COMMONWEALTH OF VIRGINIA
Virginia Board for People with Disabilities

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TO: Emily Bowles, Legal Coordinator
Department of Behavioral Health and Developmental Services

FROM: Heidi Lawyer, Director

RE: Periodic Review of Regulations for Children's Residential Facilities

DATE: February 8, 2018

The Virginia Board for People with Disabilities (The Board) appreciates this opportunity to comment on the Periodic Review of Regulations for Children's Residential Facilities (12VAC35-46-10 *et. seq.*). While the existing regulations are strong and contain a number of important safeguards for the individuals who reside in Children's Residential Facilities in the Commonwealth, the Board believes that the quality assurance and compliance oversight provisions of the regulations can be strengthened. The recently published Joint Report by the U.S. Department of Health and Human Services Office of Inspector General, Administration for Community Living, and Office for Civil Rights, titled *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight* provides a useful framework for assessing the efficacy of regulatory frameworks for incident management and quality assurance in group homes and other residential facilities. This report informed the Board's specific recommendations listed below, and the Board recommends a careful review of this document by the Department.

The Board offers the following specific recommendations, organized according to the code sections to which the recommendations relate:

12VAC35-46-10: Definitions

Recommendation 1: Replace the phrase "mental retardation" with "intellectual disability" in the definitions section of the Chapter, as well as throughout the Chapter wherever the term appears.

Rationale: The Board is appreciative of the continuing efforts by the Department to remove the phrase “mental retardation” from Virginia’s Administrative Code and replace it with the more appropriate and more person centered “intellectual disability.” While the Board is confident that this change will be made upon the review of the Regulations for Children’s Residential Facilities, we would be remiss not to note the presence of the phrase “mental retardation” throughout the Chapter.

Recommendation 2: Add the following language to the definition of "serious incident":

> *6. Any instance of physical or sexual assault or abuse;*
> *7. Any suicide attempt*
> *8. Any unplanned hospitalization*

Rationale: Serious incidents receive heightened attention in the regulations, which require, for instance, compliance with specific documentation and reporting procedures. Physical and Sexual assault or abuse, suicide attempts, and unplanned hospitalizations constitute incidents of sufficient seriousness to warrant this heightened attention, and the Board therefore recommends their inclusion in the definition of a “serious incident.” Additionally, this recommendation is consistent with the U.S. Department of Health and Human Services report *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight.*

12VAC35-46-80: Written Corrective Action Plans

Recommendation 3: Add the following subsection:

> *F. Provider shall submit to the Department periodic updates on the provider's completion of each corrective action which shall include for any action not completed by the specified date of completion, an updated date of completion and explanation of why it was not completed as planned*

Rationale: Under the existing provisions of 12VAC35-46-80, providers are required to submit a corrective action plan if there is “noncompliance with applicable regulations during an initial or ongoing review or investigation.” These plans must be approved by the Department. Requiring providers to submit updates to the Department certifying completion of the corrective actions

included in such plan would heighten the Department's capacity to conduct ongoing oversight of noncompliant providers.

12VAC35-46-750: Individual Service Plans/Quarterly Reports

Recommendation 4: Add an additional subsection between subsection H and subsection I, which should read as follows:

> *If it is determined to be clearly inappropriate to involve any of the parties listed in subsection H in developing and updating the individualized service plan and/or in developing the quarterly progress report, the reasons for this determination shall be documented in the individualized service plan and/or quarterly report*

Rationale: The existing regulations require that the resident, resident's family and/or legal guardian, placing agency, and facility staff be involved in the development and updating of individualized service plans and quarterly progress reports, unless it is "clearly inappropriate" to involve them. The proposed language would ensure that the reasons for a determination that it is clearly inappropriate to involve one of the enumerated participants is made clear in the individual's records, which will provide assurances that such determinations are reasoned and appropriate.

12VAC35-46-900: Behavior Support

Recommendation 5: Add new subsection E as follows:

> *E: After each serious incident resulting in the restraint or seclusion of the resident, the resident's behavior support plan shall be reevaluated and modifications made to the plan to prevent future use of restraint or seclusion shall be considered.*

Rationale: Restraint and seclusion constitute treatment failures, and as such should prompt reevaluation of existing approaches to managing an individual's behavior. Thus, any instance of restraint or seclusion should be followed by a reevaluation of treatment modalities and behavior support strategies.

12VAC35-46-920:

Recommendation 6: Add a new subsection as follows:

> *15. the use of prone restraints or other restraint techniques that limit an individual's ability to breath or speak.*

Rationale: Prone restraints pose special risks of harm or death to the individuals who are subjected to them. This is especially true in the case of children. For this reason, the use of prone restraints is prohibited in a number of settings pursuant to state and federal laws and regulations, including in the *Regulations to Assure the Rights of Individuals Receiving Services from Providers Licenses, Funded, or Operated by the Department of Behavioral Health and Developmental Services*, 12VAC35-115-110. This provision would make the Regulations for Children's Residential Facilities consistent with this best practice.

12VAC35-46-960: Seclusion Room Requirements

Recommendation 7: Edit subsection G as follows:

> The seclusion room shall ~~only~~ contain a mattress with a washable mattress covering designed to avoid damage by tearing. *Additionally, therapeutic objects may be included in the seclusion room only if in the judgment of staff members the presence of such objects in the seclusion room does not pose a threat to the safety of the resident or others.*

Rationale: The placement of individuals in seclusion rooms can be a traumatic experience for individuals. Excluding all therapeutic objects from seclusion rooms can unnecessarily accentuate and prolong this traumatic experience. While the Board appreciates the dangers involved in placing an individuals who is at risk of harming him or herself, or others alone in a room with objects that could be harmful, therapeutic objects that do not pose a risk of harm can help alleviate the traumatic nature of this intervention and shorten the duration of the crisis necessitating it.

12VAC35-46-1070: Serious Incident Reports

Recommendation 8: Edit subsection A. as follows:

> Any serious incident, accident, or injury to the resident; *any instance of physical or sexual assault against a resident; any suicide attempt; any unplanned hospitalization;* any overnight absence from the facility without permission; any runaway; and any other unexplained absence shall be reported ~~within~~ *as soon as possible and no later than* 24 hours after the discovery of the incident....

Rationale: This recommendation is consistent with recommendations contained in the U.S. Department of Health and Human Services report *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight.*

Recommendation 9: Add a new subsection as follows:

> *E. The provider shall have a policy that protects employees, service recipients, and family members from retaliation for reporting serious incidents in accordance with this chapter.*

Rationale: This change will ensure that individuals are free to report serious incidents without fear of reprisal. This is consistent with the recommendations of the U.S. Department of Health and Human Services in *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight.*

Recommendation 10: Add a new subsection, which should read as follows:

> *F. The Department may take corrective action, up to and including suspension or revocation of a provider's license, for flagrant or repeated violations of these provisions.*

Rationale: This recommendation is consistent with recommendations of the U.S. Department of Health and Human Services in *Ensuring Beneficiary Health and Safety in Group Homes through State Implementation of Comprehensive Compliance Oversight.*

Thank you for the opportunity to provide comment on these regulations. If you have any questions, please feel free to contact me at Heidi.Lawyer@vbpd.virginia.gov or John Cimino, Deputy Director at John.Cimino@vbpd.virginia.gov.