they are supplied on a scheduled basis as part of a unit dose medication system.

(b) Separate records of use shall be maintained on all Schedule II drugs. Such records shall be maintained accurately and shall include the name of the patient, the prescription number, the drug name, strength and dose administered, the date and time of administration and the signature of the person administering the drug. Such records shall be reconciled at least daily and shall be retained for at least one year. If such drugs are supplied on a scheduled basis as part of a unit dose medication system, such records need not be maintained separately.

(c) Drug records shall be maintained for drugs listed in Schedules III and IV of the above Act in such a way that the receipt and disposition of each dose of any such drug may be readily traced. Such records need not be separate from other medication records.

NOTE: Authority cited: Sections 208(a) and 1267.10(*l*), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79665. Pharmaceutical Service—Disposition of Drugs.

(a) Drugs which have been dispensed for individual inmate–patient use and are labeled in conformance with state and federal law may be furnished to inmate–patients on discharge on the order of a physician.

(b) A record of the drugs sent with the inmate–patient shall be made in the inmate–patient's health record.

(c) An inmate–patient's drugs which remain in the facility after discharge of the inmate–patient shall be destroyed by the facility in the following manner:

(1) Drugs listed in Schedules II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, Title 21, United States Code, Section 801 et seq., shall be destroyed by the facility in the presence of a pharmacist and a registered nurse or two pharmacists employed by the facility. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signature of the witness required above shall be recorded in the patient's health record in a separate log. Such log shall be retained for at least three years.

(2) Drugs not listed under schedules II, III, IV or V of the above Act shall be destroyed by the facility in the presence of a pharmacist or licensed nursing personnel. The name of the patient, the name and strength of the drug, and prescription number (if applicable), the amount destroyed, the date of destruction, the signature of the pharmacist or nurse witnessing the destruction, and one other witness shall be recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.

(d) Unless otherwise prohibited under applicable federal or state laws, individual patient drugs supplied in sealed containers shall be returned, if unopened, to the issuing pharmacy for disposition.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79667. Pharmaceutical Service—Unit Dose Medication System.

In correctional treatment centers employing a unit dose medication system, there shall be at least a twenty–four (24)–hour supply of all inmate–patient medications on hand at all times, except those drugs which are to be discontinued within the twenty–four (24)–hour period. Drugs that are a part of a unit dose medication system shall not exceed a forty–eight (48)–hour supply excepting weekends and holidays.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79669. Pharmaceutical Service Staff.

A pharmacist shall have overall responsibility for the pharmaceutical service. He or she shall be responsible for the procurement, storage, distribution and disposal of all drugs as well as the development, coordination, supervision and review of pharmaceutical services in the correctional treatment center. Correctional treatment centers with a limited pharmacy permit shall employ a pharmacist on at least a consulting basis. Responsibilities shall be set forth in a job description or agreement between the pharmacist and the correctional treatment center. The pharmacist shall be responsible to the administrator and shall furnish him or her written reports and recommendations regarding the pharmaceutical services within the correctional treatment center. Such reports shall be provided no less often than quarterly.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79671. Pharmaceutical Service—Equipment and Supplies.

(a) There shall be equipment and supplies necessary for the provision of pharmaceutical services within the correctional treatment center, including at least the following:

(1) Refrigerator with an accurate thermometer.

(2) Lockable drug cabinets, drawers, closets or rooms.

(3) Drug service trays and/or carts.

(4) Drug preparation counter area and convenient water source.

(5) Reference materials containing drug monographs on all drugs in use in the facility. Such monographs shall include information concerning generic and brand names, if applicable, available strengths, and dosage forms and pharmacological data including indications and side effects.

(b) Emergency supplies shall be readily available at each correctional treatment center. Emergency drug supplies shall meet the following requirements:

(1) Legend drugs shall only be stored in the emergency supply, under the following conditions:

(A) Injectable supplies of legend drugs shall be limited to a maximum of six single doses in ampules or vials or one container of the smallest available multi–dose vial and shall be in sealed, unused containers.

(B) Sublingual or inhalation emergency drugs shall be limited to single sealed containers of the smallest available size.

(C) Not more than ten emergency drugs in solid, oral dosage form or suppository dosage form for anti–infective, anti–diarrhea, anti–nausea or analgesic use may be stored if in sealed containers. Not more than four doses of any one drug may be so stored.

(2) The emergency drug supply shall be stored in a portable container which is sealed in such a manner that the tamper–proof seal must be broken to gain access to the drugs. A licensed nurse shall notify the pharmacist when drugs have been used from the emergency kit or when the seal has been broken. Drugs used from the kit shall be replaced within seventy–two hours and the supply resealed by the pharmacist.

(3) The contents of the supply shall be listed on the outside of the container.

(4) The supply shall be checked at least once monthly by the pharmacist.

(5) Separate records of use shall be maintained for drugs administered from the supply. Such records shall include the name and dose of the drug administered, name of the patient, the date and time of administration and the signature of the person administering the dose.

(6) A correctional treatment center with a licensed pharmacy on the premises shall make the emergency drug supply accessible without making it necessary to enter either the pharmacy or drug storage room during hours when the pharmacist is not available. Access to the supply shall be limited to designated registered nurses. Records of

drugs taken from the supply shall be maintained and the pharmacist shall be notified of such use. The records shall include the name and strength of the drug, the amount taken, the date and time, the name of the inmate–patient to whom the drug was administered, and the signature of the registered nurse. The pharmacist shall be responsible for maintenance of the supply and assuring that all drugs are properly labeled and stored. The drug supply shall contain that type and quantity of drugs necessary to meet the immediate needs of inmate–patients.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79673. Dental Service.

Dental service means the provision of emergency dental care and may include diagnostic, preventive, or corrective procedures performed by dentists with appropriate staff, space, equipment, and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79675. Dental Service—General Requirements.

(a) Written policies and procedures for the scope of services to be provided shall be developed and maintained by the person responsible for the service. Procedures shall be approved by the administration.

(b) The responsibility and the accountability of the dental service to the administration shall be defined.

(c) There shall be a well–defined plan for oral health care, based on patient need, the size of the treatment center and the type of service provided.

(d) There shall be a well–organized plan for emergency dental care.

(e) There shall be a record of all dental services provided to the inmate–patient and this shall be made a part of the inmate–patient's medical record.

(f) Periodically, an appropriate committee of staff members shall evaluate the services provided and make appropriate recommendations to the treatment center administration.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79677. Dental Service Staff.

(a) A dentist shall have overall responsibility for the dental service.

(b) The dental service shall be staffed by a sufficient number of dentists along with auxiliary dental personnel to render proper dental care.

(c) When dental hygienists or dental laboratory technicians are employed, they shall work under the supervision of the dentist who is responsible for the dental service.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79679. Dental Service Equipment and Supplies.

(a) There shall be equipment, instruments and supplies maintained to meet the needs of the services offered.

(b) There shall be equipment for sterilization of instruments and supplies.

(c) All equipment installed shall comply with standards of infection control as defined by the infection control committee, whose duties and responsibilities are delineated in Section 79781(d)(2) of this Chapter.

(d) The following materials shall be available for immediate use whenever dental treatment is provided:

(1) Oxygen.

(2) Appropriate drugs.

(3) Resuscitation equipment.

(e) Radiographic equipment shall meet the requirements of California Code of Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, commencing with Section 30100 which is hereby incorporated by reference.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79681. Dental Service Space.

(a) There shall be adequate space maintained for the dental service.

(b) There shall be facilities for dental radiography.

(c) There shall be space provided for the sterilization and storage of instruments and lockable storage for bulk supplies.

(d) There shall be a secure storage area for patient records.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79683. Dietary Service.

Dietary service means the provision of nutritionally adequate food for inmate–patients with appropriate staff, space, equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79685. Dietary Service General Requirements.

(a) The food and nutrition needs of patients in the correctional treatment center shall be met in accordance with "The Recommended Dietary Allowance", adopted by the Food and Nutrition Board of the National Research Council, National Academy of Science, revised 1989, and "The California Daily Food Guide", California Department of Health Services, April 1990 edition. Daily menus shall follow these recommendations.

(b) Substitutions shall be within the same food group.

(c) Not less than 3 meals shall be served daily, and with not more than a 14–hour span between the third meal and the first meal of the following day.

(d) Nourishment or between meal snacks shall be provided as required by a person lawfully authorized to give a dietary order.

(e) Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Food shall be served at appropriate temperatures and in a form to meet individual needs.

(f) When food is provided by an outside source, the correctional treatment center shall ensure that all federal, state and local requirements are met.

(g) All regular and therapeutic diets shall be prescribed by a person lawfully authorized to give such an order and shall be planned, prepared and served under the supervision or consultation of a dietitian.

(h) A written plan shall be followed for uniform handling of inmate–patients with diabetes, pregnant women, and others whose condition requires a medically prescribed diet as part of therapeutic treatment.

(i) A current therapeutic diet manual, approved by the dietitian, shall be readily available to all medical, nursing and dietetic personnel. The manual shall be reviewed annually and revised at least every five years.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79687. Dietary Service Policies and Procedures.

A dietary services policy and procedure manual shall be developed and available to all personnel. The manual shall be developed with the assistance of a dietitian and other appropriate staff. The manual shall address at least the following:

(a) Organization of the dietary service.

(b) Personnel management.

(c) Staff development.

(d) Menu planning.

(e) Food storage.

(f) Food preparation and services.

(g) Maintenance, sanitation and hygiene.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79689. Dietary Service Therapeutic Diets.

(a) Therapeutic diets shall be provided as prescribed by the attending physician and shall be planned by a registered dietitian. Therapeutic diets shall be prepared and served with supervision or consultation from a registered dietitian.

(b) Dietary service staff who prepare and serve therapeutic diets shall have received in–service training on the dietary standards and food groups and therapeutic diets and shall have sufficient knowledge of food values to make appropriate substitutions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79691. Dietary Service Menus.

(a) Menus for regular and therapeutic diets shall be planned by a registered dietitian and written at least one week in advance, dated and posted in the kitchen at least three days in advance.

(b) If any meal served varies from the planned menu, the change shall be noted in writing on the posted menu in the kitchen.

(c) Menus shall provide a variety of foods and indicate standard portions at each meal. If a cycle menu is used, the cycle shall be of no less than three weeks duration and shall be revised quarterly.

(d) A copy of the menu as planned and as served shall be kept on file for at least thirty (30) days.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79693. Dietary Service Food Storage.

(a) Food storage areas shall be kept clean at all times.

(b) All foods not requiring refrigeration shall be stored at least twelve inches above the floor, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning, in a ventilated room not subject to contamination by waste water backflow, condensation, leakage, rodents or vermin.

(c) Readily perishable foods or beverages shall be maintained at temperatures of 7^0C (45^0F) or below, or at 60^0C (140^0F) or above, at all times, except during necessary periods of preparation or service. Frozen foods shall be stored at -18^0C (0^0F) or below.

(d) Soaps, detergents, cleaning compounds, pesticides and other toxic substances shall be stored separately.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79695. Dietary Service Sanitation.

(a) All kitchen areas shall be kept clean, free from litter and rubbish, and protected from rodents, roaches, flies and other insects.

(b) All utensils, counters, shelves and equipment shall be kept clean and maintained in good repair.

(c) Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. Bacteriological testing shall be performed when indicated by specific problems, epidemiological findings, or recommendations by the infection control committee of the licensed correctional treatment center.

(d) Kitchen wastes not disposed of by mechanical means shall be kept in leak–proof, nonabsorbent, tightly closed containers and disposed of as frequently as necessary to prevent a nuisance or contamination of food preparation areas.

(e) Soiled containers shall be cleaned inside and outside in a way that will not contaminate food, equipment, utensils or food preparation areas.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79697. Dietary Service Cleaning and Disinfection of Utensils.

(a) All utensils used for eating and drinking and in the preparation and service of food and drink shall be cleaned and disinfected or discarded after each usage.

(b) Gross food particles shall be removed by careful scraping and rinsing in running water.

(c) Utensils not washed by mechanical means shall be placed in hot water with a minimum temperature of 43^0C (110^0F), washed using soap or detergent, rinsed in hot water to remove soap or detergent and disinfected by one of the following methods or an equivalent, as approved by the Department.

(1) Immersion for at least two minutes in clean water at 77^0C (170^0F).

(2) Immersion for at least 30 seconds in clean water at 83^0C (180^0F).

(3) Immersion in water containing a bactericidal chemical as approved by the Department.

(4) After disinfection the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used.

(d) Results obtained with dish washing machines shall be equal to those obtained by the methods outlined above and all dish washing machines shall meet the most current requirements contained in Standard No. 3 of the National Sanitation Foundation, which is hereby incorporated by reference. Hot water at a minimum temperature of 83^0C (180^0F), shall be maintained at the manifold of the final rinse.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79699. Dietary Service Equipment, Space, and Supplies.

(a) Equipment of the type and in the amount necessary for the proper preparation, serving and storage of food and for proper dish washing shall be provided and maintained in good working order.

(b) All food shall be of good quality. Food in unlabeled, rusty, leaking broken containers or cans with side seam dents, rim dents or swells shall not be retained or used.

(c) Foods held in refrigerated or other storage areas shall be covered. Liquids and foods which are prepared and not served shall be tightly covered, clearly labeled and dated.

(d) Spoiled or contaminated food shall not be served.

(e) The dietetic service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes and prevent excess condensation.

(f) Persons other than dietetic service personnel shall not be allowed in the kitchen areas unless required to do so in the performance of their duties.

(g) Smoking shall not be permitted in kitchen areas.

(h) An office or other suitable space shall be provided for the dietitian or dietetic service supervisor.

(i) Kitchen sinks shall not be used for hand washing. Separate hand washing facilities with soap, running water, individual towels and waste receptacles shall be provided.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79701. Dietary Service Staff.

(a) A dietitian shall be employed on at least a part–time or consulting basis in all correctional treatment centers. A part–time dietitian shall provide the number of hours of service in each calendar month to meet the needs of the inmate–patients. Services shall be of

sufficient duration to ensure continuing liaison with medical and nursing staffs, patient care counseling, approval of menus and planning and conducting of in–service education programs.

(b) If a dietitian is not employed full time, a full time person who is a graduate of a state approved course that provides 90 or more hours of classroom instruction in food supervision shall be employed to be responsible for the operation of the food service. The dietetic supervisor may also cook, provided sufficient time is allowed for managerial responsibilities.

(c) Staff (civilian and inmate workers) shall be employed, oriented, and their working hours scheduled to provide for the nutritional needs of inmate–patients and to maintain the dietetic service area.

(d) Dietetic service personnel shall be trained in basic food sanitation techniques, shall be clean, wear clean clothing, including cap or hair net, and shall be excluded from duty when affected by skin infection or communicable diseases. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

Article 4. Optional Services

§ 79703. Optional Services.

(a) A correctional treatment center may provide the following services:

(1) Laboratory.

(2) Radiology.

(3) Perinatal.

(4) Outpatient surgery.

(5) Mental health treatment program.

(6) Standby Emergency Medical Services.

(7) Any other services requested in writing and approved by the state department in writing.

(b) A correctional treatment center may provide outpatient surgical care with anesthesia if the correctional treatment center meets the same requirements as a surgical clinic licensed pursuant to Section 1204 of the Health and Safety Code, except for the requirement that patients remain less than 24 hours.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79705. Optional Services—Laboratory Services.

(a) Clinical laboratories shall be operated in conformance with the California Business and Professions Code, Division 2, Chapter 3 (Sections 1200 to 1322, inclusive) and the California Code of Regulations, Title 17, Division 1, Chapter 2, Subchapter 1, Group 2 (Sections 1030 to 1057, inclusive).

(b) The correctional treatment center shall maintain clinical laboratory services and equipment for routine laboratory work such as urinalysis, complete blood counts, and such tests necessary to meet the needs of the correctional treatment center.

(c) The correctional treatment center shall maintain or make provision for clinical laboratory services for performance of tests in chemistry, microbiology, serology, hematology, pathology and blood banking.

(d) Written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the patient care policy committee, medical director, and the governing body. Policies and procedures shall be reviewed annually.

(e) The responsibility and the accountability of the clinical laboratory service to the medical director shall be defined.

(f) The director of the clinical laboratory shall assure that:

(1) Examinations are performed accurately and in a timely fashion.

(2) Procedures are established governing the provision of laboratory services for outpatients.

(3) Laboratory systems identify the patient, test requested, date and time the specimen was obtained, the time the request reached the laboratory, the time the laboratory completed the test and any special handling which was required.

(4) Procedures are established to ensure the satisfactory collection of specimens.

(5) A communications system to provide efficient information exchange between the laboratory and related areas of the correctional treatment center is established.

(6) A quality control system within the laboratory designed to ensure medical reliability of laboratory data is established. The results of control tests shall be readily available in the correctional treatment center.

(7) Reports of all laboratory examinations are made a part of the inmate–patient's medical record as soon as is practical.

(8) No laboratory procedures are performed except on the order of a person lawfully authorized to give such an order.

(g) Tissue specimens, where obtained, shall be examined by a physician who is certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology or possesses qualifications which are equivalent to those required for certification. Oral specimens may be examined by a dentist who is certified or eligible for certification as an oral pathologist by the American Board of Oral Pathology. A record of their findings shall become a part of the patient's medical record. A file on these findings shall be maintained at the correctional treatment center or the principal office of the consulting pathologist.

(h) The use, storage and disposal of radioactive materials shall comply with the California Radiation Control Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, commencing with Section 30100, California Code of Regulations, as amended. These regulations are hereby incorporated by reference.

(i) Where the correctional treatment center depends on outside blood banks, there shall be a written agreement governing the procurement, transfer and availability of blood.

(j) Licensed clinical laboratory services shall be available at all times for emergencies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79707. Laboratory Service Staff.

(a) A physician shall have overall responsibility for the clinical laboratory service. The physician shall be certified or eligible for certification in clinical pathology and/or pathologic anatomy by the American Board of Pathology or the American Osteopathic Board of Pathology. If such a pathologist is not available on a full–time, regular part–time, or consulting basis, a physician or a licensed clinical laboratory bioanalyst who is available on a full–time, regular part–time, or consulting basis may administer the clinical laboratory provided a pathologist, qualified as above, is available for consultation.

(b) There shall be sufficient staff with adequate training and experience to meet the needs of the service being offered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79709. Laboratory Service—Equipment and Supplies.

(a) There shall be sufficient equipment and supplies maintained to perform the laboratory services being offered.

(b) When the correctional treatment center maintains blood storage facilities, such facilities shall be in conformance with the provisions of Section 1002(g), Title 17, California Code of Regulations. Blood storage facilities shall be inspected by the correctional treatment center at least daily for compliance with these requirements.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79711. Optional Services—Radiology Services.

Radiology service means the use of X–ray, other ionizing radiation, and/or magnetic resonance imaging, and/or ultrasound in the detection, diagnosis, and treatment of human illnesses and injuries with appropriate staff, space, equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79713. Radiology Service General Requirements.

(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the governing body, the administration and the medical director. Policies and procedures shall be reviewed annually.

(b) The responsibility and the accountability of the radiological service to the medical staff and administration shall be defined.

(c) The use, storage and shielding of all radiation machines and radioactive materials shall comply with the California Radiation Control Regulations, Section 30100 et seq., Subchapter 4, Chapter 5, Title 17, California Code of Regulations.

(d) All persons operating or supervising the operation of X–ray machines shall comply with the requirements of the Radiologic Technology Regulations, Section 30400 et seq., Subchapter 4.5, Chapter 5, Title 17, California Code of Regulations.

(e) Diagnostic radiological services shall only be performed on the order of a person lawfully authorized to give such an order.

(f) The original reports of radiological service examinations shall be filed in the inmate–patient's medical record and a copy maintained in the radiology unit.

(g) X–ray films, or reproductions thereof, shall be retained for seven years.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79715. Radiology Service Staff.

(a) A physician shall have overall responsibility for the radiological service. This physician shall be certified or eligible for certification by the American Board of Radiology or the American Osteopathic Board of Radiology. If such a radiologist is not available on a full–time or regular part–time basis, a physician, with training and experience in radiology, may administer the service. In this circumstance, a radiologist, qualified as above, shall provide consultation services.

(b) Sufficient certified radiologic technologists shall be employed to meet the needs of the service being offered.

(c) Radiological services shall be available to the correctional treatment center at all times for the provision of services on all shifts and for emergencies. Such services may be provided on the correctional treatment center or through a contractual arrangement.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79717. Radiology Service Equipment and Supplies.

(a) There shall be equipment and supplies maintained or available to perform the radiological services that are offered in the correctional treatment center. As a minimum, the following equipment shall be available:

(1) At least one radiographic unit. If fluoroscopic services are provided, fluoroscopes shall be equipped with image intensifiers.

(2) Film processing equipment.

(b) Proper resuscitation and monitoring equipment shall be immediately available.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79719. Radiology Service Space.

(a) There shall be sufficient space maintained to provide radiological services. This shall include but not be limited to the following:

(1) A separate X–ray room large enough to accommodate the necessary radiographic equipment and to allow easy maneuverability of stretchers and wheelchairs.

(2) Toilet facilities located in the radiology service space or in the immediate vicinity.

(3) Dressing rooms for patients if not otherwise provided by toilet facilities.

(4) Film processing area.

(5) Sufficient storage space for all the necessary X–ray equipment, supplies, and for exposed X–ray film, and copies of reports.

(6) Suitable area for viewing and reporting of radiographic examinations.

(b) If X–ray examinations are to be performed on outpatients, outpatient access to the radiological spaces shall not traverse a nursing unit.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79721. Optional Services—Perinatal Services.

A perinatal unit means a maternity unit and newborn service of the correctional treatment center for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79723. Perinatal Service General Requirements.

(a) A perinatal unit shall provide or arrange for:

(1) Care for the patient during pregnancy, labor, delivery, and the postpartum period. Labor, delivery, and neonatal care may be provided outside the correctional treatment center under a contractual agreement with a general acute care hospital, in which case only emergency delivery services will be provided by the correctional treatment center.

(2) Care for the normal infant and the infant with abnormalities which usually do not impair function or threaten life. Newborns shall not be retained beyond 24 hours at the correctional treatment center without the approval of the medical director.

(3) Care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major disability.

(4) Formal arrangements for consultation and/or transfer of an infant to an intensive care newborn nursery, or a mother to a hospital with the necessary services, for problems beyond the capacity of the perinatal unit.

(b) There shall be written policies and procedures developed and maintained by the person responsible for the service, in consultation with other appropriate health professionals and administration. These policies and procedures shall reflect the standards and recommendations of the 1989 American College of Obstetricians and Gynecologists "Standards for Obstetric–Gynecologic Services" and the 1988 American Academy of Pediatrics "Guidelines for Perinatal Care". These standards are hereby incorporated by reference. Policies shall be approved by the governing body. Procedures shall be approved by the patient care policy committee and medical director. Policies and procedures shall address but not be limited to:

(1) Relationships to other services in the correctional treatment center.

(2) Admission policies, including infants delivered prior to admission of the mother.

(3) Arrangements for maternity patient overflow.

(4) Consultation from an intensive care newborn nursery.

(5) Prevention and treatment of neonatal hemorrhagic disease.

(6) Care and transfer of the premature or low birth weight infant.

(7) Resuscitation of the newborn.

(8) Administering and monitoring of oxygen and respiratory therapy.

(9) Blood Transfusion.

(10) PKU screening.

(11) Rhesus (Rh) hemolytic disease identification, reporting, and prevention.

(12) Management of hyperbilirubinemia.

(13) Induction of labor and administration of oxytocic drugs.

(14) Obstetric–pediatric–pathologic–radiologic conferences.

(15) Patient identification system.

(16) Care routines for the mother and infant.

(17) Hand washing technique.

(18) Bassinet techniques in caring for infants.

(19) Treatment of the eyes of newborn, including Crede′ or antibiotic treatment.

(20) Breast feeding.

(21) Formula preparation and storage.

(c) The responsibility and the accountability of the perinatal service to the medical staff and administration shall be defined.

(d) Laboratory testing capabilities for performing blood gas analyses, pH and microtechniques shall be available.

(e) The correctional treatment center perinatal service shall have the capability for operative delivery, including caeserean section, available at all times.

(f) Infants with diarrhea of the newborn as defined in Section 2564, Title 17, California Code of Regulations, as amended, or who have draining lesions shall be transferred to a general acute care hospital.

(g) Infants suspected of having airborne infections shall be separated from other infants in the nursery and transferred to a general acute care hospital.

(h) All persons in the delivery room shall wear clean gowns, caps and masks during a delivery.

(i) Oxygen shall be administered to newborn infants only on the written order of a physician. The order shall include the concentration (volume percent) or desired arterial partial pressure of oxygen and be reviewed, modified, or discontinued after 24 hours.

(j) All patients shall be attended by a physician or registered nurse when under the effect of anesthesia or regional analgesia, when in active labor, during delivery and in the immediate postpartum period.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79725. Perinatal Service Staff.

(a) A physician shall have overall responsibility for the service. This physician shall be certified or eligible for certification by the American Board of Obstetrics and Gynecologists, the American Board of Pediatrics, the American Osteopathic Board of Obstetrics and Gynecology or the American Osteopathic Board of Pediatrics. If a physician with one of the above qualifications is not available, a physician with training and experience in obstetrics and gynecology or pediatrics may administer the service. In this circumstance, a physician with either of the required qualifications shall provide consultation to the service.

(b) A physician who is certified or eligible for certification by the American Board of Pediatrics shall be responsible for the nursery.

(c) There shall be one registered nurse on duty on each shift assigned to the labor and delivery suite. In addition, there shall be sufficient trained personnel to monitor and evaluate labor and to assist with a delivery.

(d) There shall be one registered nurse on duty for each shift assigned to the antepartum and postpartum areas. In addition, there shall be sufficient licensed personnel to assess patients and provide care.

(e) A registered nurse who has had training and experience in neonatal nursing shall be responsible for the nursing care in the nursery.

(1) A registered nurse trained in infant resuscitation shall be on duty on each shift.

(2) A ratio of one licensed nurse to eight or fewer infants shall be maintained for normal infants.

(f) The correctional treatment center shall provide directly or by arrangement continuing education and training programs for the nursing staff in perinatal nursing and infection control.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79727. Perinatal Service Equipment and Supplies.

(a) General equipment shall include at least the following:

(1) Amniocentesis tray.

(2) DC defibrillator immediately available.

(3) Blanket warmer.

(4) Solutions and supplies for intravenous fluids, blood, plasma and blood substitutions or fractions.

(b) A fetal heart rate monitor shall be available.

(c) Labor rooms shall contain at least the following equipment:

(1) Oxygen and suction outlets.

(2) A labor bed with adjustable side rails.

(3) Footstool.

(4) One or more comfortable chairs.

(5) Hand washing facilities for staff.

(6) Toilet and hand washing facilities shall be in or immediately adjacent to labor room and shall be shared by no more than two patients.

(7) Adjustable examination light.

(8) Sphygmomanometer/cuff.

(9) Regular and fetal stethoscope.

(d) Delivery rooms shall have at least the following equipment:

(1) Adjustable delivery table.

(2) Surgical overhead light.

(3) Equipment for inhalation anesthesia and regional analgesia.

(4) Clock with sweep second hand.

(5) An elapsed time clock.

(6) Emergency supplies such as packings, syringes, needles and drugs.

(7) Emergency call system.

(8) Provision for oxygen and suction for mother and infant.

(9) Thermostatically controlled incubator or radiant heating device.

(10) Erythromycin ophthalmic ointment and solutions for prophylactic Crede′ treatment of eyes.

(11) Sterile clamps or ties for umbilical cord.

(12) Resuscitation equipment and supplies to include at least:

(A) Glass trap suction device with catheter.

(B) Pharyngeal airways, assorted sizes.

(C) Laryngoscope, including a blade suitable for premature infants.

(D) Endotracheal catheters, assorted size with malleable stylets.

(E) Arterial catheters, assorted sizes.

(F) Ventilatory assistance bag and infant mask.

(G) Bulb syringe.

(H) Stethoscope.

(I) Syringes, needles and appropriate drugs.

(e) Nursery equipment shall include at least the following:

(1) A separate bassinet made of easily cleanable material such as metal or clear plastic for each infant.

(2) Enclosed storage unit for clean supplies for each infant.

(3) Diaper receptacles with a cover, foot control and disposable liner.

(4) A hamper with a disposable liner for soiled linen.

(5) A wall thermometer and hygrometer.

(6) Accurate beam scales or the equivalent.

(7) Thermostatically controlled incubators or radiant heating devices to maintain proper ambient temperature.

(8) Oxygen and compressed air supply regulating devices and administration equipment.

(9) Resuscitation equipment as required in delivery rooms.

(10) Suction equipment.

(11) At least one duplex electrical outlet for every two bassinets.

(12) One hand washing sink with controls not requiring direct contact of the hands for operation for each six bassinets. Wrist or elbow blade handles are not acceptable.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79729. Optional Services—Outpatient Surgical Care.

Outpatient surgical care means the provision of surgical services to patients not requiring hospitalization, with appropriate staff, space, equipment, and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79731. Outpatient Surgical Care—General Requirements.

(a) If outpatient surgery is performed, the written policies and procedures, approved by the governing body of the correctional treatment center, shall make provision for at least the following:

(1) The types of operative procedures that may be performed shall be specified.

(2) The types of anesthesia that may be used shall be specified.

(3) Preoperative evaluation of the patient, meeting the same standards as apply to inpatient surgery.

(4) Informed consent.

(5) The delivery of all anatomical parts, tissues and foreign objects removed to a pathologist designated by the hospital with a report of findings to be filed in the patient's medical record.

(6) Written preoperative instructions to patients covering:

(A) Applicable restrictions upon food and drugs before surgery.

(B) Any special preparations to be made by the patient.

(C) Any postoperative requirements.

(D) An understanding that admission to a hospital may be required in the event of an unforeseen circumstance.

(7) Examination of each patient by a physician prior to discharge.

(b) Where general anesthesia is to be administered, written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies and procedures shall be approved by the administration and medical director. The policies and procedures shall include provision for at least:

(1) Preanesthesia evaluation of the patient by a physician or a certified registered nurse anesthetist with appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated.

(2) Review of the patient's condition immediately prior to induction of anesthesia.

(3) Safety of the patient during the anesthetic period.

(4) Recording of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the amount and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions.

(c) Prior to commencing surgery, the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not be administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record:

(1) An interval medical history and physical examination performed and recorded within the previous 24 hours.

(2) Appropriate screening tests, based on the needs of the patient, accomplished and recorded within 72 hours prior to surgery.

(3) An informed consent, in writing, for the contemplated surgical procedure.

(d) The requirements of subsection (c), above, do not preclude rendering emergency medical or surgical care to a patient.

(e) A register of operations shall be maintained including the following information for each surgical procedure performed.

(1) Name, age, sex and identity number of the patient.

(2) Date and time of the operation and the operating room number.

(3) Preoperative and postoperative diagnosis.

(4) Name of surgeon, assistants, anesthetists and scrub and circulating assistants.

(5) Surgical procedure performed and anesthetic agent used.

(6) Complications, if any, during the operation.

(f) An affiliation agreement or contract for the referral and transfer of patients with emergency medical problems shall be established and available for inspection by the Department.

(g) Periodically, the patient care policy committee shall evaluate the services provided and make appropriate recommendations to the medical director and administration.

NOTE: Authority cited: Sections 208(a), 1205.1(k) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79733. Outpatient Surgical Care Staff.

(a) A physician shall have overall responsibility for the surgical service. This physician shall be certified or eligible for certification in surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. If such a surgeon is not available, a physician, with additional training and experience in surgery, shall be responsible for the service.

(b) A registered nurse with training and experience in operating room techniques shall be responsible for the nursing care and nursing management of the operating room service.

(c) There shall be registered nurses, licensed vocational nurses, and operating room technicians in the appropriate ratio to ensure that a registered nurse is available at all times to serve as the circulating assistant when a licensed vocational nurse or operating room technician is serving as a scrub assistant.

(d) There must be a registered nurse available for emergency treatment whenever there is an outpatient surgical care patient in the correctional treatment center.

(e) The correctional treatment center shall maintain records of continuing education and training programs fro the nursing staff to be available to the Department upon request.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79735. Outpatient Surgical Care Equipment and Supplies.

Equipment and supplies shall be maintained to meet the needs of the services offered, including at least the following monitoring equipment and supplies:

(a) Cardiac monitor, with a pulse rate meter, for each patient receiving a general anesthetic.

(b) DC defibrillator.

(c) Electrocardiographic machine.

(d) Oxygen and respiratory rate alarms.

(e) Supplies and drugs for emergency use.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79737. Outpatient Surgical Care Space.

(a) A correctional treatment center providing outpatient surgical care shall maintain an operating room, or operating rooms, as follows:

(b) Construction of the operating room shall be in compliance with provisions of California Code of Regulations, Title 24, Chapter 10C,

Section 1020C(a) and applicable sections of the California Building Standards Code.

(c) Operating room space shall conform to the provisions of California Code of Regulations, Title 24, Chapter 10C, Section 1020C(a).

(d) Special rooms such as cast rooms, fracture rooms, and cystoscopic rooms, if provided, shall maintain space in accordance with the provisions of California Code of Regulations, Title 24, Chapter 10C, Section 1020C(b).

(e) Postanesthesia recovery areas shall maintain space as required in California Code of Regulations, Title 24, Chapter 10C, Section 1020C(c).

(f) Laboratory, radiology and pharmacy services shall be readily accessible to the outpatient surgical service.

(g) The operating room shall be located so that is does not connect directly with a corridor designed and used for through traffic.

(h) Facilities shall be maintained for the sterilization of equipment and supplies.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79739. Mental Health Treatment Program.

A mental health treatment program is organized, staffed and equipped to provide mental health treatment services for inmate–patients who require 24–hour inpatient care and treatment for acute or nonacute mental health disorders.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79741. Mental Health Treatment Program—General Requirements.

(a) The mental health treatment program shall only be for inmate–patients with diagnosable mental disorder who require 24–hour mental health care.

(b) Each mental health treatment program shall have a clinical director who shall direct the clinical program, provide general direction to professional and nonprofessional staff and be responsible for the quality of clinical services performed in the facility.

(c) The clinical director of mental health treatment program, in consultation with other mental health professionals, shall develop and implement written policies and procedures for the mental health treatment program.

(d) There shall be preadmission patient screening for each inmate–patient completed by the clinical director or his or her designee.

(e) Release of medical records or mental health treatment information concerning any inmate–patient shall be only as authorized under Section 5328 of the Welfare and Institutions Code.

(f) Involuntary mental health treatment including involuntary medication, shall be provided only as authorized under Section 5328 of the Welfare and Institutions Code, as interpreted by the courts.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code; and Sections 5325 and 5328, Welfare and Institutions Code. Reference: Sections 56 et seq. and 1798 et seq., Civil Code; Sections 990 et seq. and 1158, Evidence Code; Sections 1250(j), 1254, 1278, 1293.9 and 1795, et seq., Health and Safety Code; Sections 5150 et seq. and 5328–5330, Welfare and Institutions Code; and *Keyhae v. Rushen*, 178 Cal App. 3d 526 (1986).

§ 79743. Mental Health Treatment Program—Admission and Discharge Policies.

(a) Each mental health treatment program shall develop and implement written admission and discharge policies approved by the Governing Body encompassing which staff members authorized by law to diagnose and treat may admit or discharge inmate–patients, the types of diagnoses for which inmate–patients may be admitted, limitations imposed by law or licensure, staffing limitations, preadmission patient screening, rules governing emergency admission, limitation of services, termination of services, discharge of patients and other relevant functions.

(b) No inmate–patient may be placed in a mental health treatment program who is not admitted as an inmate–patient by a member of the mental health treatment program staff.

(c) The inmate–patient's condition, provisional diagnosis and a plan for initial treatment shall be determined by the admitting staff within 24 hours of admission.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79745. Mental Health Treatment Program—Multidisciplinary Treatment Team.

(a) The multidisciplinary treatment team shall be comprised of those persons who work directly with the inmate–patient in each of the disciplines or service areas that provide service to the inmate–patient, including the clinical director or designee, a psychiatrist, a clinical psychologist, a licensed clinical social worker, a member of the nursing staff and any other staff person who is involved in the treatment and care of the inmate–patient.

(b) The multidisciplinary treatment team shall provide assessment, and any reassessment, of an inmate–patient's need for services and shall develop and implement the inmate–patient's individual treatment plan.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79747. Mental Health Treatment Program—Individual Treatment Plan.

(a) The individual treatment plan shall:

(1) Be developed in writing by the multidisciplinary treatment team and, where possible, in collaboration with the inmate–patient. The treatment plan shall be developed as soon as possible, but no longer than 72 hours following the patient's admission.

(2) Be based on a comprehensive assessment of the inmate–patient's physical, mental, emotional and social needs.

(3) Be reviewed and updated as often as indicated, but no less often than every seven (7) days, weekends and holidays excepted, for acute mental health patients and every thirty (30) days for nonacute mental health patients.

(4) Include, but not be limited to:

(A) A statement of the patient's physical and mental condition, including all mental health diagnoses.

(B) Prescribed medication, dosage and frequency of administration.

(C) Specific goals of treatment with intervention and actions that identify steps toward improvement or recovery and observable, measurable objectives.

(D) Identification of methods to be utilized, the frequency for conducting each treatment method and the person(s) or discipline(s) responsible for each treatment method.

(E) Documentation of the success or failure in achieving stated objectives.

(F) Evaluation of the factors contributing to the inmate–patient's progress or lack of progress toward recovery and a statement of the multidisciplinary treatment decision for follow–up action.

(G) An activity plan.

(H) A plan for other services needed by the inmate–patient which are not provided by the mental health treatment program.

(I) Goals for aftercare and a plan for post–discharge follow–up.

(b) The individual treatment plan shall be in writing and be approved by a clinical psychologist, psychiatrist, licensed clinical social worker, licensed marriage, family, and child counselor, or a psychiatric mental health nurse designated by the clinical director.

(c) The staff shall observe and note any changes in the

inmate–patient's condition and the treatment plan shall be modified in response to the observed changes.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79749. Mental Health Treatment Program—Services.

(a) Psychiatric and psychological services.

(1) Psychiatrists or clinical psychologists, within the scope of their licensure and subject to the rules of the facility, shall be responsible for the initial diagnosis of each inmate–patient.

(2) Inmate–patients shall be evaluated as soon as possible but not later than seventy–two (72) hours from the time staff determines that the inmate–patient requires or may require psychotropic medication.

(b) Social work services shall be organized, directed and supervised by a licensed clinical social worker.

(c) Mental health rehabilitation therapy services.

(1) Mental health treatment programs shall provide and conduct organized therapeutic social, recreational and vocational activities in accordance with the interests, abilities and needs of the inmate–patients, and will include the opportunity for exercise.

(2) Mental health rehabilitation therapy services shall be designed by and provided under the direction of a licensed mental health professional, a recreational therapist or an occupational therapist.

(d) Aftercare plan.

(1) A written aftercare plan shall describe those services that should be provided to an inmate–patient following discharge, transfer or release from the mental health program for the purpose of enabling the inmate–patient to maintain stabilization and/or achieve an optimum level of functioning.

(2) Prior to or at the time of discharge, transfer or release from the mental health treatment program, each inmate–patient shall be evaluated concerning the inmate–patient's need for aftercare services. This evaluation shall consider the inmate–patient's potential in–custody housing, proximity to release from incarceration, probable need for community treatment and social services, and need for continued mental health care.

(3) Aftercare plans shall include, but not be limited to, the following:

(A) Arrangement for medication supervision and follow–up care.

(B) Referral to social, vocational or education services, if available and appropriate.

(4) A member of the multidisciplinary treatment team designated by the clinical director shall be responsible for ensuring that the referral of the inmate–patient to the appropriate aftercare service has been completed and documented in the inmate–patient's health record.

(5) Arrangements for necessary community referral, placement, conservatorship or post–discharge care shall be made prior to release from custody.

(6) A copy of the aftercare plan conforming to the requirements of Health and Safety Code Section 1284 and Welfare and Institutions Code Section 5622 shall be transmitted to the local director of mental health services or a designee in the county of residence for any inmate–patient referred to community services funded by the Bronzan–McCorquodale Act.

(7) The inmate–patient shall receive a copy of the aftercare plan when referred to community services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254and 1282, Health and Safety Code; and Section 5622, Welfare and Institutions Code.

§ 79751. Acute Mental Health Care.

Acute mental health care means that level of voluntary or involuntary 24–hour care that is required to provide ongoing intensive evaluation and treatment by mental health staff to inmate–patients suffering from severe mental disorder. Acute levels of care include, but are not limited to: (1) treatment of acute levels of severe mental disorder or (2) clinical restraint and seclusion. Such inmate–patients would be those who, if in the community, would require a licensed health facility providing 24–hour acute mental health hospitalization. Such facilities include but are not limited to psychiatric health facilities or acute psychiatric hospitals.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79753. Nonacute 24–Hour Mental Health Care.

Nonacute 24–hour mental health care means that level of voluntary or involuntary care that is required to provide mental health services to mentally disordered inmate–patients who are not in need of acute mental health care, but who require general mental health evaluation, diagnostic assessment, treatment, nursing and/or related services, on a 24–hour–per–day basis in order to achieve stabilization and/or an optimal level of functioning. Such inmate–patients would be those who, if in the community, would require a licensed health facility providing 24–hour subacute mental health care. Such facilities include but are not limited to skilled nursing facilities with special treatment programs. Subacute has the same meaning as nonacute as defined in this section.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79755. Mental Health Treatment Program Staffing—Basic Requirements.

(a) Each mental health treatment program shall have a clinical director who shall be a psychiatrist, clinical psychologist, licensed clinical social worker, licensed marriage, family, and child counselor, or a psychiatric mental health nurse operating within his or her scope of licensure. The clinical director shall have at least three years of direct clinical experience with the severely mentally disordered after completion of his or her last year of graduate education.

(b) Only that portion of correctional treatment center staff or contracted employee hours spent on the care of patients in the mental health treatment program may be counted as part of the required staffing pattern.

(c) The required minimum staffing ratios shall be calculated based upon the actual census of inmate–patients receiving 24–hour mental health care.

(d) Mental health treatment program nursing services shall be provided under the direction of a registered nurse who shall meet at least the following qualifications:

(1) Master's degree in psychiatric nursing or related field with experience in administration; or

(2) Two years of experience in psychiatric nursing; or

(3) Two years of experience in nursing administration or supervision and one year experience in psychiatric nursing.

(e) A registered nurse with experience in psychiatric nursing shall be employed forty (40) hours per week.

(f) There shall be a registered nurse, a licensed vocational nurse or a psychiatric technician in the mental health treatment area at all times.

(g) In addition to the minimum staffing required above, the mental health treatment program shall employ professional and other staff on all shifts in the number and with the qualifications to provide all necessary services for those patients admitted for care.

(h) Clinical psychologists, licensed clinical social workers, and licensed marriage, family, and child counselors shall be employed pursuant to the provisions of Section 5751.2, Welfare and Institutions Code.

(i) Psychiatric postgraduate trainees, interns, residents, postdoctoral fellows or instructors may practice psychiatric medicine under the provisions of Section 2065 of the Business and Professions Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; Section 5751.2, Welfare and Institutions Code; and Section 2065, Business and Professions Code.

§ 79757. Mental Health Treatment Program Staffing—Acute Care Requirements.

Mental health treatment programs that provide acute 24–hour mental health care shall meet the following dedicated full–time equivalent staff to census ratio only for acute inmate–patients in any 24–hour period. This staffing pattern includes all staff that is required for the treatment of acute patients. Staff required by earlier sections of this Chapter for the disciplines listed in this section may be counted toward meeting the staffing pattern required in this section for that portion of their time that is spent in caring for acute patients. The above staffing requirements in this Section for registered nurse, licensed vocational nurse or psychiatric technician shall be followed instead of the requirement of 2.5 nursing hours per patient day required for other correctional treatment center inmate–patients. That portion of the time of a psychiatric mental health nurse that is counted toward one category of the staffing requirements shall not be counted toward another category of the staffing requirements. Unlicensed custody staff, to the degree they do work that would otherwise be done by mental health workers and who meet the qualifications of mental health workers, as defined in this chapter, may be counted toward the mental health worker requirement.

Acute Mental Health Care Census:	1–5	6–10	11–20	21–30	31–40	41–50	51–60	61–70	71–80	81–90	91–100
Staff: Psychiatrist or Clinical Psychologist or Licensed Clinical Social Worker or Licensed Marriage, Family and Child Counselor, or Psychiatric Mental Health Nurse	.5	1	2	3	4	5	6	7	8	9	10
Registered Nurse or Licensed Vocational Nurse or Psychiatric Technician	3	4	5	6	8	10	12	14	16	18	20
Mental Health Worker	1.5	3	5	8	10	13	15	18	20	23	25
TOTALS	5	8	12	17	22	28	33	39	44	50	55

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79759. Mental Health Treatment Program Staffing—Nonacute Care Requirements.

Nonacute 24–hour mental health care may be provided by any correctional treatment center meeting the basic staffing requirements specified in Section 79631, Nursing Service Staff, including the requirements for 2.5 nursing hours per patient day and by the Mental Health Treatment Program Staffing—Basic Requirements, set forth in Section 79755.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79761. Mental Health Treatment Program—Space.

(a) Space shall be provided for the conduct of the mental health treatment program and shall include:

(1) A consultation room for interviewing.

(2) An observation room for acutely disturbed inmate–patients.

(3) Indoor or outdoor facilities for therapeutic activities.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79763. Standby Emergency Medical Services, Physician on Call, Definition.

Standby emergency medical service, physician on call, means the provision of emergency medical care in a specifically designated area of the correctional treatment center which is equipped and maintained at all times to receive patients with urgent medical problems and capable of providing physician service within a reasonable time.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79765. Standby Emergency Medical Service, Physician on Call, General Requirements.

(a) Written policies and procedures shall be developed and maintained by the physician responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff.

(b) The responsibility and the accountability of the emergency medical service to the medical director, administration and governing body shall be defined.

(c) There shall be a roster of names and telephone numbers of physicians who are available to provide emergency service.

(d) A communication system employing telephones, radiotelephone or similar means shall be in place for establishing and maintaining contact with law enforcement authorities, rescue squads, and other emergency medical services of the community.

(e) The correctional treatment center shall require continuing education of all emergency medical service personnel.

(f) Medical records shall be maintained on all inmate–patients who are admitted for emergency medical care. These records shall become part of the inmate–patient's medical record. Past medical records shall be available to the emergency medical service.

(g) An emergency room log shall be maintained and shall contain at least the following inmate–patient information: name, date, time and means of arrival, age, sex, record number, nature of complaint, treatment, disposition and time of departure. The names of those dead on arrival shall also be entered in the log.

(h) Standardized emergency nursing procedures shall be developed and approved by the patient care policy committee and administration.

(i) A list of referral services shall be available in the emergency service. This list shall include the name, address, and telephone number of the following:

(1) Police department, if applicable.

(2) Blood bank, if applicable.

(3) Antivenin service.

(4) Burn center.
(5) Poison control information center.
(6) Director of State Department of Health Services or designee.
(7) Local health department.
(8) Clergy.
(9) Emergency psychiatric service.
(10) Chronic hemodialysis service.
(11) Intensive care newborn nursery (if applicable).
(12) Emergency maternity service (if applicable).
(13) Radiation accident management service.
(14) Ambulance transport and rescue services.
(15) County coroner or medical examiner.

(j) An appropriate committee of the correctional treatment center staff shall annually evaluate the services provided and make appropriate recommendations to the administration.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79767. Standby Emergency Medical Service, Physician on Call, Staff.

(a) A physician shall have overall responsibility for the service. That physician, or his or her designee, shall be responsible for:

(1) Implementation of established policies and procedures.

(2) Development of a system for assuring physician coverage on call 24–hours a day to the emergency medical service.

(3) Assurance that physician coverage is available within a reasonable length of time, relative to the inmate–patient's illness or injury.

(4) Development of a roster of specialty physicians available for consultation.

(5) Assurance of continuing education in emergency care procedures for the medical and nursing staff.

(b) All physicians, dentists and podiatrists providing services in the emergency treatment area shall be employed by the correctional treatment center.

(c) A registered nurse with training in emergency medical care shall be present or on call to the correctional treatment center at all times to provide emergency nursing care.

(d) There shall be sufficient other personnel to support the services offered.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79769. Standby Emergency Medical Service, Physician on Call, Equipment and Supplies.

Equipment and supplies necessary for life support shall be available. Equipment shall include, but not be limited to: airway control and ventilation equipment; suction devices; cardiac monitor defibrillator; intravenous fluids, including blood expanders; and administering devices.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79771. Standby Emergency Medical Service, Physician on Call, Space.

(a) The following space provisions and designations shall be met:

(1) Designated emergency treatment area.

(2) Observation room.

(b) Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

Article 5. Administration

§ 79773. Governing Body.

(a) The governing body shall have full legal authority and responsibility for the operation of the correctional treatment center including compliance with all applicable laws and regulations.

(b) The governing body shall appoint a medical director with delegated authority to carry out the functions of the correctional treatment center and the responsibility for ensuring that the correctional treatment center conforms to all applicable federal, state and local laws and regulations. The governing body shall appoint an administrator whose authority, qualifications and duties shall be defined in writing.

(c) The governing body shall adopt administrative policies and procedures designating in writing all services provided and shall oversee the management and fiscal affairs of the correctional treatment center.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79775. Medical Director.

(a) Each correctional treatment center shall employ or otherwise provide a medical director. The medical director shall be a licensed physician. The medical director shall be responsible for the daily administration and clinical management of only one correctional treatment center unless both of the following apply:

(1) All facilities for which the medical director is responsible are in the same geographic region and are operated by the same governing body.

(2) The medical director shall designate a physician who is knowledgeable in the policies and procedures of the correctional treatment center to fulfill the functions of the medical director during the medical director's absence.

(b) The medical director shall be on the premises of the correctional treatment center a sufficient number of hours to attend to the clinical operation of the facility. The Department may require the medical director to spend additional hours in the facility whenever the Department determines, through a written evaluation, that such additional hours are needed to provide adequate clinical direction of the correctional treatment center.

(c) The medical director's responsibilities, acting alone or through an organized medical staff, shall include:

(1) Establishing and approving policies and procedures for each basic and optional service provided by the correctional treatment center. These policies and procedures shall be reviewed annually.

(2) Assuring the quality of medical care provided to all inmate–patients treated by the correctional treatment center.

(3) Reviewing and approving all protocols used by the correctional treatment center.

(4) Establishing and implementing a system of peer review pursuant to written procedures.

(5) Reviewing credentials and delineating clinical privileges for the licensed professionals providing services in the correctional treatment center.

(6) Assuring that a physician, physician's assistant, or registered nurse is available whenever medical services are provided.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79777. Administrator.

(a) The governing body shall appoint an administrator. The administrator's responsibilities include, but are not limited to, the following:

(1) Establishing written administrative, management and personnel policies and procedures.

(2) Maintaining policies and procedures for each basic and optional service provided by the correctional treatment center. These policies and procedures shall be reviewed annually.

(3) Informing appropriate staff of applicable additions, deletions and changes to correctional treatment center regulations.

(4) Maintaining and monitoring contracts for professional consultant staff and health service support agencies.

(5) Reviewing employee accident and incident reports and taking appropriate corrective action.

(6) Assuring that current copies of the California Code of Regulations, Title 22 regulations pertaining to correctional treatment centers are available to all personnel.

(7) Assuring that the correctional treatment center provides only those services for which it is organized, staffed and equipped.

(8) Informing the Department within 24 hours of any unusual occurrences, as specified in these regulations.

(b) The medical director may perform the duties of the administrator.

(c) The administrator shall be in the correctional treatment center for a sufficient number of hours to permit adequate attention to the management and administration of the center.

(d) The administrator shall possess one of the following qualifications;

(1) A master's degree in health services administration and one year of experience in hospital administration in either a licensed skilled nursing facility or a general acute care hospital; or

(2) A master's degree in a health related field and two years of administrative experience in a state or local correctional health care setting; or

(3) A bachelor's degree in a health related field and four years of health related administrative experience.

(4) State civil service appointment as a correctional health services administrator.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79779. Administrative Policies and Procedures.

(a) Written administrative, management and personnel policies shall be established and implemented to govern the administration and management of the correctional treatment center. Policies and procedures shall not supersede the custody and security requirements of the correctional treatment center.

(b) Policies and procedures shall be reviewed at least annually, revised as needed, and approved in writing by the governing body.

(c) Each correctional treatment center shall establish at least the following:

(1) Personnel policies and procedures which shall include:

(A) Written job description detailing qualifications, duties and limitations of each classification of employee shall be available to all personnel.

(B) Employee orientation to facility, job, patient population, policies, procedures and staff.

(C) Staff development.

(D) Employee health.

(E) Verification of licensure, credentials and references.

(2) Policies and procedures for patient admission, leave of absence, transfer, discharge, categories of patients accepted and retained, types of services offered and limitations of services.

(3) Policies and procedures governing patient health records which shall be developed with the assistance of a person skilled in health record administration.

(4) Policies and procedures relating to the inmate–patient's right to refuse treatment when refusal of treatment results in a life–threatening situation.

(5) Policies and procedures governing conflict resolution shall address at least:

(A) The roles and responsibilities of medical and custodial personnel regarding the housing of inmate–patients in the correctional treatment center.

(B) The notification responsibilities of custodial personnel to health staff regarding any special security needs of inmate–patients admitted to the center.

(C) The notification responsibility of health care staff to custody staff regarding any special medical and mental health needs of the inmate–patient admitted to the correctional treatment center.

(d) The correctional treatment center shall have a written organizational chart showing the major programs of the facility, the person in charge of each program, the lines of authority, responsibility, and communication and the staff assignments. Accountability and responsibility shall be defined.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79781. Required Committees.

(a) Each correctional treatment center shall have at least the following committees: patient care policy, infection control and pharmaceutical service.

(b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken.

(c) In those correctional treatment centers where appropriate, these functions may be performed by a committee of the whole.

(d) Committee composition and function shall be as follows:

(1) Patient Care Policy Committee.

(A) A patient care policy committee shall establish policies governing the following services: Physician, psychiatrist, psychologist, dental, nursing, dietetic, pharmaceutical, health records, housekeeping and such additional services as are provided by the facility.

(B) The committee shall be composed of at least the medical director, the administrator (if appointed), the director of nursing service, a pharmacist and a representative of each required service as appropriate.

(C) The committee shall meet at least annually.

(D) The patient care policy committee shall have the responsibility for reviewing and approving all policies relating to patient care. Based on reports received from the facility administrator, the committee shall review the effectiveness of policy implementation and shall make recommendations for the improvement of patient care.

(E) The committee shall review patient care policies annually and revise as necessary. Minutes shall list policies reviewed.

(F) The patient care policy committee shall implement the provisions of Health and Safety Code Sections 1315, 1316, and 1316.5, by means of written policies and procedures.

(G) Only physicians shall assume the overall medical care of patients, including performing the admitting history, and the physical examinations and the issuance of orders for medical care.

(2) Infection Control Committee.

(A) An infection control committee shall be responsible for infection control in the facility.

(B) The committee shall be composed of representatives from at least the following services; physician, nursing, administration, dietary, pharmaceutical, housekeeping, and laundry.

(C) The committee shall meet at least quarterly.

(D) The functions of the infection control committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for investigating, controlling and preventing infections, including tuberculosis, in the correctional treatment center. These shall be based on the 1990 recommendations of the Centers for Disease Control.

2. Maintaining, reviewing and reporting statistics of the number,

types, sources and locations of infections within the facility. This shall include maintaining a confidentiality log which contains the dates and results of Mantoux tuberculin skin tests recorded in millimeters of induration and chest X–ray results of all correctional treatment center employees and inmate–patients.

(E) A registered nurse shall be assigned on a full–time or part–time basis to infection control surveillance.

(3) Pharmaceutical Service Committee.

(A) A pharmaceutical service committee shall direct the pharmaceutical services in the facility.

(B) The committee shall be composed of the following; a pharmacist, the director of nursing service, the administrator (if appointed), and the medical director or at least one physician.

(C) The committee shall meet at least quarterly.

(D) The functions of the pharmaceutical service committee shall include, but not be limited to:

1. Establishing, reviewing, monitoring and approving policies and procedures for the safe procurement, storage, distribution and use of drugs, biologicals, and chemicals.

2. Reviewing and taking appropriate action on the pharmacist's quarterly report.

3. Recommending measures for improvement of services and the selection of pharmaceutical reference materials.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254, 1315, 1316 and 1316.5, Health and Safety Code.

§ 79783. Use of Outside Resources.

(a) If a correctional treatment center does not employ qualified personnel to render a specific service to be provided by the correctional treatment center, there shall be arrangements through a written agreement and/or contract with outside resources. Outside resources shall meet the standards and requirements of all applicable regulations before an agreement and/or contract may be entered into and shall continue to meet all applicable regulations during the term of the agreement and/or contract. Outside resources may include other facilities, organizations, individuals, or public or private agencies.

(b) Signed and dated copies of agreements, contracts, or written arrangements for advice, consultation, services, training or transportation, with outside resources shall be on file in the facility. Copies of these agreements and/or contracts shall be readily available for inspection and review by the Department. The agreements and/or contracts shall include, but not be limited to, a description of the services to be provided, the financial arrangements, the methods by which the services are to be provided, the conditions upon which the agreement or contract can be terminated, signatures of parties to the agreement, and effective dates for the agreement.

(c) The governing body shall be responsible and accountable for all services provided through agreements and/or contracts.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79785. First Aid and Referrals.

If a correctional treatment center does not maintain an emergency medical service, its employees shall exercise reasonable care to determine whether an emergency exists, render necessary life–saving first aid, and transfer the inmate–patient to the nearest hospital that can render the needed services.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79787. Reporting.

(a) Reportable communicable diseases shall be reported to the local health officer and all unusual occurrences shall be reported to the Department by the licensed correctional treatment center within twenty–four (24) hours, either by telephone with written confirmation or by telephone facsimile (FAX).

(b) The reporting of communicable diseases and outbreaks shall be in conformance with Sections 2500, 2502, 2503 and 2504 of Title 17, California Code of Regulations.

(c) Events constituting an unusual occurrence shall include, but not be limited to:

(1) Poisonings.

(2) Fires or explosions.

(3) Death of an inmate–patient, employee, or visitor because of unnatural causes.

(4) Sexual acts involving inmate–patients who are minors, nonconsenting adults, or persons incapable of consent.

(5) Physical assaults on inmate–patients, employees, or visitors.

(6) All suspected criminal acts involving inmate–patients, employees, or visitors.

(7) All suspected incidents of physical or sexual abuse to an inmate–patient.

(8) Unexplained or illicit disappearance or loss of an inmate–patient or inmate–patient remains.

(9) Disruption of services of the licensed correctional treatment center.

(d) The licensed correctional treatment center shall furnish other pertinent information related to such occurrences as the local health officer or the Department shall require.

(e) All reports required in this Section shall be retained on file by the licensed correctional treatment center for three (3) years.

(f) Every fire or explosion that occurs in or on the premises shall be additionally reported immediately to the local fire authority, or in the areas not having an organized fire service, to the State Fire Marshal.

(g) The local health officer of the county to which an inmate–patient is to be released shall be notified at least one day in advance before an inmate–patient on any tuberculosis medication is released from the correctional facility.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79789. Patient Transfer.

(a) The licensee shall maintain written transfer agreements with one or more general acute care hospitals to make the services of those facilities accessible and to facilitate the transfer of patients. Complete and accurate patient information, in sufficient detail to provide for continuity of care, shall be transferred with the patient at the time of transfer. A copy of the current agreement shall be available for review by the Department.

(b) No patient shall be transferred or discharged for purposes of effecting a transfer from a facility to another facility, unless arrangements have been made in advance for admission to such a health facility.

(c) When a patient is transferred to another facility, the following shall be entered in the patient health record:

(1) The date, time, condition of the patient and a written statement of the reason for the transfer.

(2) Documentation that the receiving facility has been informed of the patient's transfer.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79791. Personnel Policies.

(a) Each correctional treatment center shall adopt and implement written personnel policies concerning qualifications, responsibilities, and conditions of employment for each classification employed which shall be available to all personnel. Such policies shall include but not be limited to:

(1) Hours of work.

(2) A plan for orientation for all new staff members that shall ensure that all new staff providing program services shall receive at least 20 hours of orientation and training within 14 days of employment. Staff attendance shall be documented. Initial training shall include, but not be limited to, the following:

(A) Orientation to all policies, procedures and objectives of the facility.

(3) A plan for at least annual evaluation of employee performance.

(b) Provision of a continuing in–service education program designed to improve patient care and employee efficiency. This training shall be in compliance with Section 79797 of this Chapter. All staff members shall attend, and attendance shall be documented.

(c) Personnel policies shall require that employees and other persons working in or for the facility familiarize themselves with the California Code of Regulations, Title 22, pertaining to correction treatment centers and such other regulations as are applicable to their duties.

(d) The facility shall recruit qualified personnel.

(e) If language or communication barriers exist between facility staff and patients, arrangements shall be made for interpreters or for the use of other means to ensure adequate communications between patients and personnel.

(f) All correctional treatment center staff shall be subject to the reasonable application of security procedures necessary for the operation of the jail or prison. Written policy and procedures governing the application of security procedures to correctional treatment center programs and staff shall be developed and adopted by the jail or prison administrator with input from the correctional treatment center administrator or director. Correctional treatment center staff shall not be primarily responsible for the enforcement of security policies or procedures.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79793. Employee Personnel Records.

(a) All facilities shall maintain personnel records of all employees. Such records shall be retained for at least three (3) years following termination of employment.

(b) The record shall include the employee's full name, Social Security number, the license or registration number, if any, a brief resume of experience, employment classification, date of beginning employment and date of termination of employment.

(c) Records of hours and dates worked by all employees during at least the most recent six–month period shall be kept on file at the place of employment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79795. Employee Health Examinations and Health Records.

(a) A health examination, performed by a person lawfully authorized to perform such an examination shall be performed as a prerequisite for employment within ninety (90) days prior to employment or within one (1) week after employment. Written examination reports, signed by the person performing the examination, shall verify that employees are able to perform assigned duties and do not have any health conditions that would create a hazard for the employee, fellow employees, patients or visitors.

(b) The initial health examination shall include a tuberculin skin test using the Mantoux method using a 5 Tuberculin Unit dose of Purified Protein Derivative (PPD) stabilized with Tween–80, the result of which is read and recorded in millimeters of induration. If the result is positive, a chest film shall be obtained. A tuberculin skin test need not be done on a person with a documented positive reaction to PPD but a baseline chest X–ray shall be obtained.

(1) Policies and procedures that address the identification, employment utilization and medical referral of persons with positive skin tests, including those who have converted from negative to positive, shall be written and implemented.

(2) An annual skin test for tuberculosis shall be performed on those individuals with a previously documented negative tuberculin skin test. If an individual with a previously documented negative skin test has a subsequent positive reaction, a chest X–ray shall be obtained.

(c) Employee health records shall be maintained by the facility, and shall include the records of all required health examinations. Such records shall be kept for a minimum of three (3) years following termination of employment.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79797. Staff Development.

(a) Each correctional treatment center shall have an ongoing educational program planned and conducted for the development and improvement of necessary skills and knowledge for all facility personnel. Each program shall include but not be limited to:

(1) Orientation of all newly employed staff to all appropriate facility policies and procedures and specific job requirements.

(2) Prevention and control of infections.

(3) Fire prevention and safety.

(4) Cardiopulmonary resuscitation.

(5) All newly developed policies and procedures.

(6) Internal and external disaster plans.

(7) Applicable security policies and procedures of the correctional institution or detention facility.

(8) Suicide prevention techniques.

(b) Records shall be retained of all orientations and training and shall include date and time of training, title of presenter, summary of content and signatures of those attending.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79799. Inmate–Patients' Rights.

(a) Written policies regarding the rights and restrictions of inmate–patients admitted to a correctional treatment center shall be established and implemented, and made available to the inmate–patient and to the public. Inmate–patients will be afforded such rights as are commonly afforded to medical/mental patients and are consistent with jail or prison policies and procedures. Such policies and procedures shall ensure that each inmate–patient admitted to the correctional treatment center shall have the following rights and be notified of the treatment center's obligations:

(1) To be fully informed, prior to or at the time of admission and during his or her stay, of these rights and of all rules and regulations governing inmate–patient conduct.

(2) To be fully informed, prior to, or at the time of admission and during his or her stay, of services available in the correctional treatment center.

(3) To be fully informed by a physician of his or her medical condition and to be afforded the opportunity to discuss medical treatment.

(4) To give informed consent or to refuse any treatment or procedure or participation in experimental research.

(5) To be informed of and provided access to grievance forms and procedures.

(6) To be free from mental and physical abuse.

(7) To be free from chemical and (except in emergencies) clinical and treatment restraints except when necessary to protect the patient from injury to himself or to others.

(8) To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the correctional treatment center, except in the case of transfer to

another health care facility, or as required by law or third party payment contract.

(9) To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs, when not in conflict with security and custodial policies.

(10) To refuse convulsive treatment including, but not limited to, any electroconvulsive treatment, any treatment of a mental condition which depends on the induction of a convulsion by any means, and insulin coma treatment.

(11) To refuse psychosurgery as defined in Section 5325 of the Welfare and Institutions Code.

(12) To review his or her medical or psychiatric record upon request and consistent with statutory and case law.

(b) An inmate–patient's rights, as set forth above, may be denied or limited only for good cause which shall be evidenced by the written order of the attending physician or other person lawfully authorized to prescribe care, and may only be denied or limited if such denial or limitation is required by the reasonable application of security procedures or is otherwise authorized by law or regulation. Reasons for denial or limitation of such rights shall be documented by the attending physician in the inmate–patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this Section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) These rights, written in English and Spanish, shall be prominently posted.

(e) Sections 863.1, 863.2, 865.2 and 865.5 of Title 9 of the California Code of Regulations pertaining to the assignment and duties of patients' advocate(s), good cause for denial of rights, and restoration of rights shall apply to every correctional treatment center, including the appointment of a patients' advocate for a correctional treatment center. These provisions are hereby incorporated by reference.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 5325, Welfare and Institutions Code.

§ 79801. Clinical Restraint, Treatment Restraint, and Clinical Seclusion.

(a) Written policies and procedures concerning the use of clinical restraint, treatment restraint, and clinical seclusion shall be developed and approved by the correctional treatment center administration.

(b) Clinical restraint and clinical seclusion shall only be used on a written or verbal order of a psychiatrist or clinical psychologist. Clinical restraint shall additionally require a physician's or physician's assistant's or a nurse practitioner's (operating under the supervision of a physician) written or verbal approval. The order shall include the reason for restraint or seclusion and the types of restraints. Under emergency circumstances clinical restraint or clinical seclusion may be applied and then an approval and/or an order must be obtained as soon as possible, but at least within one hour of application. Emergency circumstances exist when there is a sudden marked change in the inmate–patient's condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the inmate–patient or others, and it is impractical to first obtain an order and approval. Telephone orders and approvals for clinical restraint and clinical seclusion shall be received only by licensed medical and mental health care staff, shall be recorded immediately in the inmate–patient's health record, and shall be signed within twenty–four (24) hours.

(c) A physician shall complete a medical assessment of an inmate–patient at the earliest opportunity but not later than within twenty–four (24) hours after the inmate–patient has been placed in clinical restraint or clinical seclusion.

(d) Clinical restraint, treatment restraint, and clinical seclusion shall only be used as a measure to prevent injury to self or others. Clinical restraint, treatment restraint, and clinical seclusion shall only be used when less restrictive alternative methods are not sufficient to protect the inmate–patient or others from injury, and shall not be used as punishment or as a substitute for more effective programming or for the convenience of the staff. Removing an inmate–patient from an activity or area to another unlocked area for a period of time as a way to use separation as a behavioral modification technique shall not be considered clinical seclusion.

(e) Each order for clinical restraint and clinical seclusion shall be in force no longer than twenty–four (24) hours.

(f) There shall be no PRN orders (as needed orders) for clinical restraint and clinical seclusion.

(g) An inmate–patient placed in clinical restraint shall be physically checked at least every fifteen (15) minutes by nursing staff to assure that the restraints remain properly applied, that circulation is not impaired, that the inmate–patient is not in danger of harming himself or herself, and that other medical problems are not present. Routine range of motion exercises shall be done with clinically restrained inmate–patients. Fluids and nourishment shall be provided every two (2) hours, except during sleep. An inmate–patient placed in clinical seclusion shall be observed by nursing staff at least every fifteen (15) minutes. A written record shall
be kept of these checks and range of motion exercises and maintained in the individual inmate–patient's health record.

(h) The inmate–patient's health record shall include written justification for the application of clinical restraints, note the times of application and removal of restraints and document the inmate–patient's status and the judgment of the physician or clinical psychologist on the necessity for continuation of clinical restraints at a minimum of once every twenty–four (24) hours.

(i) Clinical and treatment restraints shall be used in such a way as to minimize the risk of physical injury to the inmate–patient and to ensure the least possible discomfort. Minimum force shall be used. Belts and cuffs shall be well padded.

(j) Clinical restraints shall be placed on inmate–patients only in an area that is under direct observation of staff. Such inmate–patients shall be afforded protection from other inmate–patients who may also be in the area.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code; and Section 5325, Welfare and Institutions Code.

§ 79803. Health Record Service.

(a) The correctional treatment center shall maintain a health record service in accordance with accepted professional standards and practices. The health record service shall have sufficient staff, facilities, and equipment, and be conveniently located to facilitate the accurate processing, checking, indexing and filing of all health records.

(b) The health record service shall be under the direction of a staff member with at least two years of training and experience in records administration, at a level of responsibility equivalent to a health record technician, or a medical record technician. This designated staff member shall be assisted by such qualified personnel as are necessary to conduct the service. A registered record administrator or accredited records technician shall provide consultation on at least a quarterly basis to designated staff members responsible for record administration.

(c) If a facility, in addition to inpatient services, is providing outpatient, emergency, day treatment, or crisis intervention service, a unit health record system shall be established.

(d) The facility shall have a continuing system of collecting and recording data that describe patients served in such form as to provide

for continuity of care, program services, and data retrieval for program patient care evaluation and research. Health records shall be stored and systematically organized to facilitate retrieval of information. Retrievability shall be assured by the use of an acceptable coding system such as the latest version of the International Classification of Diseases (ICD–9).

(e) Policies and procedures shall be established and implemented to ensure the confidentiality of access to patient health information, in accordance with federal, state and local laws and acceptable standards of practice.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79805. Inmate–Patient Health Record Content.

(a) Each inmate–patient's health record for inpatient services shall consist of at least the following:

(1) Admission and discharge record identification data including, but not limited to, the following:

(A) Name.

(B) Inmate–patient identification number.

(C) Date of Birth.

(D) Sex.

(E) Marital status.

(F) Religion (optional on part of inmate–patient).

(G) Date of admission.

(H) Date of discharge.

(I) Name, address and telephone number of person or agency responsible for the inmate–patient, or next of kin.

(J) Initial diagnostic impression.

(K) Discharge or final diagnosis.

(2) Mental status.

(3) Admission medical history and physical within 24 hours of admission. This shall include written documentation of a Mantoux tuberculin skin test within the past year, unless a previously positive reaction can be documented or completion of adequate preventive therapy or adequate therapy for active disease can be documented. If no written documentation is available, the Mantoux tuberculin skin test shall be administered within 24 hours of admission, and recorded in millimeters of induration in the medical history.

(4) Dated and signed observations and progress notes recorded as often as the inmate–patient's condition warrants by the person responsible for the care of the inmate–patient.

(5) Consultation reports.

(6) Medication, treatment and diet orders.

(7) Social service evaluation, if applicable.

(8) Psychological evaluation, if applicable.

(9) Dated and signed health care notes including, but not limited to, the following:

(A) Patient care plan.

(B) Concise and accurate records of nursing care provided.

(C) Records of pertinent nursing observations of the inmate–patient and the inmate–patient's response to treatment.

(D) The reasons for the use of and the response of the inmate–patient to PRN medication administered and justification for withholding scheduled medications.

(E) Record of type of restraint, including time of application and removal.

(F) Rehabilitation evaluation, if applicable.

(G) Interdisciplinary treatment plan, if applicable.

(H) Progress notes including the patient's response to medication and treatment rendered and observation(s) of patient by all members of treatment team providing services to the patient.

(I) Medication records including name, dosage, and time of administration of medications, and treatments given. The route of administration and site of injection shall be recorded if other than by oral administration.

(J) Treatment records including group and individual psychotherapy, occupational therapy, recreational or other therapeutic activities provided.

(K) Vital sign record sheet.

(L) Consent forms as required, signed by the inmate–patient or the appropriate surrogate decision maker.

(M) All dental records, if applicable.

(N) Records of all laboratory tests ordered.

(O) Reports of all cardiographic or encephalographic tests performed.

(P) Reports of all X–ray examinations ordered.

(Q) All reports of special studies ordered.

(R) A discharge summary prepared by the admitting or primary care practitioner which shall recapitulate the significant findings and events of the inmate patient's treatment, his/her condition on discharge and the recommendation and arrangements for future care.

(S) Discharge or transfer information and continue care instructions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79807. Inmate–Patient Health Record Availability.

(a) Records shall be kept on all inmate–patients admitted or accepted for treatment. All required records, either as originals or as accurate reproductions of the contents of such originals, shall be maintained in a confidential manner, and be legible, and readily accessible upon request of persons authorized by law to have access to such records including, but not limited to persons authorized pursuant to Health and Safety Code, Section 1795 et seq., those professional persons who are providing services to the patient and authorized representatives of the Department.

(b) The correctional treatment center shall safeguard the information in the record against loss, defacement, tampering, or use by unauthorized persons.

(c) Inmate–patient health records or reproductions thereof, shall be safely preserved for a minimum of seven years following discharge of the inmate–patient, except that the records of unemancipated minors shall be kept at least one year after such minor has reached the age of 18 years and, in any case, not less than seven years.

(d) If a correctional treatment center ceases operation, the Department shall be informed, within 48 hours prior to cessation, of the arrangements made for safe preservation of inmate–patient health records.

(e) Inmate–patient records shall be filed in an easily accessible manner in the facility or in an approved health record storage facility off the facility premises.

(f) Inmate–patient records shall be completed within 14 days following the inmate–patient's discharge.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79809. Transfer Summary.

A transfer summary shall accompany or precede the inmate–patient upon transfer to another facility where continuing care will be provided. The transfer summary shall include essential information relative to the inmate–patient's diagnosis, treatment course, medications, dietary requirements, known allergies and treatment plan.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79811. Fire and Internal Disasters.

(a) A written fire and internal disaster program, incorporating evacuation procedures, shall be developed with the assistance of local fire, safety and other appropriate experts. A copy of the program shall be available on the premises for review by the Department.

(b) The written program shall be implemented in the event of a fire, or internal or external disaster, and shall include but not be limited to the following:

(1) Plans for the assignment of personnel to specific tasks and responsibilities.

(2) Instructions relating to the use of alarm systems and signals.

(3) Information concerning methods of fire containment.

(4) Systems for notification of appropriate persons.

(5) Information concerning the location of fire fighting equipment.

(6) Identification of evacuation routes and procedures.

(7) Other provisions as the local situation dictates.

(c) Fire and internal and external disaster drills shall be held at least semi–annually for each shift of facility personnel and under various conditions. Actual evacuation of patients during a drill is optional.

(d) The evacuation plan shall be available in the correctional treatment center and shall include but not be limited to the following:

(1) Evacuation routes.

(2) Location of fire alarm boxes.

(3) Location of fire extinguishers.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79813. Custodial Personnel.

(a) Custodial personnel, or other nonmedical staff, may perform patient care support activities. At no time shall custodial personnel be used as replacements for required nursing staff.

(b) Custodial personnel assigned to the correctional treatment center shall receive orientation to the correctional treatment center and instruction in any patient care support activity they will perform prior to commencing the activity. Permitted inmate–patient care support activities, conducted in conjunction with nursing staff, may include:

(1) Supervision of ambulatory, self–care inmate–patients.

(2) The serving of meals to self–feed inmate–patients.

(3) The serving of snacks or nourishment to inmate–patients.

(4) Ambulating (exercising) independent, ambulatory inmate–patients.

(5) Holding or immobilizing a patient during a treatment or a diagnostic procedure.

(6) Observation of inmate–patient mental behavior in conjunction with regular observation performed by nursing staff.

(7) Cardiopulmonary resuscitation and first aid, in emergencies, by personnel certified to perform those specific activities.

(c) Custodial personnel shall not perform any inmate–patient care activity requiring any of the following:

(1) Medical record documentation.

(2) Specialized training or medical knowledge, except first aid and cardiopulmonary resuscitation by certified personnel.

(3) Medication or treatment administration.

(4) Direct inmate–patient treatment contact, e.g., bathing, feeding, repositioning, and dressings.

(d) Custodial personnel and other nonmedical staff assigned to the correctional treatment center shall be subject to the employee health requirements of Section 79795 of this Chapter.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79815. Inmate–Patient Identification.

Each inmate–patient shall be provided with a wristband identification tag or other means of identification which shall be worn at all times. Minimum information shall include the name of the inmate–patient and the name of the correctional treatment center and/or correctional institution.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79817. Equipment and Supplies.

(a) Equipment and supplies in each correctional treatment center shall be of the quality and in the quantity necessary for care of inmate–patients as ordered or indicated. At least the following items shall be provided and properly maintained at all times:

(1) Airways.

(2) Bedpans.

(3) Catheter equipment.

(4) Clerical supplies and equipment.

(5) Denture cups.

(6) Drug service trays and/or carts.

(7) Ear syringes.

(8) Emergency oxygen supply and equipment for administration.

(9) Emesis basins.

(10) Examination light.

(11) First aid supplies, as determined by the patient care policy committee.

(12) Flashlights.

(13) Gloves (sterile and unsterile).

(14) Ice caps.

(15) Intravenous therapy supplies, if the correctional treatment center provides such services.

(16) Medicine droppers.

(17) Medicine glasses, cups, or other small containers which are accurately calibrated.

(18) Mortar and pestle.

(19) Rectal speculum.

(20) Refrigerator with accurate thermometer.

(21) Rubber tubing.

(22) Scales for weighing all inmate–patients.

(23) Shower and commode chairs, wheelchairs, and walkers.

(24) Soap for bathing.

(25) Soap dishes or soap containers.

(26) Sphygmomanometers/cuffs.

(27) Sterile dressings.

(28) Stethoscopes.

(29) Suction apparatus.

(30) Suture tray.

(31) Suture removal equipment.

(32) Syringes and needles.

(33) Test supplies necessary to perform urine sugar and acetone testing.

(34) Thermometers.

(35) Tongue depressors.

(36) Urinals.

(37) Vaginal speculum, if applicable.

(38) Washbasins.

(39) Water pitchers and drinking vessels.

(b) The correctional treatment center shall provide current authoritative, pertinent, basic books, periodicals and reference materials related to all services provided. At least the following shall be provided:

(1) Dictionaries, medical and standard.

(2) Directories of available community resources.

(3) A selection of current health care publications.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

Article 6. Physical Plant and Safety

§ 79819. Alterations to Existing Buildings or New Construction.

(a) Alterations to existing buildings licensed as correctional treatment centers or new construction shall be in conformance with Chapter 10F, Part 2, Title 24, California Code of Regulations, other applicable sections of the California Building Standards Code, and the requirements of the State Fire Marshal.

(b) Facilities licensed or subject to licensure and in operation prior to the effective date of Title 24 regulations for correctional treatment centers shall not be required to institute corrective alternatives or construction to comply with such new requirements except where specifically required or where the Department determines that a definite hazard to health and safety exists. Any facility for which preliminary or working drawings and specifications have been approved by the Office of Statewide Health Planning and Development prior to the effective date of changes to construction regulations shall not be required to comply with such new requirements provided substantial actual construction is commenced within one year of the effective date of the new requirements.

(c) Patients and/or correctional treatment center services shall not occupy buildings or spaces which have been remodeled or newly constructed without the written approval of the Department.

(d) The correctional treatment center shall maintain in operating condition all buildings, fixed equipment, utilities and spaces in the numbers and types as specified in the construction requirements under which the facility or unit was first licensed, unless the correctional treatment center has made alterations in compliance with subsequent requirements.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1275 and 15007, Health and Safety Code.

§ 79821. Space Conversion and Remodeling.

(a) Spaces approved for specific uses at the time of licensure shall not be converted to other uses or remodeled without the written approval of the Department, and shall also be in compliance with the requirements of the California Building Standards Code and the State Fire Marshal.

(b) Where remodeling, space conversion or new construction involves displacement or disruption of services which result in relocating a patient, the facility shall develop an implementation plan. Such plans shall be submitted to and be approved by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1276 and 15007, Health and Safety Code.

§ 79823. Inmate–Patient Capacity.

(a) A correctional treatment center shall not have more inmate–patient or beds set up for use than the number for which it is licensed, except in case of emergency when temporary permission may be granted by the Director or designee.

(b) Inmate–patients shall not be housed in areas which have not been approved by the Department for inmate–patient housing and which have not been given a fire clearance by the State Fire Marshal except as provided in subsection (a) above.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1275 and 15007, Health and Safety Code.

§ 79825. Fire Safety.

All correctional treatment centers shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for protection of life and property against fire and panic. All correctional treatment centers shall secure and maintain fire safety clearance from the State Fire Marshal's office or its designee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79827. Inmate–Patient Rooms.

(a) Each inmate–patient room shall be labeled with a number, letter, or combination of the two for identification.

(b) Inmate–patients shall be accommodated only in rooms meeting the space requirements of Section 1015F(a), Chapter 10F, Part 2, Title 24, California Code of Regulations.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79829. Inmate–Patient Room Furnishings.

(a) A clean, comfortable bed with a mattress, pillow, blankets, bed linen and provisions for the storage of personal items shall be provided for each licensed bed. All furnishings will be in good repair and suitable for special inmate–patient needs.

(b) Adjustable beds, side rails and overbed tables shall be provided as required by the inmate–patient's condition.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79831. Special Rooms.

Special rooms shall be maintained for the isolation of a single patient in the ratio of one room for each 35 beds or major fraction thereof. These rooms shall be used for isolation of inmate–patients with infectious disease, acute or terminal illness, or those who become agitated and create a disturbance. At least one special room shall be maintained with toilets, hand washing and bathing or showering facilities which are not shared with other inmate–patients. These rooms shall also comply with applicable provisions of the California Building Standards Code regarding isolation rooms.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79833. Provision for Emptying Bedpans.

(a) Bedpans shall be emptied and cleaned in soiled utility rooms or in toilets adjoining or within patients' rooms. Such toilets shall be equipped with flushing attachments for bedpan washing and vacuum breakers.

(b) Utility rooms shall be maintained in each correctional treatment center and shall be designed for separation of clean and dirty work areas. Separate clean and dirty utility rooms may be provided alternatively. Each utility room shall include a work counter, a hand washing fixture, and a rim flush clinic sink.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79835. Central Sterile Supply.

(a) The correctional treatment center shall have a sufficient supply of properly sterilized equipment and materials for the patient care needs.

(b) The correctional treatment center shall provide for the storage of a sufficient supply of sterile materials and shall have a system to dispense them throughout the correctional treatment center. The area in which the sterile materials are stored and dispensed shall be designated, equipped and staffed for this purpose.

(c) A specific person shall be designated to be in charge of the central sterile supply.

(d) There shall be written procedures developed and implemented pertaining to the preparation, handling and distribution of sterile supplies and equipment.

(e) There shall be effective separation of soiled or contaminated supplies and equipment from the clean or sterile supplies and equipment to prevent cross–contamination of the clean or sterile supplies and equipment.

(f) Sterile supplies and equipment shall be stored in clean cabinets, cupboards or on clean shelves. An orderly system of rotation and utilization of sterile supplies shall be used based on the shelf life of the wrap.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79837. Preparation of Sterile Supplies and Equipment.

(a) The processing and sterilizing of equipment and supplies shall

be under the supervision of a person who has knowledge of principles of cleaning, sterilizing and infection control as evidenced by training and experience.

(b) Policies and procedures shall be developed, maintained and implemented on the proper decontamination, disinfection and sterilization of equipment and supplies. Procedures shall include, but not be limited to, the following:

(1) Proper techniques for utilization of the sterilization equipment, including the loading and unloading of equipment and supplies.

(2) Establishing the proper parameters for sterilization, e.g., temperature, pressure and period of exposure for steam sterilization.

(3) Length of aeration period of gas sterilized items.

(4) Packaging, labeling and dating of sterilized items, including date of sterilization and expiration of safe shelf life.

(5) A recall system including quarantine periods and procedures to be implemented in the event of a recall.

(c) The efficacy of the sterilization process shall be verified at least weekly by the use of appropriate biological indicators. All sterilized items shall be provided with appropriate physical indicators to verify that they have been exposed to the sterilization process. For gas sterilizers, a biological test shall be incorporated into each sterilizing cycle.

(d) Each sterilizer shall be identifiable to facilitate any necessary recall actions.

(e) Where appropriate, records shall be made of relevant sterilization parameters to confirm the adequacy of each sterilization cycle, and the records shall be retained for at least three years.

(f) Sterilizers shall be maintained in proper operating condition. A sterilizer no longer in use shall be conspicuously labeled as nonoperational and disconnected from steam or gas lines.

(g) If sterilized equipment and/or supplies are obtained from an outside source, the correctional treatment center shall assure that the provider meets the same or comparable standards as set forth in this regulation.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79839. Call Systems.

(a) A call system shall be maintained in operating order in all nursing units. Call systems shall be maintained to provide visible and audible signal communication between nursing personnel and patients. The minimum requirements shall be:

(1) A call station or stations providing readily accessible patient controls to each patient bed.

(2) A visible signal in the corridor above or adjacent to the door of each patient room.

(3) An audible signal and light, on a continuous or intermittent basis indicating the room from which the call originates shall be located at the nurses' stations. Alternate systems must be approved in writing by the Department.

(b) The call system shall be extended to each patient's toilet room, bathroom and shower room in locations easily accessible to the patients.

(c) The call systems shall be designed to require resetting at the place of origin unless a two–way voice communication component is included in the system.

(d) The requirements for call systems in psychiatric units serving ambulatory patients may be waived by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79841. General Maintenance.

(a) The correctional treatment center shall be in good repair and working order.

(b) The correctional treatment center shall have an organized program to ensure that the buildings and grounds are reasonably free of environmental hazards and nuisances which may adversely affect the health or well–being of patients, personnel and visitors.

(c) The fixed equipment of the correctional treatment center shall be in proper working order. The correctional treatment center shall have an organized program for the routine inspection, testing and maintenance of the hospital's fixed equipment including the heating, air conditioning and

ventilation systems, all fire warning and fire safety systems, and other building support systems which are identified by hospital policy as capable of creating a significant physical or environmental hazard if not properly maintained.

(d) The patient care equipment of the correctional treatment center shall be in proper working order. The correctional treatment center shall have an organized program for the routine inspection, maintenance and calibration of the correctional treatment center's diagnostic, therapeutic and other patient care equipment identified by correctional treatment center policies as posing a significant risk to patients if not properly maintained.

(e) The correctional treatment center's maintenance program for fixed and patient care equipment shall include the following:

(1) A written policy identifying the types of hospital equipment likely to cause risk to patients if not properly maintained.

(2) Written procedures specifying the scope of the inspection, testing and maintenance to be performed on the equipment. The procedures shall be consistent with current standards related to health care equipment established by nationally recognized safety agencies.

(3) Nominal inspection, testing and/or maintenance intervals for the equipment. Testing shall be performed prior to initial use and thereafter at intervals consistent with current standards established by nationally recognized safety agencies, but not exceeding 12 months. Inspection and/or testing shall be completed within 60 days of the established interval.

(4) Records documenting the inspection, testing and maintenance performed. Such records shall be maintained for at least three years.

(f) All equipment used for inspection and testing shall be included in the documented calibration program to assure its accuracy. Records shall be kept for at least three years.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79843. Housekeeping.

The correctional treatment center shall be kept in a clean, safe, orderly, and sanitary condition, free from offensive odors.

(a) Each correctional treatment center shall make provision for the routine cleaning of articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures with a detergent and/or disinfectant as appropriate.

(b) There shall be written policies and procedures developed and implemented to include but not limited to the following:

(1) Cleaning of occupied patient areas, nurses' stations, work areas, halls, entrances, storage areas, rest rooms, laundry, pharmacy and offices.

(2) Cleaning of specialized care areas such as operating rooms.

(3) Cleaning of isolation areas.

(4) Cleaning of kitchen and associated areas.

(5) Cleaning of walls and ceilings.

(6) Terminal cleaning of patient unit upon discharge of patient.

(7) Utilization of housekeeping cleaning supplies and equipment.

(c) The correctional treatment center shall designate a specific person to be in charge of the housekeeping services, who shall also participate in the correctional treatment center's infection control committee.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79845. Electrical Systems.

(a) The electrical system shall be in conformance with the California Building Standards Code.

(b) Emergency power and lighting.

(1) The emergency power system/generator shall be maintained in operating condition to provide automatic restoration of power to the correctional treatment center's essential systems within ten (10) seconds after the loss of primary power.

(2) The readiness of the batteries or other starting mechanism shall be verified at intervals not exceeding seven (7) days. The generator(s) shall be started and run under the connected load for a period of not less than thirty (30) minutes at least once every thirty (30) days. Once a year the emergency power system/generator shall be operated under connected load until the engine has reached the normal operating temperatures specified by the manufacturer, but for a period of not less than five (5) hours.

(3) A written record of all tests and maintenance performed, inspection performance, exercising period and repairs shall be maintained and kept for three (3) years.

(c) The correctional treatment center shall have an electrical system which provides adequate levels of power and lighting in a safe manner to all of the facility's electrically powered equipment and systems.

(d) Electrical outlets shall be tested for proper polarity and tension upon installation and replacement. Electrical outlets in patient care areas shall be tested for tension at least annually.

(e) Environmental electrical safety conditions in patient care areas shall be checked at least annually. At a minimum, this shall include a visual inspection of the electrical outlets and light fixtures.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79847. Storage and Disposal of Solid Waste.

(a) Solid waste shall be stored and disposed of in a manner which minimizes the risk of transmitting communicable disease. These wastes shall not be a nuisance or a breeding place for insects or rodents nor be a food source for either.

(b) Solid waste containers shall be stored and located in a manner that will protect against odors.

(c) Syringes and needles shall be disposed of safely as biohazardous and/or radioactive waste in puncture proof containers, in accordance with Health and Safety Code Sections 25080 through 25082, pertaining to medical waste and, if applicable, the California Code of Regulations, Title 17, Chapter 5, Subchapter 4, Group 1, Article 1, Sections 30285 and 30289, pertaining to radioactive materials.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79849. Solid Waste Containers.

(a) All containers, used for storage or transporting of solid wastes, shall be in good repair and be leakproof and rodent proof.

(b) Movable containers shall additionally have the approval of the local health department if applicable.

(c) All containers holding or receiving medical or putrescible wastes shall have tight–fitting covers and shall be emptied at least every four (4) days, or more often if necessary.

(d) Solid waste containers shall be thoroughly washed and cleaned each time they are emptied unless soil contact surfaces have been completely protected from contamination by disposable liners, bags or other devices removed with the waste. Each movable bin shall provide for suitable access and a drainage device to allow complete cleaning at the storage area.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250, 1276, 25117 and 25117.5, Health and Safety Code.

§ 79851. Medical Waste.

Medical waste, as defined in Health and Safety Code Section 25023.2, shall be handled and disposed of in accordance with the Medical Waste Management Act, Health and Safety Code Section 25015 et seq. and the regulations adopted thereunder, California Code of Regulations, Title 22, Division 4, Chapter 21, Articles 1 through 4, commencing with Section 65600 and ending with Section 65628.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j), 1254 and 25023.2, Health and Safety Code.

§ 79853. Gases for Medical Use.

(a) Provision shall be made for safe handling and storage of medical gas cylinders, by the type of gas and its associated hazards.

(b) Transfer of gas by facility personnel from one cylinder to another is prohibited except when approved by the Department.

(c) The correctional treatment center shall insure that connections for different medical gas supplies are not interchangeable.

(d) Where a medical gas distribution system is provided, the correctional treatment center shall maintain a complete and current set of written test results which confirm that the proper gases are being provided at all of the system outlets. Testing shall be performed prior to initial use, and for all potentially affected outlets after any modification or breach of the system which could possibly result in a cross connection. The outlets shall be tested for conformance to appropriate gas delivery parameters e.g., flow and pressure and proper operation of the alarms.

(e) The correctional treatment center shall have a written procedure for ensuring an adequate supply of medical gases for normal and emergency operating conditions.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79855. Water Supply and Plumbing.

(a) Plumbing and drainage facilities shall be in compliance with the California Building Standards Code.

(b) Water for human consumption from an independent source, such as private wells, shall be subjected to bacteriological analysis by the local health department, State Department of Health Services or a licensed commercial laboratory at least every three (3) months. A copy of the most recent laboratory report shall be available for inspection.

(c) Plumbing fixtures including backflow preventers shall be maintained in operating condition.

(d) For hot water used by or readily accessible to patients, there shall be temperature controls to automatically regulate the temperature between 40.5^0C (105^0F) and 48.9^0C (120^0F).

(e) Hot water at a minimum temperature of 82.2^0C (180^0F) shall be maintained at the final rinse section of dish washing facilities unless alternate methods are approved by the Department.

(f) Taps delivering water at 51.6^0C (125^0F) or higher shall be identified prominently by warning signs with letters 5cm (2 inches) high.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79857. Lighting.

Adequate illumination shall be maintained for the comfort and safety of inmate–patients and staff, and shall be in compliance with the California Building Standards Code.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79859. Heating, Ventilating, and Air Conditioning.

(a) Heating, ventilating and air conditioning shall be in compliance with the California Building Standards Code and shall be maintained to assure the systems are in operating condition to provide comfortable environmental conditions.

(b) Air filters.

(1) All filters shall be inspected and tested at least every three (3) months and cleaned or replaced as necessary to maintain adequate ventilation flow rates and filtration integrity.

(2) Written records documenting air filter inspections, testing and servicing reports shall be maintained and kept for three (3) years.

(A) Testing shall include but not be limited to static pressure drop across each filter bank.

(B) Replacement filters shall have efficiency ratings not less than the most recently permitted by the Office of Statewide Health Planning and Development for the subject air handling unit.

(C) Following filter replacement or cleaning, the installation shall be visually inspected for torn media and bypass in filter frames by means of a flashlight or equivalent, both with fans in operation and stopped. Tears in filter media and bypass in filter frames shall be eliminated in accordance with the manufacturer's directions and as required by the Department.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

§ 79861. Laundry Service.

(a) Laundry and linen.

(1) An adequate supply of serviceable clean linen shall be provided to meet the needs of the correctional treatment center. This shall include, but not be limited to, at least three (3) complete bed changes for the correctional treatment center's licensed bed capacity.

(2) There shall be written policies and procedures developed and implemented supporting infection control policies in the handling, storage, transportation and processing of linens. Such policies shall be reviewed and approved by the infection control committee.

(3) If the facility operates its own laundry, such laundry shall be:

(A) Located in such relationship to other areas that steam, odors, lint and objectionable noises do not reach patient care, dining or kitchen areas.

(B) Well–lighted, ventilated and adequate in size for the needs of the hospital and for safe operation.

(C) Maintained in a sanitary manner and kept in good repair.

(D) Not part of a storage area.

(4) The laundering of correctional treatment center linens shall comply with the following:

(A) All linens shall be washed using an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil. Linens shall be exposed to water at a minimum temperature of 71^0C (160^0F) for at least 24 minutes during the washing process, or a lower temperature of 60^0C (140^0F) for 24 minutes may be utilized if the linens are subsequently passed through a flatwork ironer at 110–115 feet per minute at a temperature of 300^0F. or a tumbler dryer at a temperature of 180^0F.

(B) The facility shall implement a procedure for affirming the efficacy of the laundry process, including quarterly sample testing procedures for bacterial, chemical and stain residue and overall fabric quality.

(5) Clean linen and soiled linen shall be stored in separate rooms of the facility. Linen storage rooms in the laundry area shall be adequate in size for the needs of the correctional treatment center and shall not be used for any other purpose.

(6) Laundry personnel shall be provided hand washing and toilet facilities at locations convenient to the laundry, to avoid traversing patient and dietary areas.

(7) Soiled and clean linen carts shall be so labeled and provided with covers made of washable or cleanable materials. The carts and covers shall be maintained in a clean condition. Linen carts used for the storage or transportation of dirty linen shall be thoroughly washed before being used for the storage and transportation of clean linen.

(8) If the correctional treatment center does not maintain a laundry service, the commercial laundry utilized shall meet the standards of this Section.

(b) Soiled linen.

(1) Soiled linen shall be handled, stored and processed in a safe manner to prevent the spread of infection.

(2) Policies and procedures shall be developed and implemented pertaining to linen from isolation rooms and pathology and linen soiled with chemotherapeutic agents or radioactive substances.

(3) Soiled linen shall be sorted in a separate enclosed room by a person instructed in methods of protection from contamination. This person shall not have responsibility for immediately handling clean linen until protective attire worn in the soiled linen area is removed, hands are washed, and other hospital infection control procedures observed.

(4) Soiled linen shall be stored and transported in a closed container which prevents airborne contamination of corridors, dietary areas and areas occupied by patients, and also precludes the cross–contamination of clean linen.

(5) Chutes shall not be used for transporting soiled linen in correctional treatment centers constructed after the effective date of this regulation. If chutes are utilized in correctional treatment centers constructed before the effective date of this regulation, they shall be maintained in a clean, sanitary state.

(c) Clean linen.

(1) Clean linen shall be sorted, handled and transported in such a manner as to prevent contamination.

(2) Clean linen carts shall be used only for the purpose of transportation or storage of clean linen.

(3) Staff persons processing clean linen shall be dressed in clean garments at all times while on duty, and shall not handle soiled linen unless appropriate infection control procedures are observed.

(4) Clean linen from a commercial laundry shall be delivered to the correctional treatment center completely wrapped and delivered to a designated clean area.

(5) Clean linen in patient care units shall be stored in clean locations such as ventilated closets or clean utility rooms.

(6) If clean linen is stored in the laundry area, it shall be stored in a room separate from the sorting room, laundry room or soiled linen room. A partial partition or a curtain does not meet the requirements of this subsection.

NOTE: Authority cited: Sections 208(a) and 1267.10(a), Health and Safety Code. Reference: Sections 1250(j) and 1254, Health and Safety Code.

Division 6. Licensing of Community Care Facilities

(Originally Printed 8–2–75)

Chapter 1. General Licensing Requirements

Article 1. General Definitions

§ 80000. General.

(a) The general regulations in this chapter shall apply to all community care facilities regulated by Division 6, Chapters 2, 4 through 7, and Chapter 9, except where specifically exempted. Additional or special requirements found in the corresponding chapters pertaining to each category shall apply only to such individual facility categories.

(b) The licensee shall ensure compliance with all applicable law and regulation.

NOTE: Authority cited: Sections 1530 and 1530.5, Health and Safety Code. Reference: Sections 5453 and 5458, Welfare and Institutions Code; Sections 1501, 1502, 1502(a)(7), 1530 and 1531, Health and Safety Code.

§ 80001. Definitions.

The following general definitions shall apply wherever the terms are used throughout Division 6, Chapters 1, 2, 4 through 7, and Chapter 9, except where specifically noted otherwise. Additional definitions found at the beginning of each chapter in this division shall apply only to such specific facility category.

(a)(1) "Activities of Daily Living" (ADLs) mean the following six activities:

(A) Bathing: Cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing and drying.

(B) Dressing: Putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

(C) Toileting: Getting on and off a toilet or commode, emptying a commode, managing clothes, wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(D) Transferring: Moving from one sitting or lying position to another sitting or lying position (e.g., from bed to or from a wheelchair, or sofa, coming to a standing position and/or repositioning to promote circulation and to prevent skin breakdown).

(E) Continence: Ability to control bowel and bladder as well as to use ostomy and/or catheter receptacles, and to apply diapers and disposable barrier pads.

(F) Eating: Reaching for, picking up, grasping a utensil and cup; getting food on a utensil; bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

(2) "Administrator" means the licensee, or the adult designated by the licensee to act in his/her behalf in the overall management of the facility.

(3) "Adult" means a person who is 18 years of age or older.

(4) "Adult Community Care Facility" (Adult CCF) means adult residential facilities (ARF) and social rehabilitation facilities (SRF).

(5) "Adult Residential Facility" means any facility of any capacity which provides 24–hour a day nonmedical care and supervision to adults except elderly persons.

(6) "Applicant" means any individual, firm, partnership, association, corporation, county, city, public agency or other governmental entity that has made application for a community care facility license, administrator certificate, or special permit.

(7) "Authorized Representative" means any person or entity authorized by law to act on behalf of any client. Such person or entity may include but not be limited to a minor's parent, a legal guardian, a conservator or a public placement agency.

(8) "Automated External Defibrillator" (AED) means a light–weight, portable device used to administer an electric shock through the chest wall to the heart. Built–in computers assess the patient's heart rhythm, determine whether defibrillation (electrical shock) is needed and then administer the shock. Audible and/or visual prompts guide the user through the process.

(b)(1) "Basic Rate" means the rate charged by a facility to provide basic services. For SSI/SSP recipients, the basic rate means the established nonmedical out–of–home care rate which includes any exempt income allowance but does not include that amount allocated for the recipient's personal and incidental needs.

(2) "Basic Services" means those services required by applicable law and regulation to be provided by the licensee in order to obtain and maintain a community care facility license.

(c)(1) "California Clearance" means an individual has no felony or misdemeanor convictions reported by the California Department of Justice. However, the individual may have been arrested with no criminal conviction, convicted of a minor traffic offense or adjudicated as a juvenile.

(2) "Capacity" means the maximum number of persons authorized to be provided care and supervision at any one time in any licensed facility.

(3) "Care and Supervision" means any one or more of the following activities provided by a person or facility to meet the needs of the clients:

(A) Assistance in dressing, grooming, bathing and other personal hygiene.

(B) Assistance with taking medication, as specified in section 80075.

(C) Central storing and/or distribution of medications, as specified in section 80075.

(D) Arrangement of and assistance with medical and dental care.

(E) Maintenance of house rules for the protection of clients.

(F) Supervision of client schedules and activities.

(G) Maintenance and/or supervision of client cash resources or property.

(H) Monitoring food intake or special diets.

(I) Providing basic services as defined in section 80001(b)(2).

(4) "Cash Resources" means:

(A) Monetary gifts.

(B) Tax credits and/or refunds.

(C) Earnings from employment or workshops.

(D) Personal and incidental need allowances from funding sources including but not limited to SSI/SSP.

(E) Allowances paid to children.

(F) Any other similar resources as determined by the licensing agency.

(5) "Certified administrator" means an administrator who has been issued a group home or adult residential facility certificate by the Department and whose certificate is current.

(6) "Child" means a person who is under 18 years of age.

(7) "Child Abuse Central Index" means the California Department of Justice maintained statewide, multi–jurisdictional, centralized index of child abuse investigation reports. These reports pertain to alleged incidents of physical abuse, sexual abuse, mental/emotional abuse and/or severe neglect. Each child protection agency (police, sheriff, county welfare and probation departments) is required by law to forward to the California Department of Justice a report of every child abuse incident it investigates, unless an incident is determined to be unfounded.

(8) "Child Abuse Central Index Clearance" means that the California Department of Justice has conducted a name search of the index and the search did not result in a match or the search resulted in a match but the California Department of Social Services determined

after an investigation that the allegation of child abuse or neglect was not substantiated.

(9) "Child Care Center" means any facility of any capacity other than a family day care home as defined in section 102352f.(1) in which less than 24–hour per day nonmedical supervision is provided for children in a group setting.

(10) "Client" means a child or adult who is receiving care and supervision in a community care facility. Client includes "resident" as used in the Community Care Facilities Act.

(11) "Client Who Relies Upon Others To Perform All Activities of Daily Living" means a client who is unable to perform all six activities of daily living without physical assistance.

(12) Close friend. "Close friend" means a person who is attached to another by feelings of personal regard as indicated by both parties involved.

(13) "Community Care Facility" means any facility, place or building where nonmedical care and supervision, as defined in section 80001c.(2) are provided.

(14) "Community Treatment Facility" means any residential facility that provides mental health treatment services to children in a group setting which has the capacity to provide secure containment. The facility's program components shall be subject to program standards developed and enforced by the State Department of Mental Health pursuant to Section 4094 of the Welfare and Institutions Code.

(15) "Completed Application" means:

(A) The applicant has submitted and the licensing agency has received all required materials including: an approved fire clearance, if appropriate, from the State Fire Marshal; a criminal record clearance on the applicant and any other individuals specified in section 80019.

(B) The licensing agency has completed a site visit to the facility.

(16) "Conservator" means a person appointed by the Superior Court pursuant to the provisions of section 1800 et seq. of the Probate Code or section 5350 of the Welfare and Institutions Code, to care for the person, or estate, or person and estate, of another.

(17) "Consultant" means a person professionally qualified by training or experience to provide expert information on a particular subject.

(18) "Control of Property" means the right to enter, occupy, and maintain the operation of the facility property within regulatory requirements. Evidence of control of property may include, but is not limited to the following:

(A) a Grant Deed showing ownership; or

(B) the lease agreement or rental agreement; or

(C) a court order or similar document which shows the authority to control the property pending outcome of a probate proceeding or an estate settlement.

(19) "Conviction" means:

(A) A criminal conviction in California; or

(B) Any criminal conviction of another state, federal, military or other jurisdiction, which if committed or attempted in California, would have been punishable as a crime in California.

(20) "Criminal Record Clearance" means an individual has a California clearance and an FBI clearance.

(d)(1) "Day" means calendar day unless otherwise specified.

(2) "Deficiency" means any failure to comply with any provision of the Community Care Facilities Act (Health and Safety Code, section 1500 et seq.) and/or regulations adopted by the Department pursuant to the Act.

(3) "Delayed–Egress Device" means a special time–delay, egress–control device as specified in Health and Safety Code Sections 1531.1(b), (e), and 1569.699(a).

(4) "Dementia" means a deterioration of intellectual function and other cognitive skills, leading to a decline in one's ability to perform activities of daily living.

(5) "Department" is defined in Health and Safety Code section 1502(b).

(6) "Developmental Disability" means a disability as defined in Welfare and Institutions Code section 4512(a).

(7) "Dietitian" means a person who is a member of or registered by the American Dietetics Association.

(8) "Director" is defined in Health and Safety Code section 1502(c).

(e)(1) "Egress–Alert Device" means a wrist band or other device, that may be worn by a client or carried on a client's person that triggers a visual or auditory alarm when the client leaves the facility building or grounds.

(2) "Elderly Person" means any person who is 60 years of age or older.

(3) "Emergency Approval to Operate" (LIC 9117 4/93) (EAO) means a temporary approval to operate a facility for no more than 60 days pending the Department's decision on whether to approve or deny a provisional license.

(4) "Evaluator" means any person who is a duly authorized officer, employee or agent of the Department, including any officer, employee or agent of a county or other public agency authorized by the Department to license community care facilities.

(5) "Evidence of Licensee's Death" shall include, but is not limited to, a copy of the death certificate, obituary notice, certification of death from the decedent's mortuary or a letter from the attending physician or coroner's office verifying the licensee's death.

(6) "Exception" means a written authorization issued by the licensing agency to use alternative means which meet the intent of a specific regulation(s) and which are based on the unique needs or circumstances of a specific client(s) or staff person(s). Exceptions are granted for particular client(s) or staff person(s) and are not transferable or applicable to other client(s), staff person(s), facilities or licensees.

(7) "Exemption" means an exception to the requirements of Health and Safety Code section 1522 and applicable regulations. Exemptions are not transferable.

(8) "Existing Facility" means any community care facility operating under a valid, unexpired license on the date this chapter becomes effective.

(f)(1) "Federal Bureau of Investigation (FBI) Clearance" means an individual has no felony or misdemeanor convictions reported by the FBI. However, the individual may have been arrested with no criminal conviction, convicted of a minor traffic offense or adjudicated as a juvenile.

(g)(1) "Group Home" means any facility of any capacity which provides 24–hour care and supervision to children in a structured environment with such services provided at least in part by staff employed by the licensee. The care and supervision provided by a group home shall be nonmedical except as permitted by Welfare and Institutions Code Section 17736(b).

(2) "Guardian" means a person appointed by the Superior Court pursuant to the provisions of sections 1500 et seq. of the Probate Code to care for the person, or estate, or the person and estate of another.

(h)(1) "Health Condition Relocation Order" means written notice by the Department to a licensee requiring the relocation of a client from a CCF because either the licensee is not providing adequate care for a client's health condition as required by the regulations or the client cannot be cared for within the limits of the license or the client requires in–patient care in a health facility or has a prohibited health condition, as specified in Section 80091.

(2) "Home Economist" means a person who holds a baccalaureate degree in home economics with a specialization in either foods and nutrition or dietetics.

(i)(1) "Infant" means a child under two years of age.

(2) "Inhalation–assistive device" means any equipment that assists a client to breath, including, but not limited to, aerosol delivery

devices, nebulizers, humidifiers, incentive spirometry devices, positive airway pressure devices, positive expiratory pressure devices, and intermittent positive pressure breathing (IPPB) machines.

(3) "Interdisciplinary Team" (IDT) means a team that assists the Department in evaluating the need for relocating a client of an ARF or an SRF when the client requests a review of the Department's Health Condition Relocation Order. This team consists of a nurse practitioner and a social worker, designated by the Department, with experience in the needs of the client population. Persons selected for an IDT shall not have been involved in the initial decision to issue a relocation order for the client in question.

(j) (Reserved)

(k) (Reserved)

(*l*)(1) "License" means authorization to operate a community care facility and to provide care and supervision. The license is not transferable.

(2) "Licensed professional" means a person who is licensed in California to provide medical care or therapy. This includes physicians and surgeons, physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, psychiatric technicians, physical therapists, occupational therapists and respiratory therapists, who are operating within his/her scope of practice.

(3) "Licensee" means the adult, firm, partnership, association, corporation, county, city, public agency, or other governmental entity having the authority and responsibility for the operation of a licensed community care facility.

(4) "Licensing Agency" means the State Department of Social Services or any state, county or other public agency authorized by the Department to assume specified licensing responsibilities pursuant to section 1511 of the Health and Safety Code.

(m)(1) "Medical Professional" means an individual who is licensed or certified in California to perform the necessary medical procedures within his/her scope of practice. This includes, but is not limited to, Medical Doctor (MD), Registered Nurse (RN) and Licensed Vocational Nurse (LVN).

(2) "Mental Disorder" means any of the disorders set forth in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition) of the American Psychiatric Association and a degree of functional impairment which renders a person eligible for the services enumerated under the Lanterman–Petris–Short Act, commencing with section 5000 of the Welfare and Institutions Code.

(n)(1) "Needs and Services Plan" means a written plan that identifies the specific needs of an individual client, including those items specified in Section 80068.2, and delineates those services necessary to meet the client's identified needs.

(2) "Nonambulatory Person" means a person as defined in Health and Safety Code section 13131.

(A) A person who uses postural supports as specified in section 80072(a)(8) is deemed nonambulatory.

(B) A person is not deemed nonambulatory solely because he/she is deaf, blind, or prefers to use a mechanical aid.

(3) "Nutritionist" means a person who holds a master's degree in food and nutrition, dietetics, or public health nutrition, or who is employed as a nutritionist by a county health department.

(o) (Reserved)

(p)(1) "Physician" means a person licensed as a physician and surgeon by the California Board of Medical Examiners or by the California Board of Osteopathic Examiners.

(2) "Placement agency" is defined in Health and Safety Code Sections 1536.1 and 1569.47(a).

(3) "PRN Medication" (pro re nata) means any nonprescription or prescription medication which is to be taken as needed.

(4) "Provision" or "Provide" means whenever any regulation requires that provisions be made for or that there be provided any service, personnel, or other requirement, the licensee shall do so directly or present evidence to the licensing agency that the requirement has been met by some other means.

(5) "Provisional License" means a license which is temporary, nonrenewable and issued for a period not to exceed twelve months. A provisional license is issued in accordance with the criteria specified in section 80030.

(q) (Reserved)

(r)(1) "Rehabilitation" means the effort to reestablish good character since the date of the last conviction, including, but not limited to, education, counseling or therapy, training, stable employment, restitution, remorse, changes in lifestyle, or community service.

(2) "Relative" means spouse, parent, stepparent, son, daughter, brother, sister, stepbrother, stepsister, half–brother, half–sister, uncle, aunt, niece, nephew, first cousin or any such person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

(3) "Responsible person" means that individual or individuals, including a relative, health care surrogate decision maker, or placement agency, who assists the client or prospective client in placement or assumes varying degrees of responsibility for the client's well–being. A responsible person cannot act on behalf of a client unless authorized by law.

(s)(1) "Serious Deficiency" means any deficiency that presents an immediate or substantial threat to the physical health, mental health or safety of the clients of a community care facility.

(2) "Simplified Exemption" means an exemption granted on the Department's own motion, as authorized in Health and Safety Code Section 1522(c)(4), if the individual's criminal history meets specific criteria established by Department regulation.

(3) "Small Family Home" means any residential facility in the licensee's family residence providing 24–hour a day care for six or fewer children who are mentally disordered, developmentally disabled or physically handicapped and who require special care and supervision as a result of such disabilities.

(4) "Social Rehabilitation Facility" means any facility which provides 24–hour–a–day nonmedical care and supervision in a group setting to adults recovering from mental illness who temporarily need assistance, guidance or counseling.

(5) "Social Worker" means a person who has a graduate degree from an accredited school of social work.

(6) "SSI/SSP" means the Supplemental Security Income/State Supplemental Program which is a federal/state program that provides financial assistance to aged, blind and/or disabled residents of California.

(7) "Substantial Compliance" means the absence of any serious deficiencies.

(8) "Substantiated Complaint" means a complaint which has been investigated by the licensing agency, and as a result, a violation of regulations has been found.

(t)(1) "Transfer Trauma" means the consequences of the stress and emotional shock caused by an abrupt, involuntary relocation of a client or resident from one facility to another.

(u)(1) "Universal Precautions" means an approach to infection control that treats all human blood and body fluids as if they are infectious. Generally, Universal Precautions consist of regular hand–washing after coming into contact with another person's body fluids (mucous, saliva, urine, etc.) and includes the use of gloves when handling blood or body fluids that contain blood. Specifically, Universal Precautions consist of the following four basic infection control guidelines:

(A) Hand–washing — Staff should wash their hands:

1. After assisting with incontinent care or wiping a client's nose.
2. Before preparing or eating foods.
3. After using the toilet.

4. Before and after treating or bandaging a cut.

5. After wiping down surfaces, cleaning spills, or any other housekeeping.

6. After being in contact with any body fluids from another person.

7. Even if they wore gloves during contact with body fluids.

(B) Gloves — Staff should always wear gloves:

1. When they come into contact with blood or body fluids that contain blood.

2. When they have cuts or scratches on their hands.

3. When assisting with incontinent care or when cleaning up urine, stool, or vomit.

4. When administering first aid for a cut, a bleeding wound, or a bloody nose.

5. And use gloves only one time, for one incident or client.

a. Staff must air dry their hands prior to putting on a new pair of gloves.

6. And dispose of used gloves immediately after use.

(C) Cleaning with a disinfectant — Staff should clean with a disinfectant:

1. On all surfaces and in the client's room and on an "as needed" basis on any surface that has come into contact with blood.

2. Such as a basic bleach solution, made fresh daily by mixing:

a. 1/4 cup household liquid chloride bleach in one gallon of tap water, or one tablespoon bleach in one quart of water.

(D) Proper disposal of infectious materials — Staff should dispose of infectious materials by:

1. Placing it in a plastic trash bag, tying it with a secure tie, and disposing of it out of reach of clients and children.

(2) "Unlicensed Community Care Facility" means a facility as defined in Health and Safety Code section 1503.5.

(A) [Reserved]

(B) A facility which is "providing care and supervision" as defined in section 80001c(2) includes, but is not limited to, one in which an individual has been placed by a placement agency or family members for temporary or permanent care.

(C) A facility which is "held out as or represented as providing care or supervision" includes, but is not limited to:

(1) A facility whose license has been revoked or denied, but the individual continues to provide care for the same or different clients with similar needs.

(2) A facility where a change of ownership has occurred and the same clients are retained.

(3) A licensed facility that moves to a new location.

(4) A facility which advertises as providing care and/or supervision.

(D) A facility which "accepts or retains residents who demonstrate the need for care or supervision" includes, but is not limited to:

(1) A facility with residents requiring care and/or supervision, even though the facility is providing board and room only, or board only, or room only.

(2) A facility which houses unemancipated minors, even though the facility is providing board and room only, or board only, or room only.

(3) A facility where it is apparent that care and/or supervision are being provided by virtue of the client's needs being met.

(3) "Urgent Need" means a situation where prohibiting the operation of the facility would be detrimental to a client's physical health, mental health, safety, or welfare. Circumstances constituting urgent need include but are not limited to the following:

(A) A change in facility location when clients are in need of services from the same operator at the new location.

(B) A change of facility ownership when clients are in need of services from a new operator.

(v) (Reserved)

(w)(1) "Waiver" means a nontransferable written authorization issued by the licensing agency to use alternative means which meet the intent of a specific regulation and which are based on a facility–wide need or circumstance.

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Sections 1502, 1522.41(j), 1524(e), 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1502, 1502(a)(7) and (8), 1502.5, 1503, 1503.5, 1505, 1507, 1508, 1509, 1511, 1520, 1522, 1524, 1524(e), 1525, 1525.5, 1526, 1527, 1530, 1530.5, 1531, 1531.1, 1533, 1534, 1536.1, 1537, 1538.5, 1550, 1551, 1556, 1569.699(a), 1797.196 and 11834.11, Health and Safety Code; Sections 5453, 5458, 11006.9 and 17736(a) and (b), Welfare and Institutions Code; and 29 CFR 1910.1030.

Article 2. License

§ 80005. License Required.

(a) Unless a facility is exempt from licensure as specified in Section 80007, no adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity shall operate, establish, manage, conduct or maintain a community care facility, or hold out, advertise or represent by any means to do so, without first obtaining a current valid license from the licensing agency.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1505, 1508, 1509, 1513 and 1531, Health and Safety Code.

§ 80006. Operation Without a License.

(a) An unlicensed facility is providing care and supervision as defined in section 80001u.(2), the facility is in violation of Sections 1503.5 and/or 1508 of the Health and Safety Code unless exempted from licensure pursuant to section 80007.

(b) If the facility is alleged to be in violation of Sections 1503.5 and/or 1508 of the Health and Safety Code, the licensing agency shall conduct a site visit and/or evaluation of the facility pursuant to Health and Safety Code section 1538.

(c) If the facility is operating without a license, the licensing agency shall issue a notice of operation in violation of law and shall refer the case for criminal prosecution and/or civil proceedings.

(d) The licensing agency shall have the authority to issue an immediate civil penalty pursuant to section 80058 and section 1547 of the Health and Safety Code.

(e) Sections 80006(c) and (d) shall be applied pursuant to section 1549 of the Health and Safety Code.

(f) The licensing agency shall notify the appropriate placement or protective service agency if either of the following conditions exist:

(1) There is an immediate threat to the clients' health and safety.

(2) The facility does not submit an application for licensure within 15 calendar days of being served a notice of operation in violation of law.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1503.5, 1505, 1508, 1533, 1538, 1540, 1540.1, 1541, 1547 and 1549, Health and Safety Code.

§ 80007. Exemption from Licensure.

(a) The community care facility regulations contained in this division shall not apply to any of the following:

(1) Any health facility, as defined by section 1250 of the Health and Safety Code.

(2) Any clinic, as defined by section 1202 of the Health and Safety Code.

(3) Any family day care home providing care for the children of only one family, in addition to the operator's own children.

(4) Any juvenile placement facility approved by the California Youth Authority or any juvenile hall operated by a county.

(5) Any facility conducted by and for the adherents of any well–recognized church or religious denomination for the purpose of providing facilities for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of the religion of such church or denomination.

(6) Any school dormitory or similar facility where all of the following conditions exist:

(A) The school is certificated/registered by the State Department of Education.

(B) The school and the school dormitory are on the same grounds.

(C) All children accepted by the school are six years of age or older.

(D) The program operates only during normal school terms unless the academic program runs year–round.

(E) The school's function is educational only.

(F) The school program is not designated as providing rehabilitative or treatment services.

(G) The school's function does not promote intent to provide community care services, and the facility does not accept children who are in need of such services, including but not limited to children with developmental disabilities, mental disorders or physical handicaps; juveniles declared dependents of the court under Welfare and Institutions Code section 300, and juveniles declared wards of the court under Welfare and Institutions Code sections 601 and 602.

(H) The facility does not receive any public funds designated for care including but not limited to AFDC–FC and SSI/SSP. The facility shall be permitted to receive public funds intended for educational programs.

(I) No public or private agency, including but not limited to county welfare department and probation offices, provides social services to children in the facility.

(7) Any house, institution, hotel, homeless shelter, or other similar place that supplies board and room only, or room only, or board only, which provides no element of care and supervision, as defined in section 80001(c)(2).

(8) Any cooperative arrangement between parents for the day care of their children by one or more of the parents where no payment for the day care is involved, including but not limited to the exchange of child day care services between two or more families.

(9) Any care and supervision of persons by a relative, guardian or conservator.

(10) Any care and supervision of persons from only one family by a close friend of the parent, guardian or conservator, provided that such arrangement is not for financial profit and does not exceed 10 hours per week.

(A) Provision of longer hours of care shall not be precluded when provided for a brief period of time for reasons, including but not limited to family emergencies, vacation, and military leave.

(11) Any arrangement for the care and supervision of an adult or adults from only one family by a close friend, who is not a licensee or current employee of a Residential Care Facility for the Elderly or of an Adult Residential Facility, and whose friendship pre–existed a provider/recipient relationship, and all of the following are met:

(A) The care and supervision is provided in a home or residence chosen by the recipient, regardless of who owns the home or residence.

(B) The arrangement is not of a business nature, in that the provider does not represent himself or herself as being in the business of provision of care, and any compensation that may be paid to the provider is only for the value of the services rendered.

(C) The arrangement occurs and continues only as long as the needs for care and supervision of the recipient are being adequately met.

(12) Any facility exclusively used by a licensed homefinding agency and issued a certificate of approval by that agency.

(A) Such facilities shall not be required to obtain a license, but shall be in compliance with all other requirements set forth in this division. The facility's compliance with requirements shall be monitored through and assured by the homefinding finding agency. For the purposes of this section, an exclusive–use facility shall mean a nonlicensed residential facility that has been certified by a licensed homefinding agency as conforming to the regulations pertaining to the small family home category. A facility in the exclusive use of a licensed homefinding agency shall accept only those children placed by that agency which certified the home.

(13) A home which meets all of the following criteria:

(A) approved by a licensed adoption agency, or the Department, for the adoptive placement of a child, and

(B) the child is legally free for adoption, and

(C) the agency or the Department is providing supervision of the placement pending finalization of the adoption.

(14) A home which meets all of the following criteria:

(A) placement for adoption by a birth parent, and

(B) a petition for adoption has been filed by the prospective adoptive parents, and is pending, and

(C) a final decision on the petition has not been rendered by the court.

(15) Any placement agency as defined in Health and Safety Code section 1536.1 or an individual who places individuals for care in a facility licensed to receive and care for such persons.

(16) A county probation or welfare department which places children in certified license pending homes as set forth in section 87007.1.

(17) Any housing project for elderly or disabled individuals that meets federal requirements specified in Health and Safety Code Section 1505(p).

(18) The Department.

(19) Any similar facility as determined by the Director.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1505, 1508, 1530, 1530.5 and 1536.1, Health and Safety Code; Sections 362, 727 and 16100, Welfare and Institutions Code; and *Grimes v. CDSS* (1999) 70 Cal.App.4th 1065.

§ 80008. Licensing of Integral Facilities.

(a) Upon written application from the licensee, the licensing agency shall have the authority to issue a single license for separate buildings which might otherwise require separate licenses provided that all of the following requirements are met:

(1) Separate buildings or portions of the facility are integral components of a single program.

(2) All components of the program are managed by the same licensee.

(3) All components of the program are conducted at a single site with a common address.

(b) If (a) above does not apply, each separately licensed component of a single program shall be capable of independently meeting the provisions of applicable regulations as determined by the licensing agency.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1508, 1509 and 1513, Health and Safety Code.

§ 80010. Limitations on Capacity and Ambulatory Status.

(a) A licensee shall not operate a facility beyond the conditions and limitations specified on the license, including the capacity limitation.

(b) Facilities or rooms approved for ambulatory clients only shall not be used by nonambulatory clients.

(1) Clients whose condition becomes nonambulatory shall not use rooms or areas restricted to ambulatory clients.

(2) The licensing agency shall have the authority to require clients who use ambulatory sections of the facility to demonstrate that they are ambulatory.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1528 and 1531, Health and Safety Code.

§ 80011. Advertisements and License Number.

(a) Licensees shall reveal each facility license number in all advertisements in accordance with Health and Safety Code section 1514. Non–residential facilities shall be exempt from this requirement.

(b) Correspondence shall be considered a form of advertisement if the intent is to attract clients.

(c) Licensees who operate more than one facility and use a common advertisement for these facilities shall be required to list each facility license number in accordance with Health and Safety Code section 1514.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1514, Health and Safety Code.

§ 80012. False Claims.

(a) No licensee, officer, or employee of a licensee shall make or disseminate any false or misleading statement regarding the facility or any of the services provided by the facility.

(b) No licensee, officer, or employee of a licensee shall alter a license, or disseminate an altered license.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1508 and 1531, Health and Safety Code.

Article 3. Application Procedures

§ 80017. Applicant Qualifications.

(a) Any adult shall be permitted to apply for a license regardless of age, sex, race, religion, color, political affiliation, national origin, disability, marital status, actual or perceived sexual orientation, or ancestry.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1520 and 1528, Health and Safety Code; and Section 51, Civil Code.

§ 80018. Application for License.

(a) Any adult, firm, partnership, association, corporation, county, city, public agency or other governmental entity desiring to obtain a license shall file with the licensing agency a verified application on forms furnished by the licensing agency.

(b) Prior to filing an application, the applicant shall attend an orientation designed for the specific facility type and provided by the licensing agency.

(1) The orientation shall cover, but not be limited to, the following areas:

(A) Completion of the application for license.

(B) Scope of operation subject to regulation by the department.

(2) An applicant, who is already licensed for a facility in the same category, shall not be required to attend an orientation if the last orientation attended was for the same facility type and within two (2) years of the next scheduled orientation.

(3) An applicant applying for more than one facility license, in the same facility type, shall be required to attend only one orientation.

(c) The applicant/licensee shall cooperate with the licensing agency in providing verification and/or documentation as requested by the licensing agency.

(d) The application and supporting documents shall contain the following:

(2) Name, and residence and mailing addresses of applicant.

(A) If the applicant is a partnership, the name, and principal business address of each partner.

(B) If the applicant is a corporation or association, the name, title and principal business address of each officer, executive director and member of the governing board.

(C) If the applicant is a corporation which issues stock, the name and address of each person owning more than 10 percent of stock in such corporation.

(D) If the applicant is a corporation or association, a copy of the articles of incorporation, constitution and by–laws.

(E) If the applicant is a corporation, each member of the board of directors, executive director, and any officer shall list the name of facilities which they have been licensed to operate, employed by or a member of the board of the directors, executive director or an officer.

(3) Name and address of owner of facility premises if applicant is leasing or renting.

(4) Procedures as required pursuant to Section 1524.5 of the Health and Safety Code.

(5) The category of facility to be operated.

(6) Maximum number of persons to be served.

(7) Age range, sex and the categories of persons to be served, including but not limited to persons with developmental disabilities, mental disorders, physically handicapped and/or nonambulatory persons.

(8) Hours or periods of facility operation.

(9) Name of administrator, if applicable.

(10) Information required by Health and Safety Code Section 1520(d).

(11) Information required by Health and Safety Code Section 1520(e).

(12) Name, address and telephone number of the city or county fire department, the district providing fire protection services, or the State Fire Marshal's Office having jurisdiction in the area where the facility is located.

(13) A plan of operation as specified in Section 80022.

(14) Fingerprint cards as specified in Section 80019.

(15) Information required by Health and Safety Code Section 1522.1.

(16) The bonding affidavit specified in Section 80025(a).

(17) A health screening report on the applicant as specified in Section 80065(g).

(18) The fee for processing the application by the requested capacity as specified in Section 80036.

(19) Such other information as may be required pursuant to Section 1520(g) of the Health and Safety Code.

(e) The application shall be signed by the applicant.

(1) If the applicant is a partnership, the application shall be signed by each partner.

(2) If the applicant is a firm, association, corporation, county, city, public agency or other governmental entity, the application shall be signed by the chief executive officer or authorized representative.

(f) The application shall be filed with the licensing agency which serves the geographical area in which the facility is located.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1520.11, 1522, 1522.1, 1523.1, 1524.5 and 1560, Health and Safety Code.

§ 80019. Criminal Record Clearance.

(a) The Department shall conduct a criminal record review of all individuals specified in Health and Safety Code Section 1522(b) and shall have the authority to approve or deny a facility license, or employment, residence, or presence in the facility, based upon the results of such review.

[Sections 80019(b) et seq. are to be effective on January 1, 2001.]

(b) The following persons are exempt from the requirement to submit fingerprints:

(1) A medical professional, as defined by the Department in regulations, who holds a valid license or certification from the individual's governing California medical care regulatory entity and who is not employed, retained, or contracted by the licensee, if all of the following apply:

(A) The criminal record of the individual has been cleared as a condition of licensure or certification by the individual's California medical care regulatory entity.

(B) The individual is providing time–limited specialized clinical care or services.

(C) The individual is providing care or services within the individual's scope of practice.

(D) The individual is not a community care facility licensee or an employee of the facility.

(2) A third–party repair person, or similar retained contractor, if all of the following apply:

(A) The individual is hired for a defined, time–limited job.

(B) The individual is not left alone with clients.

(C) When clients are present in the room in which the repairperson or contractor is working, a staff person who has a criminal record clearance or exemption is also present.

(3) Employees of a licensed home health agency and other members of licensed hospice interdisciplinary teams who have a contract with a client of the facility, and are in the facility at the request of that client or resident's legal decision maker.

(A) The exemption shall not apply to a person who is a community care facility licensee or an employee of the facility.

(4) Clergy and other spiritual caregivers who are performing services in common areas of the residential care facility, or who are advising an individual client at the request of, or with the permission of, the client.

(A) This exemption shall not apply to a person who is a community care facility licensee or an employee of the facility.

(5) Members of fraternal, service and similar organizations who conduct group activities for clients, if all of the following apply:

(A) Members are not left alone with the clients.

(B) Members do not transport clients off the facility premises.

(C) The same group does not conduct such activities more often than once a month.

(6) The following persons in homes certified by licensed Foster Family Agencies:

(A) Adult friends and family of the certified foster parent, who come into the home to visit for a length of time no longer than one month, provided they are not left alone with the foster children. However, the certified foster parent, acting as a reasonable and prudent parent, as defined in paragraph (2) of subdivision (a) of Section 362.04 of the Welfare and Institutions Code, may allow his or her adult friends and family to provide short–term care to the foster child and act as an appropriate occasional short–term babysitter for the child.

(B) Parents of a foster child's friends when the child is visiting the friend's home and the friend, certified foster parent or both are also present. However, the certified foster parent, acting as a reasonable and prudent parent, may allow the parent of the foster child's friends to act as an appropriate short–term babysitter for the child without the friend being present.

(C) Individuals who are engaged by any certified foster parent to provide short–term babysitting to the child for periods not to exceed 24 hours. Certified foster parents shall use a reasonable and prudent parent standard in selecting appropriate individuals to act as appropriate occasional short–term babysitters.

(7) The following persons in small family homes:

(A) Adult friends and family of the licensee who come into the home to visit, for a length of time no longer than one month, provided they are not left alone with the children.

(B) Parents of a child's friends when the child is visiting the friend's home and the friend, foster parent or both are also present.

(8) The following persons in adult residential and social rehabilitation facilities unless contraindicated by the client's individualized program plan (IPP), or needs and service plan:

(A) A spouse, significant other, relative, close friend of a client, or the attendant or facilitator who is not employed, retained or contracted by the licensee for a client with a developmental disability, as long as the person is visiting the resident or providing direct care and supervision to that client only.

(B) An attendant or facilitator for a client with a developmental disability if the attendant or facilitator is not employed, retained or contracted by the licensee.

(C) The exemptions in Section 80019(b)(9)(A) or (B) apply only if the person is visiting the client or providing direct care and supervision to the client.

(9) Nothing in this paragraph shall prevent a licensee from requiring a criminal record clearance of any individual exempt from the requirements of this section, provided that the individual has client contact.

(c) Prior to the Department issuing a licensee, the applicant, administrator and any adult other than a client, residing in the facility shall obtain a California criminal record clearance or exemption as specified in Health and Safety Code Section 1522(a)(5).

(d) All individuals subject to criminal record review shall be fingerprinted and sign a Criminal Record Statement (LIC 508 [Rev. 1/03]) under penalty of perjury.

(1) A person signing the LIC 508 must:

(A) Declare whether he/she has been convicted of a crime, other than a minor traffic violation as specified in Section 80019(i) regardless of whether the individual was granted a pardon for the conviction, received an expungement pursuant to Penal Code 1203.4 or the individual's record was sealed as a result of a court order.

(B) If convicted of a crime other than a minor traffic violation, provide information regarding the conviction.

(2) The licensee shall submit these fingerprints to the California Department of Justice, along with a second set of fingerprints for the purpose of searching the records of the Federal Bureau of Investigation, or to comply with the requirements of Section 80019(e), prior to the individual's employment, residence, or initial presence in the community care facility.

(A) Fingerprints shall be submitted to the California Department of Justice by the licensee, or sent by electronic transmission to the California Department of Justice by a fingerprinting entity approved by the Department.

(e) All individuals subject to a criminal record review pursuant to Health and Safety Code Section 1522 shall prior to working, residing or volunteering in a licensed facility:

(1) Obtain a California clearance or a criminal record exemption as required by the Department or

(2) Request a transfer of a criminal record clearance as specified in Section 80019(f) or

(3) Request and be approved for a transfer of a criminal record exemption, as specified in Section 80019.1(r), unless, upon request for the transfer, the Department permits the individual to be employed, reside or be present at the facility.

(f) A licensee or applicant for a license may request a transfer of a criminal record clearance from one state licensed facility to another, or from TrustLine to a state licensed facility by providing the following documents to the Department:

(1) A signed Criminal Background Clearance Transfer Request, LIC 9182 (Rev. 4/02).

(2) A copy of the individual's:

(A) Driver's license, or

(B) Valid identification card issued by the Department of Motor Vehicles, or

(C) Valid photo identification issued by another state or the United States government if the individual is not a California resident.

(3) Any other documentation required by the Department [e.g., Criminal Record Statement — LIC 508, (Rev. 1/03) or for Foster Family Homes, Small Family Homes and Certified Family Homes an LIC 508D (Rev. 1/03) which are incorporated by reference, and job description].

(g) Violation of Section 80019(e) will result in a citation of a deficiency and an immediate assessment of civil penalties of one hundred dollars ($100) per violation per day for a maximum of five (5) days by the Department.

(1) Subsequent violations within a twelve (12) month period will result in a civil penalty of one hundred dollars ($100) per violation per day for a maximum of thirty (30) days.

(2) The Department may assess civil penalties for continued violations as permitted by Health and Safety Code Section 1548.

(h) Violation of Section 80019(e) may result in a denial of the license application or suspension and/or revocation of the license.

(i) If the criminal record transcript of any individuals specified in Health and Safety Code Section 1522(b) discloses a plea or verdict of guilty or a conviction following a plea of nolo contendere for any crime other than a minor traffic violation for which the fine was less than $300, and an exemption pursuant to Section 80019.1(a) has not been granted, the Department shall take the following actions:

(1) For initial applicants, denial of the application.

(2) For current licensees, the Department may institute an administrative action, including, but not limited to, revocation of the license.

(3) For current employees, exclude the affected individual pursuant to Health and Safety Code Section 1558, and deny the application or revoke the license, if the individual continues to provide services and/or reside at the facility.

(4) For convicted individuals residing in the facility, exclusion of the affected individual pursuant to Health and Safety Code Section 1558, and denial of the application or revocation of the license, if the individual continues to provide services and/or reside at the facility.

(j) The licensee shall maintain documentation of criminal record clearances or criminal record exemptions of employees in the individual's personnel file as required in Section 80066.

(1) Documentation shall be available for inspection by the Department.

(k) The Department may seek verification from a law enforcement agency or court of an individual's criminal record as reported to the Department from any member of the public or affected individual.

(1) Upon obtaining confirmation from a law enforcement agency or court of the offense, the Department shall proceed as if this criminal record information was provided by the California Department of Justice.

NOTE: Authority cited: Sections 1530 and 1548(e), Health and Safety Code. Reference: Sections 1503.5, 1505, 1508, 1522, 1531, 1533, 1538, 1540, 1540.1, 1541, 1547, 1548 and 1549, Health and Safety Code.

§ 80019.1. Criminal Record Exemption.

(a) The Department will notify a licensee to act immediately to remove from the facility or bar from entering the facility any person described in Sections 80019.1(a)(1) through (5) below while the Department considers granting or denying an exemption. Upon notification, the licensee shall comply with the notice.

(1) Any person who has been convicted of, or is awaiting trial for, a sex offense against a minor;

(2) Any person who has been convicted of a felony;

(3) Any person who has been convicted of an offense specified in Sections 243.4, 273a, 273d, 273g, or 368 of the Penal Code or any other crime specified in Health and Safety Code Section 1522(c)(3);

(4) Any person who has been convicted of any crime specified below:

(A) Battery

(B) Shooting at Inhabited Dwelling

(C) Corporal Injury on Spouse/Cohabitant

(D) Discharging Firearm with Gross Negligence

(E) Exhibiting Weapon/Firearm

(F) Threat to Commit a Crime Resulting in Gross Bodily Injury or Death

(G) Criminal Threat to Harm or Injure Another Person

(H) Cruelty to Animals

(I) Willful Harm or Injury to Child; or

(5) Any other person ordered to be removed by the Department.

(b) In addition to the requirements of Section 80019.1(a), the licensee must return the confirmation of removal form that is sent by the Department, within five (5) days of the date of the form, that confirms under penalty of perjury that the individual has been removed from the facility.

(1) Confirmation must be made on either a Removal Confirmation — Exemption Needed, LIC 300A (Rev. 9/03), Removal Confirmation — Denial, LIC 300B (Rev. 9/03), Removal Confirmation — Rescinded, LIC 300C (Rev. 9/03), or Removal Confirmation — Nonexemptible, LIC 300D (Rev. 9/03).

(c) After a review of the criminal record transcript, the Department may grant an exemption if:

(1) The applicant/licensee requests an exemption in writing for himself or herself, or

(2) The applicant/licensee requests an exemption in writing for an individual associated with the facility, or

(3) The applicant/licensee chooses not to seek an exemption on the affected individual's behalf, the affected individual requests an individual exemption in writing, and

(4) The affected individual presents substantial and convincing evidence satisfactory to the Department that he/she has been rehabilitated and presently is of such good character as to justify being issued or maintaining a license, employment, presence, or residence in a licensed facility.

(d) To request a criminal record exemption, a licensee or license applicant must submit information that indicates that the individual meets the requirements of Section 80019.1(c)(4). The Department will notify the licensee or license applicant and the affected individual, in concurrent, separate notices, that the affected individual has a criminal conviction and needs to obtain a criminal record exemption.

(1) The notice to the affected individual shall include a list of the conviction(s) that the Department is aware of at the time the notice is sent that must be addressed in an exemption request.

(2) The notice will list the information that must be submitted to request a criminal record exemption.

(3) The information must be submitted within forty five (45) days of the date of the Department's notice.

(A) Individuals who submit a criminal record exemption request shall cooperate with the Department by providing any information requested by the Department, including, but not limited to, police reports and certified court documents to process the exemption request, pursuant to Section 80019.1(e).

(B) If the individual for whom the criminal record exemption is requested is an employee or resident other than a spouse or a dependent family member and the licensee/license applicant does not submit the information listed in the Department's written notice within 45 days of the date of the notice, the Department may cease processing the exemption request and close the case.

(C) If the individual for whom the criminal record exemption is requested is an applicant, licensee, spouse or dependent family member and the licensee/license applicant does not submit the information listed in the Department's written notice within 45 days of the date of the notice, the Department may deny the exemption request.

(D) Individuals may request a criminal record exemption on their own behalf if the licensee or license applicant:

1. Chooses not to request the exemption and

2. Chooses not to employ or terminates the individual's employment after receiving notice of the individual's criminal history, or

3. Removes the individual who resides in the facility after receiving notice of the individual's criminal history.

(e) The Department shall consider factors including, but not limited to, the following as evidence of good character and rehabilitation:

(1) The nature of the crime including, but not limited to, whether it involved violence or a threat of violence to others.

(2) Period of time since the crime was committed and number of offenses.

(3) Circumstances surrounding the commission of the crime that would demonstrate the unlikelihood of repetition.

(4) Activities since conviction, including employment or

participation in therapy or education, that would indicate changed behavior.

(5) Granting by the Governor of a full and unconditional pardon.

(6) Character references.

(A) All character references shall be on a Reference Request form (LIC 301E — Exemptions [Rev. 7/03]).

(7) A certificate of rehabilitation from a superior court.

(8) Evidence of honesty and truthfulness as revealed in exemption application documents.

(A) Documents include, but are not limited to:

1. A Criminal Record Statement (LIC 508, [Rev. 1/03]) or for Foster Family Homes, Small Family Homes and Certified Family Homes an LIC 508D [Rev. 1/03]) and

2. The individual's written statement/explanation of the conviction and the circumstances about the arrest.

(9) Evidence of honesty and truthfulness as revealed in exemption application interviews and conversations with the Department.

(f) The Department shall also consider the following factors in evaluating a request for an exemption:

(1) Facility and type of association.

(2) The individual's age at the time the crime was committed.

(g) The Department may deny an exemption request if:

(1) The licensee and/or the affected individual fails to provide documents requested by the Department, or

(2) The licensee and/or the affected individual fails to cooperate with the Department in the exemption process.

(h) The reasons for any exemption granted or denied shall be in writing and kept by the Department.

(1) Exemption denial notices shall specify the reason the exemption was denied.

(i) The Department has the authority to grant a criminal record exemption that places conditions on the individual's continued licensure, and employment or presence in a licensed facility.

(j) It shall be conclusive evidence that the individual is not of such good character as to justify issuance of an exemption if the individual:

(1) Makes a knowingly false or misleading statement regarding:

(A) Material relevant to their application for a criminal record clearance or exemption,

(B) His or her criminal record clearance or exemption status to obtain employment or permission to be present in a licensed facility, after the Department has ordered that they be excluded from any or all licensed facilities, or

(C) His or her criminal record clearance or exemption status in order to obtain a position with duties that are prohibited to him/her by a conditional exemption; or

(2) Is on probation or parole.

(A) If the individual is currently on probation, and provides sufficient proof that the probationary period(s) is informal, unsupervised and no probation officer is assigned, the Department may, in its discretion, grant a criminal record exemption notwithstanding Section 80019.1(j)(2).

(B) Section 80019.1(j)(2) does not apply to Certified Family Homes.

(k) The Department shall consider granting a criminal record exemption if the individual's criminal history meets all of the applicable criteria specified in Sections 80019.1(k)(1) through (6) and the individual provides the Department with substantial and convincing evidence of good character as specified in Section 80019.1(c)(4). For purposes of this section, a violent crime is a crime that, upon evaluation of the code section violated or the reports regarding the underlying offense, presents a risk of harm or violence.

(1) The individual has been convicted of one nonviolent misdemeanor, and one year has lapsed since completing the most recent period of incarceration or probation.

(2) The individual has been convicted of two or more nonviolent misdemeanors and four consecutive years have lapsed since completing the most recent period of incarceration, probation or parole, whichever is latest.

(3) The individual has been convicted of one or more violent misdemeanors and 15 consecutive years have lapsed since completing the most recent period of incarceration, probation or parole, whichever is latest.

(4) The individual has been convicted of one nonviolent felony and four consecutive years have lapsed since completing the most recent period of incarceration, probation or parole, whichever is latest.

(5) The individual has been convicted of two or more nonviolent felonies and ten consecutive years have lapsed since completing the most recent period of incarceration, probation or parole, whichever is latest.

(6) The individual has not been convicted of a violent felony.

(7) If the individual is currently on probation, and provides sufficient proof that the probationary period(s) is informal, unsupervised and no probation officer is assigned, the period of lapsed time required in Sections 80019.1(k)(1) through (5) above shall begin from the last date of conviction(s).

(*l*) It shall be a rebuttable presumption that an individual is not of such good character as to justify the issuance of an exemption if the individual fails to meet the requirements specified in Sections 80019.1(k)(1) through (6).

(m) The Department shall not grant an exemption if the individual has a conviction for any offense specified in Section 1522(g)(1) of the Health and Safety Code.

(n) The Department shall consider granting a simplified criminal record exemption only if the individual has the criminal history profile outlined in Sections 80019.1(n)(1) through (4) below:

(1) The individual does not have a demonstrated pattern of criminal activity;

(2) The individual has no more than one conviction;

(3) The conviction is a misdemeanor and is a crime that is nonviolent and does not pose a risk of harm to an individual; and

(4) It has been at least five consecutive years since the completion of the most recent period of incarceration or supervised probation.

(o) At the Department's discretion, an individual who is otherwise eligible for a simplified exemption may be required to go through the standard exemption process if the Department determines such action will help to protect the health and safety of clients.

(p) If the Department denies or cannot grant a criminal record exemption the Department shall:

(1) For initial applicants, deny the application.

(2) For current licensees, the Department may institute an administrative action, including, but not limited to, revocation of the license.

(3) For current employees, exclude the affected individual pursuant to Health and Safety Code Section 1558, deny the application or revoke the license, if the individual continues to provide services and/or reside at the facility.

(4) For individuals residing in the facility or the licensee, exclude the affected individual pursuant to Health and Safety Code Section 1558, deny the application or revoke the license, if the individual continues to provide services and/or reside at the facility.

(q) If a request for an exemption has been denied, the individual shall be excluded for a period of two years unless the individual has been convicted of a crime for which no exemption may be granted pursuant to Section 80019.1(m). If a request for an exemption has been denied based on a conviction of a crime for which no exemption may be granted, the individual shall be excluded for the remainder of the individual's life.

(1) If the Department determines during the review of an exemption request, that the individual was denied an exemption for a conviction of a crime for which an exemption may be granted within the preceding two years, the Department shall cease any further review of the request until two years have elapsed from the date of the

denial. In cases where the individual requested a hearing on an exemption denial, the Department shall cease review of the request for an exemption until two years from the effective date of the decision and order of the Department upholding the denial. In cases where the individual submitted a petition for reinstatement or reduction in penalty pursuant to Government Code Section 11522 that was denied, the Department shall cease review of the request for an exemption until two years from the effective date of the decision and order of the Department denying the petition.

(2) An exclusion order based solely upon a denied exemption shall remain in effect and the individual shall not be employed in or present in a licensed facility or certified home, unless either a petition or an exemption is granted.

(3) If an individual who has previously been denied an exemption re–applies after the relevant time period described in Section 80019.1(q)(1) above, the Department may, according to the provisions in Section 80019.1 et seq., grant or deny the subsequent request for an exemption.

(4) If an individual submits a petition pursuant to Government Code Section 11522 for reinstatement or reduction of penalty for an exclusion, an individual must submit his/her fingerprints through an electronic fingerprinting system approved by the Department and submit to the Department a statement of the reason why the individual should be permitted to work or be present in a facility, along with all information required of an individual requesting a criminal record exemption as provided in Section 80019.1. If it is determined, based upon information provided by the Department of Justice, that the individual has been convicted of a crime for which no exemption may be granted, the petition shall be denied. An individual's failure to submit fingerprints or other information as requested by the Department, shall be grounds for denial of the petition. The burden shall be on the petitioner to prove sufficient rehabilitation and good character to justify the granting of the petition.

(r) A licensee or applicant for a license may request a transfer of a criminal record exemption from one state licensed facility to another by providing the following documents to the Department:

(1) A signed Criminal Record Exemption Transfer Request, LIC 9188 (Rev. 9/03).

(2) A copy of the individual's:

(A) Driver's license, or

(B) Valid identification card issued by the Department of Motor Vehicles, or

(C) Valid photo identification issued by another state or the United States Government if the individual is not a California resident.

(3) Any other documentation required by the Department (e.g., Criminal Record Statement — LIC 508, [Rev.1/03] or for Foster Family Homes, Small Family Homes and Certified Family Homes an LIC 508D [Rev. 1/03] and job description).

(s) The Department may consider factors including, but not limited to, the following in determining whether or not to approve an exemption transfer:

(1) The basis on which the Department granted the exemption;

(2) The nature and frequency of client contact in the new position;

(3) The category of facility where the individual wishes to transfer;

(4) The type of clients in the facility where the individual wishes to transfer;

(5) Whether the exemption was appropriately evaluated and granted in accordance with existing exemption laws or regulations; or

(6) Whether the exemption meets current exemption laws or regulations.

(t) If the Department denies the individual's request to transfer a criminal record exemption, the Department shall provide the individual and the licensee with written notification that states the Department's decision and informs the affected individual of their right to an administrative hearing to contest the Department's decision.

(u) At the Department's discretion, an exemption may be rescinded if it is determined that:

(1) The exemption was granted in error, or

(2) The exemption does not meet current exemption laws or regulations, or

(3) The conviction for which an exemption was granted subsequently becomes non–exemptible by law.

(v) The Department may rescind an individual's criminal record exemption if the Department obtains evidence showing that the individual engaged in conduct that is inconsistent with the good character requirement of a criminal record exemption, as evidenced by factors including, but not limited to, the following:

(1) Violations of licensing laws or regulations;

(2) Any conduct by the individual that indicates that the individual may pose a risk to the health and safety of any individual who is or may be a client;

(3) Nondisclosure of a conviction or evidence of lack of rehabilitation that the individual failed to disclose to the Department, even if it occurred before the exemption was issued; or

(4) The individual is convicted of a subsequent crime.

(w) If the Department rescinds an exemption the Department shall:

(1) Notify the licensee and the affected individual in writing; and

(2) Initiate an administrative action.

(x) If the Department learns that an individual with a criminal record clearance or exemption has been convicted of a subsequent crime, the Department, at its sole discretion, may immediately initiate an administrative action to protect the health and safety of clients.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1522 and 1531, Health and Safety Code; and *Gresher v. Anderson* (2005) 127 Cal. App. 4th. 88.

§ 80019.2. Child Abuse Central Index.

(a) Prior to issuing a license to care for children, the Department shall conduct a Child Abuse Central Index (CACI) review pursuant to Health and Safety Code Section 1522.1 and Penal Code Section 11170(b)(3). The Department shall check the CACI for the applicant(s), and all individuals subject to a criminal record review, pursuant to Health and Safety Code Section 1522(b) and shall approve or deny a facility license, employment, residence or presence in the facility based on the results of the review.

(1) The applicant shall submit the Child Abuse Central Index check (LIC 198A [3/99] which is incorporated by reference, for state licensed facilities and LIC 198 [4/99] which is incorporated by reference, for county licensed facilities) for all individuals required to be checked, directly to the California Department of Justice at the same time that the individual's fingerprints are submitted for a criminal background check as required by Section 80019(c).

(A) Individuals who have submitted the Child Abuse Central Index check (LIC 198A) with fingerprints on or after January 1, 1999 need not submit a new check if the individual can transfer their criminal record clearance or exemption pursuant to Section 80019(e) or Section 80019.1(f).

(2) The Department shall investigate any reports received from the CACI. The investigation shall include, but not be limited to, the review of the investigation report and file prepared by the child protective agency that investigated the child abuse report. The Department shall not deny a license based upon a report form the CACI unless the Department substantiates the allegation of child abuse.

(b) Subsequent to licensure, all individuals subject to a criminal record review, pursuant to Health and Safety Code Section 1522(b), shall complete a Child Abuse Central Index check (LIC 198A [3/99]), prior to employment, residence or initial presence in the facility that cares for children.

(1) The licensee shall submit the Child Abuse Central Index checks (LIC 198A [3/99]), directly to the California Department of Justice at the same time that the individual's fingerprints are submitted for a criminal background check as required by Section 80019(d).

(A) Individuals who have submitted the Child Abuse Central Index check (LIC 198A) with fingerprints on or after January 1, 1999 need not submit a new check if the individual can transfer their criminal record clearance or exemption pursuant to Section 80019(e) or Section 80019.1(f).

(2) The Department shall check the CACI pursuant to Penal Code Section 11170(b)(3), and shall investigate any reports from the CACI. The investigation shall include, but not be limited to, the review of the investigation report and file prepared by the child protective agency that investigated the child abuse report. The Department shall not deny a license or take any other administrative action based upon a report from the CACI unless the Department substantiates the allegation of child abuse.

(3) The Department shall investigate any subsequent reports received from the CACI. The investigation shall include, but not be limited to, the review of the investigation report and file prepared by the child protective agency that investigated the child abuse report. The Department shall not revoke a license or take any other administrative action based upon a report from the CACI unless the Department substantiates the allegation of child abuse.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1521, 1522, 1522.04, 1531 and 14564, Health and Safety Code.

§ 80020. Fire Clearance.

(a) All facilities shall secure and maintain a fire clearance approved by the city or county fire department, the district providing fire protection services, or the State Fire Marshal.

(1) The request for fire clearance shall be made through and maintained by the licensing agency.

(b) The applicant shall notify the licensing agency if the facility plans to admit any of the following categories of clients so that an appropriate fire clearance, approved by the city or county fire department, the district providing fire protection services, or the State Fire Marshal, can be obtained prior to the acceptance of such clients:

(1) Persons 65 years of age and over.

(2) Persons who are nonambulatory, as defined in section 80001(n)(1).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1528 and 1531, Health and Safety Code.

§ 80021. Water Supply Clearance.

(a) All community care facilities where water for human consumption is from a private source shall meet the following requirements:

(1) As a condition of initial licensure, the applicant shall provide evidence of an onsite inspection of the source of the water and a bacteriological analysis which establishes the safety of the water, conducted by the local health department, the State Department of Health Services or a licensed commercial laboratory.

(2) Subsequent to initial licensure, the licensee shall provide evidence of a bacteriological analysis of the private water supply as frequently as is necessary to ensure the safety of the clients, but no less frequently than specified in the following table:

Licensed Capacity	*Analysis Required*	*Periodic Subsequent Analysis*
6 or fewer	Initial licensing	Not required unless evidence supports the need for such analysis to protect clients
7 through 15	Initial licensing	Annually
16 through 24	Initial licensing	Semiannually
25 or more	Initial licensing	Quarterly

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1528 and 1531, Health and Safety Code.

§ 80022. Plan of Operation.

(a) Each licensee shall have and maintain on file a current, written, definitive plan of operation.

(b) The plan and related materials shall contain the following:

(1) Statement of purposes, and program methods and goals.

(2) Statement of admission policies and procedures regarding acceptance of clients.

(3) A copy of the admission agreement.

(4) Administrative organization, if applicable.

(5) Staffing plan, qualifications and duties, if applicable.

(6) Plan for inservice education of staff if required by regulations governing the specific facility category.

(7) A sketch of the building(s) to be occupied, including a floor plan which describes the capacities of the buildings for the uses intended, room dimensions, and a designation of the rooms to be used for nonambulatory clients, if any.

(8) A sketch of the grounds showing buildings, driveways, fences, storage areas, pools, gardens, recreation areas and other space used by the clients.

(A) The sketch shall include the dimensions of all areas which will be used by the clients.

(9) Sample menus and a schedule for one calendar week indicating the time of day that meals and snacks are to be served.

(10) Transportation arrangements for clients who do not have independent arrangements.

(11) Rate setting policy including, but not limited to, policy on refunds.

(12) A statement whether or not the licensee will handle the clients' money, personal property, and/or valuables. If money, personal property, and/or valuables will be handled, the method for safeguarding shall ensure compliance with Sections 80025 and 80026.

(13) Consultant and community resources to be utilized by the facility as part of its program.

(14) A statement of the facility's policy concerning family visits and other communications with the client pursuant to Health and Safety Code Section 1512.

(c) If the licensee of an ARF, group home (GH), small family home (SFH), foster family home (FFH) or certified family home (CFH) certified by a foster family agency (FFA) plans to use delayed egress devices as specified in Health and Safety Code Section 1531.1(d), the plan must meet the requirements of Health and Safety Code Sections 1531.1(g) and (h).

(d) If the licensee intends to admit or care for one or more clients who have a restricted health condition specified in Section 80092, the facility policies/and a program description shall be included. At a minimum, the information related to those clients and their needs shall specify all of the following:

(1) The type of restricted health condition that the licensee plans to admit.

(2) The licensee's plans for serving that client.

(A) If the licensee plans to admit or care for one or more clients who have a staph or other serious, communicable infection, the plan must include:

1. A statement that all staff will receive training in universal precautions within the first 10 days of employment, and before providing care to these clients.

2. A statement of how the licensee will ensure that the training is obtained, and the name and qualifications of the person or organization that will provide the training.

(3) The services that will be provided.

(4) Staffing adjustments if needed in order to provide the proposed services.

(A) This may include increased staffing, hiring staff with additional or different qualifications, utilizing licensed professionals as consultants, or hiring licensed professionals.

(e) If the licensee intends to admit or care for one or more clients who rely upon others to perform all activities of daily living, the plan of operation must also include a statement that demonstrates the

licensee's ability to care for these clients. The evidence of ability may include, but not be limited to:

(1) The licensee's experience in providing care to these clients.

(2) The licensee's experience providing care to a family member with this condition.

(3) The licensee's plan to hire staff who have experience providing care to these clients, and documentation of what the staff person's experience has been.

(4) Documentation of training the licensee and/or staff have completed specific to the needs of these clients.

(5) History of continued placements by a Regional Center.

(f) If the licensee intends to admit and/or specialize in care for one or more clients who has a propensity for behaviors that result in harm to self or others, the facility plan of operation shall include a description of precautions that will be taken to protect that client and all other clients.

(g) Any changes in the plan of operation which affect the services to clients shall be subject to licensing agency approval and shall be reported as specified in Section 80061.

(h) The facility shall operate in accordance with the terms specified in the Plan of Operation and may be cited for not doing so.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1512, 1520, 1528, 1531 and 1531.1, Health and Safety Code.

§ 80023. Disaster and Mass Casualty Plan.

(a) Each licensee shall have and maintain on file a current, written disaster and mass casualty plan of action.

(b) The plan shall be subject to review by the licensing agency and shall include:

(1) Designation of administrative authority and staff assignments.

(2) Contingency plans for action during fires, floods, and earthquakes, including but not limited to the following:

(A) Means of exiting.

(B) Transportation arrangements.

(C) Relocation sites which are equipped to provide safe temporary accommodation for clients.

(D) Arrangements for supervision of clients during evacuation or relocation, and for contact after relocation to ensure that relocation has been completed as planned.

(E) Means of contacting local agencies, including but not limited to the fire department, law enforcement agencies, and civil defense and other disaster authorities.

(c) The licensee shall instruct all clients, age and abilities permitting, all staff, and/or members of the household in their duties and responsibilities under the plan.

(d) Disaster drills shall be conducted at least every six months.

(1) Completion of such drills shall not require travel away from the facility grounds or contact with local disaster agencies.

(2) The drills shall be documented and the documentation maintained in the facility for at least one year.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1528 and 1531, Health and Safety Code.

§ 80024. Waivers and Exceptions.

(a) Unless prior written licensing agency approval is received as specified in (b) below, all licensees shall maintain continuous compliance with the licensing regulations.

(b) The licensing agency shall have the authority to approve the use of alternate concepts, programs, services, procedures, techniques, equipment, space, personnel qualifications or staffing ratios, or the contact of experimental or demonstration projects under the following circumstances:

(1) Such alternatives shall be carried out with provisions for safe and adequate services, and shall in no instance be detrimental to the health and safety of any facility client.

(2) The applicant or licensee shall submit to the licensing agency a written request for a waiver or exception, together with substantiating evidence supporting the request.

(3) (See Manual of Policies and Procedures)

(4) The licensing agency shall provide written approval or denial of the request.

(c) Within 30 days of receipt of a request for a waiver or an exception, the licensing agency shall notify the applicant or licensee, in writing, of one of the following:

(1) The request with substantiating evidence has been received and accepted for consideration.

(2) The request is deficient, describing additional information required for the request to be acceptable and a time frame for submitting this information.

(A) Failure of the applicant or licensee to comply within the time specified in (2) above shall result in denial of the request.

(d) Within 30 days of receipt of an acceptable request for a waiver or an exception, the licensing agency shall notify the applicant or licensee, in writing, whether the request has been approved or denied.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1509 and 1531, Health and Safety Code; and Section 15376, Government Code.

§ 80025. Bonding.

(a) The licensee shall submit an affidavit, on a form provided by the licensing agency, stating whether he/she safeguards or will safeguard cash resources of clients and the maximum amount of cash resources to be safeguarded for all clients or each client in any month.

(b) All licensees, other than governmental entities, who are entrusted to care for and control clients' cash resources shall file or have on file with the licensing agency, a bond issued by a surety company to the State of California as principal.

(c) The amount of the bond shall be according to the following schedule:

Amount Safeguarded Per Month	*Bond Required*
$750 or less	$1,000
$751 to $1,500	$2,000
$1,501 to $2,500	$3,000

Every further increment of $1,000 or fraction thereof shall require an additional $1,000 on the bond.

(d) The licensee shall submit a new affidavit and bond to the licensing agency prior to the licensee safeguarding amounts of clients' cash resources in excess of the current bond.

(e) Whenever the licensing agency determines that the amount of the bond is insufficient to provide necessary protection of clients' cash resources, or whenever the amount of any bond is impaired by any recovery against the bond, the licensing agency shall have the authority to require the licensee to file an additional bond in such amount as the licensing agency determines to be necessary to protect the clients' cash resources.

(f) The provisions of this section shall not apply if the licensee meets the requirements specified in Section 1560 of the Health and Safety Code.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1560 and 1561, Health and Safety Code.

§ 80026. Safeguards for Cash Resources, Personal Property, and Valuables.

(a) A licensee shall not be required to accept for admission or continue to care for any client whose incapacities, as documented by the initial or subsequent needs appraisals, would require the licensee to handle such client's cash resources.

(b) If such a client is accepted for or maintained in care, his/her cash resources, personal property, and valuables not handled by a person outside the facility who has been designated by the client or his/her authorized representative shall be handled by the licensee or facility staff, and shall be safeguarded in accordance with the requirements specified in (c) through (n) below.

(c) Except where provided for in approved continuing care agreements, no licensee or employee of a licensee shall:

(1) accept appointment as a guardian or conservator of the person and/or estate of any client;

(2) accept any general or special power of attorney except for Medi–Cal or Medicare claims for any client;

(3) become the substitute payee for any payments made to any client.

(A) This requirement does not apply to a licensee who is appointed by the Social Security Administration as representative payee for the client.

(4) become the joint tenant on any account specified in Section 80026(i) with a resident.

(d) Cash resources, personal property, and valuables of clients handled by the licensee shall be free from any liability the licensee incurs.

(e) Cash resources, personal property, and valuables of clients shall be separate and intact, and shall not be commingled with facility funds or petty cash.

(1) The above requirement shall not prohibit the licensee from providing advances or loans to clients from facility funds.

(A) Documentation of such transactions shall be maintained in the facility.

(f) The licensee or employee of a licensee shall not make expenditures from clients' cash resources for any basic services specified in these regulations, or for any basic services identified in a contract/admission agreement between the client and the licensee.

(1) This requirement does not apply to a licensee who is appointed by the Social Security Administration as representative payee for the clients.

(g) The licensee shall not commingle cash resources and valuables of clients with those of another community care facility of a different license number regardless of joint ownership.

(h) Each licensee shall maintain accurate records of accounts of cash resources, personal property, and valuables entrusted to his/her care, including, but not limited to the following:

(1) Records of clients' cash resources maintained as a drawing account, which shall include a current ledger accounting, with columns for income, disbursements and balance, for each client. Supporting receipts for purchases shall be filed in chronological order.

(A) Receipts for cash provided to any client from his/her account(s) shall include the client's full signature or mark, or authorized representative's full signature or mark, and a statement acknowledging receipt of the amount and date received, as follows:

"(full signature of client) accepts (dollar amount) (amount written cursive), this date (date), from (payor)."

(B) The store receipt shall constitute the receipt for purchases made for the client from his/her account.

(C) The original receipt for cash resources, personal property or valuables entrusted to the licensee shall be provided to the client's authorized representative, if any, otherwise to the client.

(2) Bank records for transactions of cash resources deposited in and drawn from the account specified in (i) below.

(i) Immediately upon admission of a client, all of his/her cash resources entrusted to the licensee and not kept in the licensed facility shall be deposited in any type of bank, savings and loan, or credit union account meeting the following requirements:

(1) The account shall be maintained as a trust account separate from the personal or business accounts of the licensee.

(2) The account title shall clearly note that the account contains client cash resources.

(3) The licensee shall provide access to the cash resources upon demand by the client or his/her authorized representative.

(4) The account shall be maintained in a local bank, savings and loan or credit union authorized to do business in California, the deposits of which are insured by a branch of the Federal Government.

(A) A local public agency shall have the authority to deposit such cash resources with the public treasurer.

(j) Cash resources entrusted to the licensee and kept on the facility premises, shall be kept in a locked and secure location.

(k) Upon discharge of a client, all cash resources, personal property, and valuables of that client which have been entrusted to the licensee shall be surrendered to the client, or his/her authorized representative, if any.

(1) The licensee shall obtain and retain a receipt signed by the client or his/her authorized representative.

(*l*) Upon the death of a client, all cash resources, personal property and valuables of that client shall immediately be safeguarded in accordance with the following requirements:

(1) All cash resources shall be placed in an account as specified in (i) above.

(2) The executor or the administrator of the estate shall be notified by the licensee of the client's death, and the cash resources, personal property, and valuables shall be surrendered to said party in exchange for a signed, itemized receipt.

(3) If no executor or administrator has been appointed, the authorized representative, if any, shall be notified by the licensee of the client's death, and the cash resources, personal property, and valuables shall be surrendered to said person in exchange for a signed, itemized receipt.

(4) If the licensee is unable to notify a responsible party as specified in (2) or (3) above, the licensee shall give immediate written notice of the client's death to the public administrator of the county as provided in Section 7600.5 of the California Probate Code.

(m) The following requirements shall be met whenever there is a proposed change of licensee:

(1) The licensee shall notify the licensing agency of any pending change of licensee, and shall provide the licensing agency an accounting of each client's cash resources, personal property and valuables entrusted to his/her care.

(A) Such accounting shall be made on form provided or approved by the licensing agency.

(2) Provided the licensing agency approves the application for the new licensee, the form specified in (1)(A) above shall be updated, signed by both the former and new licensee, and forwarded to the licensing agency.

(n) The licensee shall maintain a record of all monetary gifts and of any other gift exceeding an estimated value of $100, provided by or on behalf of a client to the licensee, administrator or staff.

(1) The record shall be attached to the account(s) specified in (h) above if the client's cash resources, personal property or valuables have been entrusted to the licensee.

(2) Monetary gifts or valuables given by the friends or relatives of a deceased client shall not be subject to the requirement specified in (n) and (n)(1) above.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1531 and 1560, Health and Safety Code; and 20 CFR 416.601.

§ 80027. Initial Application Review.

(a) Within 90 days of receipt of the application by the licensing agency, the licensing agency shall give written notice to the applicant of one of the following:

(1) The application is complete.

(2) The application is deficient, describing what documents are outstanding and/or inadequate, and informing the applicant that the information must be submitted within 30 days of the date of the notice.

(A) If the applicant does not submit the required information within the 30 days, the application shall be deemed withdrawn unless either the licensing agency has denied the application or the facility is under construction.

(b) The licensing agency shall cease review of any application under the conditions specified in Section 1520.3 of the Health and Safety Code.

(1) If cessation of review occurs, the application shall be returned to the applicant. It shall be the responsibility of the applicant to request resumption of review as specified in Health and Safety Code Section 1520.3.

(c) The circumstances and conditions in which the licensing agency may continue to review a previously denied application shall include, but are not limited to, the following:

(1) A fire clearance previously denied, but now approved;

(2) An Administrator who did not meet the minimum qualifications, but now fulfills the qualifications; or

(3) A person with a criminal record, which was the basis for license denial, is no longer associated with the facility.

(d) The application review shall not constitute approval of the application.

(f) The application fees shall be nonrefundable as specified in Section 80036(d).

NOTE: Authority cited: Sections 1524 and 1530, Health and Safety Code. Reference: Sections 1520 1520.3, 1522.1, 1523.1 and 1524, Health and Safety Code; and Section 15736, Government Code.

§ 80028. Capacity Determination.

(a) A license shall be issued for a specific capacity.

(b) The number of persons for whom the facility is licensed to provide care and supervision shall be determined on the basis of the application review by the licensing agency, which shall take into consideration the following:

(1) The fire clearance specified in Section 80020.

(2) The licensee's/administrator's ability to comply with applicable law and regulation.

(3) Any other household members, including but not limited to persons under guardianship or conservatorship, who reside at the facility and their individual needs.

(4) Facilities which accept minor parents and his/her child(ren) shall have such children included in the facility's licensed capacity.

(5) Physical features of the facility, including available living space, which are necessary in order to comply with regulations.

(6) Number of available staff to meet the care and supervision needs of the clients.

(7) Any restrictions pertaining to the specific category of facility.

(c) The licensing agency shall be authorized to issue a license for fewer clients than is requested when the licensing agency determines that:

(1) The licensee's responsibilities to other persons in the home, including persons under guardianship and conservatorship, would preclude provision of the care required by these regulations.

(d) When the license is issued for fewer clients than requested, the licensee shall be notified in writing of the reasons for the limitation and of the licensee's rights to appeal the decision as specified in Section 80040.

(e) The licensing agency shall have the authority to decrease existing licensed capacity with the licensee's agreement, when there is a change in any of the factors specified in (b) above.

(1) If the licensee does not agree to the decrease in capacity, the licensing agency shall have the authority to initiate revocation action as specified in Section 80042.

(f) The licensing agency shall be authorized to restrict care to specific individuals.

(1) If care and supervision is limited to specific individuals, the licensing agency shall specify the names of the individuals in a letter to the licensee.

(2) Except where the limitation is requested by the licensee, the licensee shall be notified in writing of the reasons for such limitation and of the licensee's right to appeal the decision as specified in Section 80040.

NOTE: Authority cited: Section 1530, Health and Safety Code; and Section 10554, Welfare and Institutions Code. Reference: Section 11465, Welfare and Institutions Code; and Sections 1501, 1523, 1524, 1528 and 1531, Health and Safety Code.

§ 80029. Withdrawal of Application.

(a) An applicant shall have the right to withdraw an application.

(1) Such withdrawal shall be in writing.

(2) The fee for processing the application shall be forfeited.

NOTE: Authority cited: Sections 1530 and 1553, Health and Safety Code. Reference: Sections 1520, 1523.1, 1524 and 1553, Health and Safety Code.

§ 80030. Provisional License.

(a) The licensing agency shall have the authority to issue a provisional license to an applicant, pending action under Sections 80031 or 80040 on a completed application for an initial license, if it determines that all of the following circumstances exist:

(1) The facility is in substantial compliance with applicable law and regulation.

(2) An urgent need for licensure exists.

(3) A corporate applicant's board of directors, executive director and officer are eligible for licensure as specified in Health and Safety Code Section 1520.11(b).

(b) The capacity of a provisional license shall be limited to the number of clients for whom urgent need has been established, or the capacity established for the specific facility, whichever is less.

(c) The licensing agency shall have the authority to issue a provisional license for a maximum of six months when it determines that full com-
pliance with licensing regulations will be achieved within that time period.

(d) The licensing agency shall have the authority to issue a provisional license for a maximum of 12 months when it determines, at the time of application, that more than six months is required to achieve full compliance with licensing regulations due to circumstances beyond the control of the applicant.

(e) If, during the provisional license period, the licensing agency discovers any serious deficiencies, the Department shall have the authority to institute administrative action or civil proceedings, or to refer the case for criminal prosecution.

(f) A provisional license shall not be renewable and shall terminate on the date specified on the license, or upon denial of the application, whichever is earlier.

NOTE: Authority cited: Sections 1523, 1530 and 1553, Health and Safety Code. Reference: Sections 1520, 1520.11, 1523, 1524, 1525.5, 1528 and 1553, Health and Safety Code.

§ 80031. Issuance of License.

(a) Within 90 days of the date that a completed application, as defined in Section 80001c.(8), has been received, the licensing agency shall give written notice to the applicant of one of the following:

(1) The application has been approved.

(2) The application has been denied.

(A) The notice of denial shall include the information specified in Section 80040.

(b) The licensing agency shall notify the applicant, in writing, of the issuance of the license.

(1) Issuance of the license itself shall constitute written notification of license approval.

(c) No limitation shall be imposed on the licensee or printed on the license solely on the basis that a licensee is a parent who has administered or will continue to administer corporal punishment, not constituting child abuse as defined in Section 11165, subdivision (g) of the Penal Code, or Section 1531.5(c) of the Health and Safety Code, on his/her own child(ren).

(d) The licensing agency's completed review of an application for the two years immediately preceding this regulation has been approximately:

(1) A minimum of 30 days.

(2) A median of 90 days.

(3) A maximum of 180 days.

NOTE: Authority cited: Sections 1530 and 1553, Health and Safety Code. Reference: Sections 1509, 1520, 1520.5, 1525, 1526, 1531.5 and 1553, Health and Safety Code; and Section 15376, Government Code.

§ 80032. Term of an Initial or Renewal License.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1524, 1525 and 1529, Health and Safety Code.

§ 80033. Application for Renewal of a License.

NOTE: Authority cited: Sections 1523 and 1530, Health and Safety Code. Reference: Sections 1520, 1523, 1524, 1525 and 1528, Health and Safety Code.

§ 80034. Submission of New Application.

(a) A licensee shall file a new application as required by Section 80018 whenever there is a change in conditions or limitations described on the current license, or other changes including but not limited to the following:

(1) Any change in the location of the facility.

(2) Any change of licensee, including but not limited to the following when the licensee is a corporation.

(A) Sale or transfer of the majority of stock.

(B) Separating from a parent company.

(C) Merger with another company.

(3) Any change in facility category.

(4) Any increase in capacity.

(A) The licensing agency shall have the authority to grant capacity increases without resubmission of an application following a licensing agency review and the securing of an appropriate fire clearance.

(5) A permanent change in any client from ambulatory to nonambulatory status.

(b) A new application as required by Section 80018 shall be filed whenever an applicant fails to complete a new application within the time limit required by Section 80027(a) if the applicant chooses to continue the application process.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1523.1 and 1531, Health and Safety Code.

§ 80035. Conditions for Forfeiture of a Community Care Facility License.

(a) Conditions for forfeiture of a community care facility license may be found in Section 1524 of the Health and Safety Code.

(1) "Licensee abandons the facility" shall mean either of the following:

(A) The licensee informs the licensing agency that the licensee no longer accepts responsibility for the facility, or

(B) The licensing agency is unable to determine the licensee's whereabouts after the following:

1. The licensing agency requests information of the licensee's whereabouts from the facility's staff if any staff can be contacted; and

2. The licensing agency has made at least one (1) phone call per day, to the licensee's last telephone number of record, for five (5) consecutive workdays with no response; and

3. The licensing agency has sent a certified letter, requesting the licensee to contact the licensing agency, to the licensee's last mailing address of record with no response within seven (7) calendar days.

(b) If the facility licensee dies, an adult relative who has control of the property shall be permitted to operate a previously licensed facility under an Emergency Approval to Operate (LIC 9117 4/93) (EAO) providing the following conditions are met:

(1) The relative or an adult acting on the relative's behalf notifies the Department by telephone during the first working day after the licensee's death that the relative intends to operate the community care facility.

(2) The relative files with the Department within five days of the licensee's death an Application for License (LIC 200 7/91) and evidence of the licensee's death as defined in Section 80001(e)(4).

(A) Notwithstanding the instructions on the Application for License (LIC 200 7/91), the Department shall permit the relative to submit only the information on the front side of that form.

(3) The relative files with the California Department of Justice within five calendar days of the licensee's death his/her fingerprint cards.

(c) If the adult relative complies with (b)(1) and (2) above, he/she shall not be considered to be operating an unlicensed facility pending the Department's decision on whether to approve a provisional license.

(d) The Department shall make a decision within 60 days after the application is submitted on whether to issue a provisional license pursuant to Section 80030.

(1) A provisional license shall be granted only if the Department is satisfied that the conditions specified in (b) above and Section 80030 have been met and that the health and safety of the residents of the facility will not be jeopardized.

NOTE: Authority cited: Sections 1524(e) and 1530, Health and Safety Code. Reference: Sections 1524 and 1524(e), Health and Safety Code.

§ 80036. Licensing Fees.

(a) An applicant or a licensee shall be charged fees as specified in Health and safety Code Section 1523.1.

(b) An additional fee shall be charged when the licensee requests an increase or decrease in capacity as specified in Health and Safety Code Section 1523.1(b)(1)(C).

(c) When a licensee moves a facility from one location to another, the relocation fee shall be as specified in Health and Safety Code Section 1523.1(b)(1)(A).

(1) To qualify for the relocation fee the following shall apply:

(A) The licensee shall have notified the licensing agency before actually relocating the facility.

(B) The categorical type of facility shall remain the same when relocating the facility.

(C) The fee shall be by requested capacity at the new location.

(d) The fees shall be nonrefundable.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1523.1 and 1524, Health and Safety Code.

Article 4. Administrative Actions

§ 80040. Denial of Initial License.

(a) Except as specified in Section 80030, which provides for issuance of a provisional license based upon substantial compliance and urgent need, the licensing agency shall deny an application for an initial license if it is determined that the applicant is not in compliance with applicable law and regulation.

(1) The licensing agency shall have the authority to deny an application for an initial license if the applicant has failed to pay any civil penalty assessments pursuant to Section 80058 and in accordance with a final judgment issued by a court of competent jurisdiction, unless payment arrangements acceptable to the licensing agency have been made.

(2) An application for initial licensure shall not be denied solely on the basis that the applicant is a parent who has administered or will continue to administer corporal punishment, not constituting child abuse as defined in Section 11165, subdivision (g) of the Penal Code, or Section 1531.5(c) of the Health and Safety Code, on his/her own child(ren).

(3) An application for licensure shall be denied as specified in Health and Safety Code Sections 1520.11(b), (d) and 1550.

(b) If the application for an initial license is denied, the licensing agency shall mail the applicant a written notice of denial.

(1) The notification shall inform the applicant of and set forth the reasons for the denial, and shall advise the applicant of the right to appeal.

(c) If the application for an initial license is denied, the application processing fee shall be forfeited.

(d) An applicant shall have the right to appeal the denial of the application pursuant to Health and Safety Code Section 1526.

(e) Notwithstanding any appeal action, the facility is unlicensed and shall not operate pending adoption by the director of a decision on the denial action.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1520, 1520.11, 1525, 1526, 1528, 1547 and 1548, Health and Safety Code.

§ 80041. Denial of a Renewal License.

NOTE: Authority cited: Sections 1523 and 1530, Health and Safety Code. Reference: Sections 1520, 1523, 1524, 1525, 1526 and 1528, Health and Safety Code.

§ 80042. Revocation or Suspension of License.

(a) The Department shall have the authority to suspend or revoke any license on any of the grounds specified in Health and Safety Code Sections 1550 and 1550.5.

(b) Proceedings to hear a revocation action or a revocation and temporary suspension action shall be conducted pursuant to the provisions of Health and Safety Code Section 1551.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1550, 1550.5 and 1551, Health and Safety Code.

§ 80043. Licensee/Applicant Complaints.

(See Manual of Policies and Procedures)

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80044. Inspection Authority of the Licensing Agency.

(a) The licensing agency shall have the inspection authority specified in Health and Safety Code Sections 1526.5, 1533, 1534 and 1538.

(b) The licensing agency shall have the authority to interview clients, including children, or staff members without prior consent.

(1) The licensee shall ensure that provisions are made for private interviews with any clients, including children, or any staff members.

(c) The licensing agency shall have the authority to inspect, audit, and copy client or facility records upon demand during normal business hours. Records may be removed if necessary for copying. Removal of records shall be subject to the requirements specified in Sections 80066(c) and 80070(d).

(1) The licensee shall ensure that provisions are made for the examination of all records relating to the operation of the facility.

(d) The licensing agency shall have the authority to observe the physical condition of the client, including conditions that could indicate abuse, neglect, or inappropriate placement, and to have a licensed medical professional physically examine the client.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1526.5, 1531, 1533, 1534 and 1538, Health and Safety Code.

§ 80045. Evaluation Visits.

(a) Community care facilities shall be evaluated as specified in Health and Safety Code sections 1534 and 1548.

(b) The licensing agency shall have the authority to make any number of other visits to a facility in order to determine compliance with applicable law and regulation.

NOTE: Authority cited: Sections 1530 and 1548, Health and Safety Code. Reference: Sections 1533, 1534, 1538 and 1548, Health and Safety Code.

§ 80046. Exclusions.

(a) An individual can be prohibited from serving as a member of a board of directors, executive director, or officer; from being employed or allowing an individual in a licensed facility as specified in Health and Safety Code Sections 1558 and 1558.1.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1558 and 1558.1, Health and Safety Code.

§ 80051. Serious Deficiencies.

(See Manual of Policies and Procedures)

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1531 and 1534, Health and Safety Code.

§ 80052. Deficiencies in Compliance.

(a) When a licensing evaluation is conducted and the evaluator determines that a deficiency exists the evaluator shall issue a notice of deficiency, unless the deficiency is not serious and is corrected during the visit.

(b) Prior to completion of an evaluation or other licensing visit, the licensee, administrator, operator, or other person in charge of the facility shall meet with the evaluator to discuss any deficiencies noted, to jointly develop a plan for correcting each deficiency, and to acknowledge receipt of the notice of deficiency.

(c) The evaluator shall provide notice of deficiency to the licensee by one of the following:

(1) Personal delivery to the licensee, at the completion of the visit.

(2) If the licensee is not at the facility site, leaving the notice with the person in charge of the facility at the completion of the visit.

(A) Under such circumstances, a copy of the notice shall also be mailed to the licensee.

(3) If the licensee or the person in charge of the facility refuses to accept the notice a notation of the refusal shall be written on the notice and a copy left at the facility.

(A) Under such circumstances, a copy of the notice shall also be mailed to the licensee.

(d) The notice of deficiency shall be in writing and shall include the following:

(1) Citation of the statute or regulation which has been violated.

(2) A description of the nature of the deficiency stating the manner in which the licensee failed to comply with a specified statute or regulation, and the particular place or area of the facility in which it occurred.

(3) The plan developed, as specified in (b) above, for correcting each deficiency.

(4) A date by which each deficiency shall be corrected.

(A) In determining the date for correcting a deficiency, the evaluator shall consider the following factors:

1. The potential hazard presented by the deficiency.

2. The number of clients affected.

3. The availability of equipment or personnel necessary to correct the deficiency.

4. The estimated time necessary for delivery, and for any installation, of necessary equipment.

(B) The date for correcting a deficiency shall not be more than 30 calendar days following service of the notice of deficiency, unless the evaluator determines that the deficiency cannot be completely corrected in 30 calendar days.

(C) If the date for correcting the deficiency is more than 30 calendar days following service of the notice of deficiency, the notice shall specify the corrective actions which must be taken within 30 calendar days to begin correction.

(D) The evaluator shall require correction of the deficiency within 24 hours and shall specify on the notice the date by which the correction must be made whenever penalties are assessed pursuant to sections 80054(c), (d) and (e).

(5) The amount of penalty being assessed and the date the penalty begins.

(6) The address and telephone number of the licensing office responsible for reviewing notices of deficiencies for the area in which the facility is located.

NOTE: Authority cited: Sections 1530 and 1548, Health and Safety Code. Reference: Sections 1534 and 1548, Health and Safety Code.

§ 80053. Follow–Up Visits to Determine Compliance.

(a) A follow–up visit shall be conducted to determine compliance with the plan of correction specified in the notice of deficiency.

(1) At a minimum, a follow–up visit shall be conducted within ten working days following the dates of corrections specified in the notice of deficiency, unless the licensee has demonstrated that the deficiency was corrected as required.

(2) No penalty shall be assessed unless a follow–up visit is conducted as specified in (a) and (a)(1) above.

(b) If a follow–up visit indicates that a deficiency was not corrected on or before the date specified in the notice of deficiency, the evaluator shall issue a notice of penalty.

(c) A notice of penalty shall be in writing and shall include:

(1) The amount of penalty assessed, and the date the payment is due.

(2) The name and address of the agency responsible for collection of the penalty.

(d) When an immediate penalty has been assessed pursuant to sections 80054(c), (d), (e) and (f) and correction is made when the evaluator is present, a follow–up visit is not required.

NOTE: Authority cited: Sections 1530 and 1548, Health and Safety Code. Reference: Sections 1533, 1534 and 1548, Health and Safety Code.

§ 80054. Penalties.

(a) A penalty of $50 per day, per cited violation, shall be assessed for serious deficiencies that are not corrected by the date specified in the notice of deficiency, up to a maximum of $150 per day.

(b) Notwithstanding Section 80054(a) above, an immediate penalty of $100 per cited violation per day for a maximum of five (5) days shall be assessed if any individual required to be fingerprinted under Health and Safety Code Section 1522(b) has not obtained a California clearance or a criminal record exemption, requested a transfer of a criminal record clearance or requested and be approved for a transfer of an exemption as specified in Section 80019(e) prior to working, residing or volunteering in the facility.

(1) Subsequent violations within a twelve (12) month period will result in a civil penalty of one hundred dollars ($100) per violation per day for a maximum of thirty (30) days.

(2) The Department may assess civil penalties for continued violations as permitted by Health and Safety Code Section 1548.

(3) Progressive civil penalties specified in Sections 80054(d) and (e) below shall not apply.

(c) Notwithstanding Section 80054(a) above, an immediate penalty of $150 per day shall be assessed for any of the following:

(1) Sickness, injury or death of a client has occurred as a result of the deficiency.

(d) When a facility is cited for a deficiency and violates the same regulation subsection within a 12–month period, the facility shall be cited and an immediate penalty assessment of $150 per cited violation shall be assessed for one day only. Thereafter a penalty of $50 per day, per cited violation, shall be assessed until the deficiency is corrected.

(e) When a facility, that was cited for a deficiency subject to the immediate penalty assessment in Section 80054(d) above, violates the same regulation subsection within a 12–month period of the last violation, the facility shall be cited and an immediate penalty of $150 per cited violation shall be assessed for one day only. Thereafter, a penalty of $150 per day, per cited violation, shall be assessed until the deficiency is corrected.

(1) For purposes of Sections 80054 (d) and (e) above, a regulation subsection is the regulation denoted by a lower–case letter after the main regulation number.

(f) If any deficiency is not corrected by the date specified in the notice of deficiency, a penalty shall be assessed for each day following that date until compliance has been demonstrated.

(1) Immediate penalty assessment as specified in (c), (d) and (e) above, shall begin on the day the deficiency is cited.

(g) If a licensee or his/her representative reports to the licensing agency that a deficiency has been corrected, the penalty shall cease as of the day the licensing agency receives notification that the correction was made.

(1) If the deficiency has not been corrected, civil penalties shall continue to accrue from the date of the original citation.

(2) If it can be verified that the correction was made prior to the date of notification, the penalty shall cease as of that earlier date.

(h) If necessary, a site visit shall be made immediately or within five working days to confirm deficiency has been corrected.

(i) If an immediate civil penalty is assessed, and the deficiency is corrected on the same day, the penalty shall still be assessed for that day.

(j) Unless otherwise ordered by the Department all penalties are due and payable upon receipt of notice for payment, and shall be paid only by check or money order made payable to the agency indicated in the notice.

(k) The licensing agency shall have the authority to file a claim in a court of competent jurisdiction or to take other appropriate action for failure to pay penalties as specified in (j) above.

NOTE: Authority cited: Sections 1530 and 1548, Health and Safety Code. Reference: Sections 1522, 1534 and 1548, Health and Safety Code.

§ 80055. Administrative Review.

(a) A licensee or his/her representative shall have the right to request a review of a notice of deficiency and/or notice of penalty within 10 working days of receipt of such notice(s).

(1) If the deficiency has not been corrected, civil penalties shall continue to accrue during the review process.

(b) The review shall be conducted by a higher level staff person than the evaluator who issued the notice(s).

(c) If the reviewer determines that a notice of deficiency or notice of penalty was not issued or assessed in accordance with applicable statutes and regulations of the Department, or that other circumstances existed, he/she shall have the authority to amend or dismiss the notice.

(d) The reviewer shall have the authority to extend the date specified for correction of a deficiency if warranted by the facts or circumstances presented to support a request for extension.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1534, Health and Safety Code.

§ 80055.1. Denial or Revocation of License for Failure to Pay Civil Penalties.

(a) The licensee shall be responsible for paying civil penalties.

(1) Unless otherwise provided, the transfer, surrender, forfeiture or revocation of a license shall not affect the licensee's responsibility for paying any civil penalties accrued while the license was in effect.

(b) The Department shall have the authority to deny or revoke any license for failure to pay civil penalty assessments.

(1) The Department shall have the authority to approve payment arrangements acceptable to the Department.

(2) The Department shall have the authority to approve the form of payment.

(3) The licensee's failure to pay civil penalty assessments pursuant to a payment plan approved by the Department may result in the denial or revocation of any license, and/or any other appropriate action.

(c) Any denial or revocation of the license for failure to pay civil penalties may be appealed as provided by Health and Safety Code Section 1551.

NOTE: Authority cited: Sections 1530 and 1548, Health and Safety Code. Reference: Sections 1522, 1534, 1548 and 1551, Health and Safety Code.

§ 80056. Exemption from Civil Penalties.

(a) Civil penalties shall not be assessed against any governmental entity, including a state, or city, holding a community care facility license.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1534, Health and Safety Code.

§ 80058. Unlicensed Facility Penalties.

(a) A penalty of $200 per day shall he assessed for the operation of an unlicensed facility under either of the following conditions:

(1) The operator has not submitted a completed application for licensure within 15 calendar days of issuance of the Notice of Operation in Violation of Law pursuant to Section 80006, and continues to operate.

(A) For purposes of this section, an application shall be deemed completed if it includes the information required in Section 80018.

(B) The completed application shall be deemed to be submitted when received by the licensing agency.

(2) Unlicensed operation continues after denial of the initial application.

(A) Notwithstanding any appeal action, facility operation must cease within 10 calendar days of the mailing of the notice of denial or upon receipt of the denial notice by the operator, whichever occurs first.

(b) The $200 per day penalty shall be assessed for the continued operation of an unlicensed facility as follows:

(1) On the 16th calendar day after the operator has been issued the Notice of Operation in Violation of Law, and has not submitted a completed application as required.

(A) The $200 per day penalty shall continue until the operator ceases operation, or submits a completed application pursuant to Sections 80058(a) (1)(A) and (B).

(2) Within 10 calendar days of the mailing of the notice of denial or upon receipt of the denial notice by the operator, whichever occurs first.

(A) The $200 per day penalty shall continue until the operator ceases operation.

(c) If the unlicensed operator or his/her representative reports to the licensing agency that unlicensed operation, as defined in Section 1503.5 of the Health and Safety Code, has ceased, the penalty shall cease as of the day the licensing agency receives the notification.

(1) A site visit shall be made immediately or within five working days to verify that the unlicensed facility operation has ceased.

(2) Notwithstanding (c) above, if the unlicensed facility operation has not ceased, penalties shall continue to accrue without interruption from the date of initial penalty assessment.

(d) All penalties shall be due and payable upon receipt of the Notice for Payment from the licensing agency, and shall be paid by check or money order made payable to the agency indicated in the notice.

(e) The licensing agency shall have the authority to file a claim in a court of competent jurisdiction or to take other appropriate action for failure to pay penalties as specified in (d) above.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1503.5, 1508, 1520, 1533, 1538, 1540, 1540.1, 1541, 1547 and 1549, Health and Safety Code.

§ 80059. Unlicensed Facility Administrative Appeal.

(a) An unlicensed facility operator or his/her representative shall have the right to appeal the penalty assessment within 10 working days after service of the penalty assessment.

(1) If the unlicensed facility operation has not ceased, the $200 per day penalty shall continue to accrue during the appeal process.

(b) The appeal review shall be conducted by a higher level staff person than the evaluator who issued the penalty.

(c) If the reviewer of the appeal determines that the penalty assessment was not issued in accordance with applicable statutes and regulations of the Department, he/she shall have the authority to amend or dismiss the penalty assessment.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1503.5, 1508, 1547 and 1548, Health and Safety Code.

Article 6. Continuing Requirements

§ 80061. Reporting Requirements.

(a) Each licensee or applicant shall furnish to the licensing agency reports as required by the Department, including, but not limited to, those specified in this section.

(b) Upon the occurrence, during the operation of the facility, of any of the events specified in (1) below, a report shall be made to the licensing agency within the agency's next working day during its normal business hours. In addition, a written report containing the information specified in (2) below shall be submitted to the licensing agency within seven days following the occurrence of such event.

(1) Events reported shall include the following:

(A) Death of any client from any cause.

(B) In a residential facility, death of any client as a result of injury, abuse, or other than natural causes, regardless of where the death occurred. This includes a death that occurred outside the facility such as at a day program, workshop, job, hospital, en route to or from a hospital, or visiting away from the facility.

1. The licensee shall obtain a certified copy of the client's death certificate as soon as it is available, maintain it in the client's file, and shall send a copy to the Department as soon as it is obtained.

2. For Regional Center clients, the licensee shall also send a copy of the death certificate to the Regional Center.

(C) In an adult CCF, the use of an Automated External Defibrillator.

(D) Any injury to any client which requires medical treatment.

(E) Any unusual incident or client absence which threatens the physical or emotional health or safety of any client.

(F) Any suspected physical or psychological abuse of any client.

(G) Epidemic outbreaks.

(H) Poisonings.

(I) Catastrophes.

(J) Fires or explosions which occur in or on the premises.

(2) Information provided shall include the following:

(A) Client's name, age, sex, and date of admission.

(B) Date and nature of event.

(C) Attending physician's name, findings, and treatment, if any.

(D) Disposition of the case.

(c) The items below shall be reported to the licensing agency within 10 working days following the occurrence.

(1) The organizational changes specified in section 80034(a)(2).

(2) Any change in the licensee's or applicant's mailing address.

(3) Any change of the chief executive officer of a corporation or association.

(A) Such notification shall include the new chief executive officer's name and address.

(B) Fingerprints shall be submitted as specified in section 80019(d).

(4) Any changes in the plan of operation which affect the services to clients.

(e) The items specified in (b)(1)(A) through (H) above shall also be reported to the client's authorized representative, if any.

(f) The items specified in (b)(1)(E) through (G) above shall also be reported to the local health officer when appropriate pursuant to title 17, California Administrative Code, sections 2500, 2502 and 2503.

(g) The item specified in (b)(1)(H) shall also be reported immediately to the local fire authority. In areas not having organized fire services a report shall be made to the State Fire Marshal within 24 hours.

(h) Licensees shall send copies of all substantiated complaints to

board members of the licensed facility, parents, legal guardians, conservators, client rights advocates or placement agencies, as designated in each client's placement agreement in accordance with Health and Safety Code section 1538.5.

NOTE: Authority cited: Sections 1530 and 1538.5, Health and Safety Code. Reference: Sections 1501, 1507, 1531, 1538.5 and 1797.196, Health and Safety Code.

§ 80062. Finances.

(a) The licensee shall meet the following financial requirements:

(1) Development and maintenance of a financial plan which ensures resources necessary meet operating costs for care and supervision of clients.

(2) Maintenance of financial records.

(3) Submission of financial reports as required upon the written request of the department or licensing agency.

(A) Such request shall explain the necessity for disclosure.

(B) The licensing agency shall have the authority to reject any financial report, and to request and examine additional information including interim financial statements. The reason(s) for rejection of the report shall be in writing.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1501, 1520 and 1531, Health and Safety Code.

§ 80063. Accountability.

(a) The licensee, whether an individual or other entity, is accountable for the general supervision of the licensed facility, and for the establishment of policies concerning its operation.

(1) If the licensee is a corporation or an association, the governing body shall be active and functioning in order to ensure such accountability.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80064. Administrator—Qualifications and Duties.

(a) The administrator shall have the following qualifications:

(1) Attainment of at least 18 years of age.

(2) Knowledge of the requirements for providing the type of care and supervision needed by clients, including ability to communicate with such clients.

(3) Knowledge of and ability to comply with applicable law and regulation.

(4) Ability to maintain or supervise the maintenance of financial and other records.

(5) Ability to direct the work of others, when applicable.

(6) Ability to establish the facility's policy, program and budget.

(7) Ability to recruit, employ, train, and evaluate qualified staff, and to terminate employment of staff, if applicable to the facility.

(b) Each licensee shall make provision for continuing operation and carrying out of the administrator's responsibilities during any absence of the administrator.

(c) The licensee, if an individual, or any member of the governing board of the licensed corporation or association, shall be permitted to be the administrator provided that he/she meets the qualifications specified in this section, and in applicable regulations in Chapters 2 through 7.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80065. Personnel Requirements.

(a) Facility personnel shall be competent to provide the services necessary to meet individual client needs and shall, at all times, be employed in numbers necessary to meet such needs.

(b) The licensing agency shall have the authority to require any licensee to provide additional staff whenever the licensing agency determines and documents that additional staff are required for the provision of services necessary to meet client needs. The licensee shall be informed in writing of the reasons for the licensing agency's determination. The following factors shall be taken into consideration in determining the need for additional staff.

(1) Needs of the particular clients.

(2) Extent of the services provided by the facility.

(3) Physical arrangements of the particular facility.

(4) Existence of a state of emergency or disaster.

(c) The licensee shall be permitted to utilize volunteers provided that such volunteers are supervised, and are not included in the facility staffing plan.

(d) The following facility personnel shall be at least 18 years of age:

(1) Persons who supervise employees and/or volunteers.

(2) Persons, including volunteers, who provide any element of care and supervision to clients.

(e) The licensee shall provide for direct supervision of clients during participation in or presence at potentially dangerous activities or areas in the facility.

(1) An adult other than a client shall be present at all times while clients are using a pool or other body of water from which rescue requires the rescuer's ability to swim.

(2) Adults who supervise while clients are using a pool or other body of water from which rescue requires the rescuer's ability to swim, shall have a valid water safety certificate.

(f) All personnel shall be given on–the–job training or shall have related experience which provides knowledge of and skill in the following areas, as appropriate to the job assigned and as evidenced by safe and effective job performance.

(1) Principles of nutrition, food preparation and storage and menu planning.

(2) Housekeeping and sanitation principles.

(3) Provision of client care and supervision, including communication.

(4) Assistance with prescribed medications which are self–administered.

(5) Recognition of early signs of illness and the need for professional assistance.

(6) Availability of community services and resources.

(7) For adult CCFs, Universal Precautions as defined in Section 80001(u)(1).

(A) Training in Universal Precautions may be provided in the facility or staff may attend training provided by a local health facility, county health department, or other local training resources.

(g) All personnel, including the licensee, administrator and volunteers, shall be in good health, and shall be physically, mentally, and occupationally capable of performing assigned tasks.

(1) Except as specified in (3) below, good physical health shall be verified by a health screening, including a test for tuberculosis, performed by or under the supervision of a physician not more than one year prior to or seven days after employment or licensure.

(2) A health screening report signed by the person performing such screening shall be made on each person specified above, and shall indicate the following:

(A) The person's physical qualifications to perform the duties to be assigned.

(B) The presence of any health condition that would create a hazard to the person, clients or other staff members.

(3) The good physical health of each volunteer who works in the facility shall be verified by:

(A) A statement signed by each volunteer affirming that he/she is in good health.

(B) A test for tuberculosis performed not more than one year prior to or seven days after initial presence in the facility.

(h) Personnel with evidence of physical illness that poses a threat to the health and safety of clients shall be relieved of their duties.

(i) Prior to employment or initial presence in the facility, all employees and volunteers subject to a criminal record review shall:

(1) Obtain a California clearance or a criminal record exemption as required by law or Department regulations or

(2) Request a transfer of a criminal record clearance as specified in Section 80019(f) or

(3) Request and be approved for a transfer of a criminal record exemption, as specified in Section 80019.1(r), unless, upon request for the transfer, the Department permits the individual to be employed, reside or be present at the facility.

(j) Clients shall not be used as substitutes for required staff but shall be permitted, as a voluntary part of their program of activities, to participate in household duties and other tasks suited to the client's needs and abilities.

(1) Such duties and tasks shall be specified in the client's needs and services plan as specified in chapters 2, 4, 5 and 6.

(k) When regular staff members are absent, there shall be coverage by personnel capable of performing assigned tasks as evidenced by on–the–job performance.

(*l*) Personnel shall provide for the care and safety of persons without physical or verbal abuse, exploitation or prejudice.

(m) All personnel shall be instructed to report observations or evidence of violations of any of the personal rights specified in section 80072 and/or any of the personal rights provisions of chapters 2 through 7.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 5453 and 5458, Welfare and Institutions Code; Sections 1501, 1502(a)(7), 1522, 1531 and 1562, Health and Safety Code; and Section 42001, Vehicle Code.

§ 80066. Personnel Records.

(a) The licensee shall ensure that personnel records are maintained on the licensee, administrator and each employee. Each personnel record shall contain the following information:

(1) Employee's full name.

(2) Driver's license number if the employee is to transport clients.

(3) Date of employment.

(4) A statement signed by the employee that he/she is at least 18 years of age.

(5) Home address and phone number.

(6) Documentation of the educational background, training and/or experience specified in licensing regulations for the type of facility in which the employee works.

(7) Past experience, including types of employment and former employers.

(8) Duties of the employee.

(9) Termination date if no longer employed by the facility.

(10) A health screening as specified in Section 80065(g).

(11) Tuberculosis test documents as specified in Section 80065(g).

(12) For employees that are required to be fingerprinted pursuant to Section 80019:

(A) A signed statement regarding their criminal record history as required by Section 80019(d).

(B) Documentation of either a criminal record clearance or exemption as required by Section 80019(e).

1. For Certified Administrators, a copy of their current and valid Administrator Certification meets this requirement.

(b) Personnel records shall be maintained for all volunteers and shall contain the following:

(1) A health statement as specified in Section 80065(g)(3).

(2) Tuberculosis test documents as specified in Section 80065(g).

(3) For volunteers that are required to be fingerprinted pursuant to Section 80019:

(A) A signed statement regarding their criminal record history as required by Section 80019(d).

(B) Documentation of either a criminal record clearance or exemption as required by Section 80019(e).

(c) All personnel records shall be available to the licensing agency to inspect, audit, and copy upon demand during normal business hours. Records may be removed if necessary for copying. Removal of records shall be subject to the following requirements:

(1) Licensing representatives shall not remove any current emergency and health–related information for current personnel unless the same information is otherwise readily available in another document or format.

(2) Prior to removing any records, a licensing representative shall prepare a list of the records to be removed, sign and date the list upon removal of the records, and leave a copy of the list with the administrator or designee.

(3) Licensing representatives shall return the records undamaged and in good order within three business days following the date the records were removed.

(d) All personnel records shall be retained for at least three years following termination of employment.

(e) All personnel records shall be maintained at the facility site.

(1) The licensee shall be permitted to retain such records in a central administrative location provided that they are readily available to the licensing agency at the facility site as specified in Section 80066(c).

(f) In all cases, personnel records shall document the hours actually worked.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80068. Admission Agreements.

(a) The licensee shall complete an individual written admission agreement with each client and the client's authorized representative, if any.

(1) Prior to admitting a developmentally disabled adult recommended by a Regional Center, the licensee of an ARF or SRF shall obtain from the Regional Center written certification which states that there was no objection to the placement by any persons specified in Welfare and Institutions Code Section 4803.

(2) The licensee shall maintain a copy of the certification in the client's file.

(b) The licensee shall complete and maintain in the client's file a Telecommunications Device Notification form (LIC 9158, 5/97) for each client whose pre–admission appraisal or medical assessment indicates he/she is deaf, hearing–impaired, or otherwise disabled.

(c) Admission agreements must specify the following:

(1) Basic services.

(2) Available optional services.

(3) Payment provisions, including the following:

(A) Basic rate.

(B) Optional services rates.

(C) Payor.

(D) Due date.

(E) Frequency of payment.

(4) Modification conditions, including requirement for provision of at least 30 calendar days prior written notice to the client or his/her authorized representative of any basic rate change.

(A) It shall be acceptable for agreements involving clients whose care is funded at government–prescribed rates to specify that the effective date of a government rate change shall be considered the effective date for basic service rate modifications and that no prior notice is necessary.

(5) Refund conditions.

(6) Right of the licensing agency to perform the duties authorized in Section 80044(b) and (c).

(7) Conditions under which the agreement may be terminated.

(A) The client's refusal to cooperate with the licensee's implementation of his/her Restricted Health Condition Care Plan as specified in Section 80092.2, if any, and his/her Needs and Services Plan, as specified in Section 80068.2 or 80068.3, must be one of the conditions.

(8) The facility's policy concerning family visits and other communication with clients, pursuant to Health and Safety Code Section 1512.

(9) If the client in an ARF or SRF has a restricted health condition,

as specified in Section 80092, the admission agreement must contain a statement that he/she agrees to comply with the Restricted Health Condition Care Plan developed for him/her as specified in Section 80092.2.

(d) Such agreements shall be dated and signed, acknowledging the contents of the document, by the client and the client's authorized representative and the licensee or the licensee's designated representative no later than seven calendar days following admission.

(e) Modifications to the original agreement shall be made whenever circumstances covered in the agreement change, and shall be dated and signed by the persons specified in (c) above.

(f) The licensee shall retain in the client's file the original of the initial admission agreement and all subsequent modifications.

(1) The licensee shall provide a copy of the current admission agreement to the client and the client's authorized representative, if any.

(g) The licensee shall comply with all terms and conditions set forth in the admission agreement.

(h) The admission agreement shall be automatically terminated by the death of the client. No liability or debt shall accrue after the date of death.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1512, 1524.7 and 1531, Health and Safety Code; Section 4803, Welfare and Institutions Code; and Section 2881, Public Utilities Code.

§ 80068.2. Needs and Services Plan.

(a) The licensee shall complete a Needs and Services Plan for each client as required in Sections 81068.2, 82068.2, 82568.2, or 85068.2.

(b) If the client has an existing needs appraisal or individual program plan (IPP) completed by a placement agency, or a consultant for the placement agency, the Department may consider the plan to meet the requirements of this section provided that:

(1) The needs appraisal or IPP is not more than one year old.

(2) The licensee and the placement agency agree that the client's physical, mental and emotional status has not significantly changed since the assessment.

(c) The written Needs and Services Plan specified in Section 80068.2(a), shall be maintained in the client's file.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 80068.3. Modifications to Needs and Services Plan.

(a) The licensee shall ensure that each client's written Needs and Services Plan is updated as often as necessary to assure its accuracy, but at least annually. These modifications shall be maintained in the client's file.

(b) If the licensee determines that the client's needs cannot be met, the licensee shall inform the client, and his/her authorized representative, if any, and the placement agency, if any, and request that the client relocate to a facility that can provide the needed services.

(1) If the client refuses to relocate, the licensee may evict the client in accordance with Section 80068.5.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 80068.5. Eviction Procedures.

(a) Except for children's residential facilities, the licensee may, upon 30 days written notice to the client, evict the client only for one or more of the following reasons:

(1) Nonpayment of the rate for basic services within ten days of the due date.

(2) Failure of the client to comply with state or local law after receiving written notice of the alleged violation.

(3) Failure of the client to comply with general facility policies that are documented in the facility admission agreement, and are for the purpose of making it possible for clients to live together.

(A) For a SRF, failure of the client to participate in the services and activities specified in the treatment/rehabilitation plan to the extent of his/her ability.

(4) Inability to meet the client's needs.

(A) A Needs and Services Plan modification must have been performed, as specified in Section 80068.3(a), which determined that the client's needs cannot be met by the facility and the client has been given the opportunity to relocate as specified in Section 80068.3(b).

(5) The client refuses to comply with his/her Restricted Health Condition Care Plan, if any, as specified in Section 80092.2.

(6) Change of use of the facility.

(b) The licensee shall obtain prior written approval from the Department to evict the client upon three (3) days written notice to quit and upon a finding of good cause.

(1) Good cause exists if the client engages in behavior that threatens the mental and/or physical health or safety of himself/herself or others in the facility.

(2) Failure of the Department to reply to the request for approval within two working days shall be considered approval.

(c) The notice to quit shall state the reasons for the eviction, with specific facts supporting the reason for the eviction, including the date, place, witnesses, if any, and circumstances.

(d) When serving the client with either a 30–day or a 3–day notice to quit, the licensee shall, on the same day, overnight mail or fax a copy of the notice to the client's authorized representative, if any, or responsible person if there is no authorized representative.

(e) The licensee shall mail or fax to the Department a copy of the 30–day written notice in accordance with (a) above within five days of giving the notice to the client.

(f) Upon request of a client or his/her authorized representative or responsible person, the Department will investigate the reasons for the eviction pursuant to the provisions of Sections 1538 and 1569.35 of the Health and Safety Code.

(g) Nothing in this section precludes the licensee or client from invoking any other available remedy.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1531 and 1770 et seq., Health and Safety Code.

§ 80069. Client Medical Assessments.

(a) Except for licensees of ARFs and SRFs, prior to or within 30 calendar days following the acceptance of a client, the licensee shall obtain a written medical assessment of the client, as specified in Section 80069(c), which enables the licensee to determine his/her ability to provide necessary health related services to the client. The assessment shall be used in developing the Needs and Services Plan.

(1) The assessment shall be performed by a licensed physician or designee, who is also a licensed professional, and the assessment shall not be more than one year old when obtained.

(b) In ARFs and SRFs, prior to accepting a client into care, the licensee shall obtain and keep on file documentation of the client's medical assessment.

(1) Such assessment shall be performed by a licensed physician, or designee, who is also a licensed professional, and the assessment shall not be more than one year old when obtained.

(c) The medical assessment shall include the following:

(1) The results of an examination for communicable tuberculosis and other contagious/infectious diseases.

(2) Identification of the client's special problems and needs.

(3) Identification of any prescribed medications being taken by the client.

(4) A determination of the client's ambulatory status, as defined by Section 80001(n)(2).

(5) Identification of physical restrictions, including any medically necessary diet restrictions, to determine the client's capacity to participate in the licensee's program.

(d) In addition to Section 80069(c), the medical assessment for clients in ARFs and SRFs shall include the following:

(1) A physical examination of the person, indicating the physician's primary diagnosis and secondary diagnosis, if any.

(2) Identification of other medical conditions, including those described in Section 80092 which are restricted and Section 80091, which would preclude care of the person by the licensee.

(3) Documentation of prior medical services and history.

(4) Current medical status including, but not limited to, height, weight, and blood pressure.

(5) Identification of the client's needs as a result of any medical information contained in the report.

(e) The licensing agency shall have the authority to require the licensee to obtain a current written medical assessment, if such an assessment is necessary to verify the appropriateness of a client's placement.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1528, 1530 and 1531, Health and Safety Code.

§ 80069.1. Individual Health Condition Care Plan.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80069.2. Functional Capabilities Assessment.

(a) In order to determine whether the facility's program meets a client's service needs, the licensee of an ARF or SRF shall assess the client's need for personal assistance and care by determining his/her functional capabilities. The assessment shall be in writing, shall be used in developing the Needs and Services Plan, and shall include, but not be limited to the following activities:

(1) Bathing:

(A) Does not bathe or shower self.

(B) Performs some bathing or showering tasks.

(C) Bathes or showers self independently.

(2) Dressing:

(A) Does not dress self.

(B) Puts on some clothing by self.

(C) Dresses self completely.

(3) Grooming:

(A) Does not tend to own personal hygiene.

(B) Tends to some personal hygiene tasks.

(C) Tends to own personal hygiene.

(4) Toileting:

(A) Not toilet trained.

(B) Does not toilet by self.

(C) Goes to toilet by self.

(5) Transferring:

(A) Unable to move in and out of a bed or chair.

(B) Needs assistance to transfer.

(C) Is able to move in and out of a bed or chair.

(6) Repositioning:

(A) Unable to reposition.

(B) Repositions from side to side.

(C) Repositions from front to back and back to front.

(7) Wheelchair:

(A) Unable to sit without support.

(B) Sits without support.

(C) Needs assistance moving wheelchair.

(D) Moves wheelchair independently.

(E) Does not use wheelchair.

(8) Continence:

(A) No bowel and/or bladder control.

(B) Some bowel and/or bladder control.

(C) Use of assistive devices, such as a catheter.

(D) Complete bowel and/or bladder control.

(9) Eating:

(A) Does not feed self.

(B) Feeds self with assistance from another person.

(C) Feeds self completely.

(b) Assessment of the client's need for assistance shall include consideration of his/her physical condition affecting participation in his/her own care, including:

(1) Vision:

(A) Severe/profound impairment.

(B) Mild/moderate impairment.

(C) No vision impairment.

(2) Hearing:

(A) Severe/profound loss.

(B) Mild/moderate loss.

(C) No hearing loss.

(3) Communication:

(A) Does not express nonverbally.

(B) Does not express verbally.

(C) Expresses by sounds or movements.

(D) Expresses self well, both verbally and nonverbally.

(4) Walking:

(A) Does not walk.

(B) Walks with support.

(C) Walks well alone.

(5) Medical history and conditions.

(6) Need for prescribed and non–prescribed medications.

(c) Assessment of the client's need for assistance and care shall include consideration of the following:

(1) Mental and emotional conditions.

(2) Socialization and cognitive status.

(3) Propensity for behaviors that result in harm to self or others and that require supervision,

(4) Ability to manage his/her own finances and cash resources.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1250, 1501, 1502, 1507, 1530, 1531 and 1557.5, Health and Safety Code.

§ 80069.3. Mental Health Assessment.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1530, 1531 and 1562.6, Health and Safety Code.

§ 80070. Client Records.

(a) The licensee shall ensure that a separate, complete, and current record is maintained in the facility for each client.

(b) Each record must contain information including but not limited to the following:

(1) Name of client.

(2) Birthdate.

(3) Sex.

(4) Date of Admission.

(5) Names, addresses, and telephone numbers of the authorized representative.

(6) A signed copy of the admission agreement specified in Section 80068.

(7) Name, address and telephone number of physician and dentist, and other medical and mental health providers, if any.

(8) Medical assessment, including ambulatory status, as specified in Section 80069.

(9) Record of any illness or injury requiring treatment by a physician or dentist and for which the facility provided assistance to the client in meeting his/her necessary medical and dental needs.

(10) Record of current medications, including the name of the prescribing physician, and instructions, if any, regarding control and custody of medications.

(11) Restricted Health Condition Care Plan, if required for the client by Section 80092.2.

(12) Functional assessment as specified in Section 80069.2.

(13) Mental health assessment specified in Section 80069.3.

(14) Date of termination of services.

(15) An account of the client's cash resources, personal property, and valuables entrusted as specified in Section 80026.

(c) All information and records obtained from or regarding clients shall be confidential.

(1) The licensee shall be responsible for safeguarding the confidentiality of record contents.

(2) Except as specified in (d) below, or as otherwise authorized by law, the licensee and all employees shall not reveal or make available confidential information.

(d) All client records shall be available to the licensing agency to inspect, audit, and copy upon demand during normal business hours. Records may be removed if necessary for copying. Removal of records shall be subject to the following requirements:

(1) Licensing representatives shall not remove the following current records for current clients unless the same information is otherwise readily available in another document or format:

(A) Name, address, and telephone number of the authorized representative(s) as specified in Section 80070(b)(5).

(B) Name, address, and telephone number of a client's physician and dentist, and any other medical and mental health providers, as specified in Section 80070(b)(7).

(C) Medical assessment, including ambulatory status, as specified in Section 80070(b)(8).

(D) Record of any current illness or injury as specified in Section 80070(b)(9).

(E) Record of current medications as specified in Section 80070(b)(10).

(F) Restricted Health Condition Care Plan as specified in Section 80070(b)(11).

(G) Functional assessment as specified in Section 80070(b)(12).

(H) Mental health assessment as specified in Section 80070(b)(13).

(I) Any other records containing current emergency or health–related information for current clients.

(2) Prior to removing any records, a licensing representative shall prepare a list of the records to be removed, sign and date the list upon removal of the records, and leave a copy of the list with the administrator or designee.

(3) Licensing representatives shall return the records undamaged and in good order within three business days following the date the records were removed.

(e) A client's records shall be open to inspection by the client's authorized representative(s), if any.

(f) The information specified in (b)(1)–(b)(15) above must be updated as necessary to ensure the accuracy of the client's record.

(g) Original client records or photographic reproductions shall be retained for at least three years following termination of service to the client.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 80071. Register of Clients.

(a) In all licensed facilities, the following shall apply:

(1) The licensee shall maintain in the facility a register of all clients. The register shall be immediately available to, and copied for, licensing staff upon request, and must contain current information on the following:

(A) Client's name and ambulatory status as specified in Section 80070(b)(1) and (8).

(B) Name, address and telephone number of client's attending physician.

(C) Authorized representative information as specified in Section 80070(b)(5).

(D) Client's restricted health condition(s) specified in Section 80092(b).

1. The licensee may keep a separate client register with this information.

(2) The licensee shall keep the register in a central location at the facility.

(A) Registers are confidential, as specified in Section 80070(c).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1507 and 1557.5, Health and Safety Code.

§ 80072. Personal Rights.

(a) Except for children's residential facilities, each client shall have personal rights which include, but are not limited to, the following:

(1) To be accorded dignity in his/her personal relationships with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.

(3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with the daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.

(4) To be informed, and to have his/her authorized representative, if any, informed, by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency, and of information regarding confidentiality.

(5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice.

(A) Attendance at religious services, in or outside of the facility, shall be on a completely voluntary basis.

(6) To leave or depart the facility at any time.

(A) The licensee shall not be prohibited by this provision from setting curfews or other house rules for the protection of clients.

(B) This provision shall not apply to minors and other clients for whom a guardian, conservator, or other legal authority has been appointed.

(7) Not to be locked in any room, building, or facility premises by day or night.

(A) The licensee shall not be prohibited by this provision from locking exterior doors and windows or from establishing house rules for the protection of clients provided the clients are able to exit the facility.

(B) The licensee shall be permitted to utilize means other than those specified in (A) above for securing exterior doors and windows only with the prior approval of the licensing agency.

(8) Not to be placed in any restraining device. Postural supports may be used under the following conditions.

(A) Postural supports shall be limited to appliances or devices including braces, spring release trays, or soft ties, used to achieve proper body position and balance, to improve a client's mobility and independent functioning, or to position rather than restrict movement including, but not limited to, preventing a client from falling out of bet, a chair, etc.

1. Physician–prescribed orthopedic devices such as braces or casts used for support of a weakened body part or correction of body parts are considered postural supports.

(B) A written order from the client's physician indicating the need for the postural support shall be maintained in the client's record. The licensing agency shall be authorized to require additional documentation if needed to verify the order.

(C) Postural supports shall be fastened or tied in a manner that permits quick release by the client.

(D) Prior to the use of postural supports that cause the client to become non–ambulatory, the licensee shall ensure that a fire clearance, as required by Section 80020, has been secured.

(E) Under no circumstances shall postural supports include tying of, or depriving or limiting the use of, a client's hands or feet.

1. A bed rail that extends from the head half the length of the bed and used only for assistance with mobility shall be allowed. Bed rails

that extend the entire length of the bed are prohibited except for clients who are currently receiving hospice care and have a hospice care plan that specifies the need for full bed rails.

(F) Protective devices including, but not limited to, helmets, elbow guards, and mittens which do not prohibit a client's mobility but rather protect the client from self–injurious behavior are not to be considered restraining devices for the purpose of this regulation. Protective devices may be used if they are approved in advance by the licensing agency as specified below.

1. All requests to use protective devices shall be in writing and include a written order of a physician indicating the need for such devices. The licensing agency shall be authorized to require additional documentation including, but not limited to, the Individual Program Plan (IPP) as specified in Welfare and Institutions Code section 4646, and the written consent of the authorized representative, in order to evaluate the request.

2. The licensing agency shall have the authority to grant conditional and/or limited approvals to use protective devices.

(9) To receive or reject medical care, or health–related services, except for minors and other clients for whom a guardian, conservator, or other legal authority has been appointed.

(10) To be informed of the facility's policy concerning family visits and other communication with clients, as specified in Health and Safety Code section 1512.

(b) At admission, a client and the client's authorized representative shall be personally advised of and given a list of the rights specified in Sections 80072(a)(1) through (10) and in the applicable Personal Rights sections of chapters 2 through 7.

(c) The information specified in (b) above including the visiting policy as stated in the admissions agreement shall be prominently posted in areas accessible to clients and their visitors.

(d) The licensee shall ensure that each client is accorded the personal rights as specified in this section and the applicable sections of chapters 2 through 7.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80073. Telephones.

(a) All facilities shall have telephone service on the premises.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1528, 1531 and 1539, Health and Safety Code.

§ 80074. Transportation.

(a) Only drivers licensed for the type of vehicle operated shall be permitted to transport clients.

(b) The manufacturer's rated seating capacity of the vehicles shall not be exceeded.

(c) Motor vehicles used to transport clients shall be maintained in a safe operating condition.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1528 and 1531, Health and Safety Code.

§ 80075. Health–Related Services.

(a) The licensee shall ensure that each client receives first aid and other needed medical or dental services, including arrangement for and/or provision of transportation to the nearest available services.

(b) Clients shall be assisted as needed with self–administration of prescription and nonprescription medications.

(1) In adult CCFs, facility staff who receive training may assist clients with metered–dose inhalers, and dry powder inhalers if the following requirements are met:

(A) In ARFs and SRFs, facility staff must receive training from a licensed professional.

1. The licensee shall obtain written documentation from the licensed professional outlining the procedures and the names of facility staff who have been trained in those procedures.

2. The licensee ensures that the licensed professional reviews staff performance as the licensed professional deems necessary, but at least once a year.

(B) All staff training shall be documented in the facility personnel files.

(2) Facility staff, except those authorized by law, shall not administer injections but staff designated by the licensee shall be authorized to assist clients with self–administration of injections as needed.

(3) Assistance with self–administration does not include forcing a client to take medications, hiding or camouflaging medications in other substances without the client's knowledge and consent, or otherwise infringing upon a client's right to refuse to take a medication.

(4) If the client's physician has stated in writing that the client is able to determine and communicate his/her need for a prescription or nonprescription PRN medication, facility staff shall be permitted to assist the client with self–administration of their PRN medication.

(5) If the client's physician has stated in writing that the client is unable to determine his/her own need for nonprescription PRN medication, but can communicate his/her symptoms clearly, facility staff designated by the licensee shall be permitted to assist the client with self–administration, provided all of the following requirements are met:

(A) There is written direction from a physician, on a prescription blank, specifying the name of the client, the name of the medication, all of the information specified in Section 80075(e), instructions regarding a time or circumstance (if any) when it should be discontinued, and an indication of when the physician should be contacted for a medication reevaluation.

(B) Once ordered by the physician the medication is given according to the physician's directions.

(C) A record of each dose is maintained in the client's record. The record shall include the date and time the PRN medication was taken, the dosage taken, and the client's response.

(6) If the client is unable to determine his/her own need for a prescription or nonprescription PRN medication, and is unable to communicate his/her symptoms clearly, facility staff designated by the licensee, shall be permitted to assist the client with self–administration, provided all of the following requirements are met:

(A) Facility staff shall contact the client's physician prior to each dose, describe the client's symptoms, and receive direction to assist the client in self–administration of that dose of medication.

(B) The date and time of each contact with the physician, and the physician's directions, shall be documented and maintained in the client's facility record.

(C) The date and time the PRN medication was taken, the dosage taken, and the client's response, shall be documented and maintained in the client's facility record.

(D) For every prescription and nonprescription PRN medication for which the licensee provides assistance, there shall be a signed, dated written order from a physician on a prescription blank, maintained in the client's file, and a label on the medication. Both the physician's order and the label shall contain at least all of the following information:

(1) The specific symptoms which indicate the need for the use of the medication.

(2) The exact dosage.

(3) The minimum number of hours between doses.

(4) The maximum number of doses allowed in each 24–hour period.

(c) The isolation room or area specified in Section 80087(d) shall be used where separation from others is required.

(d) There shall be privacy for first aid treatment of minor injuries and for examination or treatment by a physician if required.

(e) In adult CCFs, when a client requires oxygen the licensee is responsible for the following:

(1) Monitoring the client's ongoing ability to operate and care for

the equipment in accordance with the physician's instructions, or if the client is unable to do so:

(A) Ensuring that an adequate number of facility staff persons are designated to operate and care for the equipment and that those staff persons receive.

1. The licensee shall comply with all of the requirements for training in Sections 80075(b)(1)(A) through (C).

(2) Ensuring that the following conditions are met if oxygen equipment is in use:

(A) The licensee makes a written report to the local fire jurisdiction that oxygen is in use at the facility.

(B) "No Smoking – Oxygen in Use" signs shall be posted in appropriate areas.

(C) Smoking is prohibited where oxygen is in use.

(D) All electrical equipment is checked for defects that may cause sparks.

(E) Oxygen tanks that are not portable are secured either in a stand or to the wall.

(F) Plastic tubing from the nasal canula (mask) to the oxygen source is long enough to allow the client movement within his/her room but does not consitutute a hazard to the client or others.

(G) Clients use oxygen from a portable source when they are outside of their rooms or when walking in a day care setting.

(H) Equipment is operable.

(I) Facility staff have knowledge and ability to operate and care for the oxygen equipment.

(J) Equipment is removed from the facility when no longer in use by the client.

(i) Staff responsible for providing direct care and supervision shall receive training in first aid from persons qualified by agencies including but not limited to the American Red Cross.

(j) If the facility has no medical unit on the grounds, first aid supplies shall be maintained and be readily available in a central location in the facility.

(1) The supplies shall include at least the following:

(A) A current edition of a first aid manual approved by the American Red Cross, the American Medical Association or a state or federal health agency.

(B) Sterile first aid dressings.

(C) Bandages or roller bandages.

(D) Adhesive tape.

(E) Scissors.

(F) Tweezers.

(G) Thermometers.

(H) Antiseptic solution.

(k) There shall be at least one person capable of and responsible for communicating with emergency personnel in the facility at all times. The following information shall be readily available:

(1) The name, address and telephone number of each client's physician and dentist, and other medical and mental health providers, if any.

(2) The name, address and telephone number of each emergency agency, including but not limited to the fire department, crisis center or paramedical unit. There shall be at least one medical resource available to be called at all times.

(3) The name and telephone number of an ambulance service.

(*l*) When a client requires prosthetic devices, or vision or hearing aids, the staff shall be familiar with the use of these devices and aids and shall assist the client with their utilization as needed.

(m) Medications shall be centrally stored under the following circumstances:

(1) Preservation of the medication requires refrigeration.

(2) Any medication determined by the physician to be hazardous if kept in the personal possession of the client for whom it was prescribed.

(3) Because of physical arrangements and the condition or the habits of persons in the facility, the medications are determined by either the administrator or by the licensing agency to be a safety hazard.

(n) The following requirements shall apply to medications which are centrally stored:

(1) Medication shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for the supervision of the centrally stored medication.

(2) Each container shall identify the items specified in (7)(A) through (G) below.

(3) All medications shall be labeled and maintained in compliance with label instructions and state and federal laws.

(4) No person other than the dispensing pharmacist shall alter a prescription label.

(5) Each client's medication shall be stored in its originally received container.

(6) No medications shall be transferred between containers.

(7) The licensee shall ensure the maintenance, for each client, of a record of centrally stored prescription medications which is retained for at least one year and includes the following:

(A) The name of the client for whom prescribed.

(B) The name of the prescribing physician.

(C) The drug name, strength and quantity.

(D) The date filled.

(E) The prescription number and the name of the issuing pharmacy.

(F) Expiration date.

(G) Number of refills.

(H) Instructions, if any, regarding control and custody of the medication.

(o) Prescription medications which are not taken with the client upon termination of services, or which are not to be retained shall be destroyed by the facility administrator, or a designated substitute, and one other adult who is not a client.

(1) Both shall sign a record, to be retained for at least one year, which lists the following:

(A) Name of the client.

(B) The prescription number and the name of the pharmacy.

(C) The drug name, strength and quantity destroyed.

(D) The date of destruction.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1530 and 1531, Health and Safety Code.

§ 80075.1. Automated External Defibrillators (AEDs).

(a) In an adult community care facility, a licensee is permitted to maintain and operate an AED at the facility if all of the following requirements are met:

(1) The licensee shall notify the licensing agency in writing that an AED is in the facility and will be used in accordance with all applicable federal and other state requirements.

(2) The AED shall be used in accordance with all applicable federal and other state requirements.

(3) The licensee shall maintain at the facility the following:

(A) A copy of the required physician's prescription for the AED.

(B) A training manual from an American Heart Association– or American Red Cross–recognized AED training class.

(C) A log of checks of operation of the AED containing the dates checked and the name of person checking.

(D) A copy of a valid AED operator's certificate for any employee(s) authorized by the licensee to operate the AED. The certificate shall indicate that the AED training course completed complies with the standards of the American Heart Association or the American Red Cross. If it does not, then other evidence indicating that the AED training course completed complies with the standards of the American Heart Association or the American Red Cross shall be available at the facility.

(E) A log of quarterly proficiency demonstrations for each holder

of an AED operator's certificate who is authorized by the licensee to operate the AED. The log shall contain the dates of the demonstrations and the manner of demonstration.

(4) A supply kit shall be maintained at the facility and be readily available for use with the AED. The kit shall contain at least the following:

(A) A back–up battery set.

(B) An extra set of pads.

(C) A safety razor for shaving chest hair when necessary to apply the pads.

(D) A cardiovascular pulmonary resuscitation barrier (a face shield or mask) for protection from transmission of infectious disease.

(E) Two pairs of unused medical examination gloves (latex or non–latex).

(5) Use of an AED shall be reported as specified in Section 80061.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1530, 1531 and 1797.196, Health and Safety Code.

§ 80076. Food Service.

(a) In facilities providing meals to clients, the following shall apply:

(1) All food shall be safe and of the quality and in the quantity necessary to meet the needs of the clients. Each meal shall meet at least 1/3 of the servings recommended in the USDA Basic Food Group Plan—Daily Food Guide for the age group served. All food shall be selected, stored, prepared and served in a safe and healthful manner.

(2) Where all food is provided by the facility, arrangements shall be made so that each client has available at least three meals per day.

(A) Not more than 15 hours shall elapse between the third meal of one day and first meal of the following day.

(3) Where meal service within a facility is elective, arrangements shall be made to ensure availability of a daily food intake meeting the requirements of (a)(1) above for all clients who, in their admission agreement, elect meal service.

(4) Between meal nourishment or snacks shall be available for all clients unless limited by dietary restrictions prescribed by a physician.

(5) Menus shall be written at least one week in advance and copies of the menus as served shall be dated and kept on file for at least 30 days. Menus shall be made available for review by the clients or their authorized representatives and the licensing agency upon request.

(6) Modified diets prescribed by a client's physician as a medical necessity shall be provided.

(A) The licensee shall obtain and follow instructions from the physician or dietitian on the preparation of the modified diet.

(7) Commercial foods shall be approved by appropriate federal, state and local authorities. All foods shall be selected, transported, stored, prepared and served so as to be free from contamination and spoilage and shall be fit for human consumption. Food in damaged containers shall not be accepted, used or retained.

(8) Where indicated, food shall be cut, chopped or ground to meet individual needs.

(9) Powdered milk shall not be used as a beverage but shall be allowed in cooking and baking. Raw milk, as defined in Division 15 of the California Food and Agricultural Code shall not be used. Milk shall be pasteurized.

(10) Except upon written approval by the licensing agency, meat, poultry and meat food products shall be inspected by state or federal authorities. Written evidence of such inspection shall be available for all products not obtained from commercial markets.

(11) All home canned foods shall be processed in accordance with standards of the University of California Agricultural Extension Service. Home canned foods from outside sources shall not be used.

(12) If food is prepared off the facility premises, the following shall apply:

(A) The preparation source shall meet all applicable requirements for commercial food services.

(B) The facility shall have the equipment and staff necessary to receive and serve the food and for cleanup.

(C) The facility shall maintain the equipment necessary for in–house preparation, or have an alternate source for food preparation, and service of food in emergencies.

(13) All persons engaged in food preparation and service shall observe personal hygiene and food services sanitation practices which protect the food from contamination.

(14) All foods or beverages capable of supporting rapid and progressive growth of microorganisms which can cause food infections or food intoxications shall be stored in covered containers at 45 degrees F (7.2 degrees C) or less.

(15) Pesticides and other similar toxic substances shall not be stored in food storerooms, kitchen areas, food preparation areas, or areas where kitchen equipment or utensils are stored.

(16) Soaps, detergents, cleaning compounds or similar substances shall be stored in areas separate from food supplies.

(17) All kitchen, food preparation, and storage areas shall be kept clean, free of litter and rubbish, and measures shall be taken to keep all such areas free of rodents, and other vermin.

(18) All food shall be protected against contamination. Contaminated food shall be discarded immediately.

(19) All equipment, fixed or mobile, dishes, and utensils shall be kept clean and maintained in safe condition.

(20) All dishes and utensils used for eating and drinking and in the preparation of food and drink, shall be cleaned and sanitized after each usage.

(A) Dishwashing machines shall reach a temperature of 165 degrees F (74 degrees C) during the washing and/or drying cycle to ensure that dishes and utensils are cleaned and sanitized.

(B) Facilities not using dishwashing machines shall clean and sanitize dishes and utensils by an alternative comparable method.

(21) Equipment necessary for the storage, preparation and service of food shall be provided, and shall be well–maintained.

(22) Tableware and tables, dishes, and utensils shall be provided in the quantity necessary to serve the clients.

(23) Adaptive devices shall be provided for self–help in eating as needed by clients.

(b) The licensing agency shall have the authority to require the facility to provide written information, including menus, regarding the food purchased and used over a given period when it is necessary to determine if the licensee is in compliance with the food service requirements in the regulations in this Division.

(1) The licensing agency shall specify in writing the written information required from the licensee.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1528, 1530, 1530.5 and 1531, Health and Safety Code.

§ 80077. Personal Services. (Reserved)

§ 80077.2. Care for Clients Who Rely Upon Others to Perform All Activities of Daily Living.

(a) A licensee of an adult CCF may accept or retain a client who relies upon others to perform all activities of daily living for them.

(b) Prior to accepting a client into care, the licensee shall complete the following:

(1) An approved plan of operation demonstrating the licensee's ability to care for these clients as specified in Section 80022(e).

(2) A Needs and Services Plan, as required by the facility–specific regulations, that includes all of the following:

(A) A plan to monitor the client's skin condition, including:

1. Specific guidelines for turning the client, (time, method, acceptable positions).

2. Skin breakdown.

3. Objective symptoms, observable by a lay person, indicating when a licensed professional must be contacted.

(B) A method for feeding the client and providing him/her with hydration.

(C) A method for determining the client's needs.

(D) A method for communicating with the client.

(E) A list of emergency contacts and a list of readily observable conditions that indicate when emergency intervention is necessary.

(F) A list of persons to contact in the event of non–emergency client distress or discomfort and a list of readily observable conditions that indicate when the licensee is to contact those persons.

(G) A description of the client–specific training that facility staff will receive.

1. The training must be provided by the client's health care provider (physician or nurse) the client's physical or mental health therapist, social worker, and placement worker, within their individual scopes of practice.

2. The training must include the client's needs and objective symptoms that indicate when the licensee is to obtain health care or other type of assistance.

(H) In an ARF or SRF, an agreement, signed by the placement agency, or authorized representative, to review the client's care at least once a month. A copy of the agreement shall be maintained in the client's file.

(I) The licensee's agreement to document significant occurrences that result in changes in the client's physical, mental, and/or functional capabilities. This documentation must be retained in the client's record in the facility and be readily available for review by the client's health care providers and the Department.

(c) The Department may require any additional information it considers necessary to ensure the safety of clients.

NOTE: Authority Cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1530, Health and Safety Code

§ 80077.3. Care for Clients Who Lack Hazard Awareness or Impulse Control.

(a) If a client requires protective supervision because of running/wandering away, supervision may be enhanced by fencing yards, using self–closing latches and gates, and installing operational bells, buzzers, or other auditory devices on exterior doors to alert staff when the door is opened. The fencing and devices must not substitute for appropriate staffing.

(1) The licensee may use wrist bands and other client egress–alert devices with the prior written approval of the client or authorized representative, if the client is legally incapable of giving consent, provided that the devices do not violate Section 80072.

(2) The licensee of an ARF, GH, SFH, FFH, or CFH may use a delayed–egress device if the client lacks hazard awareness or impulse control and only as specified in Health and Safety Code Section 1531.1.

(3) The following initial and continuing requirements must be met for the licensee to utilize delayed egress devices on exterior doors or perimeter fence gates:

(A) The licensee shall notify the Department immediately after determining the date that the device will be installed.

(B) The licensee shall ensure that the fire clearance includes approval of delayed egress devices.

(C) Following the disaster and mass casualty plan specified in Section 80023, fire and earthquake drills shall be conducted at least once every three months on each shift and shall include, at a minimum, all facility staff who provide or supervise client care and supervision.

(D) Without violating Section 80072(a)(6), facility staff shall attempt to redirect a client who lacks hazard awareness or impulse control and who attempts to leave the facility.

(E) Clients who continue to indicate a desire to leave the facility following an egress delay shall be permitted to do so.

(F) Without violating Section 80072(a)(6), facility staff shall ensure the continued safety of clients when they leave the facility.

(G) The licensee shall report to the Department, to the client's responsible representative, if any, and to any family member who has requested notification, each incident in which a client leaves the facility unassisted. The report shall be made by telephone no later than the next working day and in writing within seven calendar days.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, 1531 and 1531.1, Health and Safety Code.

§ 80077.4. Care for Clients with Incontinence.

(a) A licensee of an adult CCF may accept or retain a client who has bowel and/or bladder incontinence.

(b) If a licensee accepts or retains a client who has bowel and/or bladder incontinence, the licensee is responsible for all of the following:

(1) Ensuring that incontinent care products appropriate to the needs of the client are used whenever they are needed.

(2) Ensuring that clients who can benefit from scheduled toileting are assisted or reminded to go to the bathroom at regular intervals rather than being diapered.

(3) Assisting the client with self–care.

(4) Ensuring that clients with incontinence are kept clean and dry, and that the facility remains free of odors.

(5) Ensuring that, where prescribed, bowel and/or bladder programs are designed by a licensed professional or designee. The person designing the program must have training and experience in care of persons with bowel and/or bladder dysfunction and development of retraining programs for establishing normal patterns of continence.

(A) The licensee shall ensure that clients are assisted with a structured bowel and/or bladder retraining program if one has been designed for the client.

(B) The licensee shall ensure that facility staff responsible for implementing the program receive training from the licensed professional or designee who designed the program.

(C) The licensee obtains from the licensed professional or designee written instructions to facility staff outlining the procedures and shall document the names of facility staff who received the training.

(D) The licensee shall ensure that the licensed professional or designee evaluates the effectiveness of the program and staff as the licensed professional or designee deems appropriate, but at least annually.

(6) Ensuring that the condition of the skin exposed to urine and stool is evaluated regularly to ensure that skin breakdown is not occurring.

(7) Ensuring privacy when care is provided.

(8) Providing needed incontinence supplies when the client or a third party is unable to do so.

(9) Ensuring that fluids are not withheld to control incontinence.

(10) Ensuring that a client with incontinence is not catheterized to control incontinence for the convenience of the licensee or facility staff.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80077.5. Care for Clients with Contractures.

(a) A licensee of an adult CCF may accept or retain a client who has contractures.

(b) If a licensee accepts or retains a client who has contractures, the licensee is responsible for all of the following:

(1) Monitoring the client's ongoing ability to care for his/her contractures in accordance with the physician's instructions.

(2) Ensuring that care is provided by a licensed professional or trained facility staff when the client is unable to provide self–care.

(A) The licensee shall ensure that facility staff responsible for assisting with range of motion exercises or other exercise(s) prescribed by the physician or therapist receive supervision and training from a licensed professional.

(B) The licensee obtains from the licensed professional written documentation outlining the procedures for the exercises and the names of facility staff who received the training.

(C) The licensee shall ensure that the licensed professional reviews staff performance as the licensed professional deems necessary, but at least once a year.

(c) In addition to Section 80077.5(b), in an ARF or SRF, the licensee shall ensure that there is a plan of care for the contractures that is developed by a licensed professional.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80078. Responsibility for Providing Care and Supervision.

(a) The licensee shall provide care and supervision as necessary to meet the client's need.

(b) In any instance where the Department does not suspend the facility license and the licensing agency requires that a client/resident be relocated, as specified in Section 80094, the licensee shall prepare a written relocation plan. The plan shall contain all necessary steps to be taken to reduce stress to the client/resident which may result in transfer trauma.

(1) The written relocation plan shall include, but not be limited to the following:

(A) A specific date for beginning and a specific date for completion of the process of safely relocating the client/resident. The time frame for relocation may provide for immediate relocation but shall not exceed 30 days or 30 days after the date of the written conclusuion of the client's appeal of the relocation order, if appealed.

(B) A specific date when the client/resident and the client's/resident's authorized representative, if any, shall be notified of the need for relocation.

(C) A specific date when consultation with the client's/resident's physician shall occur to obtain a current medical assessment of the client's/resident's health needs, to determine the appropriate facility type for relocation and to ensure that the client's/resident' health care needs continue to be met at all times during the relocation process.

(D) The method by which the licensee shall participate in the identification of an acceptable relocation site with the client/resident and the authorized representative if any. The licensee shall advise the client/resi-dent and/or the authorized representative that if the client/resident is to be moved to another nonmedical community care facility, a determination must be made that the client's/resident's needs can be legally met in the new facility before the move is made. If the client's/resident's needs cannot be legally met in the new facility, the client/resident must be moved to a facility licensed to provide the necessary care.

(E) A list of contacts made or to be made by the licensee with community resources, including but not limited to, social workers, family members, Long Term Care Ombudsman, clergy and others as appropriate to ensure that services are provided to the client/resident before, during and after the move. The need for the move shall be discussed with the client/resident and the client/resident assured that support systems will remain in place.

(F) Measures to be taken until relocation to protect the client/resident and/or meet the client's/resident's health and safety needs.

(G) An agreement to notify the licensing agency when the relocation has occurred, including the client's/resident's new address, if known.

(2) The relocation plan shall be submitted in writing to the licensing agency within the time set forth in the written notice by the licensing agency that the client/resident requires health services that the facility cannot legally provide.

(3) Any changes in the relocation plan shall be submitted in writing to the licensing agency. The licensing agency shall have the authority to approve, disapprove or modify the plan.

(4) If relocation of more than one (1) client/resident is required, a separate plan shall be prepared and submitted in writing for each client/resident.

(5) The licensee shall comply with all terms and conditions of the approved plan. No written or oral contract with any other person shall release the licensee from the responsibility specified in sections 80078(b) and (c) for relocating a client/resident who has a health condition(s) which cannot be cared for in the facility and/or requires inpatient care in a licensed health facility, nor from taking necessary actions to reduce stress to the client/resident.

(6) In cases where the licensing agency determines that the resident is in imminent danger because of a health condition(s) which cannot be cared for in the facility or which requires inpatient care in a licensed health facility, the licensing agency shall have the authority to order the licensee to immediately relocate the resident.

(c) In all cases when a client or resident must be relocated, the licensee shall not obstruct the relocation process and shall cooperate with the licensing agency in the relocation in process. Such cooperation shall include, but not be limited to, the following activities:

(1) Identifying and preparing for removal of the medications, Medi–Cal or Medicare or other medical insurance documents, clothing, safeguarded cash resources, valuables and other belongings of the client or resident.

(2) Contacting the authorized representative of the client/resident to assist in transporting him or her, if necessary.

(3) Contacting other suitable facilities for placement, if necessary.

(4) Providing access to client's/resident's files when required by the Department.

NOTE: Authority Cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1511, 1528, 1531 and 1556, Health and Safety Code.

§ 80079. Activities. (Reserved)

Article 7. Physical Environment

§ 80086. Alterations to Existing Buildings or New Facilities.

(a) Prior to construction or alterations, all licensees shall notify the licensing agency of the proposed change.

(b) The licensing agency shall have the authority to require that the licensee have a building inspection by a local building inspector if the agency suspects that a hazard to the clients' health and safety exists.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80087. Buildings and Grounds.

(a) The facility shall be clean, safe, sanitary and in good repair at all times for the safety and well–being of clients, employees and visitors.

(1) The licensee shall take measures to keep the facility free of flies and other insects.

(2) The licensee shall provide for the safe disposal of water and other chemicals used for cleaning purposes.

(b) All clients shall be protected against hazards within the facility through provision of the following:

(1) Protective devices including but not limited to nonslip material on rugs.

(c) All outdoor and indoor passageways, stairways, inclines, ramps, open porches and other areas of potential hazard shall be kept free of obstruction.

(d) General permanent or portable storage space shall be available for the storage of facility equipment and supplies.

(1) Facility equipment and supplies shall be stored in this space and shall not be stored in space used to meet other requirements specified in this chapter and Chapters 2, and 4 through 7.

(e) All licensees serving children or serving clients who have physical handicaps, mental disorders, or developmental disabilities shall ensure the inaccessibility of pools, including swimming pools (in–ground and above–ground), fixed–in–place wading pools, hot tubs, spas, fish ponds or similar bodies of water through a pool cover or by surrounding the pool with a fence.

(1) Fences shall be at least five–feet high and shall be constructed

so that the fence does not obscure the pool from view. The bottom and sides of the fence shall comply with Division 1, Appendix Chapter 4 of the 1994 Uniform Building Code. In addition to meeting all of the aforementioned requirements for fences, gates shall swing away from the pool, self–close and have a self–latching device located no more than six inches from the top of the gate. Pool covers shall be strong enough to completely support the weight of an adult and shall be placed on the pool and locked while the pool is not in use.

(A) If licensed prior to June 1, 1995, facilities with existing pool fencing shall be exempt from the fence requirements specified in Section 80087(e)(1) until such fence is replaced or structurally altered. If the licensee replaces or alters the fence, it shall be required to meet the fence requirements specified in Section 80087(e)(1).

(2) Where an above–ground pool structure is used as the fence or where the fence is mounted on top of the pool structure, the pool shall be made inaccessible when not in use by removing or making the ladder inaccessible or erecting a barricade to prevent access to decking. If a barricade is used, the barricade shall meet the requirements of Section 80087(e)(1).

(f) All in–ground pools, and above–ground pools which cannot be emptied after each use shall have an operative pump and filtering system.

(g) Disinfectants, cleaning solutions, poisons, firearms and other items that could pose a danger if readily available to clients shall be stored where inaccessible to clients.

(1) Storage areas for poisons, and firearms and other dangerous weapons shall be locked.

(2) In lieu of locked storage of firearms, the licensee may use trigger locks or remove the firing pin.

(A) Firing pins shall be stored and locked separately from firearms.

(3) Ammunition shall be stored and locked separately from firearms.

(h) Medicines shall be stored as specified in Section 80075(m) and (n) and separately from other items specified in Section 80087(g) above.

(i) The items specified in Section 80087(g) above shall not be stored in food storage areas or in storage areas used by or for clients.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 80088. Fixtures, Furniture, Equipment and Supplies.

(a) A comfortable temperature for clients shall be maintained at all areas.

(1) The licensee shall maintain the temperature in rooms that clients occupy between a minimum of 68 degrees F (20 degrees C) and a maximum of 85 degrees F (30 degrees C).

(A) In areas of extreme heat the maximum shall be 30 degrees F (16.6 degrees C) less than the outside temperature.

(2) Nothing in this section shall prohibit clients from adjusting individual thermostatic controls.

(b) All window screens shall be in good repair and be free of insects, dirt and other debris.

(c) Fireplaces and open–faced heaters shall be inaccessible to clients to ensure protection of the clients' safety.

(d) The licensee shall provide lamps or lights as necessary in all rooms and other areas to ensure the comfort and safety of all persons in the facility.

(e) Faucets used by clients for personal care such as shaving and grooming shall deliver hot water.

(1) Hot water temperature controls shall be maintained to automatically regulate temperature of hot water delivered to plumbing fixtures used by clients to attain a hot water temperature of not less than 105 degrees F (40.5 degrees C) and not more than 120 degrees F (48.8 degrees C).

(2) Taps delivering water at 125 degrees F (51.6 degrees C) or above shall be prominently identified by warning signs.

(3) All toilets, handwashing and bathing facilities shall be maintained in safe and sanitary operating condition. Additional equipment, aids, and/or conveniences shall be provided in facilities accommodating physically handicapped clients who need such items.

(f) Solid waste shall be stored, located and disposed of in a manner that will not transmit communicable diseases or odors, create a nuisance, or provide a breeding place or food source for insects or rodents.

(1) All containers, including movable bins, used for storage of solid wastes shall have tight–fitting covers kept on the containers; shall be in good repair, shall be leakproof and rodent–proof.

(2) Solid waste containers, including movable bins, receiving putrescrible waste shall be emptied at least once per week or more often if necessary to comply with (f) above.

(3) Each movable bin shall provide for suitable access and a drainage device to allow complete cleaning at the storage area.

(g) The licensee shall provide linens of various kinds necessary to meet the program of services being offered by the facility and the requirements specified in Chapters 2 through 7.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

Article 8. Health Related Services

§ 80090. Health and Safety Services.

(a) The provisions of this article are applicable to adult CCFs.

(b) Waivers or exceptions will not be granted to accept or retain clients who have health conditions prohibited by Section 80091.

(c) The Department may grant an exception allowing acceptance or retention of a client who has a medical or health condition not listed in Section 80092 if all of the following requirements are met:

(1) Either the condition is chronic and stable or it is temporary in nature and is expected to return to a condition normal for that client.

(2) The client must be under the medical care of a licensed professional.

(3) The licensee has developed a plan of care for the client as specified in Sections 80068.2 and 80092.2.

(4) The client is able to care for all aspects of the condition for himself/herself or assistance in the care of the condition is provided either by an appropriately skilled and licensed professional or by facility staff who receive supervision and training from a licensed professional.

(A) Training shall include hands–on instruction in both general procedures and client–specific procedures.

(B) The licensee obtains from the licensed professional written documentation outlining the procedures and the names of facility staff who received the training.

(C) The licensee ensures that the licensed professional reviews staff performance as the licensed professional deems necessary, but at least once a year.

(5) The licensee agrees in writing to comply with all aspects of the client's care plans.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1530, Health and Safety Code.

§ 80091. Prohibited Health Conditions.

(a) In adult CCFs clients who require health services or have a health condition including, but not limited to, those specified below shall not be admitted or retained.

(1) Naso–gastric and naso–duodenal tubes.

(2) Active, communicable TB.

(3) Conditions that require 24–hour nursing care and/or monitoring.

(4) Stage 3 and 4 dermal ulcers.

(5) Any other condition or care requirements which would require the facility to be licensed as a health facility as defined by Sections 1202 and 1250 of the Health and Safety Code.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507, 1530, 1531 and 1557.5, Health and Safety Code.

§ 80092. Restricted Health Conditions.

(a) Adult CCFs may accept or retain clients who have the conditions listed in this section only if all requirements of Article 8 are met.

(b) Care for the following health conditions must be provided only as specified in Sections 80092.1 through 80092.11.

(1) Use of inhalation–assistive devices as specified in Section 80092.3.

(2) Colostomy/ileostomies as specified in Section 80092.4.

(3) Requirement for fecal impaction removal, enemas, or suppositories only as specified in Section 80092.5.

(4) Use of catheters only as specified in Section 80092.6.

(5) Staph or other serious, communicable infections as specified in Section 80092.7.

(6) Insulin–dependent Diabetes as specified in Section 80092.8.

(7) Stage 1 and 2 dermal ulcers as specified in Section 80092.9.

(8) Wounds as specified in Section 80092.9.

(9) Gastrostomies as specified in Section 80092.10.

(10) Tracheostomies as specified in Section 80092.11.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.1. General Requirements for Restricted Health Conditions.

(a) A client with a restricted health condition specified in Section 80092 may be admitted or retained in an adult CCF if all requirements in Sections 80092.1(b) through (o) are met.

(b) The licensee is willing to provide the needed care.

(c) Care is provided as specified in this article.

(d) Either the client's medical condition is chronic and stable, or is temporary in nature and is expected to return to a condition normal for that client, and

(e) The client must be under the medical care of a licensed professional.

(f) Prior to admission of a client with a restricted health condition specified in Section 80092, the licensee shall:

(1) Communicate with all other persons who provide care to that client to ensure consistency of care for the medical condition.

(2) Ensure that facility staff who will participate in meeting the client's specialized care needs complete training provided by a licensed professional sufficient to meet those needs.

(A) Training shall include hands–on instruction in both general procedures and client–specific procedures.

(g) All new facility staff who will participate in meeting the client's specialized care needs shall complete the training prior to providing services to the client.

(h) The licensee shall ensure that facility staff receive instruction from the client's physician or other licensed professional to recognize objective symptoms observable by a lay person, and how to respond to that client's health problems, including who to contact.

(i) The licensee shall monitor the client's ability to provide self–care for the restricted health condition, document any change in that ability, and inform the persons identified in Section 80092.2(a)(1) of that change.

(j) Should the condition of the client change, all staff providing care and services shall complete any additional training required to meet the client's new needs, as determined by the client's physician or a licensed professional designated by the physician.

(k) If the licensed health professional delegates routine care, the following requirements must be met for health conditions specified in Sections 80092.3, 80092.4 and 80092.6 through 80092.11:

(1) The licensee shall obtain written documentation from the licensed professional outlining the procedures and the names of the facility staff who have been trained in those procedures.

(2) The licensee ensures that the licensed professional reviews staff performance as often as necessary, but at least annually.

(*l*) All training shall be documented in the facility personnel files.

(m) The licensee of an ARF or SRF shall develop and maintain, as part of the Needs and Services Plan, a Restricted Health Condition Care Plan as specified in Section 80092.2.

(1) The care plan shall neither require nor recommend that the licensee or any facility personnel or any other person providing care, other than a physician or licensed professional, implement any health care procedure that may legally be provided only by a physician or licensed professional.

(n) The licensee shall ensure that the client's health–related service needs are met and shall follow the approved plan for each client.

(o) The licensee shall document any significant occurrences that result in changes in the client's physical, mental and/or functional capabilities and report these changes to the client's physician and authorized representative.

(p) The licensee shall demonstrate compliance with the restricted health condition care plan by maintaining in the facility all relevant documentation.

(q) The licensee shall report any substantive deviation from the care plan to the client's authorized representative.

(r) The duty established by this section does not infringe on a client's right to receive or reject medical care or services, as allowed in Section 80072.

(1) If a client refuses medical services specified in the care plan, the licensee shall immediately notify all persons identified in Section 80092.2(a)(1) and shall participate in developing a plan for meeting the client's needs.

(2) If unable to meet the client's needs, the licensee shall issue an eviction notice as specified in Section 80068.5.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.2. Restricted Health Condition Care Plan.

(a) If the licensee of an ARF or SRF chooses to care for a client with a restricted health condition, as specified in Section 80092, the licensee shall develop and maintain, as part of the Needs and Services Plan, a written Restricted Health Condition Care Plan. The plan must include all of the following:

(1) Documentation that the client and the client's authorized representative, if any, the client's physician or a licensed professional designated by the physician, and the placement agency, if any, participated in the development of the plan.

(2) Documentation by the client's physician or a licensed professional designated by the physician, of the following:

(A) Stability of the medical conditions.

(B) Medical conditions that require services or procedures.

(C) Specific services needed.

(D) Client's ability to perform the procedures.

(E) The client does not require 24–hour nursing care and/or monitoring.

(3) Identification of a licensed professional who will perform procedures if the client needs medical assistance.

(4) Identification of the person who will perform incidental medical assistance that does not require a licensed professional.

(5) Name and telephone number of emergency medical contacts.

(6) A date specified by the client's physician or designee, who is also a licensed professional, when the plan must be reviewed by all parties identified in Section 80092.2(a)(1).

(7) A signed statement from the client's attending physician that the plan meets medical scope of practice requirements.

(8) For clients of a placement agency, a signed statement from a representative of the placement agency, that they have reviewed and approved the plan and that the placement agency will monitor implementation of the plan.

(b) The Restricted Health Condition Care Plan shall neither require

nor recommend that the licensee or any facility personnel or any other person providing care, other than a physician or licensed professional, implement any health care procedure that may legally be provided only by a physician or licensed professional.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.3. Inhalation–Assistive Devices.

(a) A licensee of an adult CCF may accept or retain a client who requires the use of an inhalation–assistive device if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The licensee monitors the client's ongoing ability to operate and care for the device in accordance with the physician's instructions.

(3) The licensee ensures that either:

(A) The device is operated and cared for by a licensed professional when the client is unable to operate the device, or determine his/her own need.

(B) The device can legally be operated by an unlicensed person and is cared for by facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

(4) The licensee ensures that:

(A) The device is functional.

(B) The device is removed from the facility when no longer prescribed for use by the client.

(5) The licensee ensures that the room containing the device is large enough both to accommodate it and to allow easy passage of clients and staff.

(6) The licensee ensures that facility staff have the knowledge of and ability to care for the device.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.4. Colostomy/Ileostomy.

(a) A licensee of an adult CCF may accept or retain a client who has a colostomy or ileostomy if all of the following conditions are met:

(1) The client is mentally and physically capable of providing all routine care for his/her ostomy, and the physician has documented that the ostomy is completely healed.

(2) A licensed professional provides assistance in the care of the ostomy.

(3) The licensee is in compliance with Section 80092.1.

(4) The licensee monitors the client's ongoing ability to provide care for his/her ostomy in accordance with the physician's instructions.

(5) The licensee ensures that:

(A) A licensed professional provides ostomy care when the client is unable to provide self–care.

(B) The ostomy bag and adhesive may be changed by facility staff who receive training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

(6) The licensee ensures that used bags are discarded as specified in Section 80088(f)(2).

(7) The licensee ensures privacy when ostomy care is provided.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.5. Fecal Impaction Removal, Enemas, or Suppositories.

(a) A licensee of an adult CCF may accept or retain a client who requires manual fecal impaction removal, enemas, or use of suppositories if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The licensee monitors the client's ongoing ability to provide his/her own routine care in accordance with the physician's instructions.

(3) The license ensures that a licensed professional administers the fecal impaction removal, enemas, or suppositories when the client is unable to do so for himself/herself.

(4) The licensee ensures that a licensed professional performs manual fecal impaction removal whenever it is necessary.

(5) The licensee ensures privacy when care is being provided.

NOTE: Authority cited: Section 1530, Health and Safety Code. References: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.6. Indwelling Urinary Catheter/Catheter Procedure.

(a) A licensee of an adult CCF may accept or retain a client who requires an indwelling catheter if all of the following conditions are met:

(1) The client is physically and mentally capable of caring for all aspects of the condition except insertion, removal and irrigation.

(A) Irrigation shall only be performed by a licensed professional in accordance with the physician's orders.

(B) Insertion and removal shall only be performed by a licensed professional.

(2) The licensee is in compliance with Section 80092.1.

(3) The licensee monitors the client's ongoing ability to care for his/her catheter in accordance with the physician's instructions.

(4) The licensee ensures that either catheter care is provided by a licensed professional when the client is unable to provide self–care, or the catheter bag and tubing are changed and bags are emptied by facility staff who receive training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

(5) The licensee ensures that insertion, removal and irrigation of the catheter, or any other required catheter care other than that specified in Section 80092.6(a)(4) are performed by a licensed professional.

(6) The licensee ensures that waste materials are disposed of as specified in Section 80088(f)(2).

(7) The licensee ensures privacy when care is provided.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.7. Staph or Other Serious, Communicable Infections.

(a) A licensee of an adult CCF may accept or retain a client who has a staph or other serious communicable infection if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The licensee has obtained a statement from the client's physician that the infection is not a risk to other clients.

(3) The licensee monitors the client's ongoing ability to care for his/her own condition by complying with the instructions of the licensed professional who is managing the client's care.

(A) The licensed professional may delegate certain aspects of the care providing the facility staff responsible for providing the care receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2) prior to providing care.

(4) The licensee ensures that a licensed professional assesses the infection and evaluates the treatment at intervals set by the physician or a licensed professional designated by the physician.

(5) The licensee ensures that prior to providing care, staff are trained in and follow Universal Precautions and any other procedures recommended by the licensed professional for protection of the client who has the infection, other clients and staff.

(6) The licensee ensures that all aspects of care performed in the facility by the licensed professional and facility staff are documented in the client's file.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.8. Diabetes.

(a) A licensee of an adult CCF may accept or retain a client who has diabetes if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The client is mentally and physically capable of administering his/her own medication and performing his/her own glucose testing

if applicable, or a licensed professional administers the tests and injections.

(A) The licensed professional may delegate to trained facility staff glucose testing provided all of the following conditions are met:

1. The blood glucose–monitoring test is performed with a blood glucose–monitoring instrument that has been approved by the federal Food and Drug Administration for over–the–counter sale.

2. The licensee ensures that facility staff responsible for glucose testing receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

3. Facility staff comply with the instructions of the licensed professional regarding the performance of the test and the operation of the blood glucose–monitoring instrument.

4. Facility staff immediately notify the client's physician if the results are not within the normal range for the client.

5. The licensee ensures that the results of each blood glucose test performed by facility staff are documented and maintained in the client's record in the facility.

(3) The licensee ensures that sufficient amounts of medicines, testing equipment, syringes, needles, and other supplies are maintained and stored in the facility.

(4) The licensee ensures that injections are administered immediately after a syringe is filled unless the client is using prefilled syringes prepared by a registered nurse, pharmacist, or drug manufacturer.

(5) The licensee ensures that syringes and needles are disposed of in accordance with California Code of Regulations, Title 8, Section 5193.

(6) The licensee provides a modified diet as prescribed by a client's physician, as specified in Section 80076(a)(6). Any substitutions shall be made by the facility dietitian or in consultation with a registered dietician or the client's physician or medical provider.

(7) The licensee ensures that all facility staff who provide care receive training in recognizing the signs and symptoms of hyperglycemia and hypoglycemia and in taking appropriate action for client safety.

(b) For clients who provide self–care, the licensee shall:

(1) Monitor the client's ongoing ability to preform his/her glucose testing and administer his/her medication in accordance with the physician's instructions.

(2) Assist clients with self–administered medication, as specified in Section 80075.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1531, Health and Safety Code.

§ 80092.9. Wounds.

(a) A licensee of an adult CCF may accept or retain a client who has a serious wound if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The wound is either an unhealed, surgically closed incision or wound, or determined by the physician or a licensed professional designated by the physician to be a Stage 1 or 2 dermal ulcer and is expected by the physician or designated professional to completely heal.

(3) The licensee ensures that a licensed professional in accordance with the physician's instructions provides the wound care.

(A) The licensed professional may delegate simple dressing to facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

(4) The licensee ensures that a licensed professional assesses the wound at intervals set by the physician, or a licensed professional designated by the physician, to evaluate treatment and progress toward healing.

(5) The licensee ensures that all aspects of care performed by the licensed professional facility staff are documented in the client's file.

(b) Non–serious wounds, which include but are not limited to minor cuts, punctures, lacerations, abrasions, and first–degree burns are not affected by this section.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.10. Gastrostomy Feeding, Hydration, and Care.

(a) A licensee of an adult CCF may accept or retain a client who requires gastrostomy care, feeding, and/or hydration if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) The physician has documented that the gastrostomy is completely healed.

(3) The licensee monitors the client's ongoing ability to provide all routine feeding, hydration and care for his/her gastrostomy in accordance with the physician's instructions.

(4) The licensee ensures that gastrostomy feeding, hydration, medication administration through the gastrostomy, and stoma cleaning are provided by a licensed professional when the client is unable to provide his/her own feeding, hydration and care.

(A) The licensed professional may delegate the following tasks to facility staff who receive training from a licensed professional as specified in Sections 80092.1(k) through (k)(2).

1. Gastrostomy feeding, hydration, and stoma cleaning.

2. For routine medications, trained staff may add medication through the gastrostomy per physician's or nurse practitioner's orders.

3. For PRN medications, trained staff may add medications through the gastrostomy in accordance with Section 80075(b) through (e).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.11. Tracheostomies.

(a) A licensee of an adult CCF may accept or retain a client who has a tracheostomy if all of the following conditions are met:

(1) The licensee is in compliance with Section 80092.1.

(2) Either the client is mentally and physically capable of providing all routine care for his/her tracheostomy and the physician has documented that the tracheostomy opening (stoma) is completely healed, or assistance in the care of the tracheostomy is provided by a licensed professional.

(A) The licensed professional may delegate routine care for the tracheostomy to facility staff who receive supervision and training from the licensed professional as specified in Sections 80092.1(k) through (k)(2).

1. Suctioning shall not be delegated to facility staff.

(3) The licensee monitors the client's ongoing ability to provide all routine care for his/her tracheostomy in accordance with the physician's instructions.

(4) The licensee ensures that tracheostomy care is provided by a licensed professional when the client is unable to provide self–care.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80092.12. Tracheostomies.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1507 and 1530, Health and Safety Code.

§ 80093. Department Review of Health–Related Conditions.

(a) The Department may review actual or suspected health–related conditions, including those specified in Section 80092, to determine if a client is appropriately placed in the facility and if the client's health–related needs are being met. The Department will inform the licensee that the client's health–related condition requires review and will specify documentation that the licensee shall submit to the Department.

(1) Documentation includes, but is not limited to, the following:

(A) Restricted Health Condition Care Plan, if applicable.

(B) Needs and Services Plan.

(C) Copies of prescriptions for medical services and/or medical equipment.

(2) The licensee shall submit the documentation to the Department within 10 working days.

(b) If the Department determines that the client has a restricted health condition, as specified in Section 80092, the licensee shall provide care to the client in accordance with conditions specified in Sections 80092.1 and applicable requirements in Sections 80092.3 through 80092.11. If the licensee is not able to provide adequate care, the client shall be relocated.

(c) If the Department determines that the client has a prohibited health condition, as specified in Section 80091 or a health condition that cannot be cared for within the limits of the license or within the abilities of that specific facility, the Department will order relocation of the client as specified in Section 80094.

(1) The notification to the licensee will include notice of all appeal rights, as specified in Section 80094.

(d) This section does not entitle the licensee to a full evidentiary hearing, state hearing, or any other administrative review beyond that set forth in this section.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 80094. Health Condition Relocation Order.

(a) In an adult CCF the Department will order relocation of a client if the Department makes any of the following determinations:

(1) The client has a prohibited health condition, as specified in Section 80091.

(2) The licensee has not met all of the requirements in Sections 80092.1 and applicable requirements in Sections 80092.3 through 80092.11.

(3) The client has a health condition that cannot be cared for within the limits of the license or within the abilities of that specific facility.

(b) The Department will give written notice to the licensee ordering the relocation of the client and informing the licensee of the client's right to an IDT review of the relocation order.

(1) Concurrently, the Department will give the notice of the health condition relocation order and information about the client's right to request review of the relocation order to the client. The Department will mail, by certified mail, or deliver a copy within one working day to the client's authorized representative, if any and responsible person.

(A) If the client has no authorized representative, as defined in Section 80001, the relocation order shall be sent to the responsible person and representative payee, if any.

(2) The health condition relocation order will state the reason for the relocation order and cite the regulation(s) requiring the relocation.

(3) Upon receipt of the relocation order, the licensee shall prepare a written relocation plan in compliance with Section 80078.

NOTE: Authority Cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507, 1530, 1531 and 1556, Health and Safety Code.

§ 80094.5. Client's Request for Review of a Health Condition Relocation Order by the Interdisciplinary Team (IDT).

(a) A client or the client's authorized representative, if any, may request a review of the Department's health condition relocation order by the IDT.

(b) The client or the client's authorized representative, if any, has 10 working days from receipt of the relocation order to submit to the licensee a written, signed, and dated request for a review and determination by the IDT.

(1) For purposes of this section, a working day is any day except Saturday, Sunday, or an official state holiday.

(c) The licensee shall mail or deliver such a request to the Department within two (2) working days of receipt.

(1) Failure or refusal to do so may subject the licensee to civil penalties, as provided in Section 80054.

(d) Within five (5) working days of receipt by the Department of the request for review, the Department will give written notification to the licensee, client and the client's authorized representative, if any, acknowledging receipt of the client's request for review of the relocation order.

(e) Within twenty (20) working days from the date of the client's review request, the licensee shall submit to the Department the documentation specified in this section to complete the client's review request.

(1) If the information is not received within twenty (20) days, the request for review shall be considered withdrawn, the licensee shall be notified, and the relocation plan will be implemented.

(f) The licensee shall cooperate with the client and the client's authorized representative, if any, in gathering the documentation to complete the client's review request.

(g) The documentation to complete the client's review request shall include, but not be limited to, the following:

(1) The reason(s) for disagreeing that the client has the health condition identified in the relocation order and why the client believes he/she may legally continue to remain in a CCF.

(2) Current health and functional capabilities assessments, as specified in Sections 80069 and 80069.2.

(A) For purposes of this section, "current" means a medical assessment completed on or after the date of the relocation order.

(3) A written statement from any placement agency currently involved with the client addressing the relocation order.

(h) The Department will inform the licensee, client and the client's authorized representative, if any, in writing, of the IDTs determination and the reason for that determination not more than 30 days after the Department's receipt of the information required in this section.

(i) A client does not have a right to a review under this section in any of the following circumstances:

(1) A health condition relocation order has been issued under Section 80078(b)(6).

(2) A client has been evicted under Section 80068.5.

(3) A temporary suspension order has been issued under Section 80042.

(j) This section does not entitle the client to a right to a state hearing or any other administrative review beyond that set forth in this section.

NOTE: Authority Cited: Section 1530, Health and Safety Code. Reference: Sections 1507, 1530 and 1556, Health and Safety Code.

§ 80095. Clients in Care at Time of Final Adoption of Regulations.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

Chapter 5. Group Homes

Article 1. General Requirements and Definitions

§ 84000. General.

(a) Group homes, as defined in section 80001.g.(1), shall be governed by the provisions specified in this chapter and in chapter 1. General Requirements.

(b) Group homes shall not accept for placement children who are under the age of six years, unless the facility is licensed for that age group and meets the requirements of Subchapter 2, beginning with Section 84200.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1502, 1530, 1530.8 and 1531, Health and Safety Code; and Section 11467.1, Welfare and Institutions Code.

§ 84001. Definitions.

In addition to section 80001, the following shall apply:

(a)(1) "Approved schools, colleges or universities, including correspondence courses offered by the same," means those approved/authorized by the U.S. Department of Education, Office of Postsecondary Education or by the California Department of Consumer Affairs,

Bureau for Private Postsecondary and Vocational Education, pursuant to Education Code Sections 94900 or 94915.

(2) "Accredited schools, colleges or universities, including correspondence courses offered by the same," means those educational institutions or programs granted public recognition as meeting established standards and requirements of an accrediting agency authorized by the U.S. Secretary of Education.

(3) "Affiliated with licensee" means members of board of directors, executive director, officers and individuals paid by the group home licensee as staff, consultant or contractor used to fulfill the plan of operation.

(4) "Assaultive Behavior" means violent, physical actions which are likely to cause immediate physical harm or danger to an individual or others.

(A) Verbal Assault is not considered a form of assaultive behavior.

(5) "Minor parent program" means a group home program that serves pregnant minors and minor parents with children younger than six years of age, who are dependents of the court, nondependents, voluntary and/or regional center placements, and reside in the group home with the minor parent, who is the primary caregiver of the young child.

(b)(1) "Behavior Management Consultant", for the purpose of this Chapter, means a person who designs and/or implements behavior modification intervention services and meets one of the following requirements as specified in California Code of Regulations, Title 17, Sections 54344(d).

(c)(1) "Certificate holder" means a person who has a current administrator's certificate issued by the Department regardless of whether the person is employed as an administrator in a group home.

(2) "Child" means a person who is under 18 years of age and who is being provided care and supervision in a group home, except where specified otherwise in this chapter.

(3) "Child with Special Health Care Needs" means a child who meets all of the following conditions:

(A) Has a medical condition that requires specialized in–home health care and

(B) Is one of the following:

1. A child who has been adjudged a dependent of the court under Section 300 of the Welfare and Institutions Code.

2. A child who has not been adjudged a dependent of the court under Section 300 of the Welfare and Institutions Code but who is in the custody of the county welfare department.

3. A child with a developmental disability who is receiving services and case management from a regional center.

(4) "Complete Request" means the vendor applicant has submitted and the Department has received all required information and materials necessary to approve or deny the request for certification program and/or course approval.

(5) "Continuing Education Training Program Vendor" means a vendor approved by the Department to provide Continuing Education training courses to group home administrators and certificate holders to qualify them for renewal of their group home administrator certificate.

(d)(1) "Discipline" means a penalty assessed by the facility against a child for his/her violation of the group home's rules, commitment of illegal actions or damage to property.

(e)(1) "Early Intervention" means the use of non–physical, de–escalation interventions to control injurious behavior. Techniques include, but are not limited to, suggesting alternative behavior, crisis communication and evasive techniques.

(2) "Emergency Intervention" means the justified use of early interventions and/or otherwise prohibited manual restraints to protect the child or others from harm.

(3) "Emergency Intervention Plan" means a written plan which addresses how emergency intervention techniques will be implemented by the licensee in compliance with the requirements specified in Section 84322.

(4) "Emergency Intervention Staff Training Plan" means a written plan which specifies the training provided to group home personnel regarding the use of emergency interventions, as specified in Section 84322(g). The emergency intervention staff training plan is a component of the Emergency Intervention Plan.

(f)(1) "Facility Manager" as defined in Health and Safety Code section 1522.4(a)(1).

(g)(1) "Group Home" means a facility which provides 24–hour care and supervision to children, provides services specified in this chapter to a specific client group, and maintains a structured environment, with such services provided at least in part by staff employed by the licensee. The care and supervision provided by a group home shall be nonmedical except as permitted by Welfare and Institutions Code Section 17736(b). Since small family and foster family homes, by definition, care for six or fewer children only, any facility providing 24–hour care for seven or more children must be licensed as a group home.

(2) "Group Home Program Statement" means a written plan which identifies the client population, program structure and supervision, and provides specific program information. The group home program statement must contain all the elements required in the plan of operation, as specified in Section 84022.

(h)(1) "Health Care Professional" means a physician or an individual who is licensed or certified under Division 2 of the Business and Professions Code to perform the necessary client care procedures prescribed by a physician. Such health care professional include the following: Registered Nurse, Public Health Nurse, Licensed Vocational Nurse, Psychiatric Technician, Physical Therapist, Occupational Therapist and Respiratory Therapist.

(i)(1) "Incident Report" means a written report required by the Department to report incidents as specified in Sections 80061 and 84061.

(2) "Individualized Health Care Plan" means the written plan developed by an individualized health care plan team and approved by the team physician, or other health care professional designated by the physician to serve on the team, for the provision of specialized in–home health care.

(3) "Individualized Health Care Plan Team" means those individuals who develop an individualized health care plan for a child with special health care needs. This team must include the child's primary care physician or other health care professional designated by the physician, any involved medical team, the county social worker or regional center caseworker, and any health care professional designated to monitor the specialized in–home health care provided to the child as stated in the child's individualized health care plan. The individualized health care plan team may include, but shall not be limited to, a public health nurse, representatives from the California Children's Services Program or the Child Health and Disability Prevention Program, regional centers, the county mental health department and where reunification is the goal, the parent or parents, if available. In addition, the individualized health care plan team may include the prospective specialized group home licensee who shall not participate in any team determination required by Sections 84065.1(a)(1)(B) and (b)(2).

(4) "Initial Certification Training Program Vendor" means a vendor approved by the Department to provide the initial forty (40) hour certification training program to persons who do not posses a valid group home administrator certificate.

(j) (Reserved)

(k) (Reserved)

(l) (Reserved)

(m)(1) "Manual Restraint" means the use of a hands–on or other physically applied technique to physically limit the freedom of movement of a child. Techniques include, but are not limited to, forced es-

corts; holding; prone restraints; or other containment techniques, including protective separation.

(2) "Manual Restraint Plan" means a written plan which address how manual restraints will or will not be implemented by the licensee in compliance with the requirements specified in Sections 84322(e) and (f). The manual restraint plan is a component of the emergency intervention plan.

(3) "Mechanical Restraint" means any physical device or equipment which restricts the movement of the whole or a portion of a child's body, including, but not limited to, handcuffs, restraining sheets, restraining chairs, leather cuffs and belts or any other similar method.

(4) "Medical Conditions Requiring Specialized In–Home Health Care" means, provided that care may be safely and adequately administered in the home:

(A) A dependency upon one or more of the following: enteral feeding tube, total parenteral feeding, a cardiorespiratory monitor, intravenous therapy, a ventilator, oxygen support, urinary catheterization, colostomy, ileostomy, ileal conduit, or other medical or surgical procedures or special medication regimens, including injection, and intravenous medication; or

(B) Conditions such as AIDS, premature birth, congenital defects, severe seizure disorders, severe asthma, bronchopulmonary dysplasia, and severe gastroesophageal reflux when his/her condition could rapidly deteriorate causing permanent injury or death.

(n)(1) "Needs and Services Plan" means a time–limited, goal–oriented written plan, implemented by the licensee, which identifies the specific needs of an individual child, including those items specified in Sections 84068.2 and 84168.3; and delineates those services necessary in order to meet the child's identified needs.

(o) (Reserved)

(p)(1) "Physical Restraining Device" means any physical or mechanical device, material, or equipment attached or adjacent to a child's body which the child cannot remove easily and which restricts the child's freedom of movement. Restraining devices include leg restraints, arm restraints, soft ties or vests, wheel chair safety bars. and full length bedrails.

(2) "Protective Separation" means the voluntary or involuntary removal of a child for the purpose of protecting the child from injuring himself, herself or others.

(3) "Protective Separation Room" means an unlocked room specifically designated and designed for the involuntary separation of a child from other children for a limited time period for the purpose of protecting the child from injuring or endangering himself, herself or others.

(q)(1) "Qualified Mental Retardation Professional" means a person described in Title 22, division 5, chapter 8, section 76834.

(r)(1) "Runaway" means a child who absents himself or herself from the facility without permission from facility personnel.

(2) "Runaway Plan" means a written plan which addresses how the licensee will respond to runaway situations.

(s)(1) "Satellite Home" means a facility which is owned by, contracted with, or otherwise controlled by the licensee of another group home. The primary function of the satellite home is to provide residential services to children who are former clients of the primary group home and/or to children who receive direct services from the primary group home. As specified in section 80008(b), each satellite home is required to independently meet regulations applicable to its licensed category.

(2) "Social Work Staff" means at least one social worker or other professional person trained in the behavioral sciences who provides, either through employment or alternative means, those services specified in this chapter.

(3) "Specialized Group Home" means a licensed group home which provides specialized in–home health care to children.

(4) "Specialized In–Home Health Care" means health care identified by the child's physician as appropriately administered in the facility by a health care professional or by a licensee or staff trained by health care professionals pursuant to the child's individualized health care plan. For a child with special health care needs placed in a group home after November 1, 1993, these services must be provided by a health care professional.

(A) Such alternative means shall include services provided by the social work staff of placement agencies only when such services are within the scope of the duties assigned to the worker by his/her agency.

(t) (Reserved)

(u) (Reserved)

(v) (1) "Vendor" means a Department–approved institution, association, individual(s), or other entity that assumes full responsibility or control over a Department–approved Initial Certification Training Program and/or a Continuing Education Training Program.

(2) "Vendor Applicant" means any institution, association, individual(s), or other entity that submits a request for approval of an Initial Certification Training Program and/or a Continuing Education Training Program.

(w) (Reserved)

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Sections 1522.41(j), 1530, 1530.8 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1502, 1503, 1507, 1522.4, 1522.41, 1522.41(j), 1530.8 and 1531, Health and Safety Code; Sections 11331.5(d), 11406(c), 17710(a), (d), (g) and (h), 17731, 17736(a) and (b), Welfare and Institutions Code; and 45 CFR Section 1351.1(k).

§ 84002. Definitions—Forms.

The following forms are incorporated by reference:

(a) LIC 9165 (2/99), Board of Directors Statement.

(b) PUB 326 (4/99), Facts You Need to Know, Group Home Board of Directors.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1520.1(b)(1) and (2), Health and Safety Code.

Article 2. Licensing

§ 84009. Posting of License.

(a) The license shall be posted in a prominent, publicly accessible location in the facility.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84010.1. Term Limits for Specialized Group Homes.

(a) Group homes may provide care and supervision to children with special health care needs provided that either:

(1) The child was placed in the group home before January 1, 1992, and has since resided continuously in the home; or

(2) The child was or will be placed in the group home on or after January 1, 1992, and all of the following conditions are met:

(A) The child has not spent more than 120 calendar days in any group home or combination of group homes while having special health care needs.

1. The 120–day limitation may not be extended except with the written approval of the District or his/her designee.

(B) The placement is on an emergency basis for the purpose of arranging a subsequent placement in a less restrictive setting, such as with the child's natural parents or relatives, with a foster parent or foster family agency, or with another appropriate person or facility.

(C) The county social worker, regional center caseworker or authorized representative for each child in the home determines that the specialized group home can meet the specific needs of his/her child.

(b) The licensee of a group home shall not accept a child requiring

in–home health care, other than incidental medical services pursuant to Section 1507 of the Health and Safety Code, unless the child is a child with special health care needs.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 17732(a), (d) and (e) and 17736(a), Welfare and Institutions Code; and Section 1507, Health and Safety Code.

§ 84010.2. Prohibition of Dual Licensure for Specialized Group Homes.

(a) A group home licensee shall not hold any day care, other residential or health care facility license for the same premises as the group home while the home is providing care and supervision to children with special health care needs.

(1) Any group home licensee planning to provide care and supervision to a child with special health care needs who holds a license as specified in Section 84010.2(a) shall surrender the license to the licensing agency prior to accepting a child with special health care needs.

(2) The provisions specified in Sections 84010.2(a) and (a)(1) shall not apply to existing licensed group homes that meet both of the following:

(A) All children with special health care needs were accepted prior to the effective date of this section; and

(B) No application for a day care, other residential or health facility license was approved for the premises on or after the effective date of this section.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Section 17732(e), Welfare and Institutions Code; and Sections 1300, 1531 and 1524(c), Health and Safety Code.

§ 84012. False Claims; Ineligibility.

If a person is determined to have made, disseminated, participated in making, or caused to be made a false or misleading statement pursuant to Section 80012(a), and that statement has resulted in a group home overpayment being assessed pursuant to the Manual of Policies and Procedures Section 11–402.6 et seq., then such person shall not be eligible for a new license under Division 6 or Division 12 and shall not be eligible to serve as an officer or employee of a new or subsequent licensee under Division 6 or Division 12 until the group home overpayment is fully repaid or otherwise discharged.

NOTE: Authority cited: Section 1550, Health and Safety Code. Reference: Section 1550, Health and Safety Code; and Sections 11466.22(a), (b), (e) and (f), Welfare and Institutions Code.

Article 3. Application Procedures

§ 84018. Application for License.

(a) In addition to Section 80018, the following shall apply.

(b) Each applicant shall submit the following to the licensing agency:

(1) A financial plan of operation on forms provided or approved by the department.

(A) Start–up funds shall be available and shall include funds for the first three months of operation.

(B) Start–up funds shall be independent of prospective client fees. In cases of a change of ownership, expected income from clients currently in placement shall be considered.

(C) Start–up funds shall not include funds designated for or used for construction costs.

(D) The licensing agency shall have the authority to require written verification of the availability of the funds specified in (A) above.

(2) A written plan for training of child care staff, as specified in Section 84065(h), and facility managers, as specified in Section 84065(k).

(3) A written plan for activities as specified in Sections 84079(a) through (a)(5).

(4) The name and residence and mailing addresses of the facility administrator, a description of the administrator's background and qualifications, and documentation verifying required education and administrator certification.

(c) Each corporate applicant shall obtain a signed form, LIC 9165 from each member of the board of directors. A copy of each signed LIC 9165 shall be submitted to the Department.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1522.41(b), 1531 and 1562, Health and Safety Code.

§ 84022. Plan of Operation.

(a) In addition to Section 80022, the following shall apply.

(b) The plan of operation shall include the following:

(1) A statement regarding the types of children to be served by the facility, including dependent, neglected, delinquent, predelinquent, physically handicapped, developmentally disabled, mentally disordered, or emotionally disturbed children.

(2) A description of services to be provided by the facility which shall include the following:

(A) Procedures for development of a needs and services plan which addresses each child's needs and the services required to meet such needs.

(B) Procedures for review and evaluation of the needs and services plan.

(C) Policy regarding participation f the child and his/her authorized representative(s) in the development of the needs and services plan.

(D) Procedures for implementation and modification of the needs and services plan.

(E) Policies and procedures for the child's discharge when he/she reaches age 18; after needs and services plan goals have been reached; when the needs and services plan has proven to be ineffective; or when it has been determined that the child's continued placement in the facility is detrimental to the child or other children in the facility.

(3) The administrative policies and procedures to be used to implement the facility's plan of operation.

(4) A written Emergency Intervention Plan as specified in Section 84322.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84026. Safeguards for Cash Resources, Personal Property, and Valuables.

(a) In addition to Section 80026, the following shall apply.

(b) The licensee shall have written policies and procedures meeting the requirements in (c) below approved in advance by the licensing agency.

(c) The licensee shall ensure that a child's cash resources are not taken in the form of fines unless the following requirements are met:

(1) All fines levied shall be recorded and explained in the child's file, including the amount of the fine and the reason for the fine.

(2) Such fines shall be maintained in an account separate from the personal or business accounts of the licensee or facility.

(A) Records shall be maintained accounting for any interest earned and expenditures from the account.

(3) All fines collected shall be used for the benefit of the individual child or all children in placement.

(4) The circumstances under which fines are to be imposed shall be specified in writing.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84027. Safeguards for Cash Resources, Personal Property, and Valuables.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84030. Provisional License (Group Home).

(a) The provisions in the General Licensing Requirements, Sections 80030(a) through 80030(f) and 80031, shall not apply to group home licensees and applicants. The provisional license requirements in Sections 84030.1, 84031, 84031.1, and 84031.2 shall apply to all group home licensees and applicants.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1520.1, 1524, 1525.5 and 1531, Health and Safety Code.

§ 84030.1. Provisional License.

(a) All group home license applicants who complete an application and who meet the regulatory and statutory requirements shall receive a provisional license for the first twelve months. After eight months of operation, the licensing agency shall conduct a comprehensive review of the facility for compliance with all applicable laws and regulations and shall assist the applicant to develop a plan of correction, when necessary.

(1) Before the first business day of the thirteenth month of operation, if the Department determines that the group home is in substantial compliance with licensing standards, the Department shall issue a permanent group home license except as provided in Section 84030.1(b).

(b) If the Department determines that the group home is in substantial compliance with licensing standards, the Department may extend the provisional license for up to an additional six months for either of the following reasons:

(1) The group home requires additional time to be in full compliance with licensing standards.

(2) After twelve months of operation, the group home is not operating at fifty percent of its licensed capacity.

(c) By no later than the first business day of the seventeenth month of operation, the Department shall conduct an additional review of a facility for which a provisional license is extended pursuant to Section 84030.1(b), to determine whether a permanent license should be issued.

(d) Under the following conditions, a group home licensee with a permanent license may apply for a provisional license:

(1) A temporary change in facility location of not more than six months due to unforseen circumstances beyond the control of the licensee (i.e. flood, earthquake, etc.).

(A) The licensing agency shall have the authority to authorize a temporary facility change following a licensing agency review, a finding of substantial compliance with licensing standards, and the securing of an appropriate fire clearance.

(e) If, during the provisional license period, the licensing agency discovers any serious deficiencies, the Department shall have the authority to institute administrative action, or civil proceedings, or to refer the case for criminal prosecution. As one of the options under the administrative action process, the Department may deny a group home license application at any time during the term of the provisional license to protect the health and safety of clients. If the Department denies the application, the group home shall cease operation immediately. Continued operation of the facility after the Department denies the application or after the provisional license expires shall constitute unlicensed operation.

(f) A provisional license shall not be renewable and shall terminate on the date specified on the license or upon denial of the application, whichever is earlier.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1520, 1520.1, 1524, 1525.5 and 1531, Health and Safety Code.

§ 84031. Issuance of a License (Group Home).

(a) All group home license applicants who complete an application and who meet the regulatory and statutory requirements shall receive a provisional license for the first twelve (12) months of operation and during that period shall be evaluated for a permanent license.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1509, 1520, 1520.1, 1520.5, 1525 and 1531.5, Health and Safety Code.

§ 84031.1. Issuance of a Provisional License (Group Home).

(a) For the time frames of the initial review of the application for completeness, see Section 80027.

(b) Within ninety (90) days of the date that a completed application, as defined in Section 80001(c)(10), has been received, the licensing agency shall give written notice to the group home applicant of one of the following:

(1) A provisional license has been approved for the first twelve months of operation pending a comprehensive review and final evaluation for a permanent group home license.

(2) The application has been denied.

(A) The notice of denial shall include the information specified in Section 80040(b)(1).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1509, 1520, 1520.1, 1520.5, 1525, 1526 and 1531.5, Health and Safety Code; and Section 15376, Government Code.

§ 84031.2. Issuance of a Permanent License (Group Home).

(a) Before the first business day of the thirteenth month (up to nineteen months, if an extension was granted in accordance with Section 84030.1(b)) after the effective date of the provisional license, as defined in Section 84030.1, the licensing agency shall give written notice to the group home applicant of one of the following:

(1) A permanent license has been approved.

(2) The application has been denied.

(A) The notice of denial shall include the information specified in Section 80040(b)(1).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1509, 1520, 1520.1, 1520.5, 1525, 1526 and 1531.5, Health and Safety Code.

§ 84040. Denial of Initial License.

(a) An application for licensure shall be denied when the applicant does not provide an LIC 9165 signed by each member of the board of directors, that includes the statement specified in Health and Safety Code Section 1520.1(b)(1).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1520.1(b)(1), Health and Safety Code.

Article 4. Administrative Actions

§ 84044. Inspection Authority of the Department or Licensing Agency.

(a) In addition to Section 80044, licensees providing care and supervision to six or fewer clients shall comply with the provision of Health and Safety Code Section 1522.4(a)(5).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1522.4, Health and Safety Code.

§ 84045. Evaluation Visits.

(a) In addition to Section 80045, the following shall apply.

(b) The licensee shall maintain licensing reports as specified in Health and Safety Code Section 1538.5(a)(2).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1538.5, Health and Safety Code.

Article 5. Enforcement Provisions

§ 84051. Serious Deficiencies.

(b) Failure to operate according to the plan of operation, as specified in Section 84222, may result in a citation for a serious deficiency.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 1501, 1530.8 and 1531, Health and Safety Code; and Section 11467.1, Welfare and Institutions Code.

Article 6. Continuing Requirements

§ 84061. Reporting Requirements.

(a) In addition to Section 80061, the following shall apply.

(b) The licensee shall ensure that the child's authorized representative is notified no later than the next working day if the following circumstances have occurred without the authorized representative's participation:

(1) The child has been placed in the facility under emergency circumstances.

(2) The child has been removed from the facility.

(3) Each time the child has been placed in a manual restraint, to be reported as required in Section 84805.

(c) The licensee shall ensure that the child's authorized representative is sent prior written notification regarding the need for nonemergency relocation of the child to another facility, including a satellite home.

(d) The licensee shall ensure that the child's authorized representative is notified if the child is not enrolled in or regularly attending school.

(e) Effective January 1, 2000, the licensee shall notify the Department, in writing, within ten (10) days of any change in the facility administrator.

(f) The licensee shall notify the licensing agency in writing within ten working days of acquiring a new member of the board of directors. The notification shall include the following:

(1) Name and mailing address of the new member of the board of directors;

(2) Date he or she joined the board of directors, and

(3) A copy of the LIC 9165 signed by the new member of the board of directors.

(g) The licensee shall notify the Department, in writing, within ten (10) days of the hiring of a new administrator. The notification shall include the following:

(1) Name, and residence and mailing addresses of the new administrator.

(2) Date he/she assumed his/her position.

(3) Description of his/her background and qualifications, including documentation of required education and administrator certification.

(A) A photocopy of the documentation shall be permitted.

(h) Incident Reports must include the following:

(1) Date, time, duration and location of the incident.

(2) A detailed narrative, describing the incident and the events leading up to incident.

(3) Analysis of the incident:

(A) Other reportable incidents involving the same child in the preceding six months.

(B) Description of other incidents.

1. Dates of previous incidents.

2. Types of incidents.

3. Action taken by facility personnel in response to incidents.

(C) Are there commonalities between this incident and other incidents involving the same child in the preceding six months.

(4) Description of the facility's plan for the child, in response to the incident, including modifications to the child's needs and services plan. If the child has been involved in previous incidents, explain what the previous modifications were to the child's needs and services plan.

(5) What action was taken by facility personnel to re–integrate the child into the general population after the incident.

(6) When the Incident Report is used to report the use of manual restraints, the report must include the following:

(A) Date and time of other manual restraints involving the same child in the past 24 hours.

(B) A description of the child's behavior that required the use of manual restraints, and description of the precipitating factors which led to the intervention.

(C) Description of what manual restraints were used, and how long the child was restrained.

(D) Description of what non–physical interventions were utilized prior to the restraint; explanation of why more restrictive interventions were necessary.

(E) Description of injuries sustained by the child or facility personnel. What type of medical treatment was sought and where was child taken. Explanation if medical treatment not sought for injuries.

(F) Name(s) of facility personnel who provided the manual restraint.

(G) Name(s) of facility personnel who witnessed the child's behavior and the restraint.

(H) The child's verbal response and physical appearance, including a description of any injuries at the completion of the restraint.

(I) If it is determined by the post incident review, as required in Section 84368.3, that facility personnel did not attempt to prevent the manual restraint, a description of what action should have been taken by facility personnel to prevent the manual restraint incident. What corrective action will be taken or not taken and why.

(J) If law enforcement was involved, a detailed description of the incident.

(K) Documentation that the child's authorized representative has been notified of the incident.

(7) When the Incident Report is used to report a runaway situation, the report must include the following:

(A) When and how was the child's absence first noted.

(B) If known, child's last known activities.

(C) What were the circumstances surrounding the child's absence.

(D) What action did the facility personnel take to discourage the child from leaving; and what interventions were utilized, if any.

(E) What action was taken by facility personnel to locate the child.

(F) If a manual restraint was used, and if it is determined by the post incident review, as required in Section 84368.3, that facility personnel did not attempt to prevent the manual restraint, a description of what action should have been taken by facility personnel to prevent the manual restraint incident. What corrective action will be taken or not taken and why.

(G) If law enforcement was involved in the incident, a detailed description of the incident.

(H) Documentation that the child's authorized representative has been notified of the incident.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1522.41(b)(4), 1531 and 1562, Health and Safety Code; and Section 11406(c), Welfare and Institutions Code.

§ 84063. Accountability.

(a) The board of directors shall be active in ensuring accountability; and shall perform, at a minimum, the following duties:

(1) Establish and approve policies and procedures governing the operation of the group home;

(2) Approve and monitor the corporation's operating budget;

(3) Assess and maintain the level of funds necessary to cover the costs of operating the group home;

(4) Review and approve the facility's emergency intervention plan as specified in Section 84322(k);

(5) Employ an administrator who meets the requirements of Section 84064;

(6) Complete a written statement describing the duties delegated to the administrator. Provide a copy of this statement to the administrator and maintain a copy in the facility's file;

(7) Require that the Chief Executive Officer, administrator, or a designee be present at all board of directors meetings during which the operation or the policies of the group home(s) are discussed;

(8) Conduct board of directors meetings at least on a quarterly basis to review and discuss the group home's operation and documents as

specified in Health and Safety Code Section 1520.1(f), and based upon the review, ensure that the group home complies with all applicable regulations;

(9) Ensure that minutes are kept for all board of directors meetings and retained as a permanent record. The minutes shall reflect the board's discussion of the documents specified in Health and Safety Code Section 1520.1(f);

(10) Ensure that all minutes of board of directors' meetings are available to the licensing agency to inspect, audit, and copy upon demand during normal business hours. Minutes may be removed if necessary for copying. Removal of minutes shall be subject to the following requirements:

(A) Prior to removing any minutes, a licensing representative shall prepare a list of the minutes to be removed, sign and date the list upon removal of the minutes, and leave a copy of the list with the administrator or designee.

(B) Licensing representatives shall return the minutes undamaged and in good order within three business days following the date the minutes were removed.

(11) Submit copies of all corporate documents to the licensing agency at the time documents are submitted to the Secretary of State.

(b) The licensee shall provide each board of directors member with the "Facts You Need To Know, Group Home Board of Directors" (PUB 326) booklet furnished by the Department.

(c) The licensee shall require that each board of directors member sign and date the form, LIC 9165) as specified in Section 84018(c). The signed original form shall be maintained in the corporation's principal California office.

(1) The signed form shall be obtained from each board of directors member by the next scheduled board of directors meeting after July 1, 1999.

(2) A signed form shall be obtained from a prospective board of directors member before joining the board of directors.

(3) A permanent license shall not be issued until all members of the board of directors have signed the form.

(4) The LIC 9165 specified in (c) above shall be made available for review by the Department upon request.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1520.1(f) and 1520.11(c), Health and Safety Code.

§ 84064. Administrator Qualifications and Duties.

(a) In addition to section 80064, the following shall apply.

(b) Effective January 1, 2000, all group homes shall have a certified administrator.

(1) Between January 1, 2000 and July 1, 2001 only, where good faith efforts to employ a certified administrator are unsuccessful, applicants for a license to operate a group home may be granted a provisional license pursuant to the provisions of regulation Section 84030.1. The Department may deny the license if the licensee fails to employ a certified administrator pursuant to the terms and conditions of the provisional license.

(2) In the event a certified administrator is not employed within ten (10) days of the departure of the former administrator, a written "Plan of Correction" shall be developed to bring the group home into compliance with the requirements of this section.

(3) In those cases where the individual is both the licensee and the administrator of a group home, the individual shall comply with all of the licensee and certified administrator requirements.

(4) The Department may revoke the license of a group home for failure to comply with all requirements regarding certified administrators.

(5) Unless otherwise provided, a certified administrator may administer more than one licensed group home.

(c) The administrator shall be on the premises for the number of hours necessary to manage and administer the facility in compliance with applicable law and regulation.

(d) When the administrator is absent, one of the following requirements shall be met:

(1) In facilities with a licensed capacity of 12 or fewer children, there shall be coverage by a designated staff person.

(2) In facilities with a licensed capacity of 13 or more children, there shall be coverage by a designated substitute who has the following qualifications:

(A) Graduation from high school or equivalent.

(B) One year of administrative or supervisory experience over social work, child care and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(e) The administrator shall meet the requirements specified below:

(1) The administrator of a facility with a licensed capacity of 12 or fewer children shall meet one of the following requirements:

(A) Have a master's degree in a behavioral science from an accredited college or university, plus a minimum of one year of employment as a social worker, as defined in section 80001(a)(47), in an agency serving children or in a group residential program for children.

(B) Have a bachelor's degree from an accredited college or university, plus at least one year of administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(C) Have completed at least two years at an accredited college or university, plus at least two years administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(D) Have completed high school, or equivalent, plus at least three years administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(2) The administrator of a facility with a licensed capacity of 13 or more children shall meet one of the following requirements:

(A) Have a master's degree in a behavioral science from an accredited college or university, plus at least one year of administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(B) Have a master's degree in a behavioral science from an accredited college or university, plus two years of employment as a social worker, as defined in section 80001s.(4), in an agency serving children or in a group residential program for children.

(C) Have a bachelor's degree from an accredited college or university, plus at least three years administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(D) Have completed at least two years at an accredited college or university, plus at least five years administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(f) The administrator shall perform the following duties:

(1) Direction and evaluation of a group home facility within the limits of the functions and policies established by the licensee.

(2) Preparation of the facility's budget and management of expenditures according to the facility's budget limitations.

(3) Organization of the work of the facility and delegation of responsibility to staff members.

(4) Assessment of the facility operations and program; and reporting to the licensee and making recommendations to address identified problems.

(5) Recruitment, appointment, evaluation, and termination of staff.

(6) Development of a plan for the orientation, development and training of staff, as specified in section 84065(g).

(7) Review of complaints made by children or their authorized representative(s) as specified in section 84072.2(a), and deciding upon the action to be taken to handle the complaint.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1501, 1522.41(b), 1531 and 1562, Health and Safety Code.

§ 84064.1. Additional Administrator Qualifications and Duties in Specialized Group Homes.

(a) The administrator shall ensure the provision of services to children with special health care needs with appropriate regard for the child's physical and mental well–being and needs, including those services identified in the child's individualized health care plan.

NOTE: Authority cited:Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 1501, 1531 and 1562, Health and Safety Code.

§ 84064.2. Administrator Certification Requirements.

(a) An individual employed on or after January 1, 2000, shall be a certificate holder prior to being employed as an administrator.

(1) An individual employed as an administrator on December 31, 1999 shall be permitted to take the standardized written test administered by the Department in lieu of completing the forty (40) hours of Initial Certification Training Program classroom instruction. If a passing score is not achieved after two (2) attempts, the administrator must complete a forty (40) hour Initial Certification Training Program and pass the test no later than December 31, 2000.

(2) An individual who, though not an administrator, is employed by a group home on December 31, 1999 shall be permitted to take the standardized written test administered by the Department in lieu of completing the forty (40) hours of Initial Certification Training Program classroom instruction provided that he/she meets the following conditions:

(A) The individual must have been employed as a group home administrator for at least four (4) of the last eight (8) years, and

(B) While employed as an administrator, the individual must have had a record of administering the facility for which he/she was responsible in substantial compliance as defined in Section 80001(s)(6).

(b) To receive his/her certificate an applicant shall:

(1) Successfully complete a Department approved Initial Certification Training Program, except as specified in Section 84064.2(a)(1) above.

(2) Pass a written test administered by the Department within sixty (60) days of completion of an Initial Certification Training Program.

(3) Submit an application form to the Department's certification section within thirty (30) days of being notified of having passed the test. The application shall contain the following:

(A) Proof that the applicant has successfully completed a Department approved Initial Certification Training Program or proof of employment as an administrator on December 31, 1999.

(B) A statement certifying that the applicant is at least twenty–one (21) years of age.

(C) Fingerprint cards, or evidence that the applicant has submitted fingerprints to the Department of Justice at a livescan facility, or a statement that the applicant has a current criminal record clearance on file with the Department.

(D) A one hundred dollar ($100) processing fee.

(c) The Department shall not issue a certificate until it receives notification from the Department of Justice that the applicant has a criminal record clearance pursuant to Health and Safety Code Section 1522 or is able to transfer a current criminal record clearance pursuant to Health and Safety Code Section 1522(b)(1).

(d) It shall be unlawful for any person not certified under this section to misrepresent himself or herself as a certified administrator. Any person willfully making any false representation as being a certified group home administrator is guilty of a misdemeanor.

(e) Certificates issued under this section shall be renewed every two (2) years provided the certificate holder has complied with all renewal requirements.

(f) Certificates shall be valid for a period of two (2) years and expire on either the anniversary date of initial issuance or on the individual's birthday during the second calendar year following certification.

(1) The certificate holder shall make an irrevocable election to have his or her recertification date for any subsequent recertification either on the date two years from the date of issuance of the certificate or on the individual's birthday during the second calendar year following certification.

(g) Time deadlines specified in Section 84064.2(b)(2) and (3) above may be extended for good cause as determined by the Department. Any request for extension of time shall be in writing and shall contain a statement of all facts the applicant believes constitute good cause to extend time.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1522.41(b) through (f), Health and Safety Code.

§ 84064.3. Administrator Recertification Requirements.

(a) Administrators shall complete at least forty (40) classroom hours of continuing education during the two–year certification period. Continuing education hours must relate to the Core of Knowledge and be completed through any combination of the following:

(1) Courses provided by vendors approved by the Department, or

(2) Accredited educational institutions offering courses that are consistent with the requirements of this section, or

(3) Courses offered by vendors approved by other California State agencies provided that:

(A) The approval and enforcement procedures of the State agency are comparable to the approval and enforcement procedures of the Department, and

(B) The course relates to the Core of Knowledge as specified in Section 84090(h)(1)(A) through (I).

(4) Certified administrators required to complete continuing education hours required by regulations of the Department of Developmental Services, and approved by the Regional Center, may have up to twenty–four (24) of the required continuing education course hours credited toward the forty (40) hour continuing education requirement.

(A) Community college course hours approved by the Regional Center shall be accepted by the Department for recertifcation.

(B) Any continuing education course hours in excess of twenty–four (24) hours offered by the Department of Developmental Services and approved by the Regional Center may be credited toward the forty (40) hour requirement provided the courses are not duplicative and relate to the core of knowledge as specified in Section 84090(h)(1)(A) through (I).

(5) Continuing education hours must enhance the core of knowledge. Continuing education credit will not be provided for any Initial Certification Training Program course.

(b) Courses approved for continuing education credit shall require the physical presence of the certificate holder in a classroom setting except that:

(1) The Department may approve courses where technology permits the simultaneous and interactive participation of the certificate holder, provided such participation is verifiable.

(c) To apply for recertification prior to the expiration date of the certificate, the certificate holder shall submit:

(1) A written request to recertify post–marked prior to the certificate expiration date.

(2) Evidence of completion of forty (40) continuing education hours as specified in Section 84064.3(a) above.

(3) Payment of a one hundred dollar ($100) processing fee.

(d) To apply for recertification after the expiration date of the certificate, but within four (4) years of the certificate expiration date, the certificate holder shall submit:

(1) A written request to recertify.

(2) Evidence of completion of the required continuing education hours as specified in Section 84064.3(a) above. The total number of hours required for recertification shall be determined by computing the number of continuing education hours the certificate holder would have been required to complete if they had remained certified. The date of computation shall be the date the written request for recertification is received by the Department.

(3) Payment of a delinquency fee equal to three times the renewal fee, or three hundred dollar ($300).

(e) Certificates not renewed within four (4) years of their expiration date shall not be renewed, restored, reissued or reinstated.

(1) Holders of certificates not renewed within four (4) years of their expiration date shall complete an Initial Certification Training Program as specified in Section 84064.2(b).

(f) Certificate holders, as a condition of recertification, shall have a current criminal record clearance.

(g) A processing fee of twenty–five dollar ($25) shall be paid for the replacement of a lost certificate.

(h) A certificate holder shall report any change of mailing address within thirty (30) days to the Department's administrator certification section.

(i) Whenever a certified administrator assumes or relinquishes responsibility for administering a group home facility, he or she shall provide written notice within ten (10) days to:

(1) The licensing District Office(s) responsible for receiving information regarding personnel changes at the licensed facilities with whom the certificate holder is or was associated, and

(2) The Department's administrator certification section.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Section 1522.41(f), Health and Safety Code.

§ 84064.4. Denial or Revocation of a Certificate.

(a) The Department may deny or revoke any administrator certificate upon any of the grounds specified in Health and Safety Code Section 1550 and for any of the following:

(1) The certificate holder procured a certificate by fraud or misrepresentation.

(2) The certificate holder knowingly made or gave a false statement or information in conjunction with the application for a certificate.

(3) The Department has issued an exclusion order against the certificate holder pursuant to Health and Safety Code Sections 1558, 1568.092, 1569.58 or 1596.8897 after the Department issued the certificate, and:

(A) The certificate holder did not appeal the exclusion order or,

(B) After the appeal, the Department issued a decision and order that upheld the exclusion order.

(4) The certificate holder does not have a current criminal record clearance.

(5) The certificate holder fails to comply with certificate renewal requirements.

(A) The Department may reinstate a certificate that has been revoked for failure to comply with certificate renewal requirements provided all conditions for recertification have been satisfied, including payment of all appropriate renewal and delinquency fees.

(b) Any denial or revocation of an administrator certificate may be appealed as provided by Health and Safety Code Section 1551.

(c) Unless otherwise ordered by the Department, any application for an administrator certificate submitted after a denial or revocation action shall be processed in accordance with the provisions of Health and Safety Code Section 1520.3.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1520.3, 1522.41(f) and (g), 1550 and 1551, Health and Safety Code.

§ 84064.5. Forfeiture of a Certificate.

(a) Unless otherwise ordered by the Department, the certificate shall be considered forfeited under any of the following conditions:

(1) The Department has revoked any license held by the certificate holder after the Department issued the certificate.

(2) The Department has issued an exclusion order against the certificate holder pursuant to Health and Safety Code Sections 1558, 1568.092, 1569.58 or 1596.8897, after the Department issued the certificate, and:

(A) The certificate holder did not appeal the exclusion order or,

(B) After the appeal, the Department issued a decision and order that upheld the exclusion order.

(b) Unless otherwise ordered by the Department, any application for an administrator certificate submitted after a certificate has been forfeited shall be processed in accordance with the provisions of Health and Safety Code Sections 1520.3, 1558(h) and/or 1558.1.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1520.3, 1522.41(g), 1558(h) and 1558.1, Health and Safety Code.

§ 84065. Personnel Requirements.

(a) In addition to Section 80065, the following shall apply.

(b) The licensee shall employ those administrative, child care, social work and support staff necessary to perform the assigned duties specified in applicable law and regulation.

(c) The licensee shall ensure provision of the services specified in Section 84065.2(c)(1) through (4) by social work staff.

(d) The licensee shall designate at least one facility manager to be present at the facility at all times when children are present:

(1) The facility manager shall meet one of the following requirements prior to employment:

(2) This requirement does not apply to facilities with a licensed capacity of six or less which were licensed prior to January 1, 1985.

(A) One year of full–time experience, or its equivalent, working with the client group to be served.

1. Experience shall be verified as having been performed as a paid or volunteer staff person whose duties required direct supervision and care of the client group served.

(B) Two years experience as a member of the social work staff in a group home performing those duties specified in Section 84065.2(c).

(C) Completion with a passing grade, from an accredited or approved college or university, of 15 college semester or equivalent quarter units in behavioral sciences, 9 units of which must be in courses relating to children with behavioral problems which may be the result of abuse, neglect, or emotional trauma. The courses may include, but are not limited to curriculums in Corrections, Psychology, Social Work, or Social Welfare.

(3) Prior to assuming the duties and responsibilities of the facility manager, the individual shall complete a minimum of one hour of training as specified in Section 84065(k), in addition to training required in Sections 84065(i) and (j).

(A) Facility managers only working in community treatment facilities governed by Title 22, Division 6, Chapter 5, Subchapter 1, who have completed the training required by Section 84165(f), are exempt from the training required in Sections 84065(i) and (j).

(B) Facility managers only working in group homes that care for children under the age of six years governed by Title 22, Division 6, Chapter 5, Subchapter 2, who have completed the training required by Sections 84265(c) and (h) are exempt from the training required in Sections 84065(i) and (j).

(4) Any person willfully making any false representation as being a facility manager is guilty of a misdemeanor.

(e) In facilities with a licensed capacity of 13 or more children, one

employee shall be designated by the administrator to have primary responsibility for planned activities, and shall be given assistance as necessary to ensure that all children participate in accordance with their needs, interests, and abilities.

(1) Such employee shall develop, organize, implement, and evaluate the facility activity program, and shall possess the following qualifications:

(A) Completion of or enrollment in a related education or training program.

(B) Six months' experience in organizing and providing planned activities.

(f) The licensee of a group home providing care and supervision to children diagnosed by a physician, psychiatrist, psychologist or licensed clinical social worker as mentally disordered shall make provision for at least monthly consultation from a psychiatrist, or clinical psychologist, or licensed clinical social worker regarding the program of services.

(1) The licensee shall maintain on file copies of reports signed by any such consultant, noting the types and hours of services provided.

(g) The licensee of a group home providing care and supervision to children diagnosed by a physician, psychiatrist or psychologist as developmentally disabled shall make provision for at least monthly consultation from a qualified mental retardation professional regarding the program of services.

(1) The licensee shall maintain on file copies of reports signed by any such consultant, noting the types and hours of services provided.

(h) The licensee shall develop, maintain, and implement a written plan for the supervision, evaluation, and training of all child care staff.

(1) The child care staff training plan, as specified in Sections 84065(i) and (j) shall be incorporated in the group home's program statement.

(2) The training plan shall address the initial 24 hour training for newly hired child care staff.

(A) When the training plan includes job shadowing activities as described in Section 84065(i)(1), the following shall be included in the training plan:

1. Specific activities;

2. Job classification of the individual being shadowed;

3. Time spent on each activity; and

4. Skill to be developed through each job shadowing activity.

(3) The training plan shall address the annual training for newly hired and existing child care staff.

(4) The training plan shall include for each training session the following:

(A) Course title and subject matter;

(B) Learning objectives and activities:

(C) Number of hours per training session;

(D) Qualification of the trainer; and

(E) Training evaluation.

1. Each session shall include an evaluation of the trainer and course content to determine if the training is meeting the needs of child care staff.

(5) The training plan shall be appropriate for the client population and the training needs and skill level of child care staff.

(A) The licensee shall amend the training plan, when necessary, to meet the needs of child care staff and the client population.

(6) Amendments to the staff training plan, shall be submitted to the Department within ten days of the occurrence.

(i) Notwithstanding Section 80065(f)(1) through (6), new child care staff hired on or after July 1, 1999, shall complete a minimum of 24 hours of initial training comprised of the 8 and 16 hour training as specified in (1) and (2) below:

(1) 8–Hour Training

(A) Training shall be completed before new child care staff are:

i. left alone with children, and

ii. counted in the staff to child ratio required in Sections 84065.5 and 84065.7.

(B) Until the 8 hours of training is completed, new child care staff shall be visually supervised at all times by child care staff who meet the training requirements specified in this subsection and (2) below.

(C) A maximum of 4 hours of the training requirement may be satisfied by successful completion of job shadowing.

1. For the purpose of this regulation, job shadowing means a process whereby new child care staff follow and observe experienced facility personnel performing a specific job. The purpose of job shadowing is to gain information related to a specific job including, materials used, physical demands, necessary skills and knowledge.

2. During shadowing, the experienced facility personnel being shadowed must be performing child care duties and counted in the staff to child ratios, as required in Sections 84065.5 and 84065.7.

3. Job shadowing shall promote the development of specific skills, and shall consist of specific activities for a specific time period.

4. Successful completion of job shadowing shall be verified by a statement completed by the experienced facility personnel being shadowed affirming: a) specific activity observed; b) dates and times of shadowing; and, c) training topic listed in Section 84065(i)(3)(A) through (R) that is satisfied by the job shadowing activity.

(D) Within 7 calendar days of completion of the 8 hour training, the administrator or administrator's designee shall assess if each child care staff understands and can apply the training.

1. The assessment may include observation of performance, post–testing or demonstrated hands–on competency.

2. The assessment shall be documented in each child care staff personnel record.

3. When the administrator or administrator's designee determines a child care staff does not understand and cannot apply the training, re–training is required.

(2) Sixteen hours of training shall be completed by new child care staff within 90 days of hire.

(A) New child care staff who work a maximum of 20 hours per week shall complete the additional minimum 16 hours of training within 180 days of hire.

(B) Within 30 days of completion of the 16 hour training, the administrator or administrator's designee shall assess if each newly hired child care staff understands and can apply the training.

1. The assessment may include observation of performance, post–testing or demonstrated hands–on competency.

2. The assessment shall be documented in each child care staff personnel record.

3. When the administrator or administrator's designee determines a child care staff does not understand and cannot apply the training, re–training is required.

(3) Training shall include, at a minimum, all topics listed in (A) through (R) below. The licensee shall determine how much time is spent on each topic, and shall ensure that child care staff have appropriate skills necessary to supervise the children in care.

(A) Overview of the client population served by the group home;

(B) Facility's program and services, including program philosophy, activities and community resources;

(C) Facility's policies and procedures, including reporting requirements to the Department and as a mandated child abuse reporter;

(D) Child care workers' job description, including roles and responsibilities;

(E) Child care workers' self awareness;

(F) Role of other facility personnel in service delivery, including case staffing;

(G) Discipline policies and procedures;

(H) Disaster response;

(I) Medical emergency response;

(J) Teamwork and interpersonal communication among facility personnel and clients and client family members;

(K) Teamwork and intra–facility communication;

(L) The role of placement workers;

(M) Medication procedures, assistance with medication, universal precautions, recognition of early signs of illness and the need for professional assistance, and other health related issues;

(N) Group home children's adjustment to group care;

(O) Housekeeping and sanitation principles; principles of nutrition, food preparation and storage and menu planning;

(P) California Code of Regulations, Title 22;

(Q) Availability of community services and resources; and

(R) Recreation activities and resources.

(4) The training requirement shall be satisfied by successful completion of course work conducted in a workshop, seminar, classroom setting, individual or small group setting.

(A) Proof of successful completion of course work shall be limited to official grade slips or transcripts from colleges or adult education departments; or certificates or signed documentation issued by bona fide educational institutions or organizations, or licensee associations, or courses offered or approved by accredited educational institutions, or qualified individuals who possess the necessary skills, knowledge and experience to train others in a particular subject area.

1. A qualified individual shall possess: a) a master's degree in a behavioral science from an accredited college or university and one year experience as an administrator, social worker, child care staff, or independent contractor providing direct social work activities in a group home; or, b) a master's degree and one year of work experience with the client population or a bachelor's degree and two years of work experience with the client population; or, c) a licensed mental health professional, as defined in California Code of Regulations Title 9, Chapter 12, Section 1901(p) or, d) a certificate or credential from an accredited course of study or educational institution in the subject matter for which the individual will be providing training; e) or, an individual who has provided training to group home child care staff for three years and has at least three years work experience in the subject matter of the training.

(5) Documentation of successful completion of training shall be maintained in the personnel record for each child care staff.

(6) The 24 hour Initial training is in addition to first aid and CPR training, and other training as required in Sections 84065.1, and 84365.

(A) Initial 24 hour training does not apply to child care staff only working in community treatment facilities governed by Title 22, Division 6, Chapter 5, Subchapter 1 who have successfully completed the training required in Section 84165(f), and child care staff only working in group homes that care for children under the age of six years governed by Title 22, Division 6, Chapter 5, Subchapter 2 who have successfully completed training required in Section 84265(h).

(j) Annual Training

(1) Notwithstanding Sections 80065(f)(1) through (6), all child care staff shall complete a minimum of 20 hours of annual training, except as specified in (2) below.

(A) At least 5 hours of the annual training shall consist of course work from an entity other than the group home such as an accredited educational institution, workshops, seminars, or other direct training provided by a qualified individual, who meets the requirements specified in Section 84065(i)(4)(A)1, who is not affiliated with the group home licensee.

(2) Notwithstanding Section 80065(f)(1) through (6), newly hired child care staff, hired on or after July 1, 1999, shall complete a minimum of 16 hours of annual training within the first 12 months of employment, for a total of 40 hours of initial and annual training. After the first 12 months of employment, child care staff shall comply with (1) above.

(A) At least 4 hours of the annual training shall consist of course work from an entity other than the group home such as an accredited educational institution, workshops, seminars, or other direct training provided by a qualified individual who meets the requirements specified in Section 84065(i)(4)(A)1., who is not affiliated with the group home licensee.

(3) Training may include but is not limited to, the following topics:

(A) Neglect/abuse issues;

(B) Attachment issues;

(C) Behavior problems/psychological disorders;

(D) Mental health/behavioral interventions;

(E) Developmental disabilities;

(F) Substance abuse issues;

(G) Cultural diversity;

(H) Child and adolescent development;

(I) Child empowerment;

(J) Discharge and emancipation;

(K) Importance of sibling and family relationships;

(L) Placement agencies and the placement process;

(M) Needs and service plan/treatment planning and review;

(N) Employee training handbook; and

(O) Topics listed in Sections 84065(i)(3)(A) through (R).

(4) Training topics shall be appropriate for the client population and services provided by the facility.

(5) The training requirement may be satisfied by successful completion of course work conducted in a workshop, seminar, or classroom setting, individual or small group setting.

(A) Proof of successful completion of course work shall be limited to official grade slips or transcripts; or, certificates or signed documentation issued by colleges, or adult education departments, bona fide educational institutions or organizations, or licensee associations, or courses offered or approved by accredited educational institutions, or qualified individuals who possess the necessary skills, knowledge and experience to train others in a particular subject area.

1. The qualified individual shall meet the requirements specified in Section 84065(i)(4)(A)1.

(6) Documentation of successful completion of training shall be maintained in the personnel record for each child care staff.

(7) Annual training is in addition to first aid and CPR training, and other training as required in Sections 84065.1 and 84365.

(A) Annual training does not apply to child care staff only working in community treatment facilities governed by Title 22, Division 6, Chapter 5, Subchapter 1 who have successfully completed the training required in Section 84165(f), and child care staff only working in group homes that care for children under the age of six years governed by Title 22, Division 6, Chapter 5, Subchapter 2 who have successfully completed the training required in Section 84265(h).

(k) The licensee shall develop, maintain and implement a written plan for the training of facility managers.

(1) The facility manager training plan shall be incorporated in the group home's program statement.

(2) The training plan shall include the following for each training session:

(A) Course title and subject matter;

(B) Learning objectives and activities;

(C) Number of hours per training session;

(D) Qualifications of the trainer; and

(E) Training evaluation.

1. Each session shall include an evaluation of the trainer and course content to determine if the training is meeting the needs of facility personnel acting as facility managers.

(3) The training plan shall be appropriate for the client population and shall consider the training needs and skill level of staff.

(A) The licensee shall amend the training plan, as necessary, to meet the needs of facility personnel acting as facility managers and the client population.

(4) Amendments to the staff training plan, shall be submitted to the Department within ten days.

(5) Training shall include, but not be limited to, the following. The licensee may determine how much time is spent on each topic:

(A) Interaction with the Department, including inspection authority;

(B) Licensee appeal rights; and

(C) Interaction with placement agencies, neighbors, mental health agencies, law enforcement, medical/emergency personnel, client family members.

(6) The training requirement may be satisfied by successful completion of course work conducted in a workshop, seminar, or classroom setting, individual or small group setting.

(A) Proof of successful completion of course work shall be limited to official grade slips or transcripts; or, certificates or signed documentation issued by colleges, or adult education departments, bona fide educational institutions or organizations, or licensee associations, or courses offered or approved by accredited educational institutions, or qualified individuals who possess the necessary skills, knowledge and experience to train others in a particular subject area.

1. The qualified individual shall meet the requirements specified in Section 84065(i)(4)(A)1.

(7) Documentation of successful completion of training shall be maintained in the personnel record for each staff member.

(8) Facility manager training is in addition to first aid and CPR training, and other training as required in Sections 84065.1 and 84365.

(*l*) All employees shall be given a copy of the job description specified in Section 84066(b)(1) which is relevant to their duties, and shall have access to all other job descriptions.

(m) The staff assignment information specified in Section 84066(b)(2) shall be provided to all applicants during interviews for employment; to all staff during orientation or when changes are made which affect job assignments; and upon request to placement agencies.

(n) Upon employment, the group home shall make available for review by all group home personnel, an employee training handbook that shall include the following: facility's program philosophy; facility's policies and procedures; disaster response procedures; lines of authority and communication; Title 22 regulations; and reporting requirements.

(1) The employee training handbook shall be maintained at the facility and updated as needed.

(o) Upon employment, staff shall receive copies of the removal and/or discharge policies and procedures specified in Section 84068.4(a); of the discipline policies and procedures specified in Section 84072.1(a), and of the complaint procedures specified in Section 84072.2(a).

(p) Physician reports from general practitioners or specialists may be required after licensure if the licensing agency has reason to believe that a licensee's or staff member's physical and/or mental health is not adequate to carry out responsibilities under these regulations.

(1) The licensing agency shall provide the licensee with a written explanation of the need for any additional report.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1501, 1522.4, 1522.41, 1531 and 1562, Health and Safety Code.

§ 84065.1. Additional Personnel Requirements for Specialized Group Homes.

(a) Any person who provides specialized in–home health care to a child placed in the group home as of November 1, 1993, shall comply with the following requirements:

(1) Prior to caring for the child or when the child's needs change, the in–home health care provider shall complete training in specialized in–home health care provided by a health care professional as required by the child's individualized health care plan, except when

(A) The in–home health care provider is a licensed health care professional; and

(B) The child's individualized health care plan team determines that completion of specialized in–home health care training for the child is unnecessary on the basis of the in–home health care provider's medical qualifications and expertise.

(b) No person shall provide specialized in–home health care to a child placed in the home after November 1, 1993, unless

(1) He/she is a licensed health care professional; and

(2) The child's individualized health care plan team determines that he/she has the necessary medical qualifications and expertise to meet the child's in–home health care needs.

(A) The child's individualized health care plan team shall make a new determination each time the child's in–home health care needs change.

(c) Volunteers caring for children in a specialized group home shall meet the health screening requirements in Sections 80065(g)(1) and (g)(2).

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 17731(c) and 17736(a) and (b), Welfare and Institutions Code; and Sections 1501, 1531 and 1562, Health and Safety Code.

§ 84065.2. Personnel Duties.

(a) The facility manager(s) shall:

(1) Meet the requirements of Health and Safety Code Section 1522.4(a)(1) through (3).

(b) Child care staff shall perform the following duties:

(1) Supervision, protection and care of children individually and in groups at all times.

(2) Assistance to each child in working with a group and in handling individual problems.

(3) Administration of discipline and setting of limits for behavior.

(4) Notation of the child's progress; identification of the possible need for professional services; and communication of such findings to professional staff.

(5) Until they complete the 8 hours of training as required in Section 84065(i)(1), new child care staff hired on or after July 1, 1999 shall perform the duties as defined in Subsections (1) through (4) above while under visual supervision.

(c) Social work staff shall complete or assist in the completion of the following for each child:

(1) An intake study, as specified in Section 84068.1.

(2) A needs and services plan, as specified in Sections 84068.2(a) and 84068.3.

(3) A discharge plan, as specified in Section 84068.4.

(4) Obtaining, developing, and recording of the information necessary for the completion of (1) through (3) above, as specified in Section 84070.

(d) Support staff shall perform the following duties:

(1) Office work.

(2) Cooking.

(3) Housecleaning.

(4) Laundering.

(5) Maintenance of facility buildings, grounds, fixtures, furniture, equipment and supplies.

(e) Support staff duties shall not be assigned to child care staff unless such assignments are directly related to the care of the children, and do not interfere with the performance of their child care duties.

(1) Household duties directed towards development of self–help skills may be performed by the children in placement. Participation in these duties shall be voluntary and specified in the needs and service plan.

(2) No household duties shall go undone because a child refuses to participate.

NOTE: Authority cited: Sections 1530 and 1530.8, Health and Safety Code. Reference: Sections 1501, 1522.4, 1530.8 and 1531, Health and Safety Code.

§ 84065.5. Staff/Child Ratios.

(a) From 7 a.m. to 10 p.m., there shall be one on–duty child care staff person to each ten children, or fraction thereof, present.

(b) From 7 a.m. to 7 p.m., in minor parent programs, there shall be one on–duty child care staff person to each ten children, or fraction thereof, present.

(1) In minor parent programs, children shall include all children present in the facility, including minor parents and their child(ren). When the minor parent is not providing direct care and supervision to his or her child(ren), the facility shall provide that care and supervision.

(2) At any time the facility provides direct care and supervision of the minor parents' children, there shall be one staff for every four children of minor parents, or fraction thereof.

(c) If the children require special care and supervision because of age, problem behavior or other factors, the number of on–duty child care staff shall be increased.

NOTE: Authority cited: Sections 1530 and 1530.8, Health and Safety Code. Reference: Section 11465, Welfare and Institutions Code; and Sections 1501, 1530.8 and 1531, Health and Safety Code.

§ 84065.6. Additional Staff/Child Ratios for Specialized Group Homes.

(a) The licensee shall ensure that staff providing specialized in–home health care are responsible for the provision of care and supervision to no more than three children, with or without special health care needs.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Section 17732(a) and (b), Welfare and Institutions Code.

§ 84065.7. Night Supervision.

(a) In group homes providing care and supervision to 12 or fewer children, there shall be one child care staff person on duty from 10 p.m. to 7 a.m.; for minor parent programs this requirement shall be from 7 p.m. to 7 a.m.

(b) In group homes providing care and supervision to 13 to 30 children, there shall be one child care staff person awake and on duty from 10 p.m. to 7 a.m.; for minor parent programs this requirement shall be from 7 p.m. to 7 a.m.

(1) Another person shall be on call and capable of arriving at the facility site within 30 minutes.

(c) In group homes providing care and supervision to 31 or more children, there shall be one child care staff person awake and on duty from 10 p.m. to 7 a.m. for the first 30 children; and one child care staff person awake and on duty for each additional 30 children or fraction of that amount; for minor parent programs this requirement shall be from 7 p.m. to 7 a.m.

(d) For purposes of determining the appropriate staff to children ratio, children shall include all children present in the facility.

(e) In facilities required to have a signal system as specified in Sections 84088(d) through (d)(3), at least one staff person shall be responsible for responding to such system.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1530.8 and 1531, Health and Safety Code.

§ 84066. Personnel Records.

(a) In addition to Section 80066, the following shall apply.

(b) The licensee shall maintain the following personnel records:

(1) Complete job descriptions on all positions within the facility.

(2) A description of all staff assignments, including information regarding lines of authority and staff responsibilities.

(3) A dated employee time schedule developed at least monthly; displayed conveniently for employee reference; and containing the following information for each employee:

(A) Name.

(B) Job title.

(C) Hours of work.

(D) Days off.

(4) Documentation of the completion by each child care staff person and facility manager of the training specified in Sections 84065(h) through (k) inclusive.

(5) Documentation that the administrator has met the certification requirements specified in Section 84064.2.

(6) A record of each work performance evaluation and any correspondence with the employee.

NOTE: Authority cited: Sections 1522.41(j) and 1530, Health and Safety Code. Reference: Sections 1501, 1522.41, 1531 and 1562, Health and Safety Code.

§ 84066.1. Additional Personnel Records for Specialized Group Homes.

(a) The licensee shall ensure that the personnel records of all persons subject to the requirements of Section 84065.1(a) contain the following:

(1) For any training or additional training from which the licensee or other in–home health care provider is exempt:

(A) Documentation that the child's individualized health care plan team has determined that it is not necessary for the in–home health care provider to complete the specialized in–home health care training or additional training.

1. Documentation may be provided in different ways, including but not limited to, a written statement from a member designated by the team that the team has been notified and has determined that the training or additional training is unnecessary.

(B) A copy of a valid license or certificate indicating that he/she is a licensed health care professional.

(2) For any training or additional training from which the in–home health care provider is not exempt:

(A) Documentation, by a health care professional providing the training, that he/she has successfully completed the specialized in–home health care training specified in Section 84065.1(a)(1).

(b) The licensee shall ensure that the personnel records of all persons subject to the requirements of Section 84065.1(b) contain the following:

(1) Documentation that the child's individualized health care plan team has determined that the in–home health care provider has the necessary medical qualifications and expertise to meet the child's specialized in–home health care needs.

(A) Documentation shall be updated each time the child's specialized in–home health care needs change.

(B) Documentation may be provided in different ways, including, but not limited to, a written statement from a member designated by the team that the team has been notified and has determined that the in–home health care provider has the necessary medical qualification to meet the child's specialized in–home health care needs.

(2) A copy of a valid license or certificate indicating that he/she is a licensed health care professional.

(c) For each volunteer caring for children in a specialized group home, the licensee shall have on file the record of a health screening and test for tuberculosis as specified in Section 84065.1(c). The health screening shall be used in place of the volunteer statement specified in Section 80065(g)(3)(A).

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Section 17731, Welfare and Institutions Code; and Sections 1501, 1531 and 1562, Health and Safety Code.

§ 84068.1. Intake Procedures.

(a) The licensee shall develop, maintain, and implement intake procedures which meet the requirements specified in this section.

(b) When a child is being considered for nonemergency placement in a group home, the following requirements shall be met prior to the child's placement in the home.

(1) The information specified in Sections 80070(b)(1) through (5), (7), (8) and (10), and Sections 84070(b)(1) through (10) shall be obtained from the placement agency, if any, or from the child's authorized representative(s).

(A) If the information is not completed by a placement agency, the licensee shall make telephone and/or written requests for the information to the child's placement agency and/or authorized representative; and shall record and retain the details of those requests.

(B) If the information is not received within 15 days of the requests specified in (A) above, the licensee shall obtain the information necessary to complete a standard appraisal form from other sources.

(C) When the information is received, social work staff shall complete a standard appraisal for the child on a form approved and/or furnished by the licensing agency.

(2) The needs and services plan shall be completed as specified in Section 84068.2.

(3) The information specified in (1) and (2) above shall be reviewed by the social work staff to determine whether the facility can provide the services necessary to meet the child's needs.

(A) If it is determined that the facility cannot provide necessary services, applicable discharge procedures specified in Sections 84068.4(b), (c), and (e); and 84070(d) through (d)(3) shall be followed.

(4) If the child is accepted for placement, the following requirements shall be met:

(A) An admission agreement shall be completed and signed as specified in Section 80068.

(B) The administrator or his/her designee, and the child and/or his/her authorized representative(s), shall sign copies of the removal and/or discharge policies and procedures specified in Section 84068.4(a); of the discipline policies and procedures specified in Section 84072.1(a); and of the complaint procedures specified in Section 84072.2(a), to verify the receipt of such information.

(C) Information specified in Sections 80070 and 84070 necessary to complete the child's file shall be obtained.

(D) Needs and services plan requirements specified in Section 84068.2 which were not addressed on the standard appraisal form, if used, shall be met.

(c) If the child is placed in the facility under emergency circumstances, the licensee shall ensure that the following requirements are met:

(1) Placement of the child in the facility shall not result in the facility exceeding its licensed capacity.

(2) The admission agreement and other procedures specified in (b)(4)(A) and (B) above shall be completed no later than seven days following the emergency placement.

(3) If it is determined, following emergency placement of the child in the facility, that the facility cannot continue to provide necessary services, applicable discharge procedures specified in Sections 84068.4(b), (c) and (e); and 84070(d) through (d)(3) shall be followed.

(4) If the child is continued in placement, the following requirements shall be met no later than 30 days following the emergency placement:

(A) Information specified in Sections 84070(b) and 84068.2 shall be obtained.

(B) The information specified in (A) above, and the needs and services plan specified in Section 84068.2, shall be reviewed by social work staff to determine whether the facility can continue to provide services necessary to meet the child's needs.

(C) The admission agreement shall be modified as specified in Section 80068(d), if necessary.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84068.2. Needs and Services Plan.

(a) Social work staff shall obtain the information specified in Section 84070, and shall develop an individual needs and services plan for the child which meets the requirements specified in (b) through (d) below.

(1) A needs and services plan is not required for children who are placed in the facility on an emergency basis and who will remain in placement for less than seven days as documented in the child's record.

(b) The needs and services plan shall identify the child's needs in the following areas:

(1) Reason for placement.

(2) Education.

(A) If the information specified in Section 84070(b)(4) is not available, the plan shall specify a method for determining such needs.

(3) Training.

(4) Personal care and grooming.

(5) Ability to manage his/her own money, including the maximum amount of money the child shall be permitted to have in his/her possession at any one time.

(6) Visitation, including the frequency of and any other limitations on visits to the family residence and other visits inside and outside the facility.

(7) Other specific services, including necessary services to the child's parent(s) or guardian(s).

(c) The needs and services plan shall include the following information regarding services necessary to meet the child's needs:

(1) Types of services necessary.

(2) The facility's ability to provide the necessary services based upon the following information provided in the plan of operation:

(A) The facility's purposes, program methods, and goals.

(B) The facility's admission policies and procedures.

(C) Services to be provided by the facility in cooperation with community resources.

(3) Planned length of placement, including the discharge plan specified in Section 84068.4(b).

(4) Financial arrangements for provision of services to the child.

(d) The licensee shall ensure that the child and his/her authorized representative(s) are offered the opportunity to participate in the development of the needs and services plan.

(1) The licensee shall not implement a needs and services plan unless prior written approval of the plan has been obtained from the child's authorized representative(s).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84068.3. Modifications to Needs and Services Plan.

(a) The needs and services plan specified in Section 84068.2 shall be updated at least every six months to determine the following:

(1) The child's need for continuing services.

(2) The facility's recommendation regarding the feasibility of the child's return to his/her home; placement in another facility; or move to independent living.

(3) The need for modification in services.

(b) The licensee shall ensure that the child and his/her authorized representative(s) are offered the opportunity to participate in such modifications.

(1) The licensee shall not implement any plan modifications unless prior written approval of such modifications has been obtained from the child's authorized representative(s).

(c) In order to determine the need to modify the child's needs and services plan, the licensee shall conduct an analysis of each incident reported pursuant to Sections 80061 and 84061 which occurred in the six months preceding the biannual review of the needs and services plan.

(1) The analysis shall consist of the following:

(A) If there were multiple incidents:

(1) Was it the same situation.

(2) Was it a different situation.

(3) Did the other incidents involve the same facility personnel.

(4) Was it the same resolution.

(5) Was it a different resolution.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84068.4. Removal and/or Discharge Procedures.

(a) The licensee shall develop, maintain and implement written policies and procedures governing a child's removal and/or discharge from the facility.

(1) Children and their authorized representative(s) shall receive copies of such policies and procedures.

(2) Signed copies of such policies and procedures shall be maintained in the child's record, as specified in Section 84070(c)(2).

(b) The licensee shall ensure that the child and his/her authorized representative(s) are offered the opportunity to participate in the development of a discharge plan for the child.

(1) (See Manual of Policies and Procedures)

(2) The licensee shall not discharge a child unless prior written approval of the discharge has been obtained from the child's authorized representative(s).

(c) If it is determined that the facility cannot meet the needs of the child, the licensee shall notify the authorized representative(s) of the determination and request that the child be placed elsewhere.

(d) (See Manual of Policies and Procedures)

(e) Social work staff shall develop and maintain a written removal or discharge record containing the information specified in Sections 84070(d) through (d)(3).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84069.1. Immunizations.

(a) A child for whom vaccination against the following diseases cannot be verified shall receive the first doses of the appropriate vaccines within 30 calendar days of placement in the facility and shall receive follow–up doses as recommended by the physician who administered the first doses.

(1) Poliomyelitis.

(2) Diphtheria.

(3) Pertussis, i.e., whooping cough.

(4) Tetanus.

(5) Measles.

(6) Rubella, i.e., German measles.

(7) Mumps.

(b) Notes from parents, guardians, etc., are not acceptable documentation.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 84069.2. Individualized Health Care Plans fo Specialized Group Homes.

(a) The licensee shall not accept any child with special health care needs unless the licensee has obtained an individualized health care plan for the child. The plan shall include the following information:

(1) The name, address, and phone number of the health care professional responsible for monitoring the child's ongoing health care.

(2) The appropriate number of hours of on–site supervision and monitoring, and the appropriate number of hours of off–site supervision and monitoring, needed to be provided by the monitor designated in Section 84069.2(a)(1).

(3) For children with special health care needs placed as of November 1, 1993:

(A) Documentation by the child's individualized health care plan team identifying the specialized in–home health care to be administered by a health care professional or responsible adult trained by a health care professional.

(B) Specific responsibilities of staff for the provision of specialized in–home health care.

(C) Identification of any available and funded medical services that are to be provided to the child in the home which may include, but is not limited to, assistance from health care professionals.

(4) For children with special health care needs placed after November 1, 1993:

(A) Documentation by the child's individualized health care plan team identifying the specialized in–home health care to be administered by one or more health care professionals.

(B) Specific responsibilities of the health care professional(s) for the provision of specialized in–home health care.

(C) Identification of any available and funded medical services that are to be provided to the child in the home including the name, address and telephone number of each health care professional or agency that is to provide medical services to the child in the home.

(5) Arrangements for in–home health support services if required.

(6) Identification of any psychological, emotional, behavioral, or medical problems that will be identified in the child's needs and services plan or the medical assessment specified in Section 80069.

(b) The individualized health care plan for each child with special health care needs shall be updated at least every six months or sooner if the needs of the child change.

(c) For any child with special health care needs the hospital discharge plan may be adopted by the individualized health care plan team as the child's individualized health care plan.

(d) The individualized health care plan may be combined with the child's needs and services plan or regional center individual program plan provided that all the information required by each plan is included.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 17731(c) and 17710(h), Welfare and Institutions Code.

§ 84070. Children's Records.

(a) In addition to Section 80070, the following shall apply.

(b) The following information regarding the child shall be obtained and maintained in the child's record:

(1) The name, address, and telephone number of all adults with whom the child was living immediately prior to the current placement.

(2) The name, address, and telephone number of the child's parent(s), if known.

(3) The name, address, and telephone number of the placement worker and placement agency.

(4) Educational records, if available, describing the child's present academic level, including his/her grade or performance level, and any previous school–related problems.

(5) Dental and medical history, if available, including immunization records; and physician's orders for any medically necessary diet as specified in Section 80076(a)(6).

(6) The child's court status, if applicable, including a copy of any custody orders and agreements with parent(s) or person(s) having legal custody.

(7) The placement agency's list of persons who should or should not be allowed to visit.

(8) Medical, psychiatric and psychological reports that identify special needs of children diagnosed as mentally disordered or developmentally disabled.

(9) Medical and dental insurance coverage information, or information regarding the agency or person responsible for medical and dental costs.

(10) Consent forms, completed by the child's authorized representative(s), to permit the facility to authorize medical care.

(11) A copy of the standard appraisal form specified in Section 84068.1(b)(1)(C), if used.

(c) If it is determined that the facility can provide the services necessary to meet the child's needs, the following additional information shall be maintained in the child's record:

(1) A copy of the child's original needs and services plan; verification, signed by the child and his/her authorized representative(s), that they were offered the opportunity to participate in plan development; and verification that the authorized representative(s) have approved the plan.

(2) Signed copies of the facility's policies and procedures regarding the child's removal and/or discharge; discipline; and complaints.

(3) Documentation that vaccinations have been obtained as specified in Section 84069.1, if immunization records are not available prior to placement.

(4) Records and documentation regarding any fines levied as specified in Sections 84026(c)(1) through (4).

(5) Copies of any modifications to the child's needs and services plan; verification, signed by the child and his/her authorized representative(s), that they were offered the opportunity to participate in any such modifications; and verification that the authorized representative(s) have approved such modifications.

(d) If it is determined that the child is to be removed or discharged from the facility, the following information shall be maintained in the child's record:

(1) Date the child's authorized representative(s) was notified of the necessity for the child's removal or discharge.

(2) The name, address, and relationship to the child of the person to whom the child was released.

(3) Reason for the child's removal or discharge.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 84070.1. Additional Children's Records for Specialized Group Homes.

(a) The licensee of a specialized group home shall ensure that records for each child with special health care needs contain the following:

(1) Documentation that the child has been adjudged a dependent of the court under Section 300 of the Welfare and Institutions Code or has not been adjudged a dependent of the court pursuant to Section 300 of the Welfare and Institutions Code but is in the custody of the county welfare department, or has a developmental disability and is receiving services and case management from a regional center.

(2) A copy of the child's individualized health care plan as specified in Section 84069.2.

(3) A copy of the written reassessment of the child's individualized health care plan as specified in Section 84069.2(b).

(b) The licensee of a group home caring for children with special health care needs placed on or after January 1, 1992, shall ensure that:

(1) The needs and services plan for each child in the home documents the determinations required by Section 84010.1(a)(2)(C).

(2) For each child with special health care needs placed on or after January 1, 1992, the child's records contain the following:

(A) In the child's needs and services plan, a description of the emergency necessitating that the child be placed in the group home and a written plan of relocation specifying the arrangements for subsequent placement in a less restrictive setting as required by Section 84010.1(a)(2)(B); and

(B) In the child's admission agreement,

1. If the 120 calendar day limitation period specified in Section 84010.1(a)(2)(A) has not been exceeded, the number of calendar days the child may remain in the group home without exceeding the limitation period; or

2. If the 120 calendar day limitation period has been exceeded, the number of calendar days the child may remain in the group home as stated in the extension approved under Section 84010.1(a)(2)(A)1.

a. The child's records shall also contain a copy of the letter from the Director or his/her designee approving the extension.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 17710(a), 17731(c) and 17732(d) and (e), Welfare and Institutions Code; and Section 1531, Health and Safety Code.

§ 84072. Personal Rights.

(a) Each facility licensed to provide foster care for six or more children shall post a listing of a foster child's rights.

(b) Each facility shall provide each school age child, who is placed in foster care, and his or her authorized representative with an age and developmentally appropriate orientation that includes an explanation of the rights of the child and addresses the child's questions and concerns.

(c) At admission each child, and his/her authorized representative, shall be personally advised of and given a copy of the child's rights as specified below:

(1) To visit the facility with his/her relatives and/or authorized representative(s) prior to admission.

(2) To file a complaint with the facility, as specified in Section 84072.2.

(3) To have the facility inform his/her authorized representative(s) of his/her progress at the facility.

(4) To have communications to the facility from his/her relatives and/or authorized representative(s) answered promptly and completely.

(5) To have visitors visit privately during waking hours without prior notice, provided that such visitations are not prohibited by the child's needs and services plan; do no infringe upon the rights of other children; do not disrupt planned activities; and are not prohibited by court order or by the child's authorized representative(s).

(A) Rules regarding visitation hours, sign–in rules and visiting rooms can be established but shall apply to all visitors.

(B) Visits by the child's brothers and sisters can only be prohibited by court order.

(6) To wear his/her own clothes.

(7) To possess and use his/her own toilet articles.

(8) To possess and use his/her own cash resources except as specified in Section 84026, and to maintain an emancipation bank account and manage personal income consistent with the child's age and developmental level, unless prohibited by the case plan.

(9) To possess and use his/her own personal items unless prohibited as part of a discipline program.

(10) To have access to individual storage space for his/her private use.

(11) To make and receive confidential telephone calls, unless prohibited by court order.

(A) Reasonable restrictions to telephone use may be imposed by the licensee. The licensee shall be permitted to:

1. Restrict the making of long distance calls upon documentation that requested reimbursement for previous long distance calls has not been received;

2. Restrict phone use in accordance with the facility's discipline program;

3. Impose restrictions to ensure that phone use does not infringe on the rights of others or restrict the availability of the phone during emergencies.

(B) All restrictions shall be documented in the child's needs and services plan or the facility's discipline policies, and be signed by the child's authorized representative.

(C) Calls permitted to be restricted by subsections (A)1. and (A)2. above shall not include calls to the child's authorized representative, placement agency, family members (except by court order), social workers, attorneys, Court Appointed Special Advocates (CASA), probation officers, Community Care Licensing Division of the California Department of Social Services or the State Foster Care Ombudsperson.

(12) To send and receive unopened correspondence unless prohibited by court order.

(13) To be accorded dignity in his or her personal relationships with staff and other persons.

(14) To live in a safe, healthy, and comfortable home where he or she is treated with respect, in accordance Section with 84072(c)(16).

(15) To be free of physical, sexual, emotional, or other abuse, and corporal punishment.

(16) To have fair and equal access to all available services, placement, care, treatment, and benefits, and to not be subjected to discrimination or harassment on the basis of actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status.

(17) To receive adequate and healthy food, adequate clothing, and an allowance.

(A) Clothing and personal items provided shall be in accordance with Section 84072(c)(16).

(18) To receive medical, dental, vision, and mental health services.

(19) To be free of the administration of medication or chemical substances, unless authorized by a physician.

(20) To contact family members (including brothers and sisters), unless prohibited by court order, and social workers, attorneys, foster youth advocates and supporters, Court Appointed Special Advocates (CASA), and probation officers.

(21) To contact the Community Care Licensing Division of the California Department of Social Services or the State Foster Care Ombudsperson regarding violations of rights, to speak to representatives of these offices confidentially, and to be free from threats or punishment for making complaints.

(22) To be informed, and to have his/her authorized representative, if any, informed, by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency, and of information regarding confidentiality.

(23) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, in or outside of the facility, shall be on a completely voluntary basis.

(24) To not be locked in any room, building, or facility premises at any time.

(A) The licensee shall not be prohibited by this provision from locking exterior doors and windows or from establishing house rules for the protection of clients provided the clients are able to exit the facility.

(B) The licensee shall be permitted to utilize means other than those specified in (A) above for securing exterior doors and windows only provided the clients are able to exit the facility and with the prior approval of the licensing agency.

(25) To attend school and participate in extracurricular, cultural, and personal enrichment activities consistent with the child's age and developmental level, in accordance with Section 84072(c)(16).

(26) To work and develop job skills at an age–appropriate level that is consistent with state law.

(27) To have social contacts with people outside of the foster care system, such as teachers, church members, mentors, and friends, in accordance with Section 84072(c)(16).

(28) To attend Independent Living Program classes and activities if he or she meets age requirements.

(29) To attend court hearings and speak to the judge.

(30) To review his or her own case plan if he or she is over 12 years of age and to receive information about his or her out–of–home placement and case plan, including being told of changes to the plan.

(31) To be free from unreasonable searches of personal belongings.

(32) To confidentiality of all juvenile court records consistent with existing law.

(33) Not to be placed in any restraining device. Postural supports may be used if they are approved in advance by the licensing agency as specified in (A) through (F) below.

(A) Postural supports shall be limited to appliances or devices including braces, spring release trays, or soft ties used to achieve proper body position and balance, to improve a client's mobility and independent functioning, or to position rather than restrict movement including, but not limited to, preventing a client from falling out of bed, a chair, etc.

1. Physician–prescribed orthopedic devices such as braces or casts used for support of a weakened body part or correction of body parts are considered postural supports.

(B) All requests to use postural supports shall be in writing and include a written order of a physician indicating the need for such supports. The licensing agency shall be authorized to require other additional documentation in order to evaluate the request.

(C) Approved postural supports shall be fastened or tied in a manner which permits quick release by the child.

(D) The licensing agency shall approve the use of postural supports only after the appropriate fire clearance, as required by Section 80020(a) or (b), has been secured.

(E) The licensing agency shall have the authority to grant conditional and/or limited approvals to use postural supports.

(F) Under no circumstances shall postural supports include tying of, or depriving or limiting the use of, a child's hands or feet.

1. A bed rail that extends from the head half the length of the bed and used only for assistance with mobility shall be allowed with prior licensing approval. Bed rails that extend the entire length of the bed are prohibited.

(G) Protective devices including, but not limited to, helmets, elbow guards, and mittens which do not prohibit a client's mobility but rather protect the client from self–injurious behavior are not to be considered restraining devices for the purpose of this regulation. Protective devices may be used if they are approved in advance by the licensing agency as specified below.

1. All requests to use protective devices shall be in writing and include a written order of a physician indicating the need for such devices. The licensing agency shall be authorized to require additional documentation including, but not limited to, the Individual Program Plan (IPP) as specified in Welfare and Institutions Code Section 4646, and the written consent of the authorized representative, in order to evaluate the request.

2. The licensing agency shall have the authority to grant conditional and/or limited approvals to use protective devices.

(H) Under no circumstances shall postural supports or protective devices be used for disciplinary purposes.

(34) At 16 years or older, to have access to existing information regarding available educational options, including, but not limited to, coursework necessary for vocational and postsecondary educational programs, and financial aid information for these programs.

(d) Nothing in this section shall be interpreted to require a foster care provider to take any action that would impair the health and safety of children in out–of–home placement.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1530.91 and 1531, Health and Safety Code; and Section 16001.9, Welfare and Institutions Code.

§ 84072.1. Discipline Policies and Procedures.

(a) The licensee shall develop, maintain and implement written facility discipline policies and procedures meeting the requirements specified in (b) and (c) below.

(1) Staff, children, and authorized representatives shall receive copies of such policies and procedures, as specified in Sections 84065(o) and 84068.1(b)(4)(B).

(2) Signed copies of such policies and procedures shall be maintained in the child's record, as specified in Section 84070(c)(2).

(b) Any form of discipline which violates a child's personal rights as specified in Sections 80072 and 84072 shall be prohibited.

(c) Acceptable forms of discipline shall include the following:

(1) Exclusion in an unlocked living, sleeping, or play area.

(2) Institution of fines as specified in Section 84026(c).

(3) Prohibition against attendance at or participation in planned activities.

(4) Prohibition against use of entertainment devices including but not limited to telephones, televisions, radios and phonographs.

(5) Performance of additional duties related to training needs identified in the child's needs and services plan.

(6) Any other form of discipline approved in writing, in advance by the licensing agency.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84072.2. Complaint Procedures.

(a) The licensee of a group home shall develop, maintain and implement written complaint procedures by which children or their authorized representatives are permitted to file complaints, without fear of retaliation, with the facility administrator regarding facility staff or operations.

(1) Staff, children, and authorized representatives shall receive copies of such procedures, as specified in Sections 84065(o) and 84068.1(b)(4)(B).

(2) Signed copies of such procedures shall be maintained in each child's record, as specified in Section 84070(c)(2).

(3) Such procedures shall be posted in a location in the facility which is accessible to children and their authorized representatives.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 84072.3. Personal Rights for Children with Special Health Care Needs.

(a) Except as specified in this section, Section 80072(a)(8) shall not apply to children with special health care needs.

(b) A child with special health care needs has the right to be free from any restraining/postural support device imposed for purposes of discipline or convenience, and not required to treat the child's specific medical symptoms.

(1) Physical restraining devices may be used for the protection of a child with special health care needs during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. The restraining device, which shall not have a locking device, shall be applied for no longer than the time required to complete the treatment and shall be applied in conformance with the child's individualized health care plan. The child's individualized health care plan shall include all of the following:

(A) The specific medical symptom(s) that require use of the restraining device.

(B) An evaluation of less restrictive therapeutic interventions and the reason(s) for ruling out these other practices as ineffective.

(C) A written order by the child's physician. The order must specify the duration and circumstances under which the restraining device is to be used.

(2) Postural supports, as specified in Sections 80072(a)(8)(A) and (A)1., half–length bed rails, and protective devices as specified in Section 80072(a)(8)(G), may be used if prescribed in the individualized health care plan. The use of a postural support or protective device and the method of application shall be specified in the child's individualized health care plan and approved in writing by the child's physician.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Section 17730, Welfare and Institutions Code.

§ 84075. Health–Related Services.

(a) In addition to Section 80075, the following shall apply.

(b) The licensee shall ensure that all prescribed medications are centrally stored, as provided in Section 80075(h)(3).

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 84076. Food Service.

(a) In addition to Section 80076, the following shall apply.

(b) Written menus shall be posted weekly in an area accessible to the staff and children.

(c) The licensee shall meet the following food supply and storage requirements:

(1) Supplies of staple nonperisable foods for a minimum of one week and fresh perishable foods for a minimum of two days shall be maintained on the premises.

(2) Freezers shall be large enough to accommodate required perishables and shall be maintained at a temperature of zero degrees F (–17.7 degrees C).

(3) Refrigerators shall be large enough to accommodate required perishables and shall maintain a maximum temperature of 45 degrees F (7.2 degrees C).

(4) Freezers and refrigerators shall be kept clean, and food storage shall permit the air circulation necessary to maintain the temperatures specified in (2) and (3) above.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84077. Personal Services.

(a) The licensee shall ensure the following:

(1) Provision of basic laundry services, including but not limited to washing, drying, and ironing of children's personal clothing.

(A) Children shall be permitted to participate in the performance of such services provided that the requirements specified in Section 80065(j) are met.

(2) Provision of an allowance to all children no less frequently than once per month except:

(A) If the child in placement is an infant as defined in Section 80001.

(B) If the child is unable to manage his/her own money because of age or if the authorized representative determines that the child cannot manage his/her own money.

(1) If the authorized representative considers the child incapable of money management, it must be specified in the needs and services plan.

(3) Portions of a child's allowance may be withheld through a fining system as specified in Section 84026.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84078. Responsibility for Providing Care and Supervision.

(a) In addition to Section 80078, the following shall apply.

(b) The licensee shall provide those services identified in each child's needs and services plan and in the individualized health care plan for each child with special health care needs as necessary to meet the child's needs.

(c) The licensee is responsible for ensuring care and supervision of the child(ren) of any minor parent(s) in placement.

(1) Direct care and supervision of the child(ren) of a minor parent is to be provided during the hours that the minor parent is unavailable or unable to provide such care and supervision.

(d) The licensee shall ensure each child's attendance at an educational program in accordance with state law.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Sections 11465 and 17731, Welfare and Institutions Code; and Sections 1501 and 1531, Health and Safety Code.

§ 84079. Planned Activities.

(a) The licensee shall develop, maintain, and implement a written

plan to ensure that indoor and outdoor activities which include but are not limited to the following are provided for all children:

(1) Activities that require group interaction.

(2) Physical activities, including but not limited to games, sports and exercise.

(3) Leisure time.

(4) Educational activities, including attendance at an educational program in accordance with state law, and supervision of afterschool study as specified in Section 84078(c).

(5) Activities which meet the training, money management, and personal care and grooming needs identified in the children's needs and services plans, as specified in Section 84068.2(c)(3) through (5).

(b) Each child who is capable shall be given the opportunity to participate in the planning, preparation, conduct, cleanup, and critique of planned activities.

(c) The licensee shall permit children to attend and participate in community activities, including but not limited to the following:

(1) Worship services and activities of the child's choice.

(2) Community events, including but not limited to concerts, tours, dances, plays, and celebrations of special events.

(3) The YMCA, YWCA, and Boy and Girl Scouts.

(d) In facilities with a licensed capacity of 13 or more children, a schedule of the planned activities shall be posted on at least a weekly basis in a central facility location readily accessible to children, relatives, and representatives of placement and referral agencies.

(1) Copies of schedules shall be retained in the facility's files for at least six months.

(e) For children 16 years of age or older, the licensee shall allow access to existing information regarding available vocational and postsecondary educational options as specified in Section 84072(c)(34). The information may include, but is not limited to:

(1) Admission criteria for universities, community colleges, trade or vocational schools and financial aid information for these schools.

(2) Informational brochures on postsecondary or vocational schools/programs.

(3) Campus tours.

(4) Internet research on postsecondary or vocational schools/programs, sources of financial aid, independent living skills program offerings, and other local resources to assist youth.

(5) School–sponsored events promoting postsecondary or vocational schools/programs.

(6) Financial aid information, including information about federal, state and school–specific aid, state and school–specific scholarships, grants and loans, as well as aid available specifically to current or former foster youth and contact information for the Student Aid Commission.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 16001.9, Welfare and Institutions Code.

§ 84080. Resident Councils.

(a) Each facility, at the request of a majority of its residents, shall assist its residents in establishing and maintaining a resident–oriented facility council.

(1) The licensee shall provide space and post notice for meetings, and shall provide assistance in attending council meetings for those residents who request it.

(A) If residents are unable to read the posted notice because of a physical or functional disability, the licensee shall notify the residents in a manner appropriate to that disability including but not limited to verbal announcements.

(2) The licensee shall document notice of meetings, meeting times, and recommendations from council meetings.

(3) In order to permit a free exchange of ideas, at least part of each meeting shall be conducted without the presence of any facility personnel.

(4) Residents shall be encouraged, but shall not be compelled to attend council meetings.

(b) The licensee shall ensure that in providing for resident councils the requirements of Section 1520.2 of the Health and Safety Code are observed.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Section 1520.2, Health and Safety Code.

Article 7. Physical Environment

§ 84087. Buildings and Grounds.

(a) In addition to Section 80087, the following shall apply.

(b) Bedrooms shall meet, at a minimum, the following requirements:

(1) Not more than two children shall sleep in a bedroom.

(2) Bedrooms shall be large enough to allow for easy passage and comfortable use of any required assistive devices, including but not limited to wheelchairs, between beds and other items of furniture.

(3) Children of the opposite sex shall not share a bedroom unless each child is under five years of age.

(4) No room commonly used for other purposes shall be used as a bedroom.

(A) Such rooms shall include but not be limited to halls, stairways, unfinished attics or basements, garages, storage areas, and sheds or similar detached buildings.

(5) No bedroom shall be used as a public or general passageway to another room, bath or toilet.

(6) Except for infants, children shall not share a bedroom with an adult.

(A) In bedrooms shared by adults and infants, no more than one infant and no more than two adults shall share the room.

(B) If two children have been sharing a bedroom and one of them turns 18 they may continue to share the bedroom as long as they remain compatible and the licensing agency has granted as exception pursuant to Section 80024.

(7) Private bedrooms, separate from the children's bedrooms shall be provided for staff or other adults who sleep at the facility.

(A) Staff bedrooms are to be located near the children's sleeping area.

(8) Subsections (1), (2), (3), (4), (5), and (6) apply to all bedrooms used by all children in the facility including children who are members of the licensee's family, children of staff members and children in placement.

(9) Subsections (4), (5) and (7) apply to all bedrooms used by the licensee(s), staff and any other adults in the facility.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84087.1. Additional Buildings and Grounds Requirements for Specialized Group Homes.

(a) Areas in the home, including bedrooms, bathrooms, toilets, dining areas, passageways and recreational spaces used by a child with special health care needs shall be large enough to accommodate any medical equipment needed by the child therein.

(1) Bedrooms occupied by children with special health care needs shall be large enough to allow the storage of each child's personal items and any required medical equipment or assistive devices, including wheelchairs, adjacent to the child's bed.

(A) The bedroom shall be large enough to permit unobstructed bedside ministration of medical procedures and medications.

(b) Notwithstanding Section 84087(b)(1), a bedroom used by a child with special health care needs shall not be shared with another minor residing in the facility if the child's need for medical services or the child's medical condition would be incompatible with the use and enjoyment of the bedroom by each minor.

NOTE: Authority cited: Section 17730, Welfare and Institutions Code; and Section 1530, Health and Safety Code. Reference: Section 17732, Welfare and Institutions Code.

§ 84087.2. Outdoor Activity Space.

(a) Children shall have access to safe outdoor activity space.

(1) Outdoor activity space meeting the requirement of (a) above shall include but not be limited to activity centers and public parks.

(2) A sketch of the physical plant as required in the plan of operation pursuant to Section 80022, shall include the location(s) of outdoor activity space.

(3) The outdoor activity space shall not include any area made inaccessible by fencing pursuant to Section 80087(f).

(4) Where natural or man–made hazards such as canals, cliffs, condemned buildings, creeks, ditches, lakes, ocean fronts, mines, power lines, quarries, rivers, ravines, swamps, watercourses, and areas subject to flooding lie on or adjacent to the facility premises, the outdoor activity space shall be inaccessible to such hazards.

(A) Where a fence or wall is used to make the outdoor activity space inaccessible, the requirements of Section 80087(f)(1) shall be met.

(b) As a condition of licensure, the areas around and under high climbing equipment, swings, slides and other similar equipment shall be cushioned with material which absorbs falls.

(1) Sand, woodchips, peagravel or rubber mats commercially produced for this purpose, shall be permitted.

(2) The use of cushioning material other than that specified in (1) above shall be approved by the licensing agency in advance of installation.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84087.3. Indoor Activity Space.

(a) As a condition of licensure, there shall be common rooms, including a living room, dining room, den or other recreation/activity room, which provide the necessary space and/or separation to promote and facilitate the program of planned activities specified in Section 84079; and to prevent such activities from interfering with other functions.

(1) At least one such room shall be available to children for relaxation and visitation with friends and/or relatives.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84088. Fixtures, Furniture, Equipment, and Supplies.

(a) In addition to Section 80088, the following shall apply.

(b) As a condition of licensure, toilets, wash basin, bath and shower fixtures shall, at a minimum, meet the following requirements:

(1) There shall be at least one toilet and wash basin maintained for each six persons residing in the facility, including children and personnel.

(2) There shall be at least one shower or bathtub maintained for each ten persons residing in the facility, including children and personnel.

(3) Toilets and bathrooms shall be located so that children do not have to go out–of–doors to have access to such accommodations.

(4) Individual privacy shall be provided in all toilet, bath, and shower areas.

(c) The licensee shall provide and make readily available to each child the following furniture, equipment and supplies necessary for personal care and maintenance of personal hygiene:

(1) An individual bed maintained in good repair; equipped with good springs and a clean mattress; and supplied with pillow(s) which are clean and in good repair.

(A) No group home shall have more beds for children's use than required for the maximum capacity approved by the licensing agency.

1. This requirement shall not apply to the bed(s) made available for ill-ness or separation of others in an isolation room or area as specified in Section 80075(b).

(B) Fillings and covers for mattresses and pillows shall be flame retardant.

(C) The use of cots, trundle, or bunk beds shall be prohibited.

(2) Clean linen in good repair, including lightweight, warm blankets and bedspreads; top and bottom bed sheets; pillow cases; mattress pads; and bath towels, hand towels and wash cloths.

(A) The quantity of linen provided shall permit changing the linen at least once each week, or more often when indicated to ensure that clean linen is in use by children at all times.

(B) Use of common towels and wash cloths shall be prohibited.

(3) Items used to maintain basic personal hygiene practices, including but not limited to shampoo, feminine napkins, nonmedicated soap, toilet paper, toothbrush, toothpaste, and comb.

(4) Portable or permanent closets and drawer space in the child's bedroom to accommodate the child's clothing and personal belongings.

(A) A minimum of two drawers or eight cubic feet (.2264 cubic meters) of drawer space, whichever is greater, shall be provided for each child.

(d) The following facilities shall maintain a signal system which meets the requirements specified in (e) and (f) below. Such system shall be used by children to summon staff during an emergency:

(1) All facilities with a licensed capacity of 31 or more children.

(2) All facilities having separate floors and not providing full–time staff on each floor whenever children are present.

(3) All facilities having separate buildings and not providing full–time staff in each building whenever children are present.

(e) The signal system shall have the ability to meet the following requirements:

(1) Operation from each children's living unit.

(2) Transmission of a visual and/or auditory signal to a central location, or production of an auditory signal at the specific children's living unit which is loud enough to summon staff.

(3) Identification of the specific children's living unit from which the signal originates.

(f) Facilities having more than one wing, floor or building shall be allowed to have a separate signal system in each component provided that each such system meets the requirements specified in (e) above.

(g) The licensee shall provide and maintain the supplies, equipment and reading material necessary to implement the planned activities.

(h) The licensee shall provide and make readily available to each child well–lighted desk or table space and necessary supplies, including reference materials, for school–related study.

(i) Construction or other equipment, including but not limited to incinerators and air conditioning equipment, shall be made inaccessible to children.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84088.3. Outdoor Activity Equipment.

(a) Outdoor activity equipment shall be securely anchored to the ground unless it is portable by design.

(1) Equipment shall be maintained in a safe condition free of sharp, loose or pointed parts.

NOTE: Authority cited: Section 1530, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

Subchapter 1. Community Treatment Facilities

Article 1. General Requirements and Definitions

§ 84110. General.

(a) Community treatment facilities, as defined in Section 80001(c)(11), shall be governed by the provisions specified in this subchapter. In addition, community treatment facilities, except where specified otherwise, shall be governed by Title 22, Division 6, Chapter 5, Group Homes, Articles 1 through 7, and Chapter 1, General Licensing Requirements.

(b) In addition to Section 84110(a), community treatment facilities shall be governed by the provisions specified in the California Code of Regulations, Title 9, Chapter 11, Sections 1900 through 1938.

NOTE: Authority cited: Section 1530.9, Health and Safety Code. Reference: Sections 1501, 1502, 1530, 1530.9 and 1531, Health and Safety Code; and Section 4094, Welfare and Institutions Code.

§ 84111. Definitions.

In addition to Section 84001, the following shall apply:

(a)(1) "Advocate" means the person or persons authorized to provide advocacy services pursuant to Section 5520 et seq. of the Welfare and Institutions Code.

(b) (Reserved)

(c)(1) "Certified" means a community treatment facility that has been approved by the Department of Mental Health as complying with the standards established for that program.

(2) "Child" means a person under 18 years of age who is seriously emotionally disturbed as defined in Section 5600.3 of the Welfare and Institutions Code, including those individuals 18 through 21 years of age as specified in Section 1924(b) of the California Code of Regulations, Title 9, Chapter 11.

(3) "Conservator" means a person appointed pursuant to Section 5350 of the Welfare and Institutions Code. In the event a child has a conservator and a parent(s), the conservator shall take precedence.

(d) (Reserved)

(e)(1) "Emergency" as defined in Section 1901(k) of the California Code of Regulations, Title 9, Chapter 11.

(f) (Reserved)

(g) (Reserved)

(h) (Reserved)

(i)(1) "Interagency Placement Committee" (IPC) means a committee established by the county, with a membership that includes at least the county placement agency and a licensed mental health professional from the county department of mental health pursuant to Section 4096(c) of the Welfare and Institutions Code.

(j) (Reserved)

(k) (Reserved)

(*l*)(1) "Licensed Mental Health Professional" as defined in Section 1901(p) of the California Code of Regulations, Title 9, Chapter 11.

(m)(1) "Mental Health Program Director" means the licensed mental health professional who has been designated by a community treatment facility licensee to oversee and implement the overall mental health treatment program.

(n) (Reserved)

(o) (Reserved)

(p)(1) "Physical Restraint" as defined in Section 1901(v) of the California Code of Regulations, Title 9, Chapter 11.

(q) (Reserved)

(r) (Reserved)

(s)(1) "Seclusion" as defined in Section 1901(dd) of the California Code of Regulations, Title 9, Chapter 11.

(2) "Secure Portion of the Facility" as defined in Section 1901(ee) of the California Code of Regulations, Title 9, Chapter 11.

(3) "Seriously Emotionally Disturbed" as defined in Section 5600.3(a)(2) of the Welfare and Institutions Code.

(t) (Reserved)

(u) (Reserved)

(v) (Reserved)

(w) (Reserved)

(x) (Reserved)

(y) (Reserved)

(z) (Reserved)

NOTE: Authority cited: Sections 1502, 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

Article 2. Licensing (Reserved)

Article 3. Application Procedures

§ 84118. Application for License.

(a) In addition to Section 84018, with the exception of Sections 84018(b)(2) and (3), the following shall apply.

(b) Prior to licensure each applicant shall submit to the Department evidence of a current community treatment facility mental health program certification, which shall be signed by an authorized representative of the Department of Mental Health.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1520 and 1531, Health and Safety Code; and Section 4094(b), Welfare and Institutions Code.

§ 84120. Fire Clearance.

(a) In addition to Section 80020, the following shall apply:

(b) The applicant shall notify the Department if the facility plans to use the following:

(1) Mechanical restraint devices.

(2) Seclusion room(s).

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 4094.5(d), Welfare and Institutions Code.

§ 84122. Plan of Operation.

(a) In addition to Section 84022, the following shall apply.

(b) The plan of operation shall include the following:

(1) A utilization review plan and program to monitor the appropriateness of a child's admission and continued stay or discharge, and to establish the basis for identifying and assessing the utilization of mental health program services and continued need for placement.

(A) The utilization review plan shall include a description of the procedures to be used by the facility to determine the placement, continued stay, or transfer of a child into either the secure or nonsecure portion of the facility.

(B) These procedures shall include documentation of approval of the proposed change of a child's placement within the facility and continued stay.

(2) A description of the array of mental health treatment services that can be made available to a child during their placement with the community treatment facility.

(3) A listing of and copies of all agreements, contracts, or memorandums of understanding with participating private or public mental health and health providers.

(4) A quality assurance program designed to enhance services and care through an objective assessment of the facility's overall programs to ensure the correction of identified problems.

(A) The quality assurance program shall include procedures for insuring the accountability of the facility's licensed mental health professional(s) and child care workers for the services and care provided to residents of the facility, and implementation of indicated changes.

(5) The name of the proposed mental health program director and his or her professional license number(s).

(6) A description of procedures and policies which shall include:

(A) Policies and procedures for the daily recording of observations and interactions with each child, psychotropic medication control, monthly review of each child's needs and services plan, and seclusion and restraint procedures.

(B) Procedures for ensuring a child's due process rights as specified in Section 84172(c).

(C) Policies and procedures for providing access to community resources to be utilized, as necessary, in the delivery of prescribed services, including medical and crisis intervention, inpatient psychiatric hospitalization, and education placements and classes.

(7) A written plan for the orientation, continuing education, on–the–job training, supervision, and evaluation of staff as required by Section 84165(f).

(8) A written plan for activities as specified in Sections 84079(a) through (a)(5).

(9) A written description of the facility's security features and procedures.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code;

and Section 1919, Title 9, Chapter 11, Article 5, California Code of Regulations.

§ 84128. Capacity Determination.

(a) In addition to Section 80028, the following shall apply.

(b) A license for a community treatment facility shall not exceed the Department of Mental Health's certification of specified number of beds.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Section 1531, Health and Safety Code; and Section 4094.7(b), Welfare and Institutions Code.

§ 84134. Submission of New Application.

(a) In addition to Section 80034, the following shall apply.

(b) The Department may only approve capacity increases that have been approved by the Department of Mental Health.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Section 1531, Health and Safety Code; and Section 4094.7(b), Welfare and Institutions Code.

Article 4. Administrative Actions

§ 84140. Denial of License.

(a) In addition to Section 80040, the following shall apply.

(b) An application shall be denied if it is determined that the applicant has not been certified by the Department of Mental Health as specified in Section 84118(b).

(1) A single proceeding to hear an appeal for denial of an application will be held jointly with the Department of Mental Health and conducted by the Department.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1520 and 1525, Health and Safety Code; and Section 4094(b), Welfare and Institutions Code.

§ 84142. Revocation or Suspension of License.

(a) In addition to Section 80042, the following shall apply.

(b) The Department shall suspend or revoke the license of a community treatment facility upon written notification from the Department of Mental Health that the facility's certification has been revoked or suspended.

(1) A single proceeding to hear a revocation or a temporary suspension action will be held jointly with the Department of Mental Health and conducted by the Department.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 4094(b) and (c), Welfare and Institutions Code.

§ 84145. Evaluation Visits.

(a) The Department shall notify the Department of Mental Health when there is reasonable cause to believe that a community treatment facility is not in compliance with program standards as specified in the California Code of Regulations, Title 9, Chapter 11, Article 5 and 6.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Section 4094(c)(4), Welfare and Institutions Code.

Article 5. Enforcement Provisions

§ 84151. Serious Deficiencies.

(a) In addition to Section 80051, with the exception of Section 84051, the following are regulations which, if not complied with, nearly always result in a serious deficiency.

(1) Sections 84164 and 84164.1 — related to the qualification and duties of the administrator and mental health program director.

(2) Section 84165(b) — related to personnel requirements.

(3) Sections 84165.5 and .6 — related to staff/child ratios.

(4) Section 84168.1 — related to admission criteria.

(5) Section 84168.3 — related to the needs and services plan for the child.

(6) Section 84172 — related to personal rights.

(7) Section 84172.2 — related to complaint procedures.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

Article 6. Continuing Requirements

§ 84161. Reporting Requirements.

(a) In addition to Section 84061, the following shall apply.

(b) The licensee shall furnish a report to the licensing agency and the admitting parent(s), conservator, or the person designated by the court to manage the placement as specified in Section 80061(b) for all occurrences of a physical restraint as specified in Section 84175.2(a).

(c) The licensee shall notify the child's parent(s), conservator or person designated by the court to manage placement before the child is transferred between the nonsecure and secure program, except in an emergency.

(1) In an emergency, notification shall occur within 24 hours if the child has been transferred between the nonsecure and secure program without the participation of the parent(s), conservator, or person designated by the court to manage placement.

(d) The licensee shall notify the Department in writing, within 10 working days, of a change of mental health program director. The notification of a change shall include the following:

(1) Name, residence, and mailing address of the new employee.

(2) Effective date of position change.

(3) Description of the new employee's background and qualification, including documentation of required education. A photocopy of the documentation shall be permitted.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1531 and 1562, Health and Safety Code; and Section 11406(c), Welfare and Institutions Code.

§ 84164. Administrator Qualifications and Duties.

(a) In addition to Sections 84064(a) and (f), with the exception of Sections 84064(b) through (e), the following shall apply.

(b) All community treatment facilities shall have an administrator.

(c) The administrator shall be on the premises for the number of hours necessary to manage and administer the facility in compliance with applicable law and regulation.

(d) The administrator shall meet one of the following requirements:

(1) Have a master's degree in a behavioral science from an accredited college or university, and one year of full–time administrative or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(2) Have a master's degree in a behavioral science from an accredited college or university, and two years of full–time employment as a mental health professional or social worker, as defined in Section 80001s.(4), in an agency serving children or in a group residential program serving children.

(3) Have a bachelor's degree from an accredited college or university, and three years of full–time administrative or supervisory experience over social work, child care, and/or support staff providing direct care services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(e) When the administrator is absent, there shall be coverage by a designated substitute whose qualifications are at minimum, a bachelor's degree from an accredited college or university, plus at least two years of full–time administrative experience or supervisory experience over social work, child care, and/or support staff providing direct services to children in an agency or in a community care facility with a licensed capacity of seven or more.

(f) The administrator shall perform the duties as specified in Section 84064(f) and the following:

(1) Development of a plan for the orientation, development, and training of child care staff, as specified in Section 84165(f).

(2) Review of complaints made by children or on behalf of children, a specified in Section 84172.2(b), and the determination of the action to be taken to handle the complaint.

NOTE: Authority cited: Sections 1522.41(j), 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1522.41(h), 1531 and 1562, Health and Safety Code.

§ 84164.1. Mental Health Program Director Qualifications and Duties.

(a) All community treatment facilities shall have a Mental Health Program Director that meets the qualifications and responsibilities as specified in Section 1920 of the California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1531 and 1562, Health and Safety Code; and Section 4094(d), Welfare and Institutions Code.

§ 84165. Personnel Requirements.

(a) In addition to Section 80065, Section 84065(k) shall apply.

(b) The licensee shall employ administrative, child care, licensed mental health professional, and support staff necessary to perform the assigned duties specified in Sections 84164(f), 84164.1, and 84165.1.

(c) The licensee shall designate at least one facility manager to be present at the facility at all times when children are present.

(1) The facility manager shall meet one of the following minimum requirements prior to employment:

(A) Have two years of full–time experience as a social worker staff person in a group home performing those duties specified in Sections 84165.1(b)(1) through (3).

(B) Have an associate of arts or science degree from an accredited college or university and four years providing full–time direct care to children in an agency serving children or in a group residential program serving children.

(C) Have two years of full–time residential child care experience and completion, with a passing grade, of 18 college semester or equivalent quarter units on behavioral science from an accredited or approved college or university. Nine of those units must be in courses relating to children with behavioral problems which may be the result of abuse, neglect, or emotional trauma. The courses may include, but are not limited to, curriculums in corrections, psychology, social work, or social welfare.

(d) The licensee shall ensure that all child care staff meet one of the following minimum qualifications prior to employment:

(1) Have two years of full–time residential child care experience and an associate of arts or science degree from an accredited or approved college or university, with a major or emphasis in behavioral science. Nine of those units must be in courses relating to children with behavioral problems which may be the result of abuse, neglect, or emotional trauma. The courses may include, but are not limited to, curriculums in corrections, psychology, social work, or social welfare.

(2) Have two years of full–time work experience in a program serving persons with mental disabilities and be currently a licensed psychiatric technician by the Board of Vocational Nurse and Psychiatric Technician Examiners.

(e) Child care staff, employed by the facility prior to the effective date of these regulations, who do not have the required degree or semester units or equivalent quarter units relating to children with behavioral problems as specified in Section 84165(d), shall successfully complete the required units within one year of the effective date of these regulations.

(f) The licensee shall develop, maintain, and implement a written plan for the orientation, continuing education, on–the–job training and development, supervision, and evaluation of all child care staff.

(1) The plan shall require child care staff to receive and document a minimum of 20 hours of continuing education during the first 12 months of employment and during each year thereafter.

(A) Continuing education shall include completion of courses related to the principles and practices of child care, mental health and care of the mentally ill including, but not limited to, workshops, seminars, and academic classes.

(B) Continuing education, training, and classes may be provided at the facility.

(C) Proof of course attendance and completion shall be limited to official grade slips, transcripts, certificates, or signed documentation from a college, adult education department, a bona fide educational institution/organization, or licensee association.

(2) The on–the–job training and development program shall include training in the following areas:

(A) Assaultive behavior management and preventing assaultive behavior training course which shall be approved by the Department of Mental Health. Staff shall complete at least 16 hours of a basic assaultive behavior and prevention training course prior to their participation in the containment, seclusion, and/or restraint of a child. The staff shall also participate in a four–hour semiannual review course.

1. The behavior management training courses shall be pre–approved by the Department of Mental Health.

(B) Recognition of possible side effects of psychotropic medication.

(C) Children's personal rights, due process rights, procedures for accessing these rights and staff responsibilities.

(D) The facility's emergency and safety procedures including, but not limited to, fire drills and disaster plan procedures.

(g) During orientation or when changes are made which affect job assignments, and upon request to placement agencies, all employees shall be given a copy of the job description and staff assignment information specified in Sections 84066(b)(1) and (2) which is relevant to their duties. All employees shall have access to all other job descriptions.

(h) Upon employment, staff shall receive copies of the discharge policies and procedures specified in Section 84168.5, due process procedures specified in Section 84172(c), complaint procedures specified in Section 84172.2, and the restraint policies specified in Section 84175.2.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1522.4, 1531 and 1562, Health and Safety Code.

§ 84165.1. Personnel Duties.

(a) In addition to Section 84065.1, with the exception of Section 84065.1(c), the following shall apply.

(b) Licensed mental health professional staff shall complete or perform the following for each child:

(1) An intake report and admission assessment as specified in Sections 84168.2(c) and (d)(1).

(2) A needs and services plan, as specified in Sections 84168.3 and 84168.4.

(3) A discharge plan, discharge summary, and discharge report as specified in Section 84168.5.

(4) The medication report and Monthly Clinical Review report as specified in Section 84175.1.

(5) The required procedures for denying a child's personal right as specified in Section 1934 of the California Code of Regulations, Title 9, Chapter 11.

(6) An authorization to initiate and document any form of restraint and/or seclusion as specified in Section 84175.2.

(7) Progress notes or descriptions documenting the client's participation and responses to the implementation of prescribed mental health treatment services.

(8) Administration and monitoring of the mental health treatment services.

(9) Develop and record the information necessary for the completion of Sections 84165.1(b)(1) through (8) as specified in Section 84170.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1522.4 and 1531, Health and Safety Code.

§ 84165.5. Staff/Child Ratios.

(a) Section 84065.5 is not applicable to community treatment facilities.

(b) In community treatment facilities, there shall be one child care person awake and on duty for each five children, or fraction thereof, present from 7 a.m. to 10 p.m.

(c) If the children require special care and supervision because of age, problem behavior, or other factors, the number of on–duty child care staff shall be increased to meet the needs of the children in accordance with Section 80065(a).

(d) Each community treatment facility shall meet health treatment full–time staffing to client census ratio as specified in Sections 1921(a) and (e) of the California Code of Regulations, Title 9.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84165.6. Night Supervision.

(a) Section 84065.7 is not applicable to community treatment facilities.

(b) In community treatment facilities providing care and supervision to, 10 or fewer children, there shall be one child care staff person awake and on duty from 10 p.m. to 7 a.m.

(1) Another staff person shall be on call and capable of arriving at the facility site within 30 minutes.

(c) In community treatment facilities providing care and supervision to 11 or more children, there shall be two child care staff persons awake and on duty from 10 p.m. to 7 a.m. for the first 20 children, and one child care staff person awake and on duty for each additional 20 children or fraction of that amount.

(d) In facilities required to have a signal system as specified in Section 84088(d), at least one staff person shall be responsible for responding to such system.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84168.1. Admission Criteria.

(a) The licensee shall develop, maintain, and implement admission procedures which only admit children who meet the criteria specified in this section.

(b) Prior to admitting a child, the facility shall obtain and keep in each child's record the following documentation which substantiates that the appropriate requirements have been met:

(1) A written statement, signed by an appropriate licensed mental health professional, certifying that the child is seriously emotionally disturbed, as defined in Section 84111(s)(3); requires periods of containment to participate in and benefit from mental health treatment; that a proposed treatment program is reasonably expected to improve the child's mental disorder; and meets one of the following requirements:

(A) The child's records must indicate that the child has participated in other less restrictive mental health interventions.

1. Less restrictive interventions include, but are not limited to, outpatient therapy, family counseling, case management, family preservation efforts, special education classes, or nonpublic schooling.

(B) The child is currently placed in a psychiatric or state hospital or a facility outside the state for mental health treatment.

(2) A written consent to treatment on behalf of each child in one of the following forms:

(A) An application for a child of any age under the jurisdiction of juvenile court and the court's consent to treatment shall be documented by a copy of the juvenile court ruling making the findings specified in Section 6552 of the Welfare and Institutions Code, together with the child's application for treatment.

(B) An application made by the conservator for a child of any age in custody of a conservator appointed in accordance with Section 5350 of the Welfare and Institutions Code, shall be documented by the court papers appointing the conservator and delineating the conservator's authorization to place the child in a community treatment facility as well as any other powers that may be relevant in this setting along with the conservator's written consent for treatment.

(C) An application made by the parent(s) of a child under the age of 14 shall be documented by a written consent to treatment signed by both parents or the admitting parent must submit a court order demonstrating that they have sole legal custody and control of the child.

(D) An application for a child 14 through 17 years of age not within the jurisdiction of the juvenile court shall be documented by a written consent to treatment signed by both parents or the admitting parent must submit a court order demonstrating that they have sole legal custody and control of the child and one of the following:

1. A statement signed by the child and the child's attorney or patients' rights advocate that the child has made a knowing and voluntary waiver of his or her right to a pre–admission administrative hearing after being advised by the attorney or notified by the advocate of his or her rights to a pre–admission hearing in accordance with In re Roger S. (1977) 19 Cal. 3d 921. If the child waives his or her right to a pre–admission hearing based on the notification of rights by the advocate the child's statement must also indicate that he or she has been notified of his or her right to receive the advice of an attorney and has made a knowing and voluntary waiver of that right; or

2. The findings and order from a pre–admission hearing conducted in accordance with Section 1923(b)(4)(B) of the California Code of Regulations, Title 9, Chapter 11, pursuant to Section 4094(g) of the Welfare and Institutions Code that specifies all of the following findings:

(i) The child suffers a mental disorder;

(ii) There is a substantial probability that treatment will significantly improve the minor's mental disorder;

(iii) The proposed placement is the least restrictive setting necessary to achieve the purposes of the treatment; and

(iv) There is no suitable alternative to the community treatment facility placement.

(3) A written authorization from the placing county's Interagency Placement Committee certifying that the child is in need of the level of care and services provided by the community treatment facility and to the appropriateness of the following documentation:

(A) The written statement by a licensed mental health professional demonstrates that the child meets the requirements of Section 84168.1(b)(1).

(B) Informed consent is given by the child, the child's parents, or the parent having sole legal custody and control of the child or conservator as specified in Sections 84168.1(b)(2)(A) through (D)(1).

(C) The findings and order by the pre–admission administrative hearing officer specifying that all of the findings specified in Sections 84168.1(b)(2)(D)2.(i) through (iv) have been made for a child 14–17 years of age under parental custody who has not waived their right to a pre–admission hearing.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Section 1502.4, Health and Safety Code; and Sections 4094(f) and (g), 4094.5(a) and (e)(1), Welfare and Institutions Code.

§ 84168.2. Intake Procedures.

(a) Section 84068.1 is not applicable to community treatment facilities.

(b) The licensee shall develop, maintain, and implement intake procedures which meet the requirements specified in this section.

(c) Before a child can be admitted to a community treatment facility, the facility must obtain sufficient information to determine whether the facility can provide the services necessary to meet the child's needs. This information shall be recorded in the intake report. Admission decisions shall be made by the licensed mental health

professional who shall sign and date the intake report. The intake report shall be typed and include at a minimum:

(1) The child's name, birth date, and sex;

(2) The name, address, and telephone numbers of the parents, conservator, or if applicable, the person and agency designated by the court to manage the child's placement;

(3) A medical assessment, including ambulatory status as specified in Section 80069.

(4) The child's presenting problems;

(5) The child's current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis;

(6) An assessment of the child's danger to self and others;

(7) Medications;

(8) The child's immediate educational, service, and treatment needs;

(9) Certification that the child is seriously emotionally disturbed and meets the requirements as specified in Section 84168.1(b)(1);

(10) Consent to treatment as specified in Section 84168.1(b)(2); and

(11) Authorization from the placing county's Interagency Placement Committee as specified in Section 84168.1(b)(3).

(d) When the child is accepted for placement, the following requirements shall be met:

(1) An admission assessment shall be completed and signed as specified in Sections 1927(c) and (d) of the California Code of Regulations, Title 9, Chapter 11.

(2) An admission agreement shall be completed and signed as specified in Section 80068.

(3) The administrator or his/her designee, the child, and his/her parent(s), conservator, or person designated to manage the placement shall sign copies of documentation of the following:

(A) Procedures regarding the continuing stay criteria as specified in Section 84168.2(e);

(B) Procedures regarding transfer of a child to and from secure and nonsecure portions of the facility as specified in Section 84122(b)(1)(A);

(C) Due process rights procedures as specified in Section 84172(c);

(D) Discharge procedures as specified in Section 84168.5;

(E) Discipline policies and procedures as specified in Section 84072.1;

(F) Complaint procedures as specified in Section 84172.2; and

(G) Informed consent of prescribed psychotropic medications as specified in Section 84175.1.

(4) Any other information specified in Sections 80070 and 84170 necessary to complete the child's record shall be obtained.

(e) Continuing stay criteria shall be met as specified in Section 1924 of the California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 4094.5, Welfare and Institutions Code.

§ 84168.3. Needs and Services Plan.

(a) The licensed mental health professional(s) shall complete the needs and services plan and include the information required by Section 84068.2 and Section 1927(e) of the California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84168.4. Modifications to Needs and Services Plan.

(a) Section 84068.3 is not applicable to community treatment facilities.

(b) The needs and services plan specified in Section 84168.3 shall be updated at least every 30 days to determine the following:

(1) The child's need for continuing services.

(2) The types and intensity of services provided to the child including the use of secure containment and the impact of these services upon treatment goals, changes in or continuation of treatment plan objectives.

(3) The progress of the child toward his or her discharge goals.

(c) The licensee shall ensure that the child and his or her admitting parent, conservator, or person authorized by the court to manage the placement are offered the opportunity to participate in the modification of the child's needs and services plan.

(1) Modifications to the needs and services plan shall not be implemented until written approval is provided by the child's admitting parent, conservator, or person designated by the court to manage the placement.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 5699.3, Welfare and Institutions Code.

§ 84168.5. Discharge Procedures.

(a) In addition to Section 84068.4, the following are applicable.

(b) If it is determined that the facility cannot meet the needs of the child, the licensee shall notify the child's parent(s), conservator, or person designated by the court to manage the placement of the determination and shall request that the child be placed elsewhere.

(c) When it is deemed clinically appropriate, a child shall be discharged after completing normal discharge procedures.

(d) When it is not deemed clinically appropriate for a child to be discharged from the facility, a child shall be released as specified in Section 1925(b) of the California Code of Regulations, Title 9, Chapter 11.

(e) The licensed mental health professional staff shall complete and provide to the child's parent, conservator, or person designated by the court to manage the placement a typed discharge summary and discharge report as specified in Sections 1927(i) and (j) of the California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84170. Children's Records.

(a) In addition to Section 84070, the following shall apply.

(b) The following information regarding the child shall be obtained and maintained in the child's record:

(1) Signed copies of the facility's policies and procedures regarding the child's transfer to and from secure and nonsecure portions of the facility, due process rights, and the continued stay criteria as specified in Section 84168.2(d)(3).

(2) A complete mental health record as specified in Section 1927(a) of the California Code of Regulations, Title 9, Chapter 11.

(3) A copy of a child's request for release and any notification documents to the superior court as specified in Section 84172(c).

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501, 1507 and 1531, Health and Safety Code.

§ 84172. Personal Rights.

(a) Sections 80072 and 84072 are not applicable to community treatment facilities.

(b) The licensee shall ensure that every child admitted to a community treatment facility is informed and afforded the personal rights as specified in Sections 5325, 5325.1, 5325.2, and 5326 of the Welfare and Institutions Code; Sections 862 through 865 and 867 of the California Code of Regulations, Title 9, Chapter 4; and Sections 1934, 1935, 1936, and 1937 of the California Code of Regulations, Title 9, Chapter 11.

(c) Every child has a right to a hearing by writ of habeas corpus. The licensee shall develop, maintain and implement written procedures that shall meet the following requirements:

(1) Any member of the facility staff to whom a request is made shall promptly do the following:

(A) Provide the child making the request with a form for a request for release or mark a copy of the form for the child. The form shall be substantially as follows:

(Name of the Facility) _____ day of ____ 19 __

I, _____ (member of the community treatment facility staff) have today received a request for the release of _____ (name of patient) from the undersigned patient on his or her own behalf or from the undersigned person on behalf of the patient.

_____
Signature or mark of patient making request for release

_____
Signature or mark of patient making request for release on behalf of patient

_____
Signature of staff person receiving request for release

(B) Deliver the completed request form to the Administrator and note the request in the child's facility record.

(2) Submit the request for release form to the superior court for the county in which the facility is located by the next working day of the request for release.

(3) Inform the person who admitted the child of the request for release within 24 hours of the request for release.

(4) Maintain a copy of the child's request for release as specified in Section 84172(c)(1)(A) along with notification documents to the superior court in the child's record.

(5) The facility's administrator shall ensure that the child is informed as soon as possible of the date, time, and location of the hearing.

(6) The child shall be permitted to communicate with counsel confidentially and to prepare for and attend the judicial hearing demanding his or her release.

(d) The facility's policy concerning family visits and other communications with clients shall be provided as specified in Section 1512 of the Health and Safety Code.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Sections 4096(g), 4094.6 and 5275, Welfare and Institutions Code.

§ 84172.2. Complaint Procedures.

(a) Section 84072.2 is not applicable to community treatment facilities.

(b) The licensee of a community treatment facility shall develop, maintain, and implement written complaint procedures by which children or their authorized representatives are permitted to file, without fear of retaliation, complaints regarding facility staff or operations with the facility administrator or mental health program director, an advocate, and/or the Department.

(c) The following information shall be posted, in English and Spanish, in all wards and common living areas of the facility.

(1) A list of the personal rights in Sections 5325, 5325.1, and 5325.2 of the Welfare and Institutions Code.

(2) A statement that any child admitted to a community treatment facility has the right to a hearing by writ of habeas corpus pursuant to Section 4094.6 of the Welfare and Institutions Code.

(3) The facility's complaint procedures which shall include the following:

(A) The name, address and telephone number for filing a complaint with the Department.

(B) The information on filing a complaint with a Patients' Advocate as specified in Section 1933 of California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 4094.6, Welfare and Institutions Code.

§ 84175.1. Medication Control/Monitoring.

(a) The licensee shall develop, maintain, and implement medication control and monitoring procedures/protocols which meet the requirements specified in the California Code of Regulations, Title 9, Chapter 11, Section 1928.

NOTE: Authority cited: Section 1530 and 1530.9, Health and Safety Code. Reference: Section 1501 and 1531, Health and Safety Code; and Section 4094(d), Welfare and Institutions Code.

§ 84175.2. Restraint and Seclusion.

(a) The licensee shall develop, maintain, and implement seclusion and restraint policies and procedures which meet the requirements specified Section 1929 of the California Code of Regulations, Title 9, Chapter 11.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code; and Section 4094(d), Welfare and Institutions Code.

Article 7. Physical Environment

§ 84187. Buildings and Grounds.

(a) In addition to Section 84087, the following shall apply.

(b) A room used for seclusion as defined in Section 84111(s)(1), shall meet the following requirements:

(1) No room door shall include locking or jamming devices.

(2) A control for the lighting shall be located outside the room.

(3) The room shall be absent of any hazards such as objects which can be broken or used by a child to inflict injury to himself/herself or others.

(c) The licensee shall meet the local building code requirements for any fence enclosures of outside spaces and recreational areas that are associated with the facility.

(d) The licensee shall secure and maintain a fire clearance approval for locking devices and their use on exterior doors, windows, and perimeter fence gates.

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.

§ 84188. Fixtures, Furniture, Equipment, and Supplies.

(a) In addition to Section 84088, the following shall apply.

(b) No community treatment facility shall have more beds for children's use than required for the maximum license capacity except for the bed(s) made available for seclusion room(s) as specified in Section 84187(b).

NOTE: Authority cited: Sections 1530 and 1530.9, Health and Safety Code. Reference: Sections 1501 and 1531, Health and Safety Code.