Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF LONG TERM CARE RESIDENTS PROTECTION

Statutory Authority: 16 Delaware Code, Section 1101(a) (16 **Del.C.** §1101(a))

FINAL

ORDER

3320 Intensive Behavioral Support and Educational Residence

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department"), Division of Long Term Care Residents Protection, initiated proceedings to establish regulations regarding Intensive Behavioral Support and Educational Residences (IBSER). The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code**, Section 10114, with authority prescribed by 29 **Delaware Code**, Section 7971.

The Department published its notice of proposed regulatory change pursuant to 29 **Delaware Code** Section 10115 in the March 2012 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by March 31, 2012, at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSED CHANGES

This regulatory proposal creates regulations for various aspects and business practices of these facilities as listed below:

- Definition
- Authority
- Glossary
- Licensing requirements and procedures
- General requirements
- Physical Plant
- Kitchen and food storage
- Emergencies and disasters
- Administration
- Description of
- services
- Maintenance of records
- Insurance
- Personnel policies and procedures
- Orientation and training of employees and volunteers
- Personnel records
- Use of volunteers
- Human rights
- Abuse and neglect
- Use of restraints
- Health
- Administration or Assistance with Self-Administration of Medication
- Universal Precautions
- Incident reports
- Facility closure
- Waivers and severability

Statutory Authority

29 **Del.C.** §7971, Division of Long Term Care Residents Protection

Background

DLTCRP and DDDS identified the need to establish regulations regarding the operation of Intensive Behavioral Support and Educational Residences (IBSER).

Comments Received with Agency Response and Explanation of Changes

The Governor's Advisory Council for Exceptional Citizens (GACEC), the State Council for Persons with Disabilities (SCPD) commented on the proposed revisions.

1. The revised regulation incorporates many of the Councils' recommendations, including the following: inclusion of "purposes" and "authority" sections (§§1.0 and 2.0); improving the definition of "legal representative" (§3.0); clarifying the application of the regulation to day program participants (§3.0); including an accessibility reference in §6.1.2; authorizing non-glass shower doors (§6.5.3); disallowing children sharing rooms with adults (§6.6.15); requiring notice near phones of the DLTCRP telephone number (§6.12.3); requiring carbon monoxide detectors (§8.3); requiring certain information be included in agency website (§10.2); adding a general 5 year retention of records standard (§11.1.3); requiring maintenance of fire and comprehensive general liability insurance (§12.0); eliminating "criminal justice" as a relevant background degree (§13.2.4); requiring training in safe and effective behavior management techniques (§14.3.3); requiring monthly HRC meetings (§17.1.1.3); and requiring retention of incident reports for four years (§24.2). SCPD certainly appreciates that the Division incorporated Council's recommendations in these contexts.

Response: No comment required.

2. The title to §1.0 is "Purpose Definition". This makes no sense. Moreover, there is still no "operational" language reciting that the standards apply to IBSERs and no "purposes" language despite the title. Compare the neighborhood home regulation, 15 DE Reg. 968 (January 1, 2012), §1.0:

> The purpose of these regulations is to provide a sequence of expectations for services rendered by the Neighborhood Home provider and a system for Neighborhood Home providers to be accountable to the Division of Long Term Care Residents Protection (DLTCRP) and the Division of Developmental Disabilities Services (DDDS). [emphasis supplied] There is no analog in the IBSER regulation.
>
> SCPD recommends changing the heading to "Purpose" (deleting "Definition") and adding the following sentence:
>
> > The purpose of these regulations is to provide a set of expectations for the operation of IBSERs and ensure accountability to the Division of Long Term Care Residents Protection (DLTCRP).

Response: The recommendation has been adopted. The regulation is amended as follows:

1.0 Purpose [~~Definition~~]

[An Intensive Behavioral Support and Educational Residence (IBSER) is a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs.]

[The purpose of these regulations is to provide minimum standards for the operation of Intensive Behavioral Support and Educational Residence (IBSER) and ensure accountability to DHSS.]

* * * * *

["Intensive Behavioral Support Residence" (IBSER) means a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs.]

3. The definition of "mechanical restraint" ostensibly seeks to exempt equipment and devices with a medical basis (e.g. prone stander; bed siderails). However, the definition would literally authorize a non-medical, undefined mental health "therapist" to authorize any form of mechanical restraint to prevent SIBS. At a minimum, the reference should be changed to occupational or physical therapist.

Response: The recommendation has been adopted. The regulation is amended as follows:

*"**Restraint**" includes both **[mechanical devices and physical procedures.] [~~of the following:~~] [A]** Mechanical restraint **[is]** a mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove or that restricts freedom of movement or normal access to one's body. Mechanical restraint does not include adaptive or protective devices recommended by a physician **[or by a physical or occupational]** therapist when used as recommended by the physician **or [by a physical or occupational]** therapist to promote normative body position and physical functioning, and/or to prevent self-injurious behavior. The term also does not include seat belts and other safety equipment when used to secure clients during transportation~~;~~**[~~. and~~.] [A]** Physical restraint **[procedure] [~~physically~~]** restrict**[s] [~~ngs~~]** a resident's freedom of movement or normal access to his or her body, including the forcible moving of a resident against the person's will. No physical restraint shall be used that restricts the free movement of the resident's diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech.*

4. The definition of "mechanical restraint" is otherwise problematic. Literally, any equipment used to deter SIBS is per se not a "restraint". As a consequence, it would be exempt from inclusion in the SBS plan (§20.2.2), review by the Behavior Management Committee (§§18.2 and 18.3), and review by the HRC (§§17.1.2 and 18.3). Thus, use of a helmet, mittens, or other AT would be exempt from many procedural safeguards. This is not "best practice" and is inconsistent with DDDS policy (e.g. DDDS HRCs review use of helmets, mittens, and AT used for SIBS prevention).

Response: See above.

5. In the definition of "physical restraint, it would be more logical to transfer the second sentence (barring certain forms of restraint) to §20.11 (containing list of 12 forms of prohibited restraint). Moreover, the reference to "free movement of the resident's diaphragm or chest that restricts the airway" could be improved. Some states have focused on pressure

on certain body parts as more instructive. Consider the following prohibition: "Restraint that interferes with the resident's ability to breathe or places weight or pressure on the resident's throat, neck, lungs, chest, sternum, diaphragm, or back."

Response: The proposed language is too specific. Certain acceptable physical restraints will place some level of pressure specifically on a person's chest or back. The broader language of the existing proposal emphasizes the critical concern not to obstruct the airway or speech functions.

6. There is a definition of "seclusion" but no regulation which addresses it. The November version of the regulation explicitly barred use of seclusion. The Bill of Rights Act explicitly bars "involuntary seclusion" without exception [Title 16 Del.C. §1121(24)]. Therefore, the IBSER regulation must conform to the statute and the ban should be reinstated. Parenthetically, this is consistent with "best practice". See Section 4 of attached S. 2020 introduced by Sen. Harkins in December, 2011.

Response: The definition of seclusion is intended to capture the prohibition against isolating an individual. Defining seclusion as the involuntary confinement of a resident alone in an area from which the resident is physically prevented from leaving is consistent with the Bill of Rights prohibition against involuntary seclusion. This definition is more restrictive than 42 CFR §482.13 (e)(1)(ii).

7. The definition of "Specialized Behavior Support Plan" is defective. Literally, the plan is expected to include a restraint to a resident to protect the resident from others. Why would an agency use a restraint on an individual to prevent his/her victimization from others? Immobilizing the victim will only exacerbate the victimization.

Response: The definition has been amended to clarify the objective.

***Specialized Behavior Support Plan**" (SBS Plan) is a written document which describes the resident's care plan. It also identifies the types of restraints which may be employed if necessary to protect the resident from self or **[to protect]** others.*

8. In §5.5, delete the comma.

Response: The sentence has been amended.

9. The DLTCRP Neighborhood Home regulation imposes the following obligation:

   4.2.7.2. The Policy Memorandum 46 (PM 46) policy for reporting abuse, assault, attempted suicide, mistreatment, neglect, financial exploitation and significant injury is followed.

15 DE Admin Code 968, §4.2.7.2 (January 1, 2012) (proposed). There is no analog in the IBSER regulation. The DLTCRP could consider inserting a similar recital as a new §5.10 or within §19.0.

Response: PM 46 investigations are limited to individuals living in state operated facilities or individuals living in private facilities subject to a contract with DHSS. Delaware residents residing at an IBSER will be subject to PM 46 investigations when the resident is placed at the IBSER pursuant to a contract with DHSS. All IBSER residents are afforded the protections of 16 Del. C. §1131 - 1140.

10. In the commentary on the November version of the regulations, SCPD provided a multi-pronged critique of allowing a 16-bed facility. See, e.g., Par. 11 of attached SCPD comments. The new regulation reflects a compromise in which 16-bed facilities are "grandfathered" and new facilities must have no more than 10 residents. Segregated residential settings with 10 or 16 individuals per unit are not consistent with best practice and may violate the ADA. Consider the DHSS-DOJ DPC Settlement Agreement signed in July, 2011. That Agreement, which is based on the DOJ's interpretation of the ADA, does not contemplate large congregate living arrangements. Rather it restricts supported housing to 2 individuals per unit with a separate bedroom for each resident (§II.E.). A 10 or 16-bed facility in which adult residents are "squeezed" into tiny rooms (§6.6.1) with age-inappropriate bunk beds (§6.6.11) smacks of "warehousing".

Response: While we recognize the benefits of moving toward smaller residential arrangements, and that is the objective going forward, the decision to grandfather existing facilities is a compromise which enables the viability of the current operation.

10.A In Section 6.2.1., SCPD recommends inserting "related to living unit space" after "DelaCare regulations" to clarify that the DelaCare regulations only apply to this section for facilities that may be grandfathered. In addition, since the facilities are grandfathered, SCPD recommends the Division clarify that additional capacity should not be allowed if the Office of Child Care Licensing issues a temporary waiver of the living unit space standard.

Response: The recommended text was inserted. The postulated temporary waiver of living unit space standard is unlikely. The objective here is merely to capture the existing regulations currently applicable.

*6.2.1 IBSER facilities operating prior to the adoption of these regulations may continue to operate based on the DelaCare regulations **[related to living unit space]** then applicable. IBSER facilities licensed subsequent to the adoption of these regulations may house no more than 10 residents—regardless of whether the residents are subject to IBSER or DelaCare regulations.*

11. Section 6.2.2 should be amended to include a reference to "legal representative" since the list of authorized visitors entitled to meet in private is literally limited to four types. Compare Title 16 **Del.C.** §1121(11).

Response: The recommendation has been adopted. The regulation is amended as follows:

*6.2.2 A facility must ensure that the living unit(s) have designated space for daily living activities, including dining, recreation, indoor activities and areas where residents may visit privately with their parent(s), legal **[~~guardian~~] [representative]**, relatives and friends.*

12. SCPD previously objected to 200 square foot bedrooms with 4 individuals. See attached SCPD letter, Par. 14.

New §6.6 contains a "grandfather" provision for bedroom occupancy. New facilities will require 80 square feet for single occupancy and 130 square feet for double occupancy. This is still less floor space than required in group homes for double occupancy for persons with mental illness. See 16 DE Admin Code 3305, §12.2.2 (requiring 160 square feet for double occupancy). Likewise, the latter regulation disallows counting areas with lockers, wardrobes, vestibules, and alcoves. This limit is absent from the IBSER regulation. At a minimum, double occupancy standards should be no less than mental health group home standards (160 square feet exclusive of closets, lockers, wardrobes, vestibules and alcoves).

Response: While we recognize the benefits of moving toward more spacious residential arrangements, and that is the objective going forward, the decision to grandfather existing facilities is a compromise which enables the viability of the current operation.

12.A In Section 6.6.1.2, SCPD recommends inserting "related to bedroom accommodations" after "DelaCare regulations" to clarify that the DelaCare regulations only apply to this section for facilities that may be grandfathered.

Response: The recommendation has been adopted. The regulation is amended as follows:

*6.6.1.2 IBSER facilities operating prior to the adoption of these regulations may continue to operate based on the DelaCare regulations **[related to bedroom accommodations]** then applicable.*

13. In §6.6.11, the authorization for adults to sleep in bunk beds is not age-appropriate.

Response: While we recognize the benefits of moving toward more spacious residential arrangements, and that is the objective going forward, the decision to grandfather existing facilities is a compromise which enables the viability of the current operation.

14. In §6.5 or 6.7, the Division may wish to consult a dental expert. It may be appropriate to require a facility using well water to offer a fluoride rinse to some residents. Medicaid does not cover adult dental care and DDDS struggles with dental remediation which could be reduced through access to fluoride rinse in the absence of fluoridated water.

Response: Three of the 13 residential IBSER sites are on well water, the rest are on public water. DDDS requires annual dental examinations for its residents and will follow the recommendations from the dentist for fluoride treatment. Other residents are subject to care plans negotiated by their funding agency.

15. The DLTCRP Neighborhood Home regulations [15 DE Reg. 968, §4.6.6.7 (January 1, 2012) (proposed)] contain the following requirement: "(n)on-perishable food and capacity to store 1 gallon of potable water per person per day for at least a 72-hour period is present". The Division could consider adding a similar water storage capacity standard to §7.10.

Response: Best practices governing disaster preparedness are currently under consideration for all licensed facilities.

16. In §13.2.3.1, a direct care worker is required to be 21 years of age and possess a high school diploma. The Division may wish to consider the merits of substituting "18" for "21". The change would allow college students (e.g. in human service fields such as psychology) to work part-time as direct care workers. Alternatively, the regulation could allow individuals to be employed as direct care workers between the ages of 18-20 only if they are college students in a human services field (defined in §§13.2.1.1, 13.2.4.1 and 13.2.5.1). In addition, the Division may want to assess whether the requirement of a high school diploma or equivalent is sufficiently job related to include in the regulations as a standard for direct care workers.

Response: The Departments deems that imposing a 21 year age requirement is reasonable.

17. In §14.5.2, substitute "resident" for "patient".

Response: The recommendation has been adopted. The regulation is amended as follows:

*14.5.2 Have education, training, and demonstrated knowledge based on the specific needs of the **[~~patient~~]** **[resident]** population in techniques to identify staff and resident behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint in order to diffuse, prevent or reduce a problem before it evolves into a significant event that places the resident or others at risk.*

18. Section 17.0 merits reconsideration. The only agency to which the IBSER regulation applies presented its first of many cases to the DDDS HRC on February 29, 2012. The DDDS HRC does not include individuals with the qualifications listed in §17.1.1.2, including a licensed physician and licensed psychologist. On the other hand, the standards for the "internal" HRC are weak in the context of impartiality. DDDS amended its policy many years ago to require 100% membership by individuals external to DDDS. The IBSER regulation only requires a majority of external members and the "spirit" of this regulation may be undermined in practice by including a recent agency retiree as an "external" HRC member.

Response: The higher HRC standards are reasonable given the nature of the people served. It is correct that the majority of the membership is must be external to the licensee. A recent agency retiree is not external.

19. Section 18.1 refers to "the licensee's clinical director". There is no requirement that an agency have a "clinical director" and no definition of a "clinical director" in §13.0.

Response: We have amended the sentence to reflect the recommendation.

*18.1 The BMC must be comprised of **[~~the licensee's clinical director and~~]** all **[~~on-staff~~]** clinicians **[whose expertise meets the needs of the resident].** It must establish a SBS Plan upon admission of a resident and must conduct SBS Plan reviews on each resident on at least a monthly basis.*

20. Although §20.7 contains a reference to data collection, it would be preferable to explicitly include a reference to presentation of data to the BMC in §18.2.1.

Response: The recommendation has been adopted. The regulation is amended as follows:

18.2.1.8 A summary statement as to the general effectiveness of the SBS Plan**[, including presentation of the data**

to the BMC] and a recommendation for future use.

21. In §19.2, it would be preferable to include a reference to "contractor". The only agency currently subject to the IBSER regulation uses physician contractors.

Response: The recommendation has been adopted. The regulation is amended as follows:

*19.2 A licensee must not discourage, inhibit, penalize or otherwise impede any employee, volunteer**[, contractor]** or resident reporting any suspected or alleged incident of abuse, neglect, mistreatment or financial exploitation.*

22. Section 20.2.1 may be the most problematic standard in the regulations. It authorizes restraint based on the following benchmark:

> The resident is exhibiting a problem behavior that is so severe that it poses a risk to the safety and wellbeing of the resident or others;

Authorizing the use of restraint based on the "safety and wellbeing" of the resident or others is amorphous and an invitation to overuse of restraint. If restraint is authorized by government, it is commonly restricted to an imminent risk of serious bodily injury to self or others. See, e.g., attached S.2020, Section 4. The concept of "imminency" is incorporated into §20.8.3 as material to termination of restraint but is absent from the standards for initiation of restraint. Moreover, if government does authorize use of restraint, it is also common to ban use of mechanical restraint. See S. 2020, Section 4. Use of straight jackets, wrap mats, rope and tape to restrict access to body parts is viewed as inherently intrusive. Cf. the attached February 12, 2012 News Journal article describing prosecution of a teacher for false imprisonment and endangering the welfare of a child based on tying the hands of a child with autism.

Response: The recommendation has been adopted. The regulation is amended as follows:

*20.2.1 The resident is exhibiting a problem behavior that is so severe that it poses **[a] [an imminent]** risk **[of serious bodily injury]** to **[self or others.] [~~the safety and wellbeing of the resident or others~~]**;*

23. Section 20.3 refers to an undefined "SPTeam" which includes an undefined "properly credentialed professional". It would be preferable to add ", licensed or certified" after "credentialed" since agencies may otherwise use marginally qualified "behavior analysts" without an advanced degree to develop an SBS Plan.

Response: The language, "properly credentialed professional" is broader and requires consideration of the special needs of the resident. The reference to the SPTeam has been removed.

24. The only agency to which the regulation will apply uses video cameras throughout its buildings. It would be preferable to amend §20.9 to require maintenance of any recorded episode of restraint. Such a recording would be of diagnostic and training value for the SBTeam, HRC, and administration. It may also be of value to the DLTCRP.

Response: DHSS is developing a policy which will govern the use of video monitoring in all licensed facilities.

25. Section 20.9.1 contemplates "clinical review and approval for interventions longer than 15 minutes". Who has the authority to issue the approval? Is a "direct care worker" with high school diploma (§13.2.3.1) a "clinician" who can approve extended restraint? Within the DDDS HRC, it is common to require approval by the agency's clinical director or alternate. The IBSER regulation refers to a clinical director in §18.1 but does not require a clinical director (§13.0) and does not define a "clinical director".

Response: The section has been amended to require approval by the Director, defined as the facility CEO, or designee.

*20.9.1 Date and time, staff involved, location, activity, antecedent conditions, specific behaviors observed, interventions implemented, duration of intervention, well being checks, clinical review and approval **[by the Director or designee]** for interventions longer than 15 minutes, physical examination for possible injury after the termination of the restraint utilization, treatment provided, supervisor signature….*

26. Section 20.9.2 requires "(a)pproval by a clinician within one business day of an intervention when a restraint utilization event is less than 15 minutes." There are two concerns with this provision. First, there is no definition of a "clinician". Second, it is somewhat odd to retroactively "approve" an intervention a day after it was employed unless the intent is to prompt review to deter misuse.

Response: The section has been amended to require review by the Director, defined as the facility CEO, or his/her designee.

*20.9.2 **[~~Approval~~] [Review]** by **[the Director or designee] [~~a clinician~~]** within one business day of an intervention when a restraint utilization event is less than 15 minutes.*

27. It would be preferable to include a new §20.11.13 to read as follows: "Consistent with 34 C.F.R. §§300.2 (c) and 300.146, use of restraint or forms of aversive techniques on adult IDEA-funded residents or students which violate applicable law or regulation of the public IDEA funding agency.

Response: The recommendation has been adopted. The regulation is amended as follows:

[20.11.13 Consistent with 34 C.F.R. §§300.2 (c) and 300.146, use of restraint or forms of aversive techniques on adult IDEA-funded residents or students that violate applicable law or regulation of the public IDEA funding agency.]

28. Since the regulation covers adults, the reference to "parents" in §22.6 is inapposite. It would be preferable to refer to the consent of "the resident or legal representative" rather than "parents or legal guardian".

Response: The recommendation has been adopted. The regulation is amended as follows:.

22.6 Psychotropic medications are prohibited for disciplinary purposes, for the convenience of staff or as a substitute

*for appropriate treatment service. An informed, written consent of the **[~~parents or~~]** legal **[representative] [~~guardian~~]** is secured and maintained in the resident's file prior to the administration of any psychotropic medication.*

29. Although there is a short "universal precautions" section (§23.0), there is no section which addresses laundry. In practice, the facility could commingle the laundry of 16 individuals in cold water and spread disease. Compare 16 DE Admin Code 3201, §7.6.

Response: The recommendation has been adopted. The regulation is amended as follows:

[6.13. Laundry:

6.13.1. For on-site laundry processing, the facility shall:

6.13.1.1. If hot water is used for destroying micro-organisms, washers must be supplied with water heated to a minimum of 160º F.

6.13.1.2. If low temperature laundry cycles are used, a total available chlorine residual of 50-150 ppm must be present and monitored during the wash cycle.]

30. Section 24.1 could be improved by including the following after "witnesses;": "the existence of any video record of the incident".

Response: DHSS is developing a policy which will govern the use of video monitoring in all licensed facilities.

31. In §§24.4.2 and 24.4.4, it is inconsistent to require reporting of resident - resident emotional abuse while exempting reporting of resident - resident physical abuse in the absence of injury.

Response: Given the dangerous implications of emotional abuse and the great difficulty proving injury, the injury element is not necessary to require a report of emotional abuse.

32. Section 24.4.11 only requires reporting of medication errors unless the error causes discomfort, jeopardizes health/ safety, or requires 48 hours of monitoring. The exceptions provide subjective bases to withhold reporting to the Division.

Response: The exceptions become objective based on the enumerated consequences.

FINDINGS OF FACT:

The Department finds that the proposed changes set forth in the March 2012 *Register of Regulations* should be adopted, subject to the withdrawal and the modification set forth above which are not substantive.

THEREFORE, IT IS ORDERED, that the proposed changes to Regulation 3320 Intensive Behavioral Support and Educational Residences (IBSER), with the withdrawal and the modification indicated herein, is adopted and shall be final effective May 1, 2012.

Rita Landgraf, Cabinet Secretary
Dept. of Health and Social Services

3320 Intensive Behavioral Support and Educational Residence

1.0 Purpose [~~Definition~~

~~An Intensive Behavioral Support and Educational Residence (IBSER) is a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs.~~

The purpose of these regulations is to provide minimum standards for the operation of Intensive Behavioral Support and Educational Residence (IBSER) and ensure accountability to the Department of Health and Social Services (DHSS.)]

2.0 Authority.

These regulations are promulgated in accordance with 16 **Del.C.** §1102(4). IBSER regulations apply to all residents except those under the age of 18 who are subject to Delaware Requirements for Residential Child Care Facilities and Day Treatment Programs, Title 9, §100 of the Delaware Administrative Code (Delacare). IBSER regulations establish the minimal acceptable level of living and programmatic conditions and services for residents of an IBSER.

3.0 Glossary of Terms

"**AWSAM**" means assistance with medications as defined in 24 **Del.C.** §1902(c).

"**Behavior Management Committee**" (BMC) is the committee that establishes and reviews each resident's Specialized Behavior Support Plan (SBS Plan) as described in §18.0 of these regulations.

"**Chemical Restraint**" means the use of any medication that is used for discipline or convenience to effect control over a resident's behavior, is not part of the resident's usual medication regimen, and is not required to treat a medical symptom, i.e. a physical or psychological condition. The usual medication regimen does not include any PRN use of psychoactive medications.

"**Director**" means the Chief Operating Officer of the IBSER.

"**Division**" means the Division of Long Term Care Residents Protection, Department of Health and Social Services.

"**Funding Agency**" – means a governmental or private agency that provides funding for the support and treatment of residents in the IBSER's care.

"**Human Rights Committee**" (HRC) means an advisory committee established as a mechanism for the protection of rights and welfare of persons receiving services from the facility.

"**Incident**" means an occurrence or event, a record of which must be maintained in facility files, which includes all reportable incidents and the additional occurrences or events listed in section 24.0 of these regulations.

["Intensive Behavioral Support Residence" (IBSER) means a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs.]

"**Legal Representative**" means the resident or agent legally authorized to act on behalf of the resident.

"**Medical Protective Equipment**" means health-related protective devices prescribed by a physician or dentist for use only during and after specific medical or surgical procedures, or for use as protection in response to an existing medical condition. Medical Protective Equipment includes: physical equipment or orthopedic appliances or other restraints necessary for medical treatment, routine physical examinations, or medical tests; devices used to support functional body position or proper balance, or to prevent a person from falling out of bed, falling from a wheelchair; or equipment used for safety such as seat belts, helmets, mittens, wheelchair tie-downs or other types of devices.

"PRN" is an abbreviation of the Latin *pro re nata*. In these regulations it means "as needed."

"**Reportable Incident**" means an occurrence or event which must be reported immediately to the Division and for which there is reasonable cause to believe that a resident has been abused, neglected, mistreated or subjected to financial exploitation or misappropriation of their property as those terms are defined in 16 **Del.C.** §1131. Reportable incident also includes an occurrence or event listed in §24.4 of these regulations.

"**Resident**" is the individual residing in or attending a day program at the IBSER.

"**Restraint**" includes both **[~~of the following:~~ mechanical devices and physical procedures. A]** mechanical restraint **[is]** a mechanical device, material, or equipment attached or adjacent to a client's body that he or she cannot easily remove or that restricts freedom of movement or normal access to one's body. Mechanical restraint does not include adaptive or protective devices recommended by a physician or **[by a physical or occupational]** therapist when used as recommended by the physician or **[by a physical or occupational]** therapist to promote normative body position and physical functioning, and/or to prevent self-injurious behavior. The term also does not include seat belts and other safety equipment when used to secure clients during transportation**[~~; and~~. A]** physical restraint **[~~physically~~ procedure]** restrict**[~~ings~~s]** a resident's freedom of movement or normal access to his or her body, including the forcible moving of a resident against the person's will. No physical restraint shall be used that restricts the free movement of the resident's diaphragm or chest or that restricts the airway so as to interrupt normal breathing or speech.

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

"**Specialized Behavior Support Plan**" (SBS Plan) is a written document which describes the resident's care plan. It also identifies the types of restraints which may be employed if necessary to protect the resident from self or **[to protect]** others.

4.0 Licensing Requirements and Procedures

4.1 A licensed facility that intends to construct, extensively remodel or convert any building must submit one (1) copy of properly prepared plans and specifications for the entire facility to the Division. An approval in writing is to be obtained before such work is begun. After the work is completed, in accordance with the plans and specifications, a new license to operate will be issued.

4.2 Separate licenses are required for facilities at separate locations, even though operated under the same management. A separate license is not required for separate buildings maintained at the same location by the same management. A change in ownership necessitates a new application and a new license.

4.3 Inspections

4.3.1 Every residence for which a license has been issued under this chapter shall be periodically inspected by a representative of the Division. Inspections shall include the review of current facility policies and procedures. Inspections must be unannounced.

4.3.2 Each Licensed facility must submit to the Division quarterly reports on each of its residents. The quarterly reports prepared for the funding agency supporting each resident meets this reporting requirement unless otherwise informed by the Division that additional information is required.

4.4 Licenses shall be issued in the following categories:

4.4.1 Annual License. An annual license (12 months) may be renewed yearly if the holder is in full compliance with the provisions of 16 **Del.C.** Ch. 11 and the rules and regulations of the Department of Health and Social Services.

4.4.2 Provisional License. A provisional license shall be granted for a term of ninety (90) days only, and shall be granted to a facility during its first 90 days of operation. A provisional license may also be granted to a facility whenever the Division deems it appropriate. The Division shall provide an explanation for the issuance of a provisional license instead of an annual license.

5.0 General Requirements

5.1 All required records maintained by the residence must be open to inspection by the authorized representatives of the Division.

5.2 The term "Intensive Behavioral Support and Educational Residence" must not be used as part of the name of any facility in this State, unless it has been so classified and licensed by the Department of Health and Social Services.

5.3 No rules may be adopted by the licensee or administrators which are in conflict with these regulations.

5.4 The Division must be notified, in writing, within 10 days of any change in the Director.

5.5 The residence must establish and follow written policies and procedures regarding the rights and responsibilities of the residents**[.** ~~**and t**~~**T]**hese policies and procedures are to be made available to sponsoring agencies, and authorized representatives of the Division.

5.6 The facility must provide safe storage for residents' valuables.

5.7 The provider must assure emergency transportation and care through use of appropriate transfer agreements with local medical facilities.

5.8 All residents must be afforded all protections and privileges contained in the Delaware Patient's Bill of Rights.

5.9 The facility must cooperate fully with the state protection and advocacy agency, as defined in 16 **Del.C.** §1107.

6.0 Physical Plant

6.1 Premises and Equipment

6.1.1 A licensee must ensure that the facility's or program's premises and equipment accessible to or used by residents are free from any danger to their health, safety and well-being.

6.1.2 A licensee must maintain on file written documentation that the buildings and premises of the facility or program conform to all applicable federal, state and local zoning fire, health, education, accessibility and construction laws, ordinances and regulations.

6.1.3 A licensee must ensure that porches, elevated walkways and elevated areas of more than two feet in height have barriers that meet all regulatory standards to prevent falls.

6.1.4 A licensee must ensure that all indoor and outdoor areas, toilets, wash basins, tubs, sinks, and showers are maintained in an operable, safe and sanitary manner. Showers and tubs must have a handrail or a handgrip.

6.1.5 A licensee must utilize approved products and procedures in accordance with labeled instructions to ensure that the premises are protected from insect infestation.

6.1.6 A licensee must ensure that all premises used by residents are rodent-free.

6.2 Living Unit Space

6.2.1 IBSER facilities operating prior to the adoption of these regulations may continue to operate based on the DelaCare regulations **[related to living unit space]** then applicable. IBSER facilities licensed subsequent to the adoption of these regulations may house no more than 10 residents—regardless of whether the residents are subject to IBSER or Delacare regulations.

6.2.2 A facility must ensure that the living unit(s) have designated space for daily living activities, including dining, recreation, indoor activities and areas where residents may visit privately with their parent(s), legal **[**~~**guardian**~~ **representative]**, relatives and friends.

6.2.3 A facility must ensure that a dining area is provided which must be maintained in a clean manner, be well-lighted and ventilated. The licensee must ensure that dining room tables and chairs or benches are sturdy and appropriate for the sizes and ages and capabilities of the residents.

6.3 Furnishings and Maintenance

6.3.1 A licensee must ensure that buildings are furnished with comfortable, clean furniture in good repair and appropriate to the age, size and capabilities of the residents.

6.3.2 A licensee must ensure that the premises are maintained and cleaned in a scheduled or routine manner.

6.3.3 A licensee must ensure that all cleaning equipment, including mops and buckets, are cleaned and stored in an area separate and distinct from the kitchen and food preparation, serving and storage areas. Kitchen and bathroom sinks must not be utilized for cleaning mops, emptying mop buckets. Kitchen sinks must not be used for any purpose not connected with food preparation or the cleaning of dishes, pots, pans and utensils.

6.3.4 A facility housing 13 or more residents (see 6.2.1) must have a service sink.

6.4 Storage

6.4.1 A licensee must provide areas with sufficient space for storing all supplies and equipment in a safe and sanitary manner.

6.4.2 A licensee must ensure that all poisonous and toxic materials are stored in accordance with the following:

6.4.2.1 All poisonous and toxic materials must be prominently and distinctly labeled for easy identification as to contents;

6.4.2.2 All poisonous and toxic materials must be stored so as to not contaminate food or constitute a hazard to residents, employees and volunteers; and

6.4.2.3 All poisonous and toxic materials must be stored in a secure and locked room with access only by authorized employees.

6.4.3 Flammable liquids, gasoline, or kerosene may not be stored on the premises except in a manner and place that has been authorized in writing by the Office of the Fire Marshall.

6.5 Toilet and Bathing

6.5.1 A facility must ensure that there are toilet and bathing accommodations that meet the following specifications:

6.5.1.1 For every eight residents, there must be at least one flush toilet, wash basin, and bathtub or shower;

6.5.1.2 These toileting and bathing facilities must not be located more than one floor from any bedroom; and

6.5.1.3 Bathrooms must have at least one unbreakable mirror fastened to the wall at an age-appropriate height.

6.5.1.4 A licensee must ensure that toilets, showers, sinks, and bathing facilities and other are provided for residents and:

6.5.1.5 Allow for privacy unless this privacy is in conflict with toilet training or needed supervision; and

6.5.1.6 Are maintained in a safe and sanitary manner.

6.5.2 A licensee must ensure that bathroom surfaces subject to splash are cleanable and impervious to water.

6.5.3 A licensee must ensure that bathroom floors, showers, and bathtubs have slip-proof surfaces. Shower doors must be made of resilient (impact resistant) material such as safety glass, wire glass, tempered glass or plastic that resists breaking and creates no dangerous cutting edges when broken.

6.5.4 A licensee must ensure that bathrooms are equipped with operable windows or mechanical ventilation systems to the outside.

6.6 Bedroom Accommodations

[~~6.6.1.2~~ 6.6.1] IBSER facilities operating prior to the adoption of these regulations may continue to operate based on the DelaCare regulations **[related to bedroom accommodations]** then applicable.

[~~6.6.1.3~~ 6.6.2] Facilities licensed subsequent to the adoption of these regulations shall provide only single-occupancy and double-occupancy rooms. A single-occupancy bedroom shall provide a floor area of at least 80 square feet, excluding closet space and a double-occupancy bedroom shall provide a floor area of at least 130 square feet, excluding closet space.

6.6.**[~~1~~13]** A facility must ensure that any bedroom used by residents includes:

6.6.**[~~1.1~~3.1]** A designated area for sleeping;

6.6.**[~~1.4~~3.2]** A door that may be closed;

6.6.**[~~1.5~~3.3]** A direct source of natural light;

6.6.**[~~1.6~~3.4]** A window covering to ensure privacy; and

6.6.**[~~1.7~~3.5]** Lights with safety covers or shields.

6.6.**[~~9~~94]** A facility must ensure that each resident is provided with:

6.6.**[~~9~~94]**.1 A bed;

6.6.**[~~9~~94]**.2 A cleanable, fire retarding mattress with mattress cover;

6.6.**[~~9~~94]**.3 Clean bed linens at least every seven calendar days or more often if needed;

6.6.**[~~9~~94]**.4 A pillow; and

6.6.**[~~9~~94]**.5 Blanket(s) appropriate for season and weather.

6.6.**[~~10~~05]** A facility may use cots or portable beds in an emergency only and for no longer than a period of 72 hours.

6.6.**[~~11~~16]** A facility must ensure that there are no more than two tiers when bunk beds are used. In addition, the facility must ensure that the distance between the top bunk mattress and ceiling is of sufficient height to enable the resident to sit upright in bed without his or her head touching the ceiling.

6.6.**[~~12~~27]** Unless clinically contraindicated, a facility must provide and locate in the bedroom for each resident a chest of drawers, a bureau, or other bedroom furniture for the storage of clothing and other personal belongings.

6.6.**[~~13~~38]** A facility may not permit a resident to share the same bed with any other resident.

6.6.**[~~14~~49]** A facility must ensure that residents occupy a bedroom only with members of the same sex.

6.6.**[~~15~~510]** No child shall be placed in the same room as an adult.

6.7 Water Supply and Sewage Disposal

6.7.1 A licensee must maintain on file written documentation that the building's water supply and sewage disposal system are in compliance with applicable State laws and regulations of the Delaware Division of Public Health and the Delaware Department of Natural Resources and Environmental Control, respectively.

6.7.2 A licensee must ensure that hot tap water does not exceed 115 degrees Fahrenheit at all outlets accessible to residents, and that cold or tempered water is also provided.

6.8 Garbage and Refuse

6.8.1 A licensee must ensure that:

6.8 1.1 Garbage is stored outside in watertight containers with tight-fitting covers that are insect and rodent proof;

6.8.1.2 Garbage and refuse are removed from the premises at intervals of at least once a week; and

6.8.1.3 Garbage and refuse are contained in an area that is separate from any outdoor recreation areas.

6.9 Lighting

6.9.1 A licensee must ensure that kitchens and all rooms used by residents, including bedrooms, dining rooms, recreation rooms and classrooms, are suitably lighted for safety and comfort, with a minimum of 30 footcandles of light. All other areas must have a minimum of 10 footcandles of light.

6.9.2 A licensee must ensure that all lights located over, by or within food preparation, serving and storage areas have safety shields or light covers.

6.9.3 A licensee must ensure that all corridors are illuminated during night-time hours.

6.9.4 During night-time hours, a licensee must provide for exterior lighting of the building(s), parking areas, pedestrian walkways or other premises subject to use by residents, visitors, employees and volunteers.

6.10 Heating

6.10.1 A licensee must ensure that a minimum temperature of 68 degrees Fahrenheit is maintained at floor level in all rooms occupied by residents.

6.10.2 A licensee must ensure that all working fireplaces, pipes, and electric space heaters accessible to residents are protected by screens, guards, insulation or any other suitable, non-combustible protective device. All radiators accessible to residents must be protected by screens, guards, insulation or any other suitable, non-combustible protective device.

6.10.3 Portable fuel burning or wood burning heating appliances are prohibited.

6.11 Ventilation

6.11.1 A licensee must ensure that each habitable room has direct outside ventilation by means of windows, louvers, air conditioning or mechanical ventilation.

6.11.2 A licensee must ensure that:

6.11.2.1 Each door, operable window and other opening to the outside is equipped with insect screening in good repair and not less than 16 mesh to the inch, unless the facility is air conditioned and provided that it does not conflict with applicable fire safety requirements; and

6.11.2.2 This screening can be readily removed in emergencies.

6.11.3 A licensee must ensure that ventilation outlets are maintained in a clean and sanitary manner, and kept free from obstructions.

6.11.4 A licensee must ensure that all floor or window fans accessible to residents have a protective grill, screen or other protective covering.

6.12 Access to Telephone

6.12.1 A licensee must ensure that each building used by residents has at least one working telephone that is directly available for immediate access or that is connected to an operating central telephone system.

6.12.2 A licensee must ensure that the licensee's telephone number is clearly posted and available to residents, their parent(s) or legal guardian, and the general public.

6.12.3 A licensee must post a notice near the telephone which says that complaints can be made by calling the Division of Long Term Care Residents Protection and providing the telephone number. The same information shall be provided to the resident or legal representative upon admission.

6.12.4 A licensee must provide residents reasonable access to a free telephone that has statewide access and must have a process in place for free calls to other states.

6.12.5 A licensee must provide residents reasonable privacy for telephone use.

[6.13 Laundry:

6.13.1 For on-site laundry processing, the facility shall:

6.13.1.1 If hot water is used for destroying micro-organisms, washers must be supplied with water heated to a minimum of 160º F.

6.13.1.2 If low temperature laundry cycles are used, a total available chlorine residual of 50-150 ppm must be present and monitored during the wash cycle.]

7.0 Kitchen and Food Storage

7.1 A licensee must ensure that kitchens are provided with the necessary operable equipment for the preparation, storage, serving and clean-up of all meals for all of the residents and employees regularly served by such kitchens. A licensee that does not prepare food on the premises and that utilizes single-service (disposable) dishes, pots, pans and utensils is not governed by this Requirement.

7.2 A licensee must ensure that a kitchen or food preparation area has a hand washing sink within the food preparation area and separate from the sink used for food preparation and dish washing.

7.3 A licensee must ensure that:

7.3.1 A mechanical dishwasher is used for the cleaning and sanitizing of all dishes, pots, pans and utensils after each meal; and

7.3.2 The dishwasher is capable of sanitizing at the proper time, temperature and pressure ratio, and those dishes, pots, pans and utensils are washed in accordance with the manufacturer's instructions. Dishwasher temperatures must be checked periodically and documented.

7.4 A licensee must ensure that all food service equipment and utensils are constructed of material that is nontoxic, easily cleanable and maintained in good repair.

7.5 A licensee must ensure that all food services equipment, eating and drinking utensils, counter-tops and other food contact areas are thoroughly cleaned and sanitized after each use.

7.6 A licensee must ensure that the floor, walls and counter-top surfaces of the kitchen are made of cleanable materials and impervious to water to the level of splash.

7.7 A licensee must ensure that the kitchen has a cook stove and oven with an appropriately vented hood that is maintained in a safe and operable condition in accordance with fire and safety regulations.

7.8 A licensee must ensure that the kitchen is so constructed or supervised as to limit access by residents when necessary.

7.9 A licensee must ensure that food preparation areas and appliances, dishes, pots, pans, and utensils in which food was prepared or served are cleaned following each meal.

7.10 A licensee must ensure that all foods subject to spoilage are stored at temperatures that will protect against spoilage. This means that:

7.10.1 All refrigerated foods are to be kept cold at 41 degrees Fahrenheit or below.

7.10.2 All frozen foods are to be kept at 0 degrees Fahrenheit or below.

7.10.3 All hot foods are to be kept at 140 degrees Fahrenheit or above, except during periods that are necessary for preparation and serving. Refrigerators and freezers must be equipped with accurate, easily readable thermometers located in the warmest part of the refrigerator or freezer.

7.10.4 There must be three days' supply of food in each facility at all times as posted on the menus.

7.10.5 Opened foods that are to be stored must immediately be dated with the date that the foods were opened.

7.11 A licensee must ensure that:

7.11.1 All food storage areas are clean, dry and free of food particles, dust and dirt;

7.11.2 All packaged food items and can goods are stored at least six inches above the floor in sealed or closed containers that are labeled;

7.11.3 All dishes, pots, pans and utensils are stored in a clean and dry place; and

7.11.4 All paper goods are stored at least six inches above the floor.

8.0 Emergencies and Disasters

8.1 Fire safety in Facilities must comply with the rules and regulations of the State Fire Prevention Commission or the appropriate local jurisdiction. All applications for a license or renewal of a license must include a letter certifying compliance by the Fire Marshall with jurisdiction. Notification of noncompliance with the applicable rules and regulations must be grounds for revocation of a license.

8.2 The facility must have a minimum of two means of egress.

8.3 The facility must have an adequate number of UL approved smoke/carbon monoxide detectors in working order.

8.3.1 In a single level facility, a minimum of one smoke/carbon monoxide detector must be placed between the bedroom area and the remainder of the facility.

8.3.2 In a multi-story facility, a minimum of one smoke/carbon monoxide detector must be on each level. On levels which have bedrooms, the detector must be placed between the bedroom area and the remainder of the facility.

8.4 There must be at least one functional two and one-half to five pound ABC fire extinguisher on each floor of living space in the facility that is readily accessible to staff. Inspections shall be completed by the service company or as regulated by the Fire Marshall. Each extinguisher must be checked annually.

8.5 Evacuation Drills

8.5.1 A licensee must conduct at least four emergency evacuation drills annually and maintain on file a record of each drill. Two of these drills must include evacuations, unless the Division, in writing, has determined that an evacuation is clinically contraindicated. Where a licensee utilizes two or more employee shifts, there must be at least four emergency evacuation drills conducted annually for each shift.

8.5.2 Emergency evacuation drills must include all persons on the premises, including employees, volunteers, residents and visitors.

8.5.3 The location of egress during these evacuation drills must be varied, with window evacuation procedures discussed as an alternative, if not practiced.

8.5.4 During drills, persons must be evacuated with staff assistance to the designated safe area outside of the facility.

8.5.5 As evidenced by evacuation drill reports that are maintained by the Facility, drills must assure that all persons and staff are familiar with the evacuation requirements and procedures. Any problems persons have evacuating a building during a drill must result in a written plan of specific corrective action(s) to be taken.

8.5.6 Persons who are unable to achieve the exit schedule prescribed by the Life/Safety Code with available assistance must be either relocated or provided with additional assistance.

8.6 Emergency Procedures

8.6.1 A licensee must develop, adopt, follow and maintain on file written policies and procedures governing the handling of emergencies, including:

8.6.1.1 Accident;

8.6.1.2 Bomb threat;

8.6.1.3 Fire;

8.6.1.4 Flooding;

8.6.1.5 Medical;

8.6.1.6 Missing resident, including referral to Gold Alert Program;

8.6.1.7 Power outage;

8.6.1.8 Severe weather conditions;

8.6.1.9 Radiation, if within a 10-mile radius of a nuclear reactor.

8.6.2 The policies and procedures must include:

8.6.2.1 An emergency evacuation plan;

8.6.2.2 Instructions and telephone numbers for contacting ambulance, emergency medical response team, fire, hospital, poison control center, police, and other emergency services;

8.6.2.3 Location and use of first aid kits; and

8.6.2.4 Roster and telephone numbers of employees to be contacted during an emergency.

8.6.3 A licensee must ensure that each newly admitted resident is provided an orientation regarding emergency procedures and the location of all exits within 48 hours of admission.

8.6.4 The procedures must contain instructions related to the use of alarm and signal systems. Provisions must be made to alert persons living in the facility according to their abilities, and these provisions must be included in the procedures.

8.6.5 Evacuation routes and the location of fire-fighting equipment must be posted in areas used by the public as required by the applicable fire safety regulations. The number and placement of postings are otherwise dictated by building use and configuration and by the needs of persons and staff.

8.6.6 The provider must maintain an adequate communication system to ensure that on and off-duty personnel and local fire and safety authorities are notified promptly in the event of an emergency or disaster.

8.6.7 The telephone numbers of the nearest poison control center and the nearest source of emergency medical services must be posted.

8.6.8 Provisions must be made for emergency auxiliary heat and lighting by means of alternate sources of electric power, alternate fuels, and stand-by equipment, or arrangements with neighbors, other agencies or community resources.

8.6.9 A licensee must prohibit the storage or use of any firearms or other weapons on the grounds of the facility or program or in any building used by residents.

9.0 Administration

9.1 Division Notification

9.1.1 A licensee must notify the Division in writing at least 90 consecutive calendar days before any of the following changes occur:

9.1.1.1 A change of ownership or sponsorship;

9.1.1.2 A change of location;

9.1.1.3 A change in the name of the facility or program;

9.1.1.4 A change in the applicable type of regulated service being provided;

9.1.1.5 A change in population capacity; or

9.1.1.6 The anticipated closing of the facility or program.

9.2 Governing Body

9.2.1 A licensee must have an identifiable functioning governing body. The governing body must designate a Director.

9.3 Director Responsibilities

9.3.1 A licensee must delineate in writing the job responsibilities and functions of the Director. The Director must adopt and implement a chain of command that ensures the proper and effective supervision and monitoring of employees and volunteers.

10.0 Facility or Program Description of Services

10.1 A licensee must develop, adopt, follow and maintain on file a current written description of the facility's or program's:

10.1.1 Admission policies governing the specific characteristics, and treatment or service needs of residents accepted for care; and

10.1.2 Services provided to residents, including those provided directly by the licensee or arranged through another source.

10.2 A licensee must make available to the public a brochure or other generic written description of its mission, policies and the types of services offered by the facility or program. If the licensee maintains a website, the same information shall be included on the site.

11.0 Maintenance of Resident's Records

11.1 A licensee must develop, adopt, follow and maintain on file on the premises written procedures governing the maintenance and security of resident records in care. These procedures must:

11.1.1 Assure that records are stored in a secure manner; and

11.1.2 Assure confidentiality of and prevent unauthorized access to such records.

11.1.3 Retain residents' records for 5 years after discharge or 3 years after death.

11.2 Administrative Records

11.2.1 A licensee must develop, adopt, follow and maintain on file on the premises up-to-date administrative records containing the following:

11.2.1.1 Organizational chart;

11.2.1.2 Name and position of persons authorized to sign agreements and to submit official documentation to the appropriate government agency; and

11.2.1.3 Written standard operating procedures.

11.3 All records maintained by the facility must at all times be open to inspection and copying by authorized representatives of the Division as well as all other agencies as required by state and federal laws and regulations. Such records must be made available in accordance with 16 **Del.C.** Ch. 11, Subchapter I, Licensing by the State.

12.0 Insurance Coverage

A licensee must secure and maintain on file written documentation of motor vehicle insurance as required by state law as well as fire and comprehensive general liability insurance.

13.0 Personnel Policies and Procedures

13.1 A licensee must develop, adopt, follow and maintain on file written personnel policies and procedures governing the recruitment, screening, hiring, supervision, training, evaluation, promotion, and disciplining of employees and volunteers.

13.2 Personnel; Qualifications

13.2.1 Director Qualifications

13.2.1.1 A Director, at the time of appointment, must be at least 21 years of age and must possess one of the following:

13.2.1.1.1 A master's degree in social work, sociology, psychology, guidance and counseling, education, business administration, a human behavioral science, public administration or a related field from an accredited college, and three years of full-time work experience in human services or a related field, at least two years of which must have been in an administrative or supervisory capacity; or

13.2.1.1.2 A bachelor's degree in social work, sociology, psychology, guidance and counseling, education, business administration, a human behavioral science, public administration or a related field from an accredited college, and four years of post-bachelor's degree full-time work experience in human services or a related field, at least two years of which must have been in an administrative or supervisory capacity.

13.2.2 Direct Care Supervisor Qualifications

13.2.2.1 A direct care supervisor, at the time of appointment, must be at least 21 years of age and must possess at least one of the following:

13.2.2.1.1 A bachelor's degree from an accredited college and one year of full-time work experience in a residential care facility or program;

13.2.2.1.2 An associate degree or a minimum of 48 credit hours from an accredited college and two years of full-time work experience in a residential care facility or program; or

13.2.2.1.3 A high school diploma or equivalent and three years of full-time work experience in a residential care facility or program.

13.2.3 Direct Care Worker Qualifications

13.2.3.1 A direct care worker, at the time of appointment, must be at least 21 years of age and must possess a high school diploma or an equivalent.

13.2.4 Service Supervisor Qualifications

13.2.4.1 A service supervisor, at the time of appointment, must be at least 21 years of age and must possess at least one of the following:

13.2.4.1.1 A master's degree in social work, sociology, psychology, education, guidance and counseling, human behavioral science or a related field from an accredited college and at least two years of full-time work experience in social work, human services, teaching, counseling or a related field, at least one year of which must have been in a supervisory capacity; or

13.2.4.1.2 A bachelor's degree in social work, sociology, psychology, education, guidance and counseling, human behavioral science or a related field from an accredited college and at least four years of full-time work experience in social work, human services, teaching, counseling or a related field, at least two years of which must have been in a supervisory capacity.

13.2.5 Service Worker Qualifications

13.2.5.1 A service worker, at the time of appointment, must be at least 21 years of age and must possess a bachelor's degree from an accredited college in social work, sociology, psychology, education, guidance and counseling, a human behavioral science or a related field and at least two years of full-time work experience in human services, teaching, counseling or a related field.

13.3 Administrative Oversight and Supervisor-to-Staff Ratios

13.3.1 The Director must ensure that there is a sufficient number of administrative, supervisory, social service, educational, recreational, direct care, and support employees or volunteers to perform the functions prescribed by these requirements and to provide for the care, needs, protection and supervision of residents. The ratio of direct care workers to residents during off-grounds activities or excursions must be the same as the ratios of direct care workers to residents that are required during on-grounds activities.

13.4 A licensee must have either:

13.4.1 A full-time Director; or

13.4.2 If its licensed capacity is less than 13 residents before January 1, 2015 or ten residents on January 1, 2015, a part-time Director and a full-time service supervisor.

13.4.3 A licensee must ensure that a designated employee is in charge on the premises at all times when residents are present.

13.4.4 A licensee must have a ratio of one service supervisor for every ten service workers or fraction thereof. A full-time Director may also serve as the service supervisor when there are three or fewer service workers.

13.5 Minimum Staffing at all times

13.5.1 A minimum of one (1) direct care worker who meets the training requirements of Section 14.0 below must be on duty and on site whenever (1) to five (5) residents are present in the home.

13.5.2 A minimum of two (2) staff members who meet the training requirements of Section 14.0 below must be on duty and on site whenever six (6) or more residents are present in the home.

13.5.3 At all times, at least one (1) service worker must be available on call.

14.0 Orientation and Training of Employees and Volunteers

14.1 A licensee must ensure that all employees and volunteers participate in an orientation of at least 15 hours, before commencing work, which includes:

14.1.1 The purpose, policies and procedures of the facility;

14.1.2 Their role and responsibilities for the protection of residents; and

14.1.3 The State's requirements to report allegations of abuse, neglect, mistreatment and financial exploitation, and

14.1.4 Emergency procedures and the location of emergency exits and emergency equipment, including first aid kits;

14.1.5 Confidentiality requirements, including Health Insurance Portability and Accountability Act (HIPAA),

14.1.6 Crisis management and safety.

14.2 A licensee must ensure that any employee or volunteer whose primary role or function requires interaction with residents and who works fewer than 24 hours a week, receives at least 20 hours of training annually, including the 15 hours of training provided pursuant to subsection 14.1. This training must cover subject matters designed to maintain, improve or enhance the employee's knowledge of or skills in carrying out his or her job responsibilities, including:

14.2.1 Instruction in administering cardiopulmonary resuscitation (CPR) and first aid;

14.2.2 Cultural sensitivity; and

14.2.3 Behavior management policies and procedures, and safe and effective techniques.

14.3 A licensee must ensure that each employee and volunteer whose primary role or function requires interaction with residents and who works 24 or more hours a week receives at least 40 hours of training annually, including the 15 hours of training provided pursuant to subsection 14.1. This training must cover subject matters designed to maintain, improve or enhance the employee's knowledge of or skills in carrying out his or her job responsibilities, including:

14.3.1 Instruction in administering cardiopulmonary resuscitation (CPR);

14.3.2 Cultural sensitivity; and

14.3.3 Behavior management policies and procedures, and safe and effective techniques.

14.4 The requirements of 14.1, 14.2 and 14.3 do not apply to licensed professionals under contract with the licensee.

14.5 In addition to 14.2 and 14.3, a licensee must ensure that all persons who may be required to participate in the utilization of a restraint:

14.5.1 Be trained and able to demonstrate competency in the application of restraints, monitoring, assessment and providing care for a patient in a restraint (i) as part of orientation; (ii) before participating in the implementation of a restraint; and (iii) subsequently on a periodic basis consistent with facility policy.

14.5.2 Have education, training, and demonstrated knowledge based on the specific needs of the **[~~patient~~ resident]** population in techniques to identify staff and resident behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint in order to diffuse, prevent or reduce a problem before it evolves into a significant event that places the resident or others at risk.

14.6 A licensee must maintain on file written materials documenting the delivery of orientation and training for all employees and volunteers.

15.0 Personnel Records

15.1 A licensee must develop, adopt and maintain on file a personnel record for every employee and volunteer.

15.2 The personnel record must contain the following:

15.2.1 Employment application;

15.2.2 Name, current address and phone number of the employee;

15.2.3 Verification of education where specified by these requirements;

15.2.4 Documentation of training received prior to and during employment at the facility or program;

15.2.5 Work history;

15.2.6 Three references from persons who are unrelated to the employee or volunteer, one of which must be from any previous employer;

15.2.7 Any health verification including meeting the minimum requirements for pre-employment tuberculosis (TB) testing which requires all employees to have a base line two-step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention (CDC) of the U. S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility must comply with the recommendations of the CDC for the appropriate risk category.

15.2.8 Verification of completed criminal history record information check and abuse registry information check;

15.2.9 Verification of receipt by the employee or volunteer of his or her current job description;

15.2.10 A valid Driver's License if required to transport residents;

15.2.11 An annual employee performance evaluation;

15.2.12 Employee disciplinary actions and history; and

15.2.13 All other reports required by statute or regulation.

15.3 Job Descriptions for Employees

15.3.1 A licensee must maintain on file a current written job description for every employee and for every volunteer who works more than 24 hours a week.

15.3.2 A licensee must ensure that an employee's and volunteer's permanent or temporary assignment and functions must be consistent with his or her respective current written job description.

16.0 Use of Volunteers

16.1 A licensee must develop, adopt, follow and maintain on file policies and procedures governing the qualifications and use of volunteers. The qualifications must be appropriate to the duties they perform.

16.2 A licensee must assign designated employees to supervise volunteers.

16.3 Any volunteer who provides services or assistance on a routine basis is subject to the same background check as employees, unless the volunteer is limited to less than 3 visits in a calendar year.

17.0 Human Rights

17.1 Human Rights Committee

17.1.1 Membership:

17.1.1.1 At least five adult individuals of high professional standing, two of whom must be professionally knowledgeable or experienced in the theory and ethical application of various treatment techniques used to address behavioral problems.

17.1.1.2 A majority of Committee members must be external to the licensee or its parent organization. One member must be a member of the community or parent of a resident. One member must be a licensed mental health professional, a licensed physician, a licensed clinical psychologist, or a clinical social worker.

17.1.1.3 The Committee must meet at least monthly.

17.1.2 The Human Rights Committee is responsible for:

17.1.2.1 Determining that residents in care are receiving humane and proper treatment;

17.1.2.2 Reviewing and making recommendations regarding the licensee's policies and procedures governing the use of restraint;

17.1.2.3 Reviewing the restraint records, and reviewing incident reports required by these regulations related to the use of restraints, and advising the Director accordingly;

17.1.2.4 Recording and maintaining on file written minutes of all of its meetings, and providing the Director with a copy of these minutes;

17.1.2.5 Making inquiries into any allegations of abusive techniques or the misuse of restraint procedures. A report of the inquiry must be provided by the Committee to the Director and sent to the Division;

17.1.2.6 Monitoring the qualifications and training of employees who have been given responsibility for administering restraint procedures and to make recommendations to the Director accordingly; and

17.1.2.7 Reviewing and making recommendations on all SBS Plans. See Section 20.5.

18.0 Behavior Management Committee (BMC).

18.1 The BMC must be comprised of **[~~the licensee's clinical director and~~]** all **[~~on-staff~~]** clinicians **[whose expertise meets the needs of the resident]**. It must establish a SBS Plan upon admission of a resident and must conduct SBS Plan reviews on each resident on at least a monthly basis.

18.2 With regard to each SBS Plan, the BMC review must provide input as to the presumed clinical efficacy and ethical acceptability of the plan.

18.2.1 Each SBS Plan author must present the following to the BMC:

18.2.1.1 A description of the results of the most recent functional assessment to identify environmental factors that correlate with the occurrence of dangerous target behaviors;

18.2.1.2 A description of the individual and his or her clinical/educational/vocational progress;

18.2.1.3 A description of positive reinforcement components that are designed to teach and strengthen appropriate behaviors;

18.2.1.4 A description of the most recent mental health review and recent changes in medication or other psychiatric interventions;

18.2.1.5 A description of any medical conditions that might be expected to impact on the occurrence of dangerous behaviors;

18.2.1.6 A description of any familial or other emotional variables that might be expected to impact on the occurrence of dangerous behaviors;

18.2.1.7 A summary of the risk benefit analysis for each proposed intervention; and

18.2.1.8 A summary statement as to the general effectiveness of the SBS Plan **[including presentation of the data to the BMC]** and a recommendation for future use.

18.3 Following approval by the BMC, the HRC must review the SBS Plan as soon as practicable thereafter.

18.4 Each SBS Plan that has been approved and implemented must be reviewed at least monthly by the BMC for the first 90 days following implementation and quarterly thereafter.

19.0 Abuse and Neglect

19.1 A licensee must provide each employee or volunteer who has contact with residents written information governing the reporting provisions of the Delaware abuse, neglect, mistreatment and financial exploitation law(s) and regulations, and must maintain on file written documentation of their receipt of this information.

19.2 A licensee must not discourage, inhibit, penalize or otherwise impede any employee, volunteer**[, contractor]** or resident reporting any suspected or alleged incident of abuse, neglect, mistreatment or financial exploitation.

19.3 A licensee must develop, adopt, follow and maintain on file written policies and procedures for handling any incident of suspected abuse, neglect, mistreatment or financial exploitation. The policies and procedures must contain provisions specifying that:

19.3.1 The licensee immediately must take appropriate remedial action to protect residents from harm;

19.3.2 The licensee must take appropriate long-term corrective action to eliminate the factors or circumstances that may have caused or may have otherwise resulted in a continuing risk of abuse or neglect to residents;

19.3.3 Any employee or volunteer involved in an incident of alleged abuse or neglect must be removed or suspended from having direct contact with any residents, or must be reassigned to other duties that do not involve having contact with residents until the investigation of the incident has been completed;

19.3.4 The licensee must take appropriate disciplinary action against any employee or volunteer who committed an act of abuse or neglect, mistreatment or financial exploitation.

19.3.5 All incidents must be reported to the Division pursuant to Section 24.0 below, and to the police if criminal conduct is suspected.

20.0 Use of Restraints

20.1 These regulations describe the procedures to be followed whenever the use of restraints is required. All residents have the right to be free from physical or mental abuse, discipline and corporal punishment. All residents have the right to be free from restraints of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Facility staff must review restraint protocols with each resident and his or her legal representative upon admission and document the review.

20.2 Restraint procedures may be employed only when:

20.2.1 The resident is exhibiting a problem behavior that is so severe that it poses a**[n imminent]** risk **[of serious bodily injury]** to **[~~the safety and wellbeing of the resident or others;~~ self or others.]**

20.2.2 It is part of a SBS Plan that incorporates all of the elements cited below:

20.2.2.1 An initial medical evaluation to assess and address medical conditions that may be contributing to the problem behavior;

20.2.2.2 A physician, nurse practitioner or other qualified and licensed medical professional has determined that there are no contraindications to the use of the intervention;

20.2.2.3 It has been determined that less-restrictive alternative interventions are not safe, feasible or effective; and

20.2.3.4 A functional behavioral assessment has been conducted to identify the situations and conditions that trigger and/or maintain the severe problem behavior, and means taken to address and correct those conditions.

20.3 The SBS Plan must be developed by the resident, his or her family or legal representative, and his or her education, habilitation or treatment team. The team must include: (1) a properly credentialed professional with documented training and experience in behavioral treatment of severe behavior disorders, and (2) a nurse practitioner or other relevant medical professional **[~~(The SPTeam)~~]**.

20.4 The SBS Plan must include:

20.4.1 Informed consent rendered voluntarily and in writing by the resident or legal representative after they have been provided with complete, accurate, and understandable information about all aspects of the intervention techniques that may be utilized with the resident; and

20.4.2 Safeguards to minimize risks of harm and insure the resident's safety at all times, including during restraint.

20.4.3 The SBS Plan must conform to current best practices and ethical standards pertaining to the behavioral treatment of severe problem behavior.

20.5 The SBS Plan must be reviewed by the HRC to ensure that it conforms to current best practices and to ethical standards.

20.6 Implementation must be by personnel with documented training and experience in behavioral treatment of severe behavior disorders to insure that it is done competently, safely and ethically.

20.7 The SBS Plan must be adjusted as needed based on frequent review by the SPTeam of data representing objectively measured occurrences of the problem behavior, and the impact of the intervention procedures.

20.8 Upon initiation of the restraint procedure the following must occur:

20.8.1 As soon as practicable the on-site supervisor must be notified.

20.8.2 Trained staff must continuously monitor the resident during the restraint procedure. If the resident is observed to be in medical distress, e.g., exhibiting labored breathing, or there is evidence of physical injury, the resident must immediately be released from restraint, and medical attention provided applied.

20.8.3 The restraint procedure must be terminated when there is no imminent risk to either the resident or others.

20.8.4 At the termination of the intervention the resident must be observed by both the staff terminating the procedure and a second staff person to evaluate the resident's medical and emotional condition.

20.8.5 If any signs of medical or emotional distress are observed, a medical and/or behavioral clinical professional must be contacted and decisions made about the next steps to resolve the situation.

20.8.6 Following the conclusion of each incident of restraint, the client, staff, and any witnesses, shall participate in debriefing(s). Debriefing for the client shall occur as soon as possible, or within 24 hours of the incident unless the client is unavailable or there is a documented clinical contraindication. Staff should also debrief as soon as possible, or within 24 hours to conduct a thorough review and analysis of each incident in an effort to use the knowledge gained from the debriefing to inform policy, procedures and practices to avoid repeated use in the future, and to improve treatment outcomes.

20.9 Episodes of restraint utilization must be documented as follows:

20.9.1 Date and time, staff involved, location, activity, antecedent conditions, specific behaviors observed, interventions implemented, duration of intervention, well being checks, clinical review and approval **[by the Director or designee]** for interventions longer than 15 minutes, physical examination for possible injury after the termination of the restraint utilization, treatment provided, supervisor signature; and

20.9.2 **[~~Approval~~ Review]** by **[~~a clinician~~ the Director or designee]** within one business day of an intervention when a restraint utilization event is less than 15 minutes.

20.9.3 A report of all episodes of restraint utilization must be provided to the Division on the fifth day of each month for the previous month in a manner prescribed by the Division.

20.9.4 Individual and aggregate clinical data on restraint interventions for each resident must be provided to the **[~~SPTeam~~ BMC]** and the HRC.

20.10 If a resident experiences the use of a restraint six or more times in a 30 day period, that resident's SBS Plan must be reviewed and modified, if indicated.

20.11 The following are prohibited:

20.11.1 A prone (face down) restraint of any kind;

20.11.2 A seated basket hold;

20.11.3 Restraint procedures that employ painful stimuli;

20.11.4 Restraint of a resident's hands, with or without a mechanical device, behind his or her back;

20.11.5 Physical holds relying on the inducement of pain for behavioral control;

20.11.6 Movement that results in hyperextension or twisting of body parts;

20.11.7 Any restraint procedure in which a pillow, blanket, or other item is used to cover the resident's face as part of the restraint process;

20.11.8 Any restraint procedure that may exacerbate a known medical or physical condition;

20.11.9 Use of any restraint technique medically contraindicated for a resident;

20.11.10 Restraint without continuous monitoring;

20.11.11 All forms of chemical restraint; and

20.11.12 Electroconvulsive Therapy

[20.11.13 Consistent with 34 C.F.R. §§300.2(c) and 300.146, use of restraint or forms of aversive techniques on adult IDEA-funded residents or students that violate applicable law or regulation of the public IDEA funding agency.

20.12.14 Seclusion]

21.0 Health

21.1 Employee and Volunteer Health

21.1.1 Prior to employing any person or accepting any volunteer, a licensee must secure and maintain on file written documentation certifying and verifying that the prospective employee and volunteer has had a

general physical examination within 12 months prior to the date of employment. The examination must include a medically accepted procedure for screening for tuberculosis.

21.1.2 Minimum requirements for pre-employment and tuberculosis (TB) testing are those currently recommended by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.

21.1.3 To be eligible to work in the facility or program, an employee or volunteer must be free from active tuberculosis; and

21.1.4 If a licensee determines that the prospective employee or volunteer has not had a general physical examination within 12 consecutive calendar months prior to the anticipated date of employment or volunteer work, or if a licensee is unable to document that such an examination was completed, a licensee must require the prospective employee or volunteer, as a condition of employment, to have such a general physical examination within three consecutive calendar months of the date of employment or volunteer work.

22.0 Administration or Assistance with Self-Administration of Medication

22.1 A licensee must develop, adopt, follow and maintain on file written policies and procedures governing the use, administration or assistance with administration of medications, prescription and nonprescription medications to residents.

22.2 The facility must establish and adhere to written medication policies and procedures which must address:

22.2.1 Obtaining and refilling medications;

22.2.2 Storing and controlling medications;

22.2.3 Disposing of medications;

22.2.4 Administration of medication and self-administration of medication; and

22.3 Each facility must have a drug reference guide, with a copyright date no older than 2 years, available and accessible for use by employees.

22.4 Medication must be stored and controlled as follows:

22.4.1 Medication must be stored in a locked container, cabinet, refrigerator or area that is only accessible to authorized personnel;

22.4.2 Medication that is not in locked storage may not be left unattended and may not be accessible to unauthorized personnel; and

22.4.3 Medication must be stored in the original labeled container.

22.4.4 A bathroom or laundry room may not be used for medication storage.

22.4.5 All expired or discontinued medication must be disposed of according to the facility's medication policies and procedures.

22.5 A separate medication log must be maintained for each resident documenting the administration of the medication by licensed staff member or staff assistance with self-administration by the resident (AWSAM). The log is either preprinted by the pharmacy or created by the facility. Instructions must appear as on the prescription container label. When a resident refuses a medication or is unavailable, the incident must be documented on the medication log or according to facility policy.

22.6 Psychotropic medications are prohibited for disciplinary purposes, for the convenience of staff or as a substitute for appropriate treatment service. An informed, written consent of the **[~~parents or~~]** legal **[~~guardian~~ representative]** is secured and maintained in the resident's file prior to the administration of any psychotropic medication.

22.7 A minimum of a five (5) day supply of each resident's medication must be available at all times.

22.8 The facility admitting residents on prescribed psychotropic medication and/or residents on prescribed medication for chronic illness, such as diabetes or asthma, must ensure that each of these residents receives a minimum of one hour per month of Medical Consultant services. The Medical Consultant services must include:

22.8.1 Review of administration of the resident's medication, including determination of problems in adherence or administration and development of corrective action plans;

22.8.2 Assessment and monitoring of the resident with regard to the impact of their medication, including whether the medication is having its desired effects and whether the resident is suffering from undesired side-effects;

22.8.3 Serving as liaison between the licensee and the resident's physician(s); and

22.8.4 Provision of instruction of employees regarding the expected outcomes from each resident's medication regime and the possible side-effects of that medication regime.

22.9 Residents receiving medication must be trained to take their own medication, where possible. Staff who have successfully completed a Board of Nursing approved AWSAM training program may assist residents in the taking of medication provided that the medication is in the original container and properly labeled. The medication must be taken exactly as indicated on the label.

22.10 No person other than a physician or licensed nurse may administer medication by injection.

22.11 Records must be kept on file at the facility identifying AWSAM trained staff.

22.12 Each facility must complete an annual AWSAM report on the form provided by the Board of Nursing. The report must be submitted pursuant to the Delaware Nurse Practice Act, 24 **Del.C.** Ch. 19.

23.0 Universal Precautions

A licensee must employ universal precautions for protection from disease and infection in accordance with the most current guidelines of the Centers for Disease Control and Prevention.

24.0 Incident Reports to the Division

24.1 Incident reports, with adequate documentation, must be completed for each incident. Adequate documentation includes the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's guardian or surrogate, attending physician and licensing or law enforcement authorities, when appropriate.

24.2 All incident reports whether or not required to be reported must be retained in facility files for four years. Reportable incidents must be communicated immediately, which means within eight hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.

24.3 Incident reports which must be retained in facility files are as follows:

24.3.1 All reportable incidents as detailed below;

24.3.2 Falls without injury and falls with minor injuries that do not require transfer to an acute care facility or neurological reassessment of the resident;

24.3.3 Errors or omissions in treatment or medication;

24.3.4 Injuries of unknown source;

24.3.5 Lost items which are not subject to financial exploitation;

24.3.6 Skin tears; and

24.3.7 Bruises of unknown origin.

24.4 Reportable incidents are as follows:

24.4.1 Abuse as defined in 16 **Del.C.** §1131;

24.4.2 Physical abuse with injury if resident-to-resident and physical abuse with or without injury if staff to resident or any other person to resident;

24.4.3 Any sexual act between staff and a resident and any non-consensual sexual act between residents or between a resident and any other person such as a visitor;

24.4.4 Emotional abuse whether staff to resident, resident to resident or any other person to resident;

24.4.5 Neglect, mistreatment or financial exploitation as defined in 16 **Del.C.** §1131; and

24.4.6 Resident elopement under the following circumstances:

24.4.6.1 A resident's whereabouts on or off the premises are unknown to staff and the resident suffers harm;

24.4.6.2 A cognitively impaired resident's whereabouts are unknown to staff and the resident leaves the facility premises; and

24.4.6.3 A resident cannot be found inside or outside a facility and the police are summoned.

24.4.7 Significant injuries;

24.4.8 Injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury; the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma); the number of injuries observed at one particular point in time; or the incidence of injuries over time;

24.4.9 Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours;

24.4.10 Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing;

24.4.11 An error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours;

24.4.12 A burn greater than first degree;

24.4.13 Any serious unusual and/or life-threatening injury;

24.4.14 Entrapment which causes the resident injury or immobility of body or limb or which requires assistance from another person for the resident to secure release;

24.4.15 Death from any cause including suicide;

24.4.16 Attempted suicide;

24.4.17 Poisoning;

24.4.18 Fire within a facility;

24.4.19 Utility interruption lasting more than eight hours in one or more major service including electricity, water supply, plumbing, heating or air conditioning, fire alarm, sprinkler system or telephones;

24.4.20 Structural damage or unsafe structural conditions; and

24.4.21 Water damage which impacts resident health, safety or comfort.

24.5 The facility must maintain and follow written policies and procedures, in accordance with 16 **Del.C.** Ch. 25, regarding health care decisions including advance directives. The facility must provide written information to all residents explaining such policies and procedures.

25.0 Facility Closure

25.1 In the event of the closing of a facility, the facility shall:

25.1.1 Notify the Division, and the Ombudsman, at least 90 days before the planned closure;

25.1.2 Notify each resident directly and his/her attending physician and, if applicable, his/her legal representative by telephone and in writing at least 90 days before the planned closure;

25.1.3 Give the resident or the resident's legal representative an opportunity to designate a preference for relocation to a specific facility or for other arrangements;

25.1.4 Arrange for relocation to other facilities in accordance with the resident's preference, if possible;

25.1.5 Ensure that all resident records, medications, and personal belongings are transferred with the resident and, if to another facility, accompanied by an interagency transfer form;

25.1.6 Provide an accounting of resident trust fund accounts which must be transferred to each resident's possession or to the facility to which the resident relocates. A record of the accounting of the funds must be maintained by the closing facility for audit purposes; and

25.1.7 Advise any applicant for admission to a facility which has a planned closure date in writing of the planned closure date prior to admission.

26.0 Waivers and Severability

26.1 Waivers may be granted by the Division for good cause.

26.2 Should any section, sentence, clause or phrase of these regulations be legally declared unconstitutional or invalid for any reason, the remainder of said regulations shall not be affected thereby.