The Department of Health and Human Services (Department) held a public hearing on May 21, 2018 to accept comments on proposed changes to 10-144 CMR Chapter 36, Children’s Residential Care Facilities Licensing Rule, at the Augusta Civic Center in Augusta, Maine. This hearing was advertised in five major newspapers, the Secretary of State’s Webpage and the Maine CDC’s Rule Webpage on May 2, 2018. Written comments were accepted through May 31, 2018. Comments were received from the following people:

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Commenters #1 – 4 presented oral comments, which were captured in written comments, listed below. The Department’s response follows each comment and explains whether the suggestions (if any) were followed by the Department. If the Department made no change in response to the comment, then an explanation of the reasons why no changes were made also is provided. The summary list of changes following these comments identify new changes resulting from either public comment or Assistant Attorney General review of the rule for form and legality.
GENERAL COMMENTS

1. **Comment:** Commenters 1, 4, 8, 11 and 19 stated that they appreciated that the rules were written in a user-friendly way, the additional definitions were also helpful. The commenters stated that parts of the rule were too vague for a provider and could benefit from additional clarification.

   **Response:** No changes were made to the rule based on these comments.

2. **Comment:** Commenter #19 stated that there are areas of the rule that are improved. The commenter stated that the emphasis on client rights is a good addition and that it was also good that an organization can limit admission as needed and have emergency discharges. The commenter stated that a facility should be able to decline a potential admission if that individual does not mix with the current census or if the facility cannot adequately address that individuals’ needs.

   **Response:** No changes were made to the rule based on this comment.

3. **Comment:** Commenter #1 stated that they have not had a rate increase for over ten years and that they are in a critical workforce crisis situation. The commenter stated that the rule contains additional unfunded requirements that make it very difficult for some agencies to continue serving Maine children and their families.

   **Response:** The Department notes that reimbursement rates are beyond the scope of this rulemaking. Additional requirements to this licensing rule are aimed to enhance the health and safety of residents in licensed children’s residential care facilities. No changes were made to the rule based on this comment.

4. **Comment:** Commenters 1 and 11 noted that during the development of the rule, there was discussion of adding “deemed status.” Commenter #1 stated that her organization has obtained certification from the Joint Commission and that the requirements for the Joint Commission are higher than the licensing standards. Commenter #11 added that this rule does not reflect statutory changes signed into law in 2011, mandating that the Department create deemed status for providers who hold a national accreditation. The commenters recommended that the Department add deeming to the rule.

   **Response:** Deeming has more to do with federal payment than it does with licensing standards. It is unclear whether deeming applies to psychiatric facilities which are not psychiatric hospitals. Approval from the Joint Commission would be only one criteria that a Level 2 facility would need to achieve in order to operate in Maine (See Section 8(D)(1)(a) of the rule). Also, the rule covers institutions providing this level of service that may only accept private payment. No changes were made to the rule based on this comment.

5. **Comment:** Commenters 2 and 9 stated that their organizations believe that a comprehensive support system is important for persons with development disabilities (DD) and that it should be provided in the least restrictive setting possible. The commenter added that Maine should invest in community system of care as the primary line of care and that the system needs to provide a wide continuum of services to meet the wide variety of needs for children with DD.

   **Response:** This licensing rule for children’s residential care facilities addresses a specific need within the State of Maine when community systems of care may not be an option. No changes were made to the rule based on this comment.

6. **Comment:** Commenter #3 noted that the Rulemaking Fact Sheet filed with the proposed rule stated that the proposed rule was intended to repeal outdated rules and replace those rules with a new updated rule. The commenter stated that the updated rule does not consider needed updates to the Rights of Recipients and needed updates to the statutes that govern these services. The Rights of Recipients, the commenter noted, need to be updated because they were last updated in 2000 and that the statutes are also outdated. The commenter concluded
that updating the licensing rule without updating the rest of the “framework” governing these services will lead to a fragmented system of regulations and will cause significant confusion.

Response: Updating the Rights of Recipients and governing statutes are beyond the scope of this rule. No changes were made to the rule based on this comment.

7. Comment: Commenters 2, 3, 9, 10, 17, 18 and 20 stated that Children’s Residential Care Facility with Secure Capacity and Psychiatric Treatment (Level 2), is being added to match Maine children’s level of need so that they do not need to be sent out of state to receive this level of service. The commenters stated that DHHS needs to conduct an overall system review and develop a plan to that will include adequate funding which would allow for greater access to community based services. Commenter #10 stated that the Department proposes to spend approximately $7 million on the treatment of approximately 40 children yet the problem of children waiting for community services is getting worse. Commenter #9 stated that providers are discontinuing home and community services as they cannot afford to provide the service through MaineCare’s current rates of reimbursements. The commenters stated that hundreds of children are on waiting list for community mental health and behavioral services.

Commenter #3 stated that, contrary to the belief that children are being sent out of state for a service similar to Level 2, children out of state are being served at less than a Level 2 service, such as PNMI services. Commenter #3 stated that this is occurring due to Maine’s staffing crisis and that many children are left waiting in emergency rooms, correctional facilities and psychiatric hospitals. These children, the commenters added, do not require a Level 2 service, but rather need home and community based services. Commenter #3 stated that the Department has not offered a proposal on how to address this problem and that the creation of Level 2 residential care facilities will not solve but exacerbate the problems with the children’s behavioral system.

Commenters 17 and 18 stated that Maine’s last comprehensive plan for mental health services was in 1997. The commenters pointed to the Department’s consultation with stakeholders such as the corrections and educational systems, parents and providers, as an example to follow before implementing Level 2 facilities. The commenters also recommended including additional stakeholders such as youth themselves and Disability Rights Maine. The commenters stated that without a comprehensive assessment of what youth need now and are likely to need going forward, authorizing Level 2 facilities appears to be a way to warehouse children who are languishing in emergency rooms or placed out of state. Commenters 17 and 18 stated that their organization is “incredulous” that these regulations seek to promote Level 2 facilities when community-based treatments are less expensive and generate better treatment outcomes. The commenters added that creating Level 2 facilities without expanding home and community-based wrap around services is bad policy.

Commenters 17 and 18 stated that without a comprehensive assessment and a careful process, Level 2 facilities are little more than a “hail Mary pass.” Commenter #15 cited a June 2016 report “Creating and Sustaining Fair and Beneficial Environments for LGBTQ Youth” released by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), that concluded that, “their voices must be included because these youths can provide vital input based on firsthand experience to inform the development of appropriate services and supports.” The commenter respectfully urged the Department not to skip the critical step of involving the community in the process and to listen carefully to the young people most impacted by the proposed rule, to understand what the best way to invest public funds and truly support Maine’s youth.

Response: This rule does not promote any type of treatment or facility. It provides for the licensure of children’s residential care facilities with secure capacity and psychiatric treatment (Level 2) to improve access to care by serving a population of the residents with a new level of service. The Department maintains that rather than living in an inadequately licensed facility or moving out of state, residents would be able to stay in Maine and receive the treatment that they need. Other comments do not specifically address this licensing rule and reach beyond the scope of this rule. No changes were made to the rule based on these comments.
8. **Comment:** Commenters 15, 17 and 18 stated that Level 2 facilities create direct access to the justice system as a result of a lack LGBT and trans-specific competency in the system. The commenters cited a report by the Maine Department of Corrections in 2017 which demonstrated that a third of the youth at Long Creek were referred from residential facilities. The commenters added that there is an over-representation of LGBT youth at Long Creek and estimated that 30-40% of Maine’s incarcerated youth identify themselves as LGBT. The commenters stated that LGBT people are also three times more likely to experience mental health issues than the population at large, LGBT youth in particular are four times more likely to attempt suicide, experience suicidal thoughts and engage in self-harm than their non-LGBT peers. The commenters stated that the youth are now calling for a quick reform of the residential treatment model in Maine. The commenters stated that the suffering and re-traumatization of the youth in the residential treatment system is creating a higher need for mental health interventions and psychiatric care. The commenters stated that it would be wrong morally and fiscally to move forward with the creation of new facilities without first completing a system-wide assessment of existing services and programs, so that no more harm happens in places meant for healing.

Commenter #15 stated that his organization’s youth members endure conditions in the community such as criminalization, incarceration, homelessness and poverty that are barriers to long-term health and wellbeing. Commenter #15 added that a facility-based approach perpetuates the isolation LGBT youth who are already experiencing a lack of family support and social bias by being cut off from natural supports. The commenter recommended the use of therapeutic, holistic, trauma-informed, community-based care and healing. Commenter #15 stated that the use of government funds into a community-based solution is a more long-term and cost-effective approach that will decrease the need for psychiatric care by addressing: lack of safe housing; inadequate physical and mental health resources; and discrimination.

Commenters 17 and 18 stated that their organization requests that the proposed rule be amended to address the concerns of GLBTQ Legal Advocates & Defenders, Disability Rights of Maine and the ACLU of Maine.

**Response:** The Department appreciates the challenges faced by the LGBT community, but does not dictate treatment modalities for any population within a licensing rule. This rule explicitly describes resident rights and prohibits discrimination based on sex or sexual orientation; 5(H)(1)(f). The Department believes that all residents, including members of the LGBT community, should be treated equally, fairly and with respect. A service plan would address the specific challenges of LGBT youth. No changes were made to the rule based on this comment.

9. **Comment:** Commenters 5, 8, and 9 stated that they are pleased that the Department is proposing a way to help children obtain the right level of service without languishing in emergency room hallways, jails cells, or out-of-state treatment facilities that Maine clinicians know very little about. The commenter added that youth in residential care have often failed at one or more community-based services and many have already been diverted away from the legal system prior to entering these programs. The commenter stated that two or three small, evidence-based intensive mental health residential treatment programs, specifically for those youth who clinicians have determined need this level of secure treatment, is a positive step.

**Response:** No changes were made to the rule based on this comment.

10. **Comment:** Commenter #3 stated that the proposed rule needs to address accessibility. The commenter added that staff, youth and families are required to be made aware of a variety of valuable information, such as grievance rights. The commenter’s organization recommends that this information that is required to be offered to youth and their families must not only be explained, but should also be put into accessible and plain language formats or pictures.

**Response:** The Department has added to Section 5(D)(2)(c), “in a way that is accessible and understandable to all residents.”
11. **Comment:** Commenter #5 stated that he understands that the rule is written for a wide-range of programs, staff, experience levels and abilities. The commenter added that he understands that there may be some programs that do not strive to provide the most effective and therapeutic service as possible. The commenter believes these programs are the exception and not the rule. The commenter stated that the rule is written with the assumption that providers are neglectful and lacking in professional and ethical morality. The commenter stated it would be better to assume that all programs wish to provide a high quality of service and generate excellent outcomes. The commenter stated that this rule will be used to restrict providers and encumber the treatment process by groups or individuals who have no experience working with or providing direct care behavior management and modification services to the most challenging youth in our communities.

**Response:** The rule sets objective standards to remove the subjectivity in regulating a wide-range of programs, staff, experience levels and abilities. The amendments to the rule are intended to address a trend of deficiencies which has been found over the course of licensing investigations. No changes were made to this rule based on this comment.

12. **Comment:** Commenter #8 stated that youth are being abandoned to care and that this trend is occurring with greater frequency as many parents do not wish to work toward reunification. The commenter stated that some families may not be able to provide adequate care for their child. The commenter stated that as a result, there is more frequent contact with the Department and Child Protective services. The commenter added that many children realize they will never be welcomed home, and this realization leads to hopelessness, behaviors and treatment regression. The commenter stated this condition is a significant contributing factor about why some youth may spend extended time in residential care facilities.

**Response:** This comment is beyond the scope of this rule as it does not address any of the standards in the rule. No changes were made to the rule based on this comment.

13. **Comment:** Commenters 17 and 18 pointed to the work that Minnesota has done to ensure that PRTFs (Level 2 facilities) are available to the limited population who might benefit from them. The commenters stated that Minnesota’s emphasis is on providing top-notch supports and services in the community and integrated settings. The commenters stated that Minnesota’s process began with a governor-appointed subcabinet in 2012, which was tasked with creating a comprehensive plan to support freedom of choice and opportunity for people with disabilities. The commenter stated that for over three years this subcabinet, chaired by the lieutenant governor and staffed by the heads of various departmental agencies, created a comprehensive plan to ensure the rights of Minnesotans with disabilities. That commenters highlight:

…the plan: Set forth clearly defined statistical goals to ensure people with disabilities are treated in the most integrated setting possible;

- Expanded person-centered planning to keep persons with mental health issues as integrated as possible in their communities by expanding access to home and community based treatments;
- Encouraged those in residential treatment facilities and psychiatric hospitals to, transition into the least restrictive forms of treatment;
- Provided funding for Minnesotans with disabilities to fully integrate themselves in their communities with employment and housing;
- Authorized use of PRTFs as part of a larger comprehensive plan that includes a wide variety of home and community-based services for children with mental illness; and
- Was based on a survey performed in 2014 and a more comprehensive study performed in 2015 identifying the number of children in need of the specific type of health services provided by a PRTF.
Response: The comments are beyond the scope of this rulemaking as it does not address any of the licensing standards in the rule. No changes were made to the rule based on this comment.

14. Comment: Commenters 17 and 18 stated that the use of Level 2 facilities, is not supported by data on the best practices for efficiently increasing mental health outcomes for children. The commenters stated government-commissioned studies show that home and community based treatments are more effective and efficient for improving mental health treatments. The commenters referred to a 2005, Medicaid demonstration waiver program that tested the efficacy and efficiency of community based alternatives to Level 2 facilities. During the demonstration waiver, the commenters stated, nine states implemented programs which transitioned youth out of or diverted youth away from Level 2 facilities and into community based treatment plans. The commenters stated that the conclusion was that home and community-based services maintained or improved patient outcomes, increased satisfaction for youth and their families and decreased costs. The commenters stated that Maine should follow the success of this study and expand its community-based programs instead of creating Level 2 facilities. The commenters stated that Maine is full of informed, compassionate people who could likewise develop data-informed plans to ensure that children have access to the right services in the right settings.

Response: As noted in the response to Comment #7, this rule does not promote any type of treatment or facility. It provides for the licensure of children’s residential care facilities with secure capacity and psychiatric treatment (Level 2) to improve access to care by serving a population of the residents with a new level of service. The comments are beyond the scope of the rule. Section 5(K)(9)(c) of this rule has been amended to state that periodic reviews of a resident’s service plans should include “the consideration of less restrictive alternatives.”

SECTION 1. PURPOSE AND SCOPE

15. Comment: Commenter #3 asked what other types of programs fall under this rule that are not either mental health or substance abuse treatment programs.

Response: There are children’s residential facilities covered by this rule that do not provide treatment, such as the pregnant and parenting program and transitional living programs (for example from shelter to home). No changes were made to the rule based on this comment.

16. Comment: Commenter #11 stated that it would be helpful if this section referenced the primary statutes that apply to the oversight of children’s residential care facilities.

Response: Statutory authority may be found on the last page of the rule. No changes were made to the rule based on this comment.

17. Comment: Commenters 17 and 18 stated that the proposed rule shows “extraordinary and unwarranted bias to state-financed contractors” who serve vulnerable populations and who can pick and choose their clients. The commenters stated that this “deference” is present throughout the regulations. The commenters referred to the “extensive” comments of Disability Rights Maine (DRM), as examples of this deference, specifically DRM comments to Sections 5(E)(1)(d) and 5(E)(4).

Response: Please see the Department’s response to Comment #74. The Department has revised Section (5)(E)(1)(d) in response to Comment #74 and has determined that this revised section of the rule adequately balances the needs of prospective residents and the facilities.

18. Comment: Commenters 17 and 18 stated that they oppose the double standards in the rule that allow for different rights, protections for clients and staff qualifications in residential facilities and for Level 1 and 2 facilities. The commenters stated that they believe that maximum protections and qualifications should apply equally to all facilities.
Response: The qualifications of staff and program requirements differ based on the various levels of care within the rule. The Department has determined that the requirements are appropriate for the levels and programs covered within this rule. No changes were made to the rule based on these comments.

SECTION 2. DEFINITIONS

19. Comment: Commenter #2 thanked the Department for acknowledging the use of chemical restraints in Section 2(A)(7), adding that many professionals believe this practice to be unethical. The commenter stated that alternative practices need to be identified to improve the lives of individuals with developmental disabilities.

Response: The Department refers the commenter to the Department’s response to Comment #199. The Department has amended the rule by removing the term, chemical restraints and its definition. The term “chemical restraints” has been replaced with “PRN psychotropic medications.” Section 8(C)(7) prohibits the use of PRN psychotropic medications for the purpose of sedation in Level 1 and Level 2 facilities.

20. Comment: Commenter #3 stated that the definition for children’s residential care facility at Section 2(A)(9) does not include a family foster home, but asked, whether it included a therapeutic foster home.

Response: Foster home licensing is covered under 10-148 CMR, Chapter 15, Rules for the Licensing of Specialized Children’s Foster Homes and 10-148 CMR, Chapter 16, Rules for the Licensing of Family Foster Homes for Children. No changes were made to this rule based on this comment.

21. Comment: Commenters 11 and 12 stated that the definition for children’s residential care facility in Section 2(A)(9), allows for a facility to be licensed for more than one residence, but asked how the licensing rule avoids the potential for several residences licensed together to constitute an institution for mental disease (IMD) that would be ineligible for Medicaid funding if the license covers more than 16 beds. The commenters asked if there is more recent information available that would update the prior advisement that a children’s residential program with a mental health program ought not to be licensed for, or functionally serve, over 16 clients to avoid IMD status. The commenters stated they were not sure how capacity would be addressed under this definition and asked whether this arrangement is acceptable to other stakeholders like MaineCare and Kepro. The commenters asked if it is the intent of the Department to consolidate licenses held by agencies.

Response: This rule covers licensing requirements and does not address reimbursement mechanisms for services. The Department has created an option to consolidate multiple facilities on one campus. No changes were made to the rule based on this comment.

22. Comment: Commenters 11 and 12 stated that the definition for critical incident in Section 2(A)(14), in the first sentence is too broad and they recommended its removal. The commenters recommended revising the definition. The commenters stated that “Serious illness” should be removed as it is not an occurrence resulting from agency or client action and would not be an incident subject to licensing review. The commenters also stated that “Severe psychiatric episode” should be removed adding that it also is too vague. The commenters stated that critical incidents could include accidents or medication errors resulting in a need for emergency medical treatment.

Response: Based on a review of this comment, the Department removed “Critical incidents” in Section 2(A)(14) and replaced it with “Reportable event” in Section 2(A)(40). The Department has clarified the reporting requirements, timeframes and methods for reportable events in Section 5(E)(4).

23. Comment: Commenters 11 and 12 stated that the definition of “Department or DHHS” in Section 2(A)(15) is confusing as it does not identify the unit concerned within the Maine CDC and would require amendment of the rule should there be another internal reorganization within DHHS. The commenters recommended using “DHHS” and that “Licensing Unit,” should be defined to mean the Children’s Licensing Unit, either within the Maine CDC or within any other division of DHHS to which it may be assigned. The commenters added that subsequent
references to the Department or DHHS in the rule should be changed to Licensing Unit wherever the specific unit is intended.

Response: The definition of “Department or DHHS” has been clarified to mean, the Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention, Children’s Licensing and Investigation Services.

24. Comment: Commenter #3 stated that a definition of “delayed egress” should be included and recommended the language, “Delayed egress means any doors that do not open immediately when pushed or pulled.”

Response: Delayed egress is not mentioned elsewhere within the rule. The Department has determined that a definition for delayed egress would not add further clarity to the rule. No changes were made to the rule based on this comment.

25. Comment: Commenter #3 requested the addition of the word “isolation” to the definition of emergency safety intervention in Section 2(A)(21).

Response: The Department finds that the definition of emergency safety intervention is sufficient to meet the needs of the rule. No changes were made to the rule based on this comment.

26. Comment: Commenter #3 recommended updating the definition of “Emergency safety situation” in Section 2(A)(22), to read an unanticipated resident behavior that places the resident or others at serious risk of harm if no intervention occurs and that calls for an emergency safety intervention.” Commenter #11 stated that the term, unanticipated is vague.

Response: The Department has amended the definition of emergency safety situation as a “behavior that places the resident or others at serious risk of harm if no intervention occurs.”

27. Comment: Commenter #12 stated that regarding the definition of interactive telecommunication system in Section 2(A)(25), MaineCare’s telehealth policy permits telephone use if multimedia equipment is unavailable. The commenter added that the licensing rule should also allow telephonic telehealth, if appropriate to the service and when multimedia equipment is not available.

Response: The Department has added to the definition of interactive telecommunication system, “Telephonic telehealth may be used when no other means are available and if appropriate to the service.”

28. Comment: Commenter 10 stated that there needs to be more clarity between isolation and seclusion in Sections 2(A)(26) and 2(A)(43). The commenter stated that isolation is defined as removing a resident from a stimulus by use of involuntary separation and restricted activity, isolation may mean restriction with adequate supervision in an unlocked room, isolation does not mean confinement in a locked room.” This is confusing, because seclusion is allowed only in Level 1 and 2 facilities, but isolation is allowed in any residential facility whether or not it is secure.

Response: The Department clarified the definition of isolation by adding that “egress is allowed”.

29. Comment: Commenter #3 in referring to isolation in Section 2(A)(26), asked how the definition of isolation differs from time out; if a child is isolated, whether he/she be in a room with egress prevented; how a locked door is different than a doorway with egress prevented; whether isolation is only when other children are removed from the individual child’s proximity, or whether it would also be considered isolation when the individual child is removed from the location where he/she originally was; if so, how isolation differs from seclusion?
Response: Please see the Department’s response to Comment #28. Seclusion is not permitted in any residential setting; however, they are allowed in Level 2 facilities. During isolation, there is an opportunity for the staff to engage in a therapeutic intervention or de-escalation, while a locked door prevents that type of intervention. Isolation occurs when the child is removed from the situation or if others are removed from the area. In seclusion, the door is locked. No changes were made to the rule based on this comment.

30. Comment: Commenter #5 stated that many stakeholders and providers would be supportive of language in the definition for isolation in Section 2(A)(26), to allow for “holding a door shut.” The commenter noted that the Department of Education allows for the holding of a door shut during isolation and has rules that are much more lenient for isolation policy and procedure. The commenter added that a youth in their residential programs, while at school, can be in a room with the door held shut, yet when they are back at the residence, they cannot have this safety accommodation made. The commenter stated that this a safety accommodation; the ability to hold a door shut would likely prevent physical restraints and increase safety for youth and program staff. The commenter went on to say that while isolations are undesirable and are lacking in therapeutic value, they are not void of therapeutic value as was suggested in some testimony at the initial rule hearing. The commenter stated that isolations can be a tool for assisting a youth to regain stability and to begin to develop internal control and self-regulation mechanisms, adding that they should not be used as punishment.

The commenter stated that as a professional for 20 years, he has witnessed and participated in hundreds of restraints, the commenter sees the value in preventing their use. The commenter added that parents, if given a choice that their, “aggressive and dysregulated youth” was going to either be in a room with the door held shut, for 10 or 20 minutes, allowing for an opportunity to self-regulate or he or she was going to be pinned to the floor with 3-6 staff holding my child, they would choose the door 100% of the time. Commenter #11 stated that the Legislature has directed DHHS and DOE to define these interventions in a consistent manner.

Commenters 13 and 14 stated that the definition of seclusion in Section 2(A)(45), is narrower than the same definition in the Department of Education’s Chapter 33, Rule Governing Restraint and Seclusion, Section 2(19), a rule with which proposed DHHS rule Chapter 36 requires compliance. The commenters stated that by specifying that egress is denied only by a locking mechanism, the DHHS rule fails to cover situations in which egress might be denied by other means. The commenters added that facilities will be confused with the conflicting requirements of the rules. The commenters recommend that the Department use the definition from DOE Chapter 33. Commenter #11 stated that the Legislature has directed DHHS and DOE to define these interventions in a consistent manner.

Response: When balancing the interests of resident rights and evaluating the needs of residents and protecting them from harm, the Department determined that the use of seclusion (holding the door shut) is appropriate in only in Level 2 facilities. This is based on the higher acuity level of the residents served in those facilities, to protect themselves and others. The Department clarified the definition of seclusion to be consistent with Section 5(O)(4) of this rule to include holding the door shut by staff. Other options for intervention exist besides the use of isolation and restraint of a resident. The use of isolation can be an opportunity for staff to engage in de-escalation techniques with the resident. The Department strives to maintain consistency with other departments’ rules and laws; however, that is not always possible given the different roles and responsibilities of the departments. The Department was unable to determine the legislation that the commenter was referencing. No changes were made to the rule based on this comment.

31. Comment: Commenters 2, 13 and 14 asked that the definition of mechanical restraint in Section 2(A)(32), be amended to include the restraint of other body parts; “Mechanical restraint means the restriction by mechanical means of a resident’s mobility and/or ability to use his/her hands, arms or legs, head or body freely, except when such restriction is primarily for the treatment of a physical injury.”

Response: As a result of this comment, the Department has amended the definition of mechanical restraint per the commenters’ recommendation.
32. **Comment:** Commenter #2 stated that the definition for passive physical restraint in Section 2(A)(36), is new terminology for her, and added that physical restraints are not passive. The commenter requested that the word “passive” be removed from the definition as it doesn’t exist in the literature. The commenter stated that her organization is concerned that the word passive will lead people to think that this is a “gentler” or less serious type of restraint and is therefore more acceptable and less dangerous. The commenter requested the removal of the word passive throughout the rule, stating that the term is inconsistent when describing staff direct physical contact with a client. Commenter #2 requested that the definition of physical restraint be included to replace the definition of passive physical restraint; 2(A)(36). The commenter submitted, “physical restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement or normal access to his or her body. Physical Restraint does not include physical escort, physical prompt, or physical contact for the purpose of comforting a resident and the resident voluntarily accepts the contact.” Commenters 11 and 20 stated that the definition for passive physical restraint lists harming self and others as a reason but does not include property damage which is listed as a reason later in the rules.

**Response:** The word “passive” was removed from the definition of passive physical restraint. The Department has also amended the renamed definition of “physical restraint” to include “or engaging in excessive and continuous property damage.” “Passive” was also removed throughout the rule as recommended by the commenter.

33. **Comment:** Commenter #3 asked why there is a different definition of passive physical restraint in Section 2(A)(36), from restraint in Section 2(A)(45).

**Response:** Physical restraints are meant to be applied with the least amount of direct physical contact required, while restraints can include a physical intervention and a mechanical device. No changes were made to the rule based on this comment.

34. **Comment:** Commenter #2 requested the addition of a definition for physical escort, and submitted the following language for consideration, “Physical escort is the temporary touching or holding for the purpose of inducing a resident to walk to another location, including assisting the resident to the resident’s feet in order to be escorted.”

**Response:** The Department has included a definition of physical escort in Section 2(A)(33), per the commenter’s recommendation.

35. **Comment:** Commenter #2 stated that it is critical for individuals with DD to receive the best evidence based treatment. The commenter stated that physical prompts are often required and should not be confused with physical restraint. The commenter requested the addition of a definition for physical prompt, and submitted the following language for consideration, “Physical prompt is a technique described in the resident’s treatment plan that involves physical contact with the resident and enables the resident to learn or model the physical movement necessary for the development of the desired competency.”

**Response:** The Department has included a definition of physical prompt in Section 2(A)(38), per the commenter’s recommendation.

36. **Comment:** Commenter #11 stated that the definition of relative in Section 2(A)(42) needs a comma between the terms, “grandparent and uncle.”

**Response:** The Department has revised the definition of relatives per the commenter’s recommendation.

37. **Comment:** Commenter #3 recommended changing the definition of representative in Section 2A(40) to mean, “a person who has been designated in writing…” as the requirement to designate a representative in writing can be difficult.
Response: The Department requires the confirmation of a representative in writing as evidence that a representative has been designated by the resident or the resident’s legal guardian. No changes were made to the rule based on this comment.

38. Comment: Commenters 2 and 20 asked for more clarification and distinction between the definitions of Level 1 and Level 2 facilities in Section 2(A)(42). The commenters stated that both are locked and provide mental health services, but Level 1 residents do not require 24/7 supervision, while residents in Level 2 require 24/7 supervision. The commenter asked for clarification as to who might be served in each type of facility.

Response: In a Level 2 Facility, the treatment of a resident’s active psychiatric condition requires medical supervision 24 hours per day, seven days per week under the direction of a physician. Level 1 Facility residents are not required to have an active psychiatric condition for admission. Admission to a Level 1 Facility can be for individuals with challenging behaviors or persons with developmental disabilities who need a locked facility to prevent elopement. Whether an individual requires 24/7 medical supervision is determined by clinical staff. No change was made to the rule as a result of this comment.

39. Comment: Commenter #11 stated that there are definitions for the two levels of residential treatment facility with secure capacity; 2(A)(42), but there is no definition of a residential treatment facility. The commenter stated that the definition for children’s residential care facility 2(A)(9) defines children’s residential care facility, but the definition does not include any reference to treatment. The commenter stated that given the use of the word “children” in these definitions, it would be helpful to clarify that these facilities can serve individuals up to age 21.

Response: The definition for children’s residential care facility includes a children’s residential treatment facility. The definition of resident in this rule includes, an individual who receives children’s residential care facility services. Residents include children, and adults in care between the ages of 18 and 21. For the purpose of this rule, resident has the same meaning as client. No changes were made to the rule based on this comment.

40. Comment: Commenters 2 and 3 stated that Seclusion in Section 2(A)(45), is the same whether by a locking device or a person standing outside the door preventing it from being opened. The commenter requested that the definition be adjusted to read, “Seclusion means the solitary, involuntary confinement for any amount of time of a resident in a room or a specific area in which egress is denied. The phrase, “by a locking mechanism should be removed, adding that when a child is confined in a room, it is of no matter by what means the confinement is effected. Commenter#11 stated that the Legislature has directed DHHS and DOE to define these intervention in a consistent manner.

Response: The Department has determined that the definition of seclusion as defined in the rule is adequate. A locked mechanism is used in seclusion and is an important distinction between seclusion and isolation. An individual standing in a doorway allows for an opportunity to engage in de-escalation and is potentially less traumatic in a way that protects the resident and others. No changes were made to the rule based on this comment.

41. Comment: Commenter #11 stated that the definition of serious injury 2(A)(46) is vague and will result in inconsistent reporting. The commenter recommended that the Maine CDC and Office of Child and Family Services (OCFS) consult with each other to develop the definition. The commenter recommended that the Department look at definitions provided by 21 CFR § 803.3, and the definition provided by from OSHA’s Field Operations Manual.

Response: In response to this comment, the definition of serious injury was removed from the rule. The Department refers the commenter to the Department’s response to Comment #22 in regard to critical incidents.

42. Comment: Commenter #3 asked who initiates the time out in Section 2(A)(52). The commenter further asked, how does a time out differs from isolation; how the “period of time” is determined; and what happens if the resident wants to end the time out before the “period of time” is over.
Response: A time out can be initiated by staff or the resident. The length of the time out is determined by the individual needs of the child, the staff working with the child and the situation that preceded the time out. No changes were made to the rule based on this comment.

SECTION 3. PROGRAM ADMINISTRATION

3(A). Governing authority

43. Comment: Commenter #3 stated that in Section 3(A)(4), rather than “or,” it should be “and.” The commenter stated that the organization should have both a board of directors “and” an advisory board. The commenter added that an advisory board should ideally have at least one representative from the pool of clients and families that the provider serves, and if not, a means of obtaining regular and robust input from clients and families.

Response: Organizations are structured in various ways, such as for profit and non-profit. The licensing requirements are meant to establish a minimum standard. Nothing in this rule prevents an organization from having both a board of directors and an advisory board. No changes were made to the rule based on this comment.

44. Comment: Commenter #12 stated that a review of licensing surveys and plans of correction in Section 3(A)(7)(f), are inappropriate for review at the board of director’s level. The commenter stated that board review is impractical considering the board’s limited meeting schedule and lack of expertise in the details of licensing regulations. The commenter recommended removing this requirement as a governing body function.

Response: As a result of this comment, the Department has removed this requirement from the rule.

45. Comment: Commenter #12 stated that the administrator’s annual evaluation should be completed by the administrator’s immediate supervisor or, if the administrator is the organization’s CEO, by the governing body in Section 3(A)(7)(i). The commenter added that the normal supervisory hierarchy within the organization should be observed and the administrator could be below the CEO level. The commenter stated that it is typically the responsibility of the board of directors to evaluate the CEO, but not to evaluate lower managerial personnel.

Response: As a result of this comment, the Department has removed this requirement from the rule.

46. Comment: Commenter #12 stated that the present rules specify that notice must be given to the Department within two weeks of any legal proceedings related to the provision of services or continued operation of the facility. The commenter added that a two-week period, as opposed to the proposed two business days, should be retained as it is more appropriate to give time to review, respond to and report on legal proceedings considering their normal complexity and duration under current legal practice 3(A)(7)(k). The commenter felt that notice within two weeks would appear adequate to serve the licensing purposes.

Response: As a result of this comment, the Department has changed the notice period in Section 3(A)(7)(i) from “two business days” to “within two weeks.”

47. Comment: Commenter #3 requested an addition to Section 3(A)(7)(l), abuse and neglect in the facility. The commenter recommended adding to this section “The organization must ensure that direct access workers, students and volunteers do not abuse or neglect residents in care in any way, including physical, sexual or emotional abuse; and that reporting procedures exist that are transparent and accessible to residents and employees.”

Response: As a result of this comment the Department has updated this as renumbered Section 3(A)(7)(j) of the rule based on the commenter’s recommendation.
48. **Comment:** Commenter #12 stated that the requirement in in Section 3(A)(7)(l), “The organization (governing body) is responsible to ensure that staff does not abuse or neglect clients,” falls under the section on responsibilities of the governing body and should be removed. The commenter added that a volunteer board that meets a limited number of times a year cannot exercise day-to-day oversight of staff. The commenter stated that the board can establish policy on abuse and neglect. The commenter stated that the implementation of the policy must be the responsibility of managers and supervisors. The commenter stated that if it is intended that this rule will hold directors personally responsible for any abuse or neglect by staff, that this would require legislative action, because it is not within the authority of DHHS as a licensing matter. The commenter stated that this requirement would be inconsistent with laws protecting volunteer members of non-profit boards acting in good faith.

**Response:** Based on the Department’s review of this comment, the Department has reworded this requirement in a renumbered 3(A)(7)(j) to hold the governing authority responsible for assuring that when the board learns of allegations of abuse and neglect, it must assure that the allegations have been reported appropriately.

49. **Comment:** Commenter #12 stated that allegations are not legal proceedings in Section 3(A)(7)(k). The commenter stated that the responsibility of an agency to report “alleged criminal activities” by agency personnel that impact programmatic or fiscal integrity of the organization or residents’ safety would immediately expose it to liability claims. The commenter added that DHHS lacks authority under the licensing rule to extend immunity from liability; extension of immunity to protect the agency from a private legal action would require legislative action.

**Response:** The Department refers the commenter to Maine statute 22 MRS § 4011 regarding the reporting of suspected abuse or neglect. The Department has the authority and the responsibility to ensure the safety and welfare of children in licensed residential care facilities, and this duty includes any allegations of criminal activities that may impact the programmatic or fiscal integrity of the organization. No changes were made to the rule based on this comment.

50. **Comment:** Commenter #12 expressed concern with Section 3(A)(9) that states that an agency, “must report any suspected fraud or abuse by providers, legal guardians or clients.” The commenter stated that private agencies should not be directed to be informants in these situations as it exposes them to liability claims without any immunity. The commenter stated that DHHS lacks authority under the licensing rules to extend immunity from liability and that extension of immunity to protect the agency from a private legal action would require legislative action. The commenter added that the proposed rule appears to be beyond the licensing authority of DHHS as it would extend to matters outside the scope of the facility’s operations and its care of clients.

**Response:** Under 22 MRS §4011, the Department has the authority and the responsibility to ensure the safety and welfare of children in licensed residential care facilities. Suspected fraud or abuse needs to be reported to the Department. An investigation by the Department will determine if the fraud or abuse is substantiated. No changes were made to the rule based on this comment.

3(C). Program Administrator

51. **Comment:** Commenters 4 and 12, stated that the time and method requirements for critical incident notification in Section 3(C)(1)(a), may not reflect DHHS’ Enterprise Information System (EIS) requirements. The commenters stated that the definitions are broad and not consistent with current reportable events. The commenters stated that depending on how one interprets the definition of critical incident, it could generate a considerable number of phone calls within the four-hour reportable time, overwhelming the system and staff at facilities. The commenters stated that any type of event which the licensing unit may want to review can be accessed through the OCFS reportable event system. The commenters also stated that this adds a significant administrative burden depending on how the system is established to make the calls. The commenters stated that if the licensing unit must receive its own reports then the Department should consider the following:
• The commenters recommended no telephone notice as the licensing unit lacks staff resources to respond on a 24/7 basis, the commenters recommended that the OCFS system should be relied on for this purpose. The commenters added that the proper role of the licensing unit is to review the agency’s actions and quality of care after the incident to assess compliance with licensing rules. The commenters added that these reports are typically provided to OCFS through EIS. Does the Department wish these to be reported to the Maine CDC independent of that system?
• The commenters asked how the providers will report when the Department is closed on weekends and holidays. The commenter recommended ten business days for the written notice to allow additional information to be obtained and for an initial assessment of the incident.
• The commenter stated that if an OCFS report has been made, the agency should be able to reference the OCFS report in lieu of submitting an additional report.

Response: The Department has amended Section 3(C)(1)(a) of the rule, to clarify the reporting requirements, timeframes and methods for reportable events for providers. The Department refers the commenters to the Department’s response to Comment #22 in regard to critical incidents.

52. Comment: Commenter #12 recommended removing the requirement to notify the Department within 24 hours if staff has been arrested or indicted for a crime alleged to have occurred at a site where services are provided as noted in Section 3(C)(1)(b). The commenter stated that arrests or indictments without a conviction are not events on which actions may be taken and do not constitute disqualifying events under the Maine Background Check Center Act, as only convictions and substantiations are disqualifying events. The commenter stated that no action could be taken by the agency or by DHHS based only on an arrest or indictment.

Response: The Department refers the commenter to Maine statute 22 MRS §4011 regarding the reporting of suspected abuse or neglect. The Department has the authority and the responsibility to ensure the safety and welfare of children in licensed residential care facilities. Alleged criminal activity that occurs at a facility needs to be reported to the Department, and the Department’s investigation will determine if fraud or abuse is substantiated. Background checks and reportable events are separate from the obligations of mandatory reporting.

3(D). Annual Program Evaluation

53. Comment: Commenters 2, 13, 14 and 20 stated that there should be a requirement for the facility to retain data electronically on the dates, times, and durations of each critical event for each resident in Section 3(D). The commenters stated that an audit trail should be maintained to back up the annual program evaluation and the Department should be given access to those records. The commenters recommended that the reports should also include the following information:

• The aggregate number of uses of restraint, categorized by the type of restraint used;
• The aggregate number of uses of seclusion;
• The aggregate number of uses of isolation;
• The minimum, maximum, median and mean duration of incidents of restraint, categorized by the type of restraint used;
• The minimum, maximum, median and mean duration of incidents of seclusion;
• The number of clients who sustained bodily injury related to the use of restraint or seclusion of those clients;
• The number of staff persons who sustained bodily injury related to the use of restraint or seclusion of a client.
Response: While the Department finds that this information may be helpful, it has determined that reviewing and tracking this reported data would extend beyond the basic licensing standards in this rule. No changes were made to the rule based on this comment.

54. Comment: Commenter #3 recommended adding to Section 3(D)(1), “The facility must complete an annual program evaluation. The process must include resident and family interviews. …”.

Response: As a result of this comment the Department has revised this section of the rule, per the commenter’s recommendation.

55. Comment: Commenter #3 recommended adding to 3(D)(1)(d), “Review of grievances and complaints, and responses thereto;…”

Response: As a result of this comment, the has amended this section of the rule to read, “Review of grievances and complaints, responses and outcomes;”

56. Comment: Commenter #12 stated that summarizing all incident reports is too broad of a requirement in Section 3(D)(1)(e). The commenter stated that agencies document many types of minor occurrences as incidents and that these would not need to be summarized and reviewed annually. The commenter stated that it would be appropriate to limit this to critical incident reports. The commenter stated that his organization agrees that review of restraint and isolation is appropriate. The commenter recommended against a review of frequency of elopements, as facilities lacking secure capacity often have elopements and these can occur with some frequency. The commenter stated that in these instances, elopements reflect client actions, not staff interventions and it is unclear how the frequency could be used or what actions could be planned based on elopement frequency data.

Response: As a result of this comment the Department has changed the requirement in 3(D)(1)(e) to read “Summary of reportable events.” The Department considers it is important to keep Section 3(D)(1)(F), “Frequency of use of restraints and isolation and the frequency of resident elopement.” This is information that can be used to make adjustments to program and staffing, which could result in a decrease of restraints, isolation and resident elopement.

57. Comment: Commenter #3 recommended adding to 3(D)(1)(F), “Frequency of use of restraints and isolation and the frequency of resident elopement, and plans to effect decreases in all of the above;”

Response: The Department has determined that this is not necessary for the licensing of children’s residential care facilities. No changes were made to the rule based on this comment.

58. Comment: Commenter #3 recommended adding to 3(D)(1)(i), “Frequency of unplanned discharges of residents in care, and plans to effect decreases; and”

Response: The Department has reviewed this comment and has determined that this addition would be beyond the scope of the licensing authority. No changes were made to the rule based on this comment.

SECTION 4. LICENSE APPLICATION REQUIREMENTS

59. Comment: Commenter #11 stated that the rule (Section 4) does not include any references to fees associated with applications or changes. The commenter asked whether this was intentional and if fees could be included.

Response: There is no fee associated with licensing applications for children’s residential care facilities. No changes have been made to the rule based on this comment.
60. **Comment:** Commenter #12 stated that requiring a bond or other financial instrument imposes a financial burden without apparent need in Section 4(A)(1)(b)(xii). The commenter stated that most agencies have more than sufficient financial resources to cover any business closure costs, as demonstrated by the financial information to be submitted. The commenter added that in the rule, the type and amount of the bond is not clear. The commenter stated that a bond or financial instrument should not be required for every application, but should be a requirement that the Department may impose if the financial information does not demonstrate adequate financial resources of the applicant.

**Response:** The Department has removed the phrase; “including record storage and access and evidence of the bond or other financial instrument that covers the costs associated with the close of business” from this section of the rule.

61. **Comment:** Commenter #3 requested the following additions to Section 4; “… and cell phones;” to Section 4(A)(1)(b)(xiii)(6); adding “Resident property” in a new Section 4(A)(1)(b)(xiii)(21); and adding “Copy of parent/resident handbook” to a new Section 4(A)(1)(b)(xiii)(22).

**Response:** The Department has added “cell phones and other electronic devices” to Section 4(A)(1)(b)(xiii)(6) and “parent/resident handbook” to Section 4(A)(1)(b)(xiii)(21). The Department has not added a resident property requirement to Section 4(A)(1)(b)(xiii) as it is beyond the scope of the health and safety standards in this rule.

62. **Comment:** Commenter #11 stated that the term, “diversion control” plan in Section 4(A)(1)(b)(xiii)(20), seems like a technical term that should be defined.

**Response:** The Department has added a reference in this Section of the rule to 5(N)(20)(b) which provides a description of a diversion control plan.

63. **Comment:** Commenter #11 stated that the term “documentary information” is vague, as it refers in the rule to documentation of changes when renewing a license, in Section 4(A)(1)(c)(ii). The commenter asked for the intent of this term?

**Response:** The Department has clarified this section of the rule by adding, “including, but not limited to, a change in policies, a change in the organizational chart, or a change in programming…”

**SECTION 5. CORE LICENSING REQUIREMENTS**

5(A). Service Types

64. **Comment:** Commenter #2 agreed that people may need Level 2 services, but was surprised to find that DD was not included in Section 5(A)(1)(e). The commenter requested that autism spectrum disorder (ASD) be removed and replaced with the more encompassing term, Developmental Disabilities.

**Response:** The Department has amended the rule at Section 5(A)(1)(e) to read as follows: “Services to treat persons with developmental disabilities (DD);”

5(D). Inspections

65. **Comment:** Commenter #3 stated that youth and families need to be “an integral part” of the inspection of providers, adding that they should be interviewed as part of the licensing inspection process in Section 5(D)(1)(d).

**Response:** In considering the commenter’s recommendation, the Department has added to this section of the rule, “…The Department may interview the resident’s guardian as necessary.”
66. **Comment:** Commenter #3 recommended adding to Section 5(D)(1)(e): “The Department must make diligent efforts to speak with residents and families as part of its regular inspections, and to be clear about its role and its independence from the providers.”

**Response:** The Department refers the commenter to the Department’s response to Comment #67.

67. **Comment:** Commenter #3 recommended adding to 5(D)(2)(a): “Complaints. The Department will accept complaints from any person, entity, or provider (such as a case manager, attorney, or agency) …”

**Response:** The Department believes that the term, “person,” used in this section of the rule is sufficient. No changes were made to the rule based on this comment.

68. **Comment:** Commenter #12 stated a grant of immunity regarding complainants, is not within the scope of authority of the DHHS in Section 5(D)(2)(a). The commenter stated that a grant of immunity from civil or criminal legal actions would require legislative action. The commenter concluded that the statement of immunity is legally ineffective and should be removed.

**Response:** The Department has removed this sentence from this section of the rule.

69. **Comment:** Commenter #12 asked for clarification of the toll-free number being referenced in Section 5(D)(2)(b) containing the requirement to post the Department’s toll free number for complaint investigations.

**Response:** The Department has added the toll-free numbers for Child Protective Services and Adult Protective services to this section of the rule.

70. **Comment:** Commenter #3 recommended adding to Section 5(D)(2)(c): “Organization’s grievance procedure. The facility must educate the residents and legal guardians in an accessible way about the organization’s written grievance procedure, and must include a signed resident notification of receipt of such education in the resident’s record; and must make grievance forms readily available to residents; and must provide any reasonable needed help to make the process accessible to residents and guardians.”

**Response:** The Department refers the commenter to the Department’s response to Comment #10 which changed the language to add that the grievance procedure must be communicated in a way that is accessible and understandable to all residents. Based on this change the Department has determined that any additional language is not necessary.

71. **Comment:** Commenter #12 commented on the investigation of rule violations, complaints, incidents, inadequate care and other matters and having investigations conducted on behalf of licensing. The commenter stated that the licensing unit is not a general complaint investigation division, its authority is limited to allegations of rule violations. The commenter added that the unit’s only recourse is to take action with respect to an agency’s license, which action must be based on violation of the licensing rules. The commenter stated that the scope of any investigation should be limited to the extent of any violation of the licensing rule. The commenter stated that for investigations done by others, the licensing unit lacks legal authority to delegate its duties and powers to others and that any investigation should be done by staff of the licensing unit.

**Response:** The licensing process can include the coordination with the Department’s Out of Home Investigations Unit, which is under the umbrella of the Children’s Licensing and Investigation Services, which is charged with investigating allegations of abuse and neglect in settings outside the home. Rights violations, such as abuse and neglect, results in licensing violations. No changes were made to the rule based on this comment.
72. **Comment:** Commenter #12 commented that the licensing unit has neither legal authority nor expertise to investigate violations of, or enforce State or federal laws or rules other than the licensing rules and recommended the removal of this part of the rule in Section 5(D)(2)(d)(ii).

**Response:** Children’s Licensing investigates violations or alleged violations within the scope of their authority and has the authority to report to, or refer to, other agencies as appropriate. No changes were made to this rule based on this comment.

5(E). Policies Required by Facility

73. **Comment:** Commenter #3 recommended adding to 5(E)(1)(b): “Intake, screening, and admission policies. The facility must have written policies and procedures for intake, screening, and admission processes, and a process to appeal a denial of admission.” The Department should strongly consider creating some criteria for the providers’ policies for admission.

**Response:** Children’s Licensing does not oversee the admission appeal process. Creating criteria for providers’ policies is beyond the scope of the rule. No changes were made to the rule based on this comment.

74. **Comment:** Commenter #12 commented on the denial of admission to a facility if the facility is not adequately designed to meet the need of a resident in Section 5(E)(1)(d). The commenter stated that “not adequately designed” could be challenged and that it would be more in keeping with applicable law to say that, “admissions may be limited if a prospective client’s needs cannot be met with reasonable accommodation that does not place an undue burden on the agency or constitute a fundamental change in the agency’s program or services.” Commenters 3, 17 and 18 recommended revising 5(E)(1)(d) to read; “Non-discrimination in providing services. The facility must not refuse admission to any resident on the grounds of race, sex, sexual orientation, religion, disability, or ethnic origin. The facility may limit admission, if the facility is not adequately designed to meet the specific resident’s needs. If the facility feels it cannot meet the resident’s specific needs, it must first consider any reasonable accommodation before limiting or denying admission. All federal and State disability laws and protections apply.”

**Response:** The Department has amended the rule, to remove the sentence: “The facility may limit admission, if the facility is not adequately designed to meet the specific resident’s needs.” In its place, the following language has been added: “Admissions may be limited if a prospective resident’s needs cannot be met with reasonable accommodation that does not place an undue burden on the facility or constitute a fundamental change in the facility’s program or services.”

75. **Comment:** Commenter #11 commented on the time frame in the rule to report the intent for an agency or facility to close, stating that the timeframe is too short and is tied to a board decision rather than a proposed closure date. The commenter added that decisions to close can be conditional and that a preferred timeframe would be “60 days prior to the closure date.” The commenter added if this must be timed to the decision of the governing board, “within 5 business days” could accomplish the same goal in Sections 5(E)(2)(a) and (c). The commenter asked whether the Department references the Maine CDC or would communication with the Commissioner’s office or OCFS constitute notification.

**Response:** The Department has amended Section 5(E)(2)(a) of this rule to reflect a timeframe of notification from 30 days to at least 60 days prior to the closure date, per the commenter’s recommendation. The Department has also amended the rule at Section 5(E)(2)(c) to state that the notification must occur one to five business days after the governing authority has made a determination to close. The Department’s Children’s Licensing and Investigation Services is the entity that receives the notification and refers the commenter to the Department’s response to Comment #24 where this has been clarified.
76. **Comment:** Commenter #2 requested that under reporting requirements for critical incidents in Section 5(E)(4), a requirement should be added that parents and guardians receive notification of the critical incident.

**Response:** The Department refers the commenter to the Department’s response to Comment #22 in regard to critical incidents. The requirement to notify parents and guardians of a reportable event can be found in Section 5(E)(4)(b).

77. **Comment:** Commenters 3, 17 and 18 recommended adding to Section 5(E)(4): “Critical incident response policy. Recognizing that some of the MaineCare referral and qualifying behaviors for residential treatment can also lead to and/or constitute critical incidents, providers are encouraged to utilize crisis when it is determined that outside resources are needed. The Department discourages the criminalization of the manifestation of youths’ disability. Critical incident response policies must recognize that the utilization of police by providers should be an emergency resource of last resort. Further, critical incident response policies must require a process by which the resident’s treatment team meets within 48 hours to review the treatment plan after a critical incident in which the police or crisis is called.”

**Response:** As a licensing rule, any recommendations or comments related to MaineCare service coverage policies are outside the scope of this rulemaking. No changes were made to the rule based on this comment.

78. **Comment:** Commenter #3 stated that the Department should strongly consider creating criteria for the providers’ policies for managing critical incidents in Section 5(E)(4).

**Response:** The Department refers the commenter to the Department’s response to Comment #22 in regard to critical incidents.

79. **Comment:** Commenter #11 stated that critical incident reports are typically provided to OCFS through EIS and referred from there to licensing staff in Section 5(E)(4). The commenter also stated that the OCFS Reportable Event Matrix requires a call to Child Protective Services a report to EIS within four hours for death of a resident. The commenter recommended that the requirements should be aligned.

**Response:** The Department refers the commenter to the Department’s response to Comment #22.

80. **Comment:** Commenters 3, 10, 17 and 18 commented about the frequent use of law enforcement at residential facilities in Section 5(E)(4). Commenters 10, 17 and 18 cited an August 2017 report, released by Disability Rights Maine that stated over the course of 13 months, children’s residential facilities in Maine made 815 separate phone calls to police and that the majority of these calls were for reasons related to the youth’s disability treatment needs. The commenters added that despite a requirement that residential providers report law enforcement calls to the Department, it was shown that 59% of their calls to police went unreported. Commenter #10 stated that these calls lead to the criminalization of juvenile mental health problems. Commenter #10 also cited a January 2017 report by the Maine Department of Corrections that reported nearly one-third of residents at Long Creek Youth Development Center were sent directly from youth residential facilities. The commenters stated that the Department must do more to protect youth from being criminalized because their residential facilities fail to adequately treat them. Commenters 17 and 18 stated that with adequate training, facilities could manage the large majority of such behaviors themselves. Commenter #10 recommended that the Department be clear in the rule that calls to law enforcement are a critical incident and that facilities must report these calls. Commenter #10 added that the Department should then perform its oversight duties by using calls to law enforcement as data. Commenter #10 added that DHHS should require children’s residential facilities to review calls they make to law enforcement to identify trends and take steps so that they might avoid calling law enforcement in the future. The Department should also undertake this analysis.

**Response:** Much of this comment is beyond the scope of this licensing rule so no change to the rule has been made as a result of this comment. In regard to what constitutes a critical incident, the commenter is referred to the
Department’s response to Comment #22. The Department notes that with the redefinition of critical events as reportable events, there is more clarity of what is included; some of which could entail a call to law enforcement. No changes were made to the rule based on this comment.

81. **Comment:** Commenter #12 commented on Section 5(E)(4)(a), “Critical incident policy must cover critical incidents, and also other critical or potential critical incidents. Critical incidents are reported to the placing or responsible agency; deaths are reported to the licensing unit.” The commenter stated that from the reference to the placing agency, the intended reporting process is unclear. The commenter added that if it is intended that OCFS reporting should be done, then it should be clarified. The commenter added that if it is intended that the licensing unit receive notices other than for deaths, then the commenter is unclear why duplicative reports are necessary. The commenter stated that the proposed rule refers vaguely to ‘potential’ or ‘other’ critical incidents, which are there is no way to determine what should be addressed in these categories. The commenter recommended removing these two terms.

**Response:** The Department refers the commenter to the Department’s response to Comment #22 in regard to critical incidents.

82. **Comment:** Commenter #3 stated that vocational, pre-vocational services and life-skills training appropriate to the age and abilities of the residents should be at least in part covered by the residential treatment plan in addition to the educational treatment plan 5(E)(5). The commenter added that it is very important to note that neither an individualized education plan nor eligibility for special education, may be a precondition of eligibility or admission for a residential treatment program. The commenter concluded by stating that this should be explicit in a provider’s policies.

**Response:** Service plans are individualized based on the comprehensive assessment. If vocational services are needed, then a goal would be added to the resident’s individualized service plan. The licensing rule does not cover eligibility for admission. No changes were made to this rule based on this comment.

83. **Comment:** Commenter #12 stated that policy requiring clients not in school to be either employed or enrolled in a vocational or life skills training program, should just require the training programs to be offered or arrangements be in place to make them available in Section 5(E)(6)(a). The commenter stated that a client cannot be compelled to participate in the training programs. The commenter stated that it should be clarified that this requirement should not apply to school vacation periods.

**Response:** In response to this comment, the Department has revised this section of the rule to read, “Ensure that any resident not required to attend school is either offered the opportunity to be gainfully employed or be enrolled in a training program geared to the acquisition of suitable employment or necessary life skills.” The Department notes that students on vacation are still enrolled in school.

84. **Comment:** Commenter #3 asked how work provides a “family experience” for residents, as noted in Section 5(E)(6)(b).

**Response:** Work assignments in a residence should only be assigned to a resident, as they would in a family or home setting. The Department clarified and amended this section of the rule to read, “These assignments include gardening, cleaning or similar household chores. Residents must be paid if the resident is doing anything other than chores consistent with the age of the resident.”

85. **Comment:** Commenter #1 stated that under recreational activities, activities that are consider risky or unsafe would require an additional release in Section 5(E)(7). The commenter stated that the word “unsafe” is open for interpretation.
Response: As a result of this comment, the Department has changed “unsafe” to read, “potentially high risk” and has included examples of potentially high risk activities, including, zip lining, horseback riding or swimming.

86. Comment: Commenter #3 recommended adding to 5(E)(7)(a): “Assessing the ability of a resident to participate in a potentially dangerous or unsafe recreational activity before permitting a resident to do so, but not unnecessarily limiting opportunities;”

Response: The Department refers the commenter to the Department’s response to Comment #85.

87. Comment: Commenter #3 recommended adding to 5(E)(7)(c): “Identifying a range of indoor and outdoor recreational and leisure activities that are available including community recreational activities based on the interests and needs of the residents receiving services in the residential care facility – the maximum that is possible and appropriate.”

Response: The term “range” is sufficient for the Department to determine compliance with this policy. No change was made to this rule based on this comment.

88. Comment: Commenter #3 stated that that the licensing rule may not conflict with the Rights of Recipients of Mental Health Services (RRMHS) and that the rights differ for children under 18, Rights of Recipients of Mental Health Services who are Children in Need of Service and for persons over the age of 18, RRMHS in Section 5(E)(9).

Response: The Department is not aware of any conflict between the licensing rules and the Rights of Recipients. The licensing rule applies to all facilities that may or may not provide mental health services. No change was made to this rule based on this comment.

89. Comment: Commenter #3 stated that the Department should strongly consider creating some criteria for the providers’ policies for discharges in Section 5(E)(13).

Response: The Department has determined that establishing criteria for discharge would exceed its licensing authority, therefore no changes were made to the rule based on this comment.

90. Comment: Commenter #3 recommended revising Section 5(E)(15), “Record management policy. The organization must have a written records management policy. Confidentiality, resident access to his/her record, and any exceptions thereto must be in compliance with the Rights of Recipients of Mental Health Services who are Children in Need of Service, Part A(IX). The organization’s records management policy must include objective criteria to determine when to allow a resident to access his/her record.”

Response: The licensing rule applies to all facilities that may or may not provide mental health services. No change was made to this rule based on this comment.

91. Comment: Commenter #3 recommended adding to 5(E)(17) in reference to community interactions: “The priority is the resident’s maximum appropriate and reasonable access to the community. If that standard is not consistently being reached, the policies must dictate that the resident’s treatment team will meet to assess what changes are needed to the treatment plan, and adjust accordingly.”

Response: Section 5(K)(9)(a) provides for a review of the service plan and periodic updates, as needed, by the treatment team. It further notes that the review must include evaluation of progress toward established goals. This review would include a review of the resident’s use of community resources. No change was made to the rule based on this comment.
92. **Comment:** Commenter #2 requested that grandparent rights also be included in the rule along with parent and guardian rights in Section 5(E)(18).

**Response:** The Department does not specifically limit grandparent rights. If grandparents are the legal guardian, they would be included. In addition, Section 5(K)(3) requires that a resident’s service plan team must also include, “other significant persons involved in the resident’s life.” No changes were made to the rule based on this comment.

93. **Comment:** Commenter #3 stated that under 5(E)(18)(a), (b) and (c), all policies on telephones, communication, visitation, and privacy must comply with RRMHS who are Children in Need of Service and RRMHS for adults.

**Response:** The licensing rule applies to all facilities that may or may not provide mental health services. No change was made to this rule based on this comment.

5(F). Records Required by Facility

94. **Comment:** Commenters 11 and 12 stated that unless they have been specifically made part of the electronic health record (EHR) by scanning or other means, emails and text messages are not part of the client record and are not part of the designated record set. The commenters stated that emails and text messages outside the EHR are not organized or retrievable and are not maintained for any particular period of time. The commenters added that if they happen to have been preserved and can be readily retrieved, they can be made available for a licensing review or investigation, but there should be no requirement of retention or accessibility and they should not be designated as parts of the client record. The commenters would like clarification that emails and text messages do not have to be incorporated into the resident’s record and are not subject to the retention rule articulated in 5(F)(1)(b) and (d). The commenters also added it would be helpful to clarify that an electronic signature would be acceptable.

**Response:** As a result of this comment, the Department has added, “when available and made part of the electronic health record” to Section 5(F)(1)(b). The Department has also added to this same section of the rule: “Electronic signatures are an acceptable form of documentation.”

95. **Comment:** Commenter #11 stated that the requirement for identifying the “marital status,” in Section 5(F)(3)(e)(ii), of a resident’s parent seems intrusive and unnecessary. The commenter added that if the intent of this requirement is to clarify parental rights or custodial arrangement, then current court documents should be required in the record. The commenter concluded that requiring marital status may result in stigmatization.

**Response:** As a result of this comment, the Department has removed “and marital status of the parent(s) of the resident” from this section of the rule.

96. **Comment:** Commenter #3 recommended adding to Section 5(F)(3)(f): “Incident reports. Records of special or critical incidents, including all accidents, restraints, personal injuries …”

**Response:** The Department refers the commenter to the Department’s response to Comment #22 in regard to critical incidents.

97. **Comment:** Commenter #3 recommended adding to Section 5(F)(3)(h): “Resident access to resident’s record. A resident or the resident’s legal guardian must be permitted may access to the resident’s records in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).”

**Response:** There are occasions when it may not be clinically appropriate for a resident or their legal guardian to access their resident records. There may also be occasions when it is not warranted for the legal guardian to access
the records, for example, a legal guardian may be named as an abuser of the resident. No changes were made to the rule based on this comment.

98. **Comment:** Commenter #3 recommended revising Section 5(F)(3)(i) to read: “Denial of resident access. If serious harm is likely to result from a resident’s review of his/her record, the facility may deny, or otherwise limit, a resident's access to part or all of the resident’s record, in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).

   i. Procedure to determine harm and denial. The organization’s record management policy must designate a clinical person include objective criteria to determine when it would be harmful to allow a resident to access his/her record in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).

   ii. Written findings. The organization’s decision to deny a resident’s access to his/her record must be based on a clinical determination in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).

   iii. Review of findings. The organization’s administrator or designee must review the findings and approve or deny a resident’s access to the resident’s record in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).

   iv. Decision. The organization must render a written decision, including the findings of fact, to deny a resident’s access to part or all of the resident’s record. The decision is included in the resident’s record in accordance with Section E(15) of this rule and RRMHS – Children, Part A(IX).”

**Response:** The licensing rule applies to all facilities that may or may not provide mental health services. No change was made to this rule based on this comment.

5(G). Reporting Requirements

99. **Comment:** Commenters 13 and 14 stated that in Section 5(G)(5), the reporting of critical incidents is inconsistent with Section 5(E)(4)(c), which indicates that the parent or guardian must be informed of a critical incident or potential critical incident within 24 hours. The commenters recommended including the requirement to notify the parent or guardian.

**Response:** The Department refers the commenters to the Department’s response to Comment #22 in regard to critical incidents.

100. **Comment:** Commenters 2, 13 and 14 recommended that additional reporting requirements in Section 5(G), should be added, per incident, for restraints, isolation and seclusions. The commenters stated that the parent or legal guardian should be notified in an “expeditious manner.” The commenters requested that the following language be added to the rule, “an administrator or designee shall notify the parent or guardian of any critical incident and any related first aid as soon as practical but no later than 2 hours following the incident.” The commenters added that requirements should include the reporting of the antecedents, and the less restrictive alternatives tried prior to the event. The commenters recommended adding the following reporting requirements for all incidents of restraint, seclusion, or isolation:

   • Documentation of the beginning and ending time of each restraint, isolation or seclusion;
   • Total time of the restraint, isolation or seclusion;
   • Description of prior events and circumstances immediately before the restraint, isolation, or seclusion was employed;
   • Less restrictive interventions tried prior to the use of restraint, isolation, or seclusion. If none used, explain why;
- The behavior that justified the use of restraint, isolation, or seclusion;
- A detailed description of the restraint, isolation, or seclusion used;
- Staff person(s) involved, their role in the use of restraint, isolation, or seclusion and their certification, if any, in an approved training program;
- Description of the incident including the resolution and process of returning to program, if appropriate
- If resident or staff sustained bodily injury, the date and time of medical personnel notification and treatment administered, if any;
- Date, time, and method of parent or guardian notification.

Response: The service plan is the appropriate way to address whether a parent is notified after every use of restraint, isolation or seclusion; see Section 5(K)(5)(a). Requiring this additional information would extend beyond the core health and safety licensing standards. No changes have been made to the rule based on this comment.

101. Comment: Commenter #3 recommended adding more specific information such, as phone number, to Section 5(G)(2)(a) detailing how to make a report of rights violations.

Response: As a result of this comment, the Department has revised this section of the rule to include the toll free numbers for Adult Protective Services and Child Protective Services.

102. Comment: Commenter #11 recommended revising Section 5(G)(2)(a) from “Documentation will be maintained in the facility…” to “Documentation will be maintained within the facility’s record system.”

Response: As a result of this comment, the Department has revised this section of rule, per the commenter’s recommendation.

103. Comment: Commenter #11 asked whether the reference to the Department in 5(G)(3)(b) referred to the Maine CDC.

Response: Please refer to the Department’s response to Comment #23.

104. Commenter: Commenter #12 stated that the inclusion of critical incident reporting in Section 5(G)(5)(A), is duplicative and should be removed, adding that it should be set out in one place within the rule.

Response: The Department refers the commenters to the Department’s response to Comment #22 in regard to critical incidents.

105. Comment: Commenter #12 stated that it is understandable that the licensing unit may want to know of criminal activity allegedly to have occurred on the licensed premises but added that the need for immediate notice is unclear in Section 5(G)(5)(b). The commenter stated that licensing personnel would not be able to intervene in a police investigation. The commenter recommended allowing ten business days to report to allow the agency more time to compile information about the alleged criminal activity.

Response: The Department does not intervene in police investigations, but may work with the facility to assure immediate protection of resident safety. No changes have been made to the rule based on this comment.

106. Comment: Commenter #12 stated that when notifying a legal guardian of “averse [sic], or potentially adverse, event” the term is extremely vague in Section 5(G)(5)(d). The commenter requested clarification, adding that all of the provisions on critical incident reporting already cover all appropriate reports. The commenter stated that this additional, undefined reporting requirement should be removed.
Response: As a result of this comment, the Department has removed this language from the rule.

5(H). Rights of Residents

107. Comment: Commenter #5 stated that residential programs are tasked with the behavioral and emotional treatment of problematic behaviors and symptoms, involving the safety and well-being of the client, but also the safety and well-being of peers, staff, and the community. The commenter stated that by impeding the program’s ability to provide this structure and stability, it will negatively impact length of stay, positive outcomes, and transition planning. The commenter stated that implementing policies and regulations that may “feel good” to some at the expense of the long term positive outcome is not sound. The commenter concluded by stating that decreasing a program’s and family members’ ability to manage and stabilize the environment does nothing to increase outcomes or treatment benefit.

Response: This licensing rule does not determine or direct specific methods of treatment. The purpose of the rule is to establish foundational health and safety standards for the licensing of children’s residential care facilities. No change was made to the rule based on this comment.

108. Comment: Commenter #11 stated that the use of the term “of common areas” in Section 5(H)(1)(I) is vague. The commenter asked whether a facility would have to get the consent of all guardians to search a common area of a residence. The commenter also asked whether regular and routine safety sweeps of common areas must be documented.

Response: The Department considers the use of the term “common area” appropriate to describe areas of the residence that are shared in common by residents and staff. That Department has updated this section to state “routine or regularly scheduled safety sweeps of common areas do not require documentation.”

109. Comment: Commenter #2 stated that Section 5(H)(1)(o) should require a resident to have a transition plan. The commenter stated that transition plans should contain a discharge plan and provide support through a care coordinator to assist with the transition to home or other settings. The commenter requested the addition to the rights of resident section that specifies the right of a discharge plan and the right of a transition plan. The commenter stated that a transition plan should begin upon admission and include the goal at which the member will be ready for discharge and amended as appropriate throughout the client’s treatment.

Response: The Department considers the discharge requirements and service plan requirements to be sufficient for this licensing rule. No change was made to the rule based on this comment.

110. Comment: Commenter #12 stated that DHHS, under its licensing power, does not have legal authority to require a private agency to maintain a client/agency relationship with a particular client; Section 5(H)(1)(o). The commenter stated that the client/agency relationship, “by law,” is of mutual consent and that either party may choose to terminate it. The commenter stated that a change in this basic legal premise would require legislative action. The commenter stated that licensing power can extended to how discharge occurs, such as by requiring aftercare planning, but not to a provider’s decision that discharge will occur. The commenter concluded that as the “right of continued residence” is beyond the legal, licensing authority of DHHS, it should be removed. The commenter stated that a number of additional, appropriate grounds for discharge should be recognized, including: loss of funding for the placement; lack of substantial progress in treatment; and failure of the client/family to comply with program expectations.

Response: The Department’s interest is in assuring that a resident received appropriate care and that it does not abruptly end, resulting in a health or safety risk to that resident. Section 5(H)(1)(o), has been changed to read, “Right to discharge planning.”
111. **Comment:** Commenter #11 stated that in Section 5(H)(1)(o)(i), the use of the term “tenancy” is concerning. The commenter stated that children and young adults in facilities covered by these rules are not tenants and that tenancy is a technical term with numerous legal ramifications. The commenter recommended the use of the phrase “continued stay” instead.

**Response:** The Department has reviewed this section of the rule based on this comment and has removed sections 5(H)(1)(o)(i) through (iii).

112. **Comment:** Commenter #3 recommended revising Section 5(H)(1)(o): “Rights regarding transfer and discharge in residential care. Each resident has the right to continued residence. The facility must show documented evidence of strategies used to prevent involuntary transfers or discharges. A resident must not be transferred or discharged involuntarily. A resident may, when warranted, be sent for medically or psychiatrically necessary care to a higher level of care, but a provider cannot formally discharge a resident without a safe long-term discharge option. An emergency room and the street are examples of unsafe discharge options. If the resident is at a higher level of care and there is a question of the appropriateness of return to the facility, the provider must at minimum keep the resident’s case open and remain actively engaged in planning with the resident’s team. – except for the following reasons:

i. When there is documented evidence that a resident’s tenancy constitutes a direct threat to the health or safety of him/herself or others;

ii. There must be documented evidence that the facility cannot meet the needs of the resident as the program is fundamentally designed; or

iii. The facility’s license has been revoked, not renewed or voluntarily suspended.”

**Response:** The Department has reviewed this comment and this section of the rule and has removed 5(H)(1)(o)(i) through (iii). Please see the Department’s response to comment #111.

113. **Comment:** Commenter #3 stated that communication rights must comply with the Rights of Recipients of Mental Health Services in Section 5(H)(1)(p).

**Response:** The licensing rule applies to all facilities that may or may not provide mental health services. No change was made to this rule based on this comment.

114. **Comment:** Commenter #11 stated that the sentence, “The facility must protect residents from unreasonable intrusions” in Section 5(H)(1)(p) is unclear and needs clarification.

**Response:** As a result of this comment, the Department has deleted this sentence from this section of the rule.

115. **Comment:** Commenter #12 recommended that mail and electronic communications not be included in this rule. The commenter stated that if they are included, it is recommended that the rule be clarified in Section 5(H)(1)(p)(i). Clarification according the commenter should indicate that the facility may establish procedures and practices of general applicability to all clients and is not restricted to imposing limitations on emails and electronic communications. The commenter stated that clients have used electronic media to access inappropriate content, to harass others, to make contact with unsafe people outside the program (and to plan elopements with outside assistance), to disclose images or to share confidential information about other clients. The commenter stated that it is very difficult to “police” this activity and that to maintain safety and confidentiality, it is necessary to establish and enforce consistent procedures and practices for all clients.

**Response:** As a result of this comment, the Department has removed “email and other electronic communications” from Section 5(H)(1)(p)(i). The use of electronic communication may be reflected in each child’s individualized service plan and assessed on a case-by-case basis.
116. **Comment:** Commenter #5 stated that internet access is not a right, but a privilege and that unrestricted internet access is dangerous for youth, and unsupervised access to the internet is often a contributing factor to residential placements in Section 5(H)(1)(p)(i). The commenter added that the language, in the rights of residents, places the burden of proof on the provider not the youth. The commenter stated that there is no mention of parental or guardian guidance, negating the rights and responsibilities of the parent. The commenter stated that parents should clearly have the right to decide how and with whom youth communicate. The commenter stated that residential and clinical providers have professional and ethical responsibilities to work with, support, and assist parents in decision-making. Commenter #2 recommended more guidance from the Department in this area, as there has been little uniformity to date. Commenter #2 added that in order for youth to transition into successful adults, they will need to learn how to use this technology in a supported setting.

**Response:** The Department refers the commenters to the Department’s response to Comment #115.

117. **Comment:** Commenter #3 recommended the following revision to Section 5(H)(1)(p)(i): “Recognizing that these tools are not only available but necessary in today’s world, and that building skills to use them wisely and well should be part of residential treatment when possible, residents must have access to phones, mail, email and other electronic communications. Any restrictions must be clinically determined, time limited, regularly revisited, and written into the treatment plan with goals built around them.”

**Response:** The Department notes that it would be inappropriate to dictate the details of a service plan. Access to electronic communications will be determined on a case-by-case basis in accordance with an individual’s service plan and the facility’s policy. Please see the Department’s response to Comment #115.

118. **Comment:** Commenter #3 recommended the following revision to Section 5(H)(1)(p)(ii): “If the facility has deemed it inadvisable for a resident to communicate with others, through electronic communications, the facility must notify the resident and legal guardian that electronic communication is denied, restricted or terminated. Such denial, restriction, or termination must be clinically determined, time limited, goals must be developed to build the lacking skills, and the restrictions must comply with RRMHS. This restriction may also extend to specific people if the facility deems resident communication with those individuals inadvisable. The facility must enter a written, dated statement that includes the reasons supporting the decision in the resident’s record.”

**Response:** The Department has determined that this level of oversight is not appropriate for this licensing rule. No changes were made to the rule based on this comment.

119. **Comment:** Commenter #11 stated regarding Section 5(H)(1)(p)(iii), MaineCare rules limit the situations in which case management services can overlap with residential treatment and that “placement agency” is also a specific licensed entity in the State of Maine and are not usually connected with youth in residential treatment. The commenter suggested revising this section to read, “when communication is restricted, denied or terminated, other entities working with the resident should be notified, as appropriate.”

**Response:** The Department has revised this section of the rule, based on the commenter’s recommendation.

120. **Comment:** Commenter #12 stated that the statements of resident rights are duplicative of the Maine Rights of Recipients and create confusion in that there are differences between these rules and the Rights of Recipients rules. The commenter added that for the agencies to which the Rights of Recipients rule apply in Section 5(H)(1)(q), the Rights of Recipients rule should be the only applicable statements of rights. The commenter added that the list of rights in the proposed rule should apply only to an agency, if there is one, to which the Rights of Recipients rules do not apply.

**Response:** Children’s residential care facilities provide services for all clients not just for those with mental illness. This section of the rule already states that facilities providing residential behavioral health services or
substance abuse treatment services must comply with the Rights of Adult Recipients of Mental Health Services (See 14-193 C.M.R Chapter 1) and the Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment (See 14-472 C.M.R. Chapter 1). No changes have been made to the rule as a result of this comment.

5(I). Admissions

121. **Comment:** Commenter #3 stated that the intake evaluation should guide the development of the initial treatment plan in Section 5(I).

**Response:** No changes to the rule are necessary based on this comment.

122. **Comment:** Commenter #3 stated that a process should be added to appeal the denial of an admission in Section 5(I).

**Response:** This comment is beyond the scope of the licensing rule. The licensing rule does not regulate the admission appeal process. Therefore, creating criteria for providers’ policies for admission is beyond the scope of the rule. No changes were made to the rule based on this comment.

123. **Comment:** Commenter #3 recommended the following revision to Section 5(I)(1): “Placement agreement. Elements of the placement agreement as detailed in a(i) – (viii) may be changed by a signed writing by both parties if determined to be necessary and appropriate.”

**Response:** The placement agreement is completed upon admission and is not updated. The service plan is updated and revised based on the client’s needs. No changes were made to the rule based on this comment.

124. **Commenter:** Commenter #3 asked for the clarification of whom the written placement agreement is negotiated as described in Section 5(I)(1)(a).

**Response:** The Department refers the commenter to Section 5(I)(l)(b), the placement agreement is agreed upon and signed by the resident, the parent or legal guardian, and a facility representative. No changes were made to the rule based on this comment.

125. **Comment:** Commenter #11 felt that authorization of medical care for the resident is broad and “archaic” as stated in Section 5(I)(1)(a)(v). The commenter stated that it may be appropriate for a facility to work with the parent/guardian to secure routine medical care, but the right to authorize or consent to care must be retained for the parent/guardian or resident. The commenter added that in emergency situations, the authorization should only extend to the facility’s ability to authorize treatment if the parent/guardian is not available to consent.

**Response:** As a result of this comment, the Department has added “…in the event that the parent or guardian is not available” to Section 5(I)(1)(a)(v).

126. **Comment:** Commenter #3 recommended the following revision to Section 5(I)(1)(a)(vii): “Arrangements regarding visits, mail, telephone calls, vacations, gifts and family contact and involvement, consistent with the resident’s rights; and”

**Response:** The Department finds this section of the rule sufficient as it is written. Rights are part of the rule and must be followed. The Department does not feel it is not necessary to repeat resident rights throughout the rule. No changes were made to the rule based on this comment.

127. **Comment:** Commenter #11 stated that the term comprehensive intake evaluation in Section 5(I)(3) needs clarification and suggested the revision, “…into care only when all available information and documents which
may include social, health and family history…” The commenter added that comprehensive intake evaluation sounds similar to the comprehensive assessment in Section 5(J)(3).

Response: As a result of this comment, the Department has revised Section 5(J)(3) to read, “The facility will accept an individual into care when all available information and documents, which may include social, health,…”

128. Comment: Commenter #3 recommended the following revision to Section 5(I)(3)(b): “Information provided to resident. When providing information to the resident, the facility must also strive to explain the information in an accessible way and provide it in an accessible format. As part of the admission orientation, the facility must make available the following:”

Response: As a result of this comment, the Department has revised this section of the rule to read, “As part of the admission orientation, the facility must provide the following in an accessible format:”

129. Comment: Commenter #3 stated that the normal daily routine should be individualized in Section 5(I)(3)(b)(iii):.

Response: Any individual needs will be reflected in the resident’s service plan. No changes were made to the rule based on this comment.

130. Comment: Commenter #3, stated that visitation and communication policies should be liberal, adding that restrictions should be individualized and comply with resident rights in Section I(3)(b)(iv).

Response: Any individual needs will be reflected in the resident’s service plan. No changes were made to the rule based on this comment.

131. Comment: Commenter #3 stated, the grievance procedures should be especially accessible; Section 5(I)(3)(b)(vii).

Response: Please see the Department’s response to Comment #10.

132. Comment: Commenter #3 recommended the following revision to the rule in Section 5(I)(3)(c): “Information provided to legal guardian and referring agency when applicable. When providing information to the guardian/family, the facility must also strive to explain the information in an accessible way and provide it in an accessible format. Prior to placement, whenever possible, the facility must provide the legal guardian and placing agency with written information which must include:”

Response: The Department finds that this section of the rule is sufficient for licensing purposes. No changes were made to the rule based on this comment.

133. Comment: Commenter #12 stated that extending the expiration of releases to one year is helpful; Section 5(I)(3)(e)(iv). The commenter stated that the requirement that releases be kept current is inappropriate and should be removed. The commenter stated that the legal requirement is that a release be in place prior to any disclosure, not that a release should be kept in place at all times on an if needed basis.

Response: The rule reads “as appropriate” which allows a facility to renew only those releases as they are needed. No changes were made to the rule based on this comment.

5(J). Comprehensive Assessment

134. Comment: Commenter #3 recommended the following revision to Section 5(J)(1)(a): “Within 30 days of admission the children’s residential care facility must complete a comprehensive assessment of each resident to
drive the need for treatment and services. The comprehensive assessment must be completed by a qualified person, as defined by the program. All methods and procedures used in this assessment must consider the resident's age, culture, background and dominant language or mode of communication. If possible, the resident and family must be interviewed as part of the assessment process; if it is not possible to traditionally interview the resident, the resident must at least be observed by the person completing the assessment.”

Response: As a result of this comment, the Department has amended Section 5(J)(1)(a) of the rule to read, “Within 30 days of admission, the children’s residential care facility must complete a comprehensive assessment of each resident to drive the treatment and/or services. The comprehensive assessment must be completed by a qualified person, as defined by the program. All methods and procedures used in this assessment must consider the resident's age, culture, background and dominant language or mode of communication. If possible, the resident, legal guardian and family must be interviewed as part of the assessment process.”

135. Comment: Commenter #3 recommended the following revision to the rule in Section 5(J)(1)(f): “Updating assessment. A resident’s assessment must be updated at least annually and when there is a change in the level of care, a change in status, or a major life event occurs; or upon reasonable family request; or when treatment is clearly not effective.”

Response: As a result of this comment, the Department has amended this section of the rule by adding; “or when documentation indicates that treatment is not effective.”

5(K). Service Plans

136. Comment: Commenter #3 stated that youth and family have the right to be fully involved in developing the service plan described in Section 5(K).

Response: No changes to the rule are necessary based on this comment as Section 5(K) provides for that involvement in service plan development.

137. Comment: Commenter #3 recommended the following revision to Section 5(K)(1): “Service plan. Children’s residential care facilities must develop and provide ongoing review of each resident’s individualized service plan and must document that this is done on an ongoing basis.”

Response: As a result of this comment, the Department has amended the rule by adding to the end of this section, “and document this review every 90 days in accordance with Section 5(K)(9).”

138. Comment: Commenter #3 recommended the following revision to Section 5(K)(2): “Resident participation. Each resident has the right to be fully and actively involved must be encouraged to participate in the development, revision, and ongoing review of his or her service plan. The resident's input must be taken seriously and facilitated for ease.”

Response: The Department has determined that adding this language to this licensing rule would make this requirement too difficult to assess. No changes have been made to the rule based on this comment.

139. Comment: Commenter #3 recommended the following revision to Section 5(K)(3): “Service plan team. The service plan team must include at least the following participants as appropriate when developing or reviewing a resident’s service plan: the resident; the facility staff responsible for implementing the resident’s service plan on a daily basis; school personnel; the resident’s parent or legal guardian; other significant persons involved in the resident’s life, as the resident’s preference dictates; and the facility’s clinical consultant. The facility’s service plan team provides input and participates in the development and periodic review of the resident’s service plan. …”
Response: Section 5(J)(1)(a) was revised to clarify that the resident “drives the treatment and services.” See the Department’s response to comment #136. Section 5(K)(1) of this rule states that, “each child must be encouraged to participate in the development and ongoing review of his or her service plan.” The Department finds that this language is adequate to ensure that service plans are based on the needs of the resident. A resident’s preferences may not always be in the best interest of their needs. No changes were made to the rule based on this comment.

140. Comment: Commenter #12 stated that the phrase, “Staff responsible for daily implementation” in 5(K)(3), should be removed as residential direct care staff help to implement the service plan but they do not participate in planning meetings. The commenter stated that planning meetings are facilitated by clinicians and the term “clinical consultant” is not defined and it should say “clinician.” The commenter stated that an alternative to a sign-in sheet should be allowed for documenting those who attended in the clinician’s progress note.

Response: The Department has determined that inclusion of facility staff in service plan team meetings is important. Section 5(K)(3) requires that a resident’s service plan must also include, “other significant persons involved in the resident’s life.” The Department finds a sign-in sheet is a reasonable requirement and has maintained this requirement. The Department has changed the term, “clinical consultant” in this Section to “clinician.”

141. Comment: Commenter #3 recommended the following revision to Section 5(K)(5): “Service plan. There must be a written, time-limited, goal-oriented, individualized service plan for each resident. Service plans for clients at a facility should not be identical to each other; this is a red flag. The resident’s service plan must be based on needs identified during the comprehensive assessment process. The service plan includes, but is not limited to, the following:”

Response: The Department notes that residential care facilities are cited for not having individualized service plans and finds that the language in the rule is sufficient. No changes have been made to the rule based on this comment.

142. Comment: Commenter #3 recommended the following revision to Section 5(K)(5)(b): “Measurable long-term goals and specific short-term goals and objectives for the resident and the resident’s family including but not limited to strategies for developing positive family relationships and permanency planning for the resident, in language that the resident and family can understand;”

Response: As a result of this comment, the Department has amended this section of the rule, per the commenter’s recommendation.

143. Comment: Commenter #3 recommended the following revision to Section 5(K)(5)(d), “Trauma history. Consideration of the resident’s trauma history and a determination regarding the most effective means to de-escalate behavior. The resident and the resident’s parent or legal guardian must may participate in making this determination;”

Response: Resident needs and appropriateness of treatment and interventions are taken into account through the assessment process and through the service plan. No change was made to the rule based on this comment.

144. Comment: Commenter #3 recommended the following revision to Section 5(K)(5)(e): “Development of discharge criteria from the time of admission and projected discharge date and strategies to address anticipated barriers, to be changed along the way to adjust to developments;”

Response: As a result of this comment, the Department has added “from the time of admission” to this section of the rule. Service plans are based on the needs of the resident and are reviewed periodically, the Department finds the language in the rule already sufficient and there would be no additional value by adding, “to be changed along the way to adjust to developments.”
145. **Comment:** Commenter #3 recommended adding Section 5(K)(5)(j): “Specific information about any restriction/limitation of any individual right; must be clinically indicated, time limited, treatment oriented, etc.”

**Response:** The Department has determined that the language in the rule is sufficient. No changes were made to the rule based on this comment.

146. **Comment:** Commenter #3 recommended adding Section 5(K)(5)(k): “Any objections to the service plan that the resident or family wishes to be documented.”

**Response:** As a result of this comment, the Department has added Section 5(K)(5)(j), “Any objection to the service plan that the resident or family expresses must be documented.”

147. **Comment:** Commenter #3 recommended adding Section 5(K)(5)(l): “The service plan shall periodically be reviewed for effectiveness.”

**Response:** The requirements of the rule in Section 5(K)(9) already call for a periodic review of the service plan. No changes have been made to the rule based on this comment.

148. **Commenter:** Commenter #12 stated that the administrator or designee signature should only be needed if there is no clinical supervisor, referring to Section 5(K)(6). The commenter added that the usual practice would be for the clinician and clinical supervisor to sign the service plan. The commenter stated that a referring agency representative may not be present during planning meetings and that the referring agency does not have the status of legal guardian. The commenter concluded that the signature requirement for the referring agency representative should be removed. Commenter #6 stated that there is confusion about potential referral sources. The commenter stated that in Section 5(K)(6), Signatures, that the language suggests a need for a referral to come from an agency that employs clinical staff. The commenter also asked for clarification of the role of parents and school personnel in the referral process.

**Response:** As a result of this comment, the Department agrees to remove the signature requirement for the referring agency representative as well as the term “referring agency” and “placing agency” from Section 5(I)(3)(c). The referral process is beyond the scope of the health and safety requirements of this rule. The focus of the rule is on residents who are already placed in children’s residential care facilities. Referrals for placement within these facilities are typically initiated through a case manager with involvement from parents and schools. The Department of Health and Human Services, Office of Child and Family Services would be the State Office with the most involvement in the referral process.

149. **Comment:** Commenter #11 stated that the requirement for a representative of the referring agency resident’s clinician to sign the Service Plan in Section 5(K)(6) is not clear as to who should sign. The commenter stated that this could be the case manager or a clinician at a psychiatric hospital. The commenter stated that those individuals are generally prohibited by MaineCare from continuing to provide services after placement in a PNMI. The commenter concluded by stating that this makes this an impossible for compliance.

**Response:** The Department refers the commenter to the Department’s response to Comment #148.

150. **Comment:** Commenter #11 stated that it is difficult to track the receipt of the service plan as noted in Section 5(K)(7). The commenter recommended using the term “offered” or “provided, if desired” which are both tasks that the facility executes and can be documented.

**Response:** As a result of this comment, the Department has amended this section of the rule by removing “received” and replacing it with “were offered” a copy of the written service plan.
151. **Comment:** Commenter #3 recommended the following revision to Section 5(K)(7): “Resident’s copy of service plan. Clinical staff must review the service plan with the resident and ideally with the family to ensure understanding and agreement, and document that this has been done. The facility must document in the resident’s record that within five working days after the service planning meeting, the resident and legal guardian received a copy of the written service plan.”

**Response:** The Department notes that clinical staff are not available in all facilities based on the service type. No changes were made to the rule based on this comment.

152. **Comment:** Commenter #11 stated that Section 5(K)(8) would benefit from the addition of a definition of “complete service plan.” The commenter offered two suggestions, including: “Service Plan is considered complete and in force when it is signed by the clinical supervisor and the parent/guardian or the resident if emancipated or over 18. In the event that the parent/guardian participated in the service planning process remotely, verbal consent may be acceptable. The parent/guardian must consent to the plan by signature at the earliest opportunity”; or “Service Plan is considered complete and in force when it is signed by the clinical supervisor and the parent/guardian or the resident if emancipated or over 18.”

**Response:** The components of a service plan are sufficiently addressed in Section 5(K)(5). No changes were made to the rule based on this comment.

153. **Comment:** Commenter #2 requested that the rule be amended to ensure that the full treatment team is periodically reviewing the service plan, as opposed to just facility staff. The commenter recommended the following language change to Section 5(K)(9): “The facility shall coordinate with treatment team members to periodically review and update each resident’s service plan.”

**Response:** As a result of this comment, the Department has amended this section of the rule to read, “The facility must coordinate with treatment team members to periodically review and update each resident’s service plan, in a language that the resident and family can understand.”

154. **Comment:** Commenter #3 recommended the following revision to Section 5(K)(9)(a): “Service plans must be reviewed at least every 90 days at a team meeting that includes the family, and resident if developmentally appropriate, and updated as needed. The review must evaluate progress toward established goals and the facility must revise the service plan as appropriate. The 90-day review must be documented.”

**Response:** Changes in a resident’s service plan do not need to always occur in a team meeting. All updates to a service plan require documentation. No changes were made to the rule based on this comment.

155. **Comment:** Commenter #3 recommended the following revision to Section 5(K)(10): “Explanation of service plan. Unless it is not feasible to do so, the facility must explain the service plan and any subsequent revisions to the resident (if developmentally appropriate) and the resident’s legal guardian in language understandable to them.”

**Response:** The Department refers the commenter to the Department’s response to Comment #154.

156. **Comment:** Commenter #11 stated that he agrees with the intent of the rule regarding crisis planning in Section 5(K)(11). The commenter stated that in practice, it is possible to develop an individualized crisis plan at admission based on history and dialogue with the youth and family. The commenter added that if an individualized plan were developed at admission, a subsequent plan at seven days would then be redundant. The commenter also stated that he understood the intent of the phrase “own words” but this can present challenges. The commenter suggested: “The crisis plan must include the resident’s and family’s input, perspective and ideas to describe potential problems and interventions that may prevent or alleviate the crisis.”
Response: In response to this comment, the Department has amended this Section of the rule to read, “The crisis plan must include the resident’s and family’s input, perspective and ideas to describe potential problems and interventions that may prevent or alleviate the crisis.”

157. Comment: Commenter #12 stated that it is unclear of what constitutes a “utilization” of the crisis plan in Section 5(K)(11)(c). The commenter stated that a review of the crisis plan at each service plan review would be a more identifiable review point. The commenter also added that a review could take place after each utilization “to guide staff response in a situation of full crisis or serious risk of harm to self or others.”

Response: As a result of this comment, the Department has added, “to guide staff response in a situation of full crisis or serious risk of harm to self or others” to this section of the rule.

5(L). Discharge Requirements

158. Comment: Commenter #2 stated that in addition to a discharge summary in Section 5(L), a transition plan should be required and included within the discharge summary. The commenter requested an addition to the rule that describes the transition plan and that also provides access to a care coordinator to assist in a successful transfer home. The commenter added that transition plans should include resources and care coordination to ensure that referrals decrease the chance of re-admission to the facility.

Response: The addition of a care coordinator would be an additional cost for programs. The Department has determined that the discharge requirements and service plan requirements are sufficient for this licensing rule. No change has been made to the based on this comment.

159. Comment: Commenter #3 stated that her organization believes that the discharge process in the proposed rule lacks detail in Section 5(L). The commenter added that the only requirement about discharge in the rule was the discharge summary, however there was no detail in the rule regarding the discharge planning process. The commenter advised that discharge planning should begin upon admission and that changes along the way are appropriate. The commenter also advised that goals set towards discharge should be reasonable, realistic and flexible.

Response: The Department refers the commenter to the Department’s response to Comment #154. The Department amended Section 5(K)(5)(e) to state that the development of discharge criteria begins at admission.

160. Comment: Commenter #3 stated that in Section 5(L)(2)(c) there should be no discharges to an unsafe location. The commenter asked that the Department conduct a special review after one year if a child is unable to be safely discharged and ends up “stuck” at a Level 2 Facility.

Response: Section 5(L)(2)(c) addresses safe and appropriate discharge. No changes were made to the rule based on this comment.

161. Comment: Commenter #3 recommended adding the following revision to Section 5(L): “DISCHARGE REQUIREMENTS. “Discharge process. The discharge planning process should begin at admission and should involve the resident’s input whenever possible, along with the family’s input. The team should know what the discharge plan will be, modifying it as necessary during the duration of residential treatment. This allows for the treatment plan and goals to be tailored to the skills necessary and appropriate for the discharge placement. At the 90-day service plan reviews, the discharge plan should be reviewed as well, and modified if necessary. The discharge plan should be reasonable, realistic, and flexible. Benchmarks should be built in to the treatment plan – for instance, if the discharge placement is home, home visits should be introduced when appropriate and feasible. It is the provider’s responsibility to provide support to the resident and family in achieving the discharge; this may mean, for example, involving the guardian in the milieu to practice skills that will be used at home, or providing transportation help for home visits. It is the guardian’s responsibility to participate as fully as possible in moving towards discharge; this means, for example, recognizing that the child is not intended to leave residential treatment without any behavioral challenges, and participating in family therapy to allow for a
return home at a reasonable point. When a resident reaches one year in residential care, the Department will institute a special review to determine what supports the facility may need to help bring this time-limited service to a successful conclusion.

Response: Section 5(L)(2)(c) addresses safe and appropriate discharge. The Department refers the commenter to the Department’s response to Comment #154 and #160 in regard to discharge planning starting at admission and including the resident and family input. No changes were made to the rule based on this comment.

162. Comment: Commenter #3 recommended the following revision to section in Section 5(L)(2): “Unplanned or emergency discharge. A resident must not be transferred or discharged involuntarily. A resident may, when warranted, be sent for medically or psychiatrically necessary care to a higher level of care, but a provider cannot formally discharge a resident without a safe long-term discharge option. An emergency room and the street are examples of unsafe discharge options. If the resident is at a higher level of care and there is a question of the appropriateness of return to the facility, the provider must at minimum keep the resident’s case open and remain actively engaged in planning with the resident’s team.”

Response: Section 5(L)(2)(c) addresses safe and appropriate discharge. No changes were made to the rule based on this comment.

5(M). Healthcare

163. Comment: Commenters 2, 13, 14 and 20 stated that prior to admission, at the intake process, a new physical exam should be required. The commenters stated that current requirements that allow for the use of a physical exam conducted in the previous 12 months are ineffective as much can change in 12 months. The commenters stated that Section 5(M) should require that the physical exam demonstrate clear evidence that the behavior of the resident is not due to an underlying pain or physical health issue.

Response: The Department encourages providers to assess children and pain as a possible source of problematic behavior and to arrange for a physical or medical assessment whenever pain is suspected as a source. The Department believes that the rule is sufficient as written for licensing standards. No changes were made to the rule based on this comment.

164. Comment: Commenter #3 recommended the following revision to Section 5(M)(1)(b): “Comprehensive education and guidance concerning health, personal care and hygiene, as appropriate, relevant, and accessible to the resident;”

Response: As a result of this comment the Department has added, “as appropriate and accessible to the resident” to this section.

165. Comment: Commenter #11 stated that they appreciate changes in Section 5(M)(2)(a) as MaineCare has been reluctant to pay for another physical within 12 months.

Response: No changes to the rule are necessary as a result of this comment.

166. Comment: Commenter #3 recommended the following revision to Section 5(M)(3): “Corrective devices. The facility must make a diligent effort to ensure that a resident who needs glasses, a hearing aid, a prosthetic device, or other corrective device is provided with the necessary equipment or device, and to seek assistance with advocacy in overcoming any barriers.”

Response: The Department finds that the language in the rule is sufficient. No changes were made to the rule based on this comment.
167. **Comment:** Commenters 1, 8, 11 and 19 requested clarification about the requirement to have a medical director 5(M)(5)(k). The commenters stated that finding a medical director is difficult and added that as an example, the Department has not been able to find a medical director of its own. The commenters added that Maine and Northern New England has a shortage of qualified medical professionals and this expectation will contribute to the shortage and limit access to residential care beds. The commenters stated that the duties listed under Medical Director include oversight and policy approval, which is outside the scope for some organizations’ current psychiatric positions. The commenters stated that facilities should be able to rely on the professional expertise of licensed practitioners (physicians or nurse practitioners) to conduct exams and prescribe medications properly. Clarification was requested by the commenters regarding which qualifications would be accepted and if the medical director could be shared across programs. The commenters recommended not adding the position of medical director for each agency due to the cost and duplication of service with the psychiatrist. The commenters also stated that all residential care providers contract for psychiatric medication management as part of the bundled service under the MaineCare Benefits Manual, Section 97, Appendix D. The commenters added that requiring a medical director will impede the ability of many residential treatment programs to maintain their current contracts with medical providers if they are asked to also serve the role of medical director.

**Response:** The Department in consideration of these comments has removed this requirement from Section 5(M) and has determined that the clinical oversight that already exists in this rule is sufficient.

168. **Comment:** Commenter #3 recommended the following revision to Section 5(M)(6)(e): “Ensures an appropriate sick leave policy for staff to prevent the transmission of illness.”

**Response:** The Department finds that the language within the rule is sufficient. The Department cannot dictate the personnel benefit leave time of an agency. No changes were made to the rule based on this comment.

5(N). Medication Administration and Storage

169. **Comment:** Commenters 1, 11 and 12 stated that it would be too costly for staff to meet the CRMA requirement in Section 5(N)(1). The commenters requested more information about whether the 20 hour or 40 hour CRMA training would be accepted. The commenters stated that additional costs would also be due to a staff person not being available to the program while they participated in the training and the cost of the training itself, which is $350. The commenters stated that additional funding for providers would be necessary to meet this requirement. The commenters recommended that the rules be amended to allow each agency to be allowed to use their own approved medication training similar to the approval of the physical management training approval process. Commenter #11 estimated that implementation of this requirement (24-hour CRMA training) will cost $163,200, and the annual cost thereafter will be $86,400, for his organization. Commenter #11 added that this is a significant expense in the context of recruitment challenges statewide and increasing costs of health insurance, minimum wage, heating fuels and other factors. Commenter #11 recommended at minimum, a phase in period.

**Response:** The Department acknowledges that this requirement is an additional expense; however, due to the high incidence of medication errors that have been discovered during routine licensing inspections and investigations, the Department has determined that this requirement must be added to enhance the health and safety of the residents. The minimum qualification for medication administration is a CRMA. No changes were made to the rule based on this comment.

170. **Comment:** Commenters 11 and 12 stated that medication refusals noted in Section 5(N)(5)(a)(ii), occur often and as long as there is no serious consequence, notice to the practitioner of every refusal is not consistent with accepted practice. The commenters recommended that the notice to the practitioner of every refusal should be removed or the Department should consider allowing advanced directives in the case of refusals and missed doses.
Response: As a result of this comment, the Department has changed the language of this section from, “There must be evidence of notification of the practitioner for refused medications” to “Orders from the medical provider who prescribed the medication regarding notification of missed doses.”

171. Comment: Commenter #12 stated that a documentation mistake is not a medication error in Section 5(N)(5)(b), if the right medication was given at the right dose at the right time, then there is no medication error. The commenter stated that prescribing practitioners do not want to be contacted every time a staff person makes a mistake on the Medication Administration Record. The commenter recommended that this requirement be removed.

Response: As a result of this comment, the Department has added to this section of the rule, “Medication errors and adverse reactions must be reported immediately to the medical provider who prescribed the medication, per his or her orders of notification...”

172. Comment: Commenter #12 stated that their organizations’ practice has been for qualified nursing staff to hold the medications in the original containers in a locked cabinet at a central site and to distribute the medications in cassettes to the residences for administration. The commenter added that this practice keeps the medications secure and ensures packing by professional staff. The commenter stated that this current practice may not be in keeping with the proposed rule. The commenter recommended; inserting “at a central location or at the place of administration” after “locked storage cabinet” in the first sentence; and in clause in Section 5(N)(7)(a), change “medication administration” to “medication packing or administration.” Commenter #11 recommended that the rules require that the key be secured without requiring that it be carried on a person.

Response: As a result of this comment, the Department has removed from this Section 5(N)(7) the requirement that the key to a locked cabinet must be carried by the person on duty. The Department has also removed from this same section the requirement that sample medications be stored in accordance with the facility’s policies.

173. Comment: Commenter #3 recommended the following revision to Section 5(N)(14): “Psychotropic medication. The facility’s written medication policy must govern the use of psychotropic medications. The resident’s use of psychotropic medication must be in accordance with the goals and objectives of the resident's service plan, and must be regularly reassessed for appropriateness and resident input.”

Response: The resident service plan considers resident input and is reassessed at least every 90 days. No changes were made to the rule based on this comment.

174. Comment: Commenter #11 agreed that in Section 5(N)(15) the consent of the legal guardian should be required for medication administration, but recommended a window in which documented verbal consent could be acceptable pending written consent, especially given the rural nature of the State. The commenter added that guardians often participate in medication reviews by phone or have recommended changes reviewed by phone. As written, the rule will result in appropriate changes being delayed in implementation. The commenter stated that this does not serve youth well.

Response: As a result of this comment, the Department has added to this section of the rule, “If consent is verbal or if the guardian is unavailable to obtain written consent, then the facility must document consent and ensure that written consent is received within 30 days.”

175. Comment: Commenter #3 recommended the following revision to Section 5(N)(16): “Resident’s consent to medication. When a resident is 14 years of age or older, the facility must also obtain written informed consent from the resident prior to administration of the prescribed psychotropic medication except when the resident lacks the capacity to provide informed consent. A resident of any age on any psychotropic medication should, when possible, give informed consent, and be consulted and monitored for input, progress, and side effects.”
Response: As a result of this comment, the Department has added the following sentence to the end of Section 5(N)(16): “A resident of any age on any psychotropic medication should, when possible, give informed consent, and be consulted and monitored for input, progress, and side effects.”

176. **Comment:** Commenter #3 asked, in regard to Section 5(N)(16), who determines when the resident lacks capacity and how it is determined.

**Response:** This licensing rule does not regulate how a lack of capacity is determined. No changes were made to the rule based on this comment.

177. **Comment:** Commenter #3 recommended the following revision to Section 5(N)(17)(b): “Every 30 days, or as deemed necessary by the prescribing physician, after the date of the initial prescription the medical provider who prescribed the psychotropic medication or another medical provider must submit a written report on the resident who is receiving the medication. The report must be based on actual observation of, and whenever possible, a conversation with, the resident and review of the daily monitoring reports. The report must detail the reasons the psychotropic medication is being continued, discontinued, increased or decreased in dosage or changed.”

**Response:** As a result of this comment, the Department has amended the second sentence of Section 5(N)(17)(b) of the rule as follows: “The report must be based on actual observation of, and whenever possible, a conversation with…”

178. **Comment:** Commenters 11 and 12 stated that regarding revocation of medication consent by three consecutive refusals and having the third refusal witnessed by two staff, the third refusal may often occur when only one staff person is present, and the reason for requiring a second staff witness is not apparent in Section 5(N)(18)(b). The commenters added that requiring a client signature will be problematic if the client is choosing not to cooperate with staff, which often is the case at the time of refusals. The commenters stated that it should be sufficient that the one staff who witnesses the refusal to properly document it. The commenters stated that this is practice for the first and second refusal, which are as necessary as the third refusal in order to constitute revocation of consent.

**Response:** As a result of the Department’s review of this comment, the Department revised Section 5(N)(18) and has removed Sub-sections 5(N)(18)(a) and 5(N)(18)(b) from the rule.

179. **Comment:** Commenter #3 recommended the following revision to Section 5(N)(19), “PRN orders for psychotropic medications. Written ‘as needed’ (PRN) orders signed and dated by authorized licensed practitioners for psychotropic medications for a resident must include detailed behavior-specific written instructions, including symptoms that might require use of such medication, exact dosage, exact time frames between dosages and the maximum dosage to be given in a 24-hour period. When possible, the resident’s input should be part of the plan for PRN use.”

**Response:** As a result of this comment, the Department has revised the rule by adding the following sentence at the end of Section 5(N)(19): “When possible, the resident’s input should be part of the plan for PRN use.”

180. **Comment:** Commenter #7 stated that it was helpful that as needed (PRN) medications, in Section 5(N)(19), was included. These medications can increase a youth’s self-control, and added that there should always be an emphasis on de-escalation techniques, making the need for PRN medication of any kind uncommon.

**Response:** No changes to the rule are necessary based on this comment.

181. **Comment:** Commenter #7 stated that his organization disagrees with the prohibition of PRN antipsychotics if the youth is not also receiving a regular dose of an antipsychotic as stated in Section 5(N)(19)(C). The commenter stated that most youth who receive antipsychotics are not psychotic and are taking the medication
for the purpose of increasing self-control over impulsive aggression. The commenter stated that there are youth who could benefit from them on a PRN basis who do not need to be exposed to the risk of weight gain and other associated metabolic problems from their regular use.

**Response:** The Department must keep this language in the rule, as CRMAs are prohibited from administering antipsychotic psychotropic medications PRN, unless prescribed on a regularly-scheduled dose. No changes were made to the rule based on this comment.

182. **Comment:** Commenter #12 stated that the requirements in Section 5(N)(20)(a)(3), to keep a daily count of a Schedule II medication in a bound book are appropriate for a hospital setting of high usage but not for the lower level of usage in a children’s residential care facility. The commenter stated that his organization has utilized weekly counts without the need for a bound book in its residential programs for many years and that the rule should continue to allow these practices.

**Response:** The Department has determined that this practice is necessary to reduce the incidence of medication errors. No change was made to the rule based on this comment.

183. **Comment:** Commenter #12 stated that when a client leaves the facility for over 72 hours, the rule requires that the client’s medications must be packed and labelled by a pharmacist, and this is not feasible. The commenter stated that this would require sending the entire supply of medications in their original containers. The commenter stated that most or all agencies, do not have a pharmacist on staff and outside pharmacists will not accept medications back to be repacked and relabeled. The commenter recommended that this requirement be removed and that the requirements in Section 5(N)(20)(c)(ii), should apply to absences of any duration.

**Response:** The Department has determined that this practice is necessary to reduce the incidence of medication errors. No change was made to the rule based on this comment.

5(O). Behavior Management

184. **Comment:** Commenters 10, 17 and 18 stated that the behavioral management guidelines in Section 5(O), are not clear enough to protect children in residential care facilities. The commenters stated that children in the care of the State have a “liberty interest in safety and freedom from [unreasonable] bodily restraint.” The commenters stated that the federal Substance Abuse and Mental Health Administration (SAMHSA) has advised that use of seclusion and restraint is a result of treatment failure by providers. The commenter added that SAMHSA stated that providers, leadership, policy, and programmatic change can prevent the use of seclusion and restraint. The commenter stated that numerous studies have demonstrated that seclusion and restraint are not therapeutic, and are rarely limited to use during emergencies. The commenters concluded that the State’s interest in seclusion and restraint is tenuous, and the Department should not allow them. The commenters stated that if the Department is determined to authorize the use of restraint and seclusion, it must have a policy that states they may be used only as long as necessary to address the imminent danger to self or others and no longer. The commenter stated that without limits on the use of restraint, the Department will be authorizing unconstitutional deprivations of children’s liberty.

**Response:** The licensing rule states that facilities may only use physical restraint models approved by the Department. The Department believes that the language in the rule is sufficient for this rule. No changes have been made to the rule based on this comment.

185. **Comment:** Commenter #5 stated that positive reinforcement is the preferred behavioral reinforcer, however negative reinforcement can also be a valuable tool. The commenter recommended the addition of the use of natural and logical consequences and or negative reinforcement and would avoid the unintended consequence of having the reader believe that negative reinforcers or consequences are not allowed. The commenter stated that
it is important to note that negative consequences are very real and the real world has many and that negative behaviors, choices, and actions are typically met with negative consequences in Section 5(O).

Response: As a result of this comment, the Department has revised the last sentence of Section 5(O)(1) to read “Consequences, including natural and logical, must be connected to the behavior, not excessive and administered as soon as possible after the incident.”

186. Comment: Commenter #3 recommended the following revision to Section 5(O)(1): “Behavior management. Individualized, positive behavioral supports must be in place for each resident. Behavior management interventions must comply with Department approved models within the facility’s own policy. Administration of behavior management techniques cannot be delegated to persons who are not known to the resident, and cannot be administered by residents, volunteers or inadequately trained staff. Consequences must be connected to the behavior, not excessive and should be administered as soon as possible after the incident. Rights are not privileges to be earned and cannot be part of a behavior management program.”

Response: The Department believes that resident rights are sufficiently addressed within the rule. No changes were made to the rule based on this comment.

187. Comment: Commenter 13 and 14 stated that individualized, positive behavioral supports in Section 5(O)(1) are required to be in place for each resident, but “positive behavioral supports” are not defined in this section or in the definitions. The commenters recommend including a detailed description of positive behavioral supports. The commenters provided an example of concise definition of positive supports strategies, used in State regulations which can be found in the State of Minnesota’s Positive Supports Rule 9544. The commenters stated that “positive support strategy” is defined as “a strengths-based strategy based on individualized assessment that emphasizes teaching a person productive and self-determined skills or alternate strategies and behaviors without the use of restrictive Interventions.” (See https://mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/positive-supports/).

Response: As a result of this comment, the Department has added a definition of positive support strategy to Section 2(A)(39) as follows: “Positive support strategy means a strengths-based strategy based on individualized assessment that emphasizes teaching a person productive and self-determined skills or alternate strategies and behaviors without the use of restrictive interventions.”

188. Comment: Commenter #3 recommended the following revision to Section 5(O)(2): “Approved passive physical restraint models. Facilities may only use passive physical restraint models approved by the Department and on which their staff have been trained. The facility may only use passive physical restraint, as a last resort/emergency intervention, when one or more of the following exists:

   a. The resident is credibly threatening to inflict severe harm on staff or residents; or
   b. The resident is credibly threatening to inflict severe harm on self; or
   c. The resident is causing excessive and continuous damage to property.”

Response: The Department finds that the some of the recommendations within this comment are too subjective. Based on this comment and with input from the Assistant Attorney General, the Department has removed when the resident is engaging in significant property damage which could result in harm to self or others”. Continuous and excessive property damage is necessary to be included in this section of rule to protect the facility, the safety and interests of the client as well as other clients and staff. No changes were made to the rule based on this comment.

189. Comment: Commenter #6 requested a definition of “threatening to inflict harm” in Section 5(O)(2). The commenter added that clarification is needed due to the potential for threats that occur daily in facilities. The
commenter asked for clarification of the role of intent and attempt(s) in the decision to implement a passive physical restraint.

**Response:** The Department has determined that the language in this section of the rule is clear. The Department refers the commenter to the Department’s response to Comment #32. Section 5(O)(2) provides adequate description as to when a facility may use physical restraints.

**190. Comment:** Commenter 7 stated that the rule allows seclusion in secure facilities but not in other residential facilities, whereas Section 5(O)(2) allows restraints in all facilities. The commenter stated that this makes no sense as restraints are a much more intrusive and problematic intervention than seclusion. The commenter stated that when the Department forbids seclusion in most residential facilities, it is basically requiring an increase in the use of restraint. This is because that would be the only option most facilities would have when de-escalation techniques do not work. The commenter stated that his organization believes that allowing restraint but not seclusion in non-secure facilities is not trauma informed. The commenter stated that this is a very large problem and requested that seclusion be allowed in any facility in which restraint is allowed.

**Response:** Other options for intervention exist besides the use of isolation and restraint of a resident. During the use of isolation, staff can engage in de-escalation techniques with the resident. No changes were made the rule based on this comment.

**191. Comment:** Commenter #12 stated that the use of passive and physical restraints may be used if a client is threatening harm to clients or staff and should include anyone else present, which could include family members or visitors in Section 5(O)(2)(a).

**Response:** As a result of this comment, the Department added, “or others” to this section of the rule. The Department also removed the term “passive” from restraints in its response to Comment #32.

**192. Comment:** Commenter #3 recommended the following revision to Section 5(O)(3): “Prohibited practices. The facility must prohibit practices that are cruel, severe, or unusual; may not subject a resident to verbal abuse, ridicule or humiliation; may not inflict any type of physical punishment in any manner upon the body; and may not the administeration of psychotropic medications as a means of punishment or discipline; and may not utilize group punishment.”

**Response:** As a result of this comment, the Department has revised this section, for the purposes of adding clarity, to read as follows:

**Prohibited practices.** The facility must assure that residents are not subjected to:

- Practices that are cruel, severe, or unusual;
- Verbal abuse, ridicule or humiliation;
- Any type of physical punishment in any manner upon the body;
- Administering of psychotropic medications as a means of punishment or discipline; and
- Group punishment.

**193. Comment:** Commenter 10 stated that while the use of isolation may be a reasonable response to the serious disruption of another resident, the use of physical and chemical restraints in that situation would likely constitute unreasonable restraint on a “young person’s liberty in violation of Youngberg.” The Department
should change the rule to be more careful about when restraint is allowed in Section 5(0)(3), to avoid constitutional problems.

Response: The Department believes that the language in the rule is sufficient. No changes have been made to the rule based on this comment.

194. **Comment:** Commenter 10 stated that the Department must clarify in Section 5(O)(40), whether a locking mechanism may be used when employing seclusion. The commenter stated that seclusion is defined as “the solitary, involuntary confinement for any amount of time of a resident in a room or a specific area from which egress is denied by a locking mechanism.” The commenter added, however, that the subsection discussing behavior management states that facilities “must not permit the seclusion of a resident in a locked space.”

Response: The rule sufficiently describes the use of a locking mechanism in Section 5(O)(4), and in the definition of seclusion. No changes have been made to the rule based on this comment.

195. **Comment:** Commenter #3 recommended the following revision to Section 5(0)(4): “Seclusion. The facility must not permit the seclusion of a resident by denying egress in any manner in a locked space. The resident may not be confined alone to any area with egress denied the door locked, barred or held shut by staff. Seclusion is prohibited in children’s residential care facilities except in children’s residential treatment facilities with secure capacity (Level 1 and Level 2), Sections 8(D) and 8(E) of this rule.”

Response: The Department believes that some of these recommendations would contradict the rule as it is currently written. The Department has clarified in this section of the rule that Seclusion is prohibited in children’s residential care facilities except for Level 2 facilities.

196. **Comment:** Commenter #3 recommended the following revision to Section 5(0)(5): “Passive Restraints. The facility must use only passive physical restraint models approved by the Department. Prone restraints are prohibited. Restraints not part of an approved, trained program are prohibited.”

Response: Section 5(0)(2) already states that restraints must be a model approved by the Department. The Department refers the commenter to the Department’s response to Comment #192. No changes were made to the rule as a result of this comment.

197. **Comment:** Commenter #2 asked that in addition to removing the term “passive” from this section of the rule, the Department should add language to prevent restraint position asphyxia. The commenter submitted the following language for consideration, “Physical Restraints. The facility must use passive physical restraint models approved by the Department. Prone restraints as well as any restraint in which hinders chest and abdomen movement, which can result into restraint-related positional asphyxia, is strictly prohibited.” in Section 5(0)(5).

Response: The Department refers the commenter to the Department’s response to Comment #192. This section of the rule states that physical restraints must be approved by the Department. No change has been made to the rule as a result of this comment.

198. **Comment:** Commenter #7, referring to Section 5(0)(6), stated that medication should never be used for the purpose of sedation or reduction of mobility, adding that this has been, against good clinical practice for decades. The commenter stated that using the phrase, “chemical restraints” maintains outmoded stereotypes of psychiatric treatment and maintains stigma.

Response: As a result of this comment, the Department has renamed “chemical restraint” throughout the rule to “PRN psychotropic medications” The Department has removed from 5(0)(6), “Chemical restraint means the administration of psychotropic medication for the exclusive purpose of sedation of a resident”. The Department
also removed “chemical restraint” from Section 1(A) definitions. PRN psychotropic medications are described throughout Section 5(N) of this rule.

199. **Comment:** Commenter #3 recommended the following revision to Section 5(O)(6): “Chemical restraints. The facility must not use chemical restraints, except in a children’s residential treatment facilities with secure capacity (Level 1 and Level 2), Sections 8(D) and 8(E) of this rule. Chemical restraint means the administration of psychotropic medication for the exclusive purpose of sedation of a resident.”

**Response:** The Department refers the commenter to the Department’s response to Comment #198. PRN psychotropic medications are prescribed by a licensed practitioner and their use is governed by Sections 5(O) and 5(N) of this rule. No changes were made to the rule based on this comment.

200. **Comment:** Commenters 11 and 12 stated that their organizations are in support of the clarification of isolation in Section 5(O)(7) as it could be helpful in avoiding need for restraint and protecting the client and staff without any adverse effect.

**Response:** No changes to the rule are necessary based on this comment.

201. **Comment:** Commenter #3 asked for clarification of “minor misbehaviors” in Section 5(O)(7)(a).

**Response:** As a result of this comment, the Department has removed “or as a method of controlling minor misbehaviors” from this section of the rule due to subjectivity of this term.

202. **Comment:** Commenter #3 recommended the following revision to Section 5(O)(7)(b): “Other less restrictive responses must be attempted prior to the use of isolation. These may include, but are not limited to, verbal discussion, counseling, and voluntary timeout.”

**Response:** As a result of this comment, the Department has amended this section of the rule to replace “considered” with “attempted.”

203. **Comment:** Commenter #3 recommended the following revision to Section 5(O)(7)(c): “Isolation may include facility staff preventing egress by standing in the doorway while engaging in approved de-escalation techniques.” Any denial of egress is seclusion.

**Response:** Please see the Department’s response to Comment #28 and Comment #40. No changes were made to the rule based on this comment.

204. **Comment:** Commenter #3 stated that these protections should also be applied to any use of seclusion (in a Level 2 Facility or hospital) and restraint (in any setting) in Sections 5(O)(7)(d) through (h).

**Response:** The Department finds the requirements in 8(E)(18) through (20) are sufficient for the purposes of the rule. Therefore, no changes were made based on this comment.

205. **Comment:** Commenters 13 and 14 stated that as written in Section 5(O)(7)(g), a resident can be isolated indefinitely with administrative approval every two hours. The commenters stated that this is a significant shortcoming and might even violate rights guaranteed in other State and federal rules and statutes. The commenters concluded that a reasonable time limit should be placed on the total time a resident may be isolated.

**Response:** Please see the Department’s response to Comment #28. The Department has also determined that there is adequate oversight of the process due to the requirement for policies, adherence to residential plans and that fact that it requires administrative approval is required to be issued, justified and documented every two hours. No changes were made to the rule based on this comment.
5(P). Physical plant

206. **Comment:** Commenter #11 agrees with the Department’s effort to add and clarify physical plant requirements in Section 5(P) and endorse efforts to maintain livable and safe conditions.

**Response:** No changes to the rule are necessary based on this comment.

207. **Comment:** Commenter #5 stated regarding Section 5(P)(2), “all building sites must be accessible for the population intended to be serviced,” that accessibility should be subject to Section 5(H)(1)(n)(ii), concerning modifications that may be readily implemented without significant effort or expense in the case of existing facilities.

**Response:** The Department has added, “as described in Section 5(H)(1)(n)(ii),” to Section 5(P)(2) of the rule in response to this comment.

208. **Comment:** Commenter #12 stated that public water systems in Maine already test for lead and provide public notice of unacceptable lead levels, adding that there would be no additional action that a property owner could do to affect lead levels in a public water system as required in Section 5(P)(8). The commenter stated that there is no purpose for facilities on public water to conduct additional tests for lead and added that this testing requirement should be removed.

**Response:** Due to the fact that high levels of lead can often be found in fixtures such as faucets, which lies outside the scope of a public water system’s control, and due to the Department’s commitment to protecting children in Maine from lead poisoning from all sources including drinking water, no changes have been made to the rule based on this comment.

209. **Comment:** Commenter #3 asked if the Department has a position on locked windows in residents’ rooms in Section 5(P)(12).

**Response:** The State of Maine Fire Marshall requires egress windows, unless the building contains adequate sprinkling systems. Windows would be required to be unlocked, except for manufacturer-installed locks. Windows and doors may be alarmed if they are opened without authorization. No changes were made to the rule based on this comment.

210. **Comment:** Commenter #3 recommended the following revision to the rule by adding Section 5(P)(12.5): “Delayed egress doors. Delayed egress doors are only permitted in Level 1 and 2 secure capacity facilities.”

**Response:** The Department does not consider delayed egress to be locked and, therefore, should not be restricted to just Section 8. No changes have been made to the rule based on this comment.

211. **Comment:** Commenter #3 asked whether there is a policy on renewal licenses for facilities with resident bedrooms with smaller amounts of floor space per person and whether they be “grandfathered in” in relation to Section 5(P)(21)(b).

**Response:** This section of the rule applies only to new facilities constructed after January 1, 2018. Section 5(P)(21)(b) refers to existing facilities and are grandfathered. No changes were made to the rule based on this comment.

212. **Comment:** Commenter #4 discussed the increase of square footage for bedrooms in newly-constructed facilities as described in Section 5(P)(21)(b). The commenter stated that while a child may spend a good amount of time in the bedroom, the focus should be on making sure that the child is involved in daily activities within the residence.
Response: No changes to the rule are necessary based on this comment.

213. Comment: Commenter #12 stated that the bedroom size increase is a substantial increase from the present rule; referring to Section 5(P)(21)(b). The commenter stated that the present requirement has not resulted in placement of children in spaces that are too small and that maintaining the present space requirement is recommended. The commenter stated that if the space requirement is increased, the safety factor of being able to move around a bed or other furniture to exit in case of fire would be alleviated in a facility with a sprinkler system. The commenter stated that any increase in the space requirement should not apply to a facility with an active sprinkler system. The commenter stated that with regard to a new license, a facility could be temporarily used for a different purpose and then returning that facility to a child residential use could be regarded as a new license, or a change in the applicable modules or status of its license could be considered a new license. The commenter stated that returning the facility to residential use should be allowed without imposing the increased requirements. It should be clarified that the new space requirement does not apply to facilities that had been licensed as residential child care facilities at any time prior to January 1, 2019.

Response: The Department has reviewed this requirement and has determined that it is adequately covered in Section 5(P)(22)(b). If the circumstance arises where a facility opens a pre-existing structure, the facility may apply for a waiver. No changes were made to the rule based on this comment.

214. Comment: Commenter #3 noted in regard to Section 5(P)(22)(g), the verb is missing in the following statement; “Bathtubs and showers with slip-proof surfaces.

Response: Based on this comment, the Department has amended this section of the rule to read “Bathtubs and showers must contain slip-proof surfaces;”

215. Commenter: Commenter #3 asked for clarification in meaning for Section 5(P)(22)(i): “Bathroom facilities must contain other furnishings necessary to meet each resident’s basic hygiene needs.”

Response: The Department finds that this section is clear enough to meet the needs of the rule. No changes have been made to the rule based on this comment.

216. Comment: Commenter #11 agreed with the prohibition of firearms and other weapons in Section 5(P)(26), but recommended an exception for law enforcement personnel who are on the property in their official capacity.

Response: As a result of this comment the Department has added the following language to this section of the rule; “If law enforcement personnel enter the premises in an official capacity, they may carry weapons.”

217. Comment: Commenter #3 recommended the following revision to Section 5(P)(30): “Equipment. The facility must timely replace or repair broken, run-down or defective furnishings and equipment.”

Response: The Department has determined that the addition of “timely” would be too subjective and can vary depending on the equipment and furnishing in need of repair. No changes were made to the rule based on the comment.

SECTION 6. PERSONNEL QUALIFICATIONS AND TRAINING

6(A). Qualifications

218. Comment: Commenter #3 stated that in Section 6(A)(3) the phrase, “Exercise good judgement” is very subjective.
Response: The Department finds that the wording in this section is sufficient. No changes have been made based on this comment.

219. **Comment:** Commenter #3 recommended the following revision to the rule in Section 6(A)(9)(b): “The facility must ensure that all staff providing therapeutic services must have clinical supervision in person from appropriately trained, licensed or certified individuals at least weekly.”

**Response:** The Department does not wish to exclude other means and methods of clinical supervision. No changes were made to the rule based on this comment.

220. **Comment:** Commenters 1 and 11 stated that there is a problem in getting potential employees to obtain a doctors’ note, as specified in Section 6(A)(11), which states that potential employees be free from communicable disease, prior to employment. The commenters added that if the potential employee is asked to provide a doctors’ note, they will most likely move on to the next interview. The reason, added the commenters, is that most prospective employees don’t have medical insurance. The commenters requested that this rule be eliminated and instead follow the adult services system, where there is no required doctors note, but instead, follow the reporting requirements from the CDC for staff immunizations. The commenters recommended changing the rule to make it so that the prospective employee could provide the medical note 48 hours after employment, as they would then have medical insurance. Commenter #8 stated that in his 19 years of experience with his agency, after hiring hundreds of staff, not one staff person has failed to obtain a medical statement to work, there is minimal evidence that employees were identified as not qualified to work due to a communicable disease. Commenter #8 added that education professionals are not required to obtain a medical statement prior to their employment. Commenter #11 recommended that if the Department feels it is not appropriate to eliminate this requirement, then “prior to employment” should be modified to “prior to substantive contact with residents”. Commenter #3 stated in reference to Section 6(A)(11), the requirement for new staff obtaining a medical statement prior to employment, indicating that they are free of communicable diseases, “disability” is listed and should not be considered a communicable disease.

**Response:** It is the responsibility of the facilities to ensure that their employees can safely perform the duties of their job. The Department has removed this section from the rule in response to this comment.

### 6(B). Background Checks

221. **Comment:** Commenter #4 stated that while he appreciates the need for background checks, the inability of staff to work alone until background check information is received as stated in Section 6(A)(4), would be challenging for providers. The commenter stated that the greatest challenge is the “Maine Child Protective records and out-of-home investigation reports.” The commenter stated that they can be very lengthy, taking from months to a year to receive information. The commenter added that this waiting period is very costly to providers and would have a significant impact on a providers ability to run a program if staff could not be alone with a child.

**Response:** The Department must meet the requirements of the Maine Background Center Program and without background check information, the safety risk for residents would be too high to have individuals work independently with residents. No changes were made to the rule based on this comment.

222. **Comment:** Commenter #11 stated that the background check section in Section 6(B)(1), does not reference the Maine Background Check Center. The commenter stated that this omission seems like an oversight as failing to mention it could replace the need for several other background checks. The commenter stated that this requirement is another unfunded mandate, adding that this requirement is also the case with the requirement for repeating background checks every five years.
Response: Based on this comment, the Department has amended Section 6(B)(1)(a) of the rule to include a reference to add “in accordance with the Maine Background Check Center Act.” The Department considers background checks to be essential for the health and safety of residents.

223. Comment: Commenter #4 stated that the previous rule allowed for provider discretion if there was an offense. The commenter stated that it could be reviewed by the agency and then the agency could decide if the person could work given that offense. The commenter stated that this stipulation wasn’t reflected in the proposed rule. The commenter also added that motor vehicle related convictions are an area of concern, an individual cannot transport clients for three years if he or she has a motor vehicle conviction. The commenter stated that it can be difficult at times to comply with Section 6(B)(3)(E). The commenter stated he does understand if the violation is an OUI.

Response: The Department refers the commenter to Section 6(B)(3)(E), “if the facility determines that a person identified by the above criteria is rehabilitated and that the residents in care would not be endangered by the person's involvement, documentation of evidence must be placed in the personnel file prior to that person's involvement in any capacity.” Section 6(B)(1)(C) only refers to OUI convictions. The Department has clarified this section of the rule by changing “for operating under the influence” to “related to operating under the influence.”

6(C). Training requirements

224. Comment: Commenters 17 and 18 stated that there is an absence of training requirements in multiple areas of the proposed rule, which undercuts protections provided by the proposed rule. The commenters gave an example, “facilities must maintain particular “resident rights” policies for persons aged 18-21, including the rights to “a safe and healthy environment,” to be “free from discrimination,” to “reasonable accommodations and services,” as well as “freedom from harmful actions or practices,” among others.” The commenters, however, stated that they are unaware of any State guidance for providers or youth about what those standards mean in practice. The commenters stated that the policies are required, because they are important, and added, that without State standards, they are close to useless. The commenters stated that, as with most of the required policies, there is not even required training by facilities for their staff. The commenters compared the policies from Section 5(E)(9), and personnel training at Section 6(C). The commenters recommended that the Department minimally, should revise Section 6(C) to mandate training on all topics concerning rights and protections for residents.

Response: The Department has added rights training for all staff during the orientation and regularly thereafter.

225. Comment: Commenters 1 and 8 stated that the rule requires all staff, including volunteers and interns in Section 6(C)(2), to have training in restraints. Commenter #1 stated that her organization would not place a volunteer or an intern in a situation that involved the use of restraints. The commenters requested that the requirement be reflective of their role within the agency, the positions are time limited, used in the interest of learning and work with other full-time staff members. The commenters stated that they would not have direct supervision requirements. The commenters recommended that this requirement for volunteers and interns be removed from the training requirements.

Response: As a result of this comment the Department has amended Section 6(C)(2)(a) and (b) as follows:

Orientation training requirements. All personnel, volunteers, interns and students, who have direct responsibility to care for residents must be oriented and trained in at least the following areas:

a. The facility's program goals and standard operating procedures,
b. Physical restraint techniques, if used, except that volunteers, interns and students would not be allowed to apply restraints;

226. **Comment:** Commenter #11 stated that the amount of orientation training required for interns and volunteers eliminates a number of opportunities for residents as in the past they have been able to have volunteers in to teach carpentry, gardening, cooking, art or music in Section 6(C)(2). The commenter recommended a much lower bar for volunteers who have resident contact only when in the presence of staff.

**Response:** As a result of this comment the Department has amended Section 6(C)(2) of the rule to add interns to those who must be oriented and trained and has replaced the phrase “contact with” in the proposed rule with “responsibility to care for.”

227. **Comment:** Commenter #12 stated that case management is performed by a trained case manager, often external to the residential agency, and not by residential direct care staff as described in Section 6(C)(4)(c). The commenter stated that requiring staff to be trained in case management each year would not be beneficial for direct care staff. The commenter recommended removing this specific annual training.

**Response:** As a result of this comment, the Department has revised a renumbered Section 6(C)(4)(d) of the rule to remove “case management” and has added “documentation standards.”

228. **Comment:** Commenters 11 and 12 stated that the amount of trainings required in Section 6(C)(4)(c) is difficult for part time staff and especially for relief staff, whose outside commitments may make the many trainings a burden. The commenters stated that relief staff are very important to program operations and safety. The commenters recommended flexibility that would help to alleviate the staffing pressure and added the trainings should be allowed to be taken over a two-year period for staff regularly working fewer than 30 hours a week and over a three-year period for staff regularly working on a relief or as-needed basis.

**Response:** As a result of this comment, the Department has amended the training requirements in Section 6(C)(5) by including biennial training requirements for part-time employees. This does not apply to part-time employees working in a Level 2 facility.

6(D). Distant site practitioners

229. **Comment:** Commenter #3 recommended the following revision to Section 6(D)(1): “Distant site practitioners may not be exclusively used and must be clinically indicated. To provide an included service by distant site practitioner, a provider must obtain written approval from the Department, renewed yearly. The provider must prove that it cannot find a qualified in-person provider in the geographic region to provide the required service.”

**Response:** The Department has determined that this level of oversight is not required for this rule. No changes were made to the rule based on this comment.

230. **Comment:** Commenter #12 stated that the term “clinically indicated” in Section 6(D)(1), when describing the use of distant site practitioners, is too vague. Instead of “clinically indicated” the commenter recommends, “clinically appropriate” adding that this would align with the MaineCare telehealth policy. The commenter added that the MaineCare telehealth policy allows telephonic telehealth, if interactive communication equipment is unavailable and that this should be allowed in this rule. The commenter recommended that this licensing rule incorporate by reference the MaineCare telehealth policy. The commenter stated that is not clear why telehealth may not be used in secure capacity facilities.

**Response:** As a result of this comment, the Department has amended this section of the rule by changing “clinically indicated” to “clinically appropriate.” The Department refers the commenter to the Department’s response to Comment #27 in regard to telehealth.
231. **Comment:** Commenter #3 stated that Sections 6(D)(2) and 6(D)(3) seem to contradict each other. Commenter #3 stated that D(2) says “Family counseling is the only permissible teleservice for children’s residential treatment facilities with secure capacity,” and D(3) says “Teleservice … is not allowable for children’s residential treatment facilities with secure capacity.”

**Response:** The Department has determined that the requirements in these sections of the rule are appropriate. Higher acuity clients in secure capacity levels of care require on-site treatment. No changes were made to the rule based on this comment.

232. **Comment:** Commenter #11 stated that under the section Distant Site Practitioners, permitted services in Section 6(D)(4), the reference to pharmacological management seems at odds with Section 5(N)(17)(b), which requires “actual observation of the resident.” The commenter asked if it was the Department’s intent of teleservice to include both a visual and auditory component.

**Response:** The Department intended to state that teleservice must include both a visual and an auditory component. No changes were made to the rule based on this comment.

233. **Comment:** Commenter #6 asked if qualified distant site practitioners include ancillary services such as speech and language therapy by a speech pathologist (for on-site educational services for all residential programs except facilities with secure capacity) in Section 6(D)(5). The commenter noted that ancillary services are not listed in the defined qualified distant site practitioners, yet they are utilized in school administrative units and special purpose private schools when warranted.

**Response:** Distant site practitioners can also include other qualified professionals as indicated in the residential service plan. Based on this comment, this section of the rule was revised to include “or other qualified professionals as indicated in the residential service plan.”

6(E). Independent contractors

234. **Comment:** Commenters 1 and 8 stated that Section 6(E)(6) requires a provider to perform a quality assurance (QA) review for every independent contractor. The commenter stated that her agency has close to 20 independent contractors and that a QA review for each contractor would be difficult. The commenter asked why would a provider needed to perform a separate QA review for each contractor, adding that this requirement is confusing. The commenter recommends including consultants in the agencies existing QA process and not adding an additional burden to do independent reviews.

**Response:** As a result of this comment, the Department has removed this section from the rule. The language in 6(E)(4)(c) is sufficient for an organization to monitor the services of an independent contractor.

**SECTION 7. DAILY OPERATIONS**

235. **Comment:** Commenter #11 stated the phrase “knowledge of the location of each resident at all time” in Section 7(A) seems overly broad. The commenter stated that it is developmentally appropriate for some residents to have unsupervised access to the community, including work and school. The commenter added that staff may have knowledge of approximately where a resident is supposed to be, but not their exact whereabouts.

**Response:** While it is developmentally appropriate for some residents to have unsupervised access the community, the rule was intentionally written so as not to conflict with these types of situations. No changes were made to the rule based on this comment.

236. **Comment:** Commenters 12 and 19 requested that the Department reconsider whether there is a need to reinstitute the five-year age range between residents required in Section 7(B)(6). The commenters stated that
this requirement was enforced years ago, but its enforcement stopped when it was recognized that it lacked any regulatory basis in the licensing rule. The commenters stated that his organization was not aware of any instance in which an exception request was denied, due to age differences between residents. The commenters stated that intake staff, then and now, carefully consider age range and other factors before approving a client to be placed in a program. The commenters added that exception requests were only submitted when clinically appropriate. The commenters stated that they believe other licensed agencies also follow an appropriate clinical evaluation process at intake. The commenters questioned whether there is sufficient need for this age range rule, as it is a burden for both agencies and the staff of the licensing unit to undertake the exception request and approval procedure. The commenters recommended “exceptions” to be clarified in this rule.

Response: The Department finds this requirement to be necessary to ensure that such decisions are based on sound clinical judgement. No changes were made to the rule based on this comment.

237. Comment: Commenter #3 recommended the following revision to Section 7(C)(2): “The facility may place limitations on the amount of money a resident may possess or have unencumbered access to, when such limitations are considered to be in the resident's best interests and are included in the resident's service plan pursuant to RRMHS – Children B(II)(H)(3) and the comparable provisions in the adult RRMHS.”

Response: The Department determined that resident rights are adequately protected and addressed within the rule. The rule also contains requirements relating to services other than mental health services. No changes were made to the rule based on this comment.

238. Comment: Commenter #3 stated that facilities should consider learning more about restorative justice as an alternative to monetary restitution in Section 7(C)(3).

Response: Nothing in the rule precludes a program from implementing restorative justice. Section 7(C)(3) states a facility may deduct reasonable sums of money from a resident’s allowance as restitution. The term “may” in this section of the rule implies that this would be optional. No changes were made to the rule based on this comment.

239. Comment: Commenter #3 asked why uniforms would be required in Section 7(D)(2) as they do not seem therapeutic or least restrictive.

Response: While some facilities require uniforms, the Department has removed the proposed Section 7(D)(1) from the rule.

240. Comment: Commenter #3 recommended permitting the lending and borrowing of clothing between children stating that while it can create complications, it is also a developmentally common and appropriate practice for youth in Section 7(D)(2).

Response: The rule in Section 7(D)(2), prohibits the sharing of clothing, “in common” however nothing in the prohibits individual residents from sharing their personal clothing with each other if it is their personal choice. No changes were made to the rule based on this comment.

241. Comment: Commenter #3 recommended the following revision to Section 7(E): “The facility must identify its religious orientation, if any, along with particular religious practices that are observed, and facility restrictions, based on religion. When feasible, residents shall may attend religious activities and services of their choosing in the community, and when necessary, the facility arranges such transportation.”

Response: The Department understands that facilities may not always be able to accommodate these arrangements. No changes were made to the rule based on this comment.
242. **Comment:** Commenter #3 recommended the following revision to Section 7(I)(3): “Residents with disabilities. Transportation accessibility. The operator of any vehicle transporting residents must be informed of any resident’s transportation accessibility needs, which the facility will accommodate as required by law. Need or problem of a resident which might cause difficulties during transportation, such as seizures, a tendency towards motion sickness or a disability. The facility will provide for the accessibility of appropriate transportation for residents with disabilities.” The original language seemed to presume (and stigmatize) physical disability. Essentially all youth in residential care have a disability of some type – mental illness, developmental disability, etc. This section isn’t really about disability, it’s really about transportation.

**Response:** Based on this comment, the Department has amended this section of the rule to read, “Transportation accessibility. The operator of any vehicle transporting residents must be informed of any resident’s transportation access needs. The facility will provide appropriate transportation for the accessibility needs of residents.”

243. **Comment:** Commenter #3 recommended the following revision to Section 7(J)(1)(g): “Training residents and personnel to evacuate the building, taking into account the needs of all the individuals who can reasonably be expected to be in the building during an emergency, including specialized training as necessary for the evacuation of residents and persons with disabilities;”

**Response:** Based on this comment, the Department has amended this section of the rule to read, “Training residents and personnel to evacuate the building, taking into account the needs of all individuals; conditions that may impair their ability to evacuate or their ability to understand the nature or purpose of the evacuation”

244. **Comment:** Commenter #3 recommended the following revision to Section 7(J)(6)(c): “Care must be taken to ensure that all the residents’ individual needs are accommodated in evacuation plans. Provisions must be made for the evacuation of residents with disabilities.”

**Response:** As a result of this comment, the Department has amended the rule, at Section 7(J)(6)(c) to read: “Care must be taken to ensure that all the residents’ individual needs are accommodated in evacuation plans.”

### SECTION 8. SPECIALIZED PROGRAMS

#### 8(A). Mental health treatment

245. **Comment:** Commenter #3 questioned why progress notes needing to be written per shift and whether it was realistic to expect that each resident will make progress toward their goals on each shift? Commenter #11 recommended one progress note per day as an alternative for Section 8(A)(3).

**Response:** Based on this comment, this renumbered Section 8(A)(4) was changed from progress notes to residents notes, it now reads; “Resident notes. The facility must require at least one note per shift in each resident’s record, which provides a detailed, specific observation of the resident’s behavior. Such accounts include, but are not limited to, progress notes or an assessment of the resident’s daily skills relevant to the resident’s service plan. These notes must be written, dated, timed and signed by a staff member who directly worked with the resident during that shift.

246. **Comment:** Commenter #11 recommended in Section 8(A)(5)(b) that the Department include licensed master’s social worker, conditional clinical and LCPC, conditional.

**Response:** Clinical supervisors are required to have a full license before they can supervise staff. No changes were made to the rule based on this comment.
247. **Comment:** Commenter #3 recommended the following revision to Section 8(A)(5)(b)(iv): “Be available, or ensure the availability of, an appropriate clinician for emergency consultation and intervention 24 hours a day, 7 days a week.”

**Response:** The Department believes that it is the responsibility of the facility to regulate personnel oversight. No changes were made to the rule based on this comment.

248. **Comment:** Commenters 1, 12 and 19 stated that the hours required for clinical supervision in Section 8(A)(6) have doubled from two to four hours per month, adding that this will be a burden, especially for smaller programs. The commenters stated that a direct care staff person may on occasion miss one or possibly two meetings in a month. It would be very difficult to ensure that all staff members attend all four team meetings a month. The commenter stated that the increase in the clinical supervision requirement will also result in an increased cost to providers. The commenters recommended keeping the requirement to two hours of clinical supervision for all staff monthly.

**Response:** As a result of this comment, the Department has reduced the number of clinical supervision hours required from four to two hours for full-time staff and from two hours to one hour for part-time staff.

### 8(B). Substance abuse treatment program

249. **Comment:** Commenter #3 asked whether Section 8(B), Substance Abuse Treatment Program applies to Day One programs.

**Response:** This rule will apply to all substance abuse programs where children are residing upon the effective date of this rule. No changes were made to this rule based on this comment.

250. **Comment:** Commenter #3 recommended the following revision to Section 8(B)(1)(e): “Able to treat co-occurring substance abuse and mental health disorders.”

**Response:** The facility may offer these services but the Department does require substance abuse facilities to treat co-occurring substance abuse and mental health disorders. No changes were made to the rule based on these comments.

251. **Comment:** Commenter #3 asked why the rule only requires substance abuse treatment programs to consult with a dietician, as stated in Section 8(B)(6).

**Response:** Diet is often neglected when residents present with substance abuse issues, which is why this requirement pertains to substance abuse treatment programs. No changes were made to the rule based on this comment.

252. **Comment:** Commenter #3 recommended the following revision to Section 8(B)(8): “Denial of admission. When admission is denied, the substance abuse treatment program must, in conjunction with the placing agency, facilitate referral of the child to alternative community resources for substance abuse. There must also be a process for appealing a denial of admission.”

**Response:** Facilities must comply with Section 5(E)(1) of this rule and follow their own admission policies and procedures. There is no requirement in law for such an appeal process. No changes were made to the rule based on this comment.

253. **Comment:** Commenter #3 recommended the following revision to the rule by adding Section 8(B)(10)(g): “The service plan must include a regularly updated description of limitations or restrictions on individual rights.”

**Response:** The Department refers the commenter to the Department’s response to Comment #237.
8(C). Education program

254. Comment: Commenter #6 recommend changes to the rule, to avoid confusion about responsibility for educational programming in relation to both the Department and the school administrative units in Section 8(C). The commenter stated that the Department and the school administrative unit determine the educational programming under State statute and regulations, and second, the programs that this rule addresses have the capacity to provide services to any student requiring this level of care, rather than only children with disabilities and individualized educational plans.

“An education program provided in a children’s licensed residential care facility licensed to directly provide an education program must be approved by the Maine Department of Education with oversight provided by the school administrative unit in which the institution is located, or any adjoining unit comply with the following provisions:

1. Department of Education rules. The following rules administered by the Department of Education must be followed:
   a. 05-071 C.M.R. Ch. 101 Maine Unified Special Education Regulation Birth to Age 20.
   b. 05-071 C.M.R. Ch. 33 Rule Governing Physical Restraint and Seclusion.
   c. 05-071 C.M.R. Ch. 250 School Approval for Nontraditional Limited Purpose Schools.

2. Department of Education statutes. The facility must comply with Department of Education applicable statutes, 20-A.M.R.S. Ch. 301 and Ch. 303.

3. Health, hygiene, safety and immunization requirements. When the health, hygiene, safety and immunization requirements in this rule and applicable statutes are more stringent than the Department of Education rules or statutes, the requirements of this rule and applicable statutes must apply.”

Response: As a result of this comment and with input from the Assistant Attorney General, the Department has amended and moved Section 8(C) to Section 4(A)(1)(b)(xiv). It now reads as follows: “An education program provided in a licensed children’s residential care facility must be approved by the Maine Department of Education with oversight provided by the school administrative unit in which the institution is located, or any adjoining unit.”

8(D). Children’s residential care facility with secure capacity (Level 1)

255. Comment: Commenter #6 stated that a different format (including topic titles) was utilized to outline the Children’s Residential Treatment Facility with Secure Capacity Level 1 Facility and the Level 2 Facility in Section 8, Specialized Programs. The commenter stated that the different format makes it difficult to compare the rule requirements. The commenter provided an example regarding the expectations for duration of stay for a Level 1 Facility which is addressed on page 70 in 11, “Weekly service plan team meetings” whereas a Level 2 Facility duration of stay is addressed on page 71 under 3 “Duration of care” and 4 “Service plan.” The commenter stated that in other examples, discharge planning is outlined for Level 2 facilities, but not for Level 1 facilities and the use of restraints and seclusions are outlined in detail for Level 2 facilities and only chemical restraints are outlined under Level 1 facilities. The commenter requested clarification on which requirements apply only to Level 1 facilities, which apply to only Level 2 facilities, and which apply to both Level 1 and Level 2 facilities. The commenter added that the standards for Level 1 and Level 2 facilities would be easier to read and navigate, for both providers and consumers, if they were written with consistent formats and outlines.

Response: This rule is written so that the requirements within one section build upon the previous sections. Facilities with specialized programs in the core requirements of the rule, and Level 1 facilities in renumbered Section 8(C) must meet all the requirements of 8(C), plus the core requirements in Section 5 of this rule. Level
2. Facilities must meet core requirements in Section 5, additional requirements in 8(C) and the requirements of renumbered 8(D). Additional requirements from Section 8(D) which are mentioned in Section 8(C), do not apply to Level 1 facilities and are not required for Level 1 facilities. No changes were made to the rule based on this comment.

256. **Comment**: Commenter #3 stated that security and safety are important in a Level 1 Facility as outlined within Section 8(D), however the least restrictive environment is also very important. The commenter stated that the facility should not feel like a fortress.

**Response**: No changes were necessary to the rule based on this comment.

257. **Comment**: Commenter #11 stated that he understands that a Level 2 Facility described within Section 8(E), is intended to apply to psychiatric residential treatment facilities but wants to know more of the Department’s intent regarding the inclusion of Level 1 facilities under Section 8(D), when nothing in the State seems to fall within this category. The commenter stated that the section describes a high-level facility that includes an on-site school, a registered nurse, and a high-level of staffing. The commenter stated that there is no mechanism current or proposed to cover this service.

**Response**: The Department has included Level 1 facilities as a treatment option even though no Level 1 facilities exist at the time of the proposed rule. Reimbursement mechanisms are beyond the scope of this rule. No changes were made to the rule based on this comment.

258. **Comment**: Commenter #3 asked who in a Level 1 Facility under Section 8(D), performs the diagnostic assessment. The commenter also stated that a locked setting only prevents elopement; it does not prevent harm to self or others, nor does it provide any therapeutic benefit in treating self-harm or assaultive behaviors.

**Response**: Section 5(J)(1)(a) states, “The comprehensive assessment must be completed by a qualified person, as defined by the program.” Elopement from a facility puts that individual at risk for harm. No changes were made to the rule based on this comment.

259. **Comment**: Commenter #3 asked what the facility and DHHS do with the data of annual restraints and isolation and recommended the tracking of seclusion in Section 8(D)(3). The commenter also asked why regular residential treatment programs do not have to track these numbers.

**Response**: This rule does not dictate how facilities utilize this information, however the Department must ensure that facilities track this information to drive service plans and inform their policies. This data is not submitted to Children’s Licensing and Investigation Services, but data collection and submission is a requirement of the Office of Child and Family Services. No changes were made to the rule based on this comment.

260. **Comment**: Commenter #3 noted that a CRMA can give medications in other settings and asked why they are unable to give medications in a Level 1 setting as noted within Section 8(D)(5).

**Response**: The rule does not exclude CRMAs from administering medications. Section 8(C)(5) includes, “an individual who has completed other medication administration courses approved by the Department.” No changes were made to the rule based on this comment.

261. **Comment**: Commenter #3 was concerned about the requirement in Section 8(D)(6), for residents age 14 and older, who refuse prescribed psychotropic medication, to have an evaluation to determine their risk to jeopardize themselves or others. The commenter stated that this seems like a rights violation. The commenter asked if this is true in a psychiatric hospital.
Response: This requirement is in place to ensure the safety of the resident and others. Since this rule does not regulate psychiatric hospitals. The Department refers the commenter to 10-144 CMR Ch. 12, Rules for the Licensing of Hospitals. No change was made to the rule based on this comment.

262. Comment: Commenter #3 would like to see more clarification for the training requirements for mechanical restraints and the details of their use in Section 8(D)(9).

Response: Based on this comment, this renumbered Section 8(C)(9) of the rule was amended to clarify that personnel must receive annual training on “all restraint techniques used.” The Department does not dictate specific training requirements. Staff are expected know how to adequately use mechanical restraints.

263. Comment: Commenter #3 recommended the following revision to Section 8(D)(11), “Weekly service plan team meetings. The service plan team, including (whenever possible) residents and families, must meet weekly to review each resident’s progress regarding the goals and objectives identified in the resident’s service plan. Revisions must be made as needed. Restrictions and limitations on rights must be reviewed at these meetings.”

Response: Based on this comment, the Department has added, “including (whenever possible) residents and families,” to this section of the rule. The Department refers the commenter to the Department’s response to Comment #237 in regard to limitations on rights.

8(E). Children’s residential care facility with secure capacity and psychiatric treatment (Level 2)

264. Comment: Commenter 16 stated that the proposed rule is focused mostly on behavioral treatment and not as much on clinical treatment expectations within Section 8(E). The commenter recommended revising the rule to define the behavioral treatment and to require that each program clearly defines the evidence-based clinical treatment that they provide, such as, cognitive behavioral therapy (CBI), dialectical behavior therapy (DBI), etc. The commenter concluded that developing and distributing such a requirement will ensure that clinical treatment, and not just behavioral modification, is clearly expected in a Level 2 Facility.

Response: The Department does not dictate the types of treatment modalities that are utilized. No changes were made to the rule based on this comment.

265. Comment: Commenter #3 stated that the open-ended duration of care is problematic for a Level 2 Facility in Section 8(E), and was concerned that this could easily lead to “stuck kids.”

Response: The length of service is individualized based on medical need and the residents service plan. No changes were made to the rule based on this comment.

266. Comment: Commenter #16 stated that she was concerned that the proposed rule did not include autism spectrum disorder in the qualified diagnoses for admission into a Level 2 Facility in Section 8(E), and recommended its inclusion.

Response: A primary psychiatric diagnosis is required for admission to a Level 2 Facility. The rule does not exclude children with a primary psychiatric diagnosis who may have a secondary diagnosis of autism spectrum disorder. No changes were made to the rule based on this comment.

267. Comment: Commenter #3 recommended the following revision to Section 8(E)(1), “A Children’s residential care facility with secure capacity and psychiatric treatment (Level 2 Facility), is a type of children’s residential care facility with secure capacity that provides psychiatric and intensive mental health treatment. In a Level 2 Facility, the treatment of the resident’s psychiatric condition requires medical supervision seven days per week and 24 hours per day, in a residential setting, and under the direction of a physician. Facilities providing this service must comply with all core licensing standards within this rule, including, but not limited to, Sections 5,
8(A) and 8(D) of this rule. In the event that a standard is more stringent in either this section or another section of this rule, the more stringent standard will apply. Further, with regard to the Rights of Recipients of Mental Health Services Who Are Children in Need of Service (‘RRMHS-Children’), a Level 2 Facility shall be treated as an ‘inpatient psychiatric unit’ for the purposes of RRMHS-Children Part B. Thus, RRMHS-Children Part B(III), ‘Individualized Treatment or Service and Discharge Plan,’ shall apply to service, treatment, and discharge planning in a Level 2 Facility. No subsection of Part C of RRMHS-Children shall apply to a Level 2 Facility.”

Response: The Department has determined that the language of the rule is sufficient as it is currently written. No changes were made to the rule based on this comment.

268. Comment: Commenter #3 requested a definition for active psychiatric condition in Section 8(E)(2).

Response: An active psychiatric condition refers to a psychiatric diagnosis. No changes were made to the rule based on this comment.

269. Comment: Commenter #6 asked for clarification on the timelines outlined in Sections 8(E)(3), 8(E)(4a), and 8(E)(4b) to prevent timeline confusion in implementation.

Response: The Department intentionally omitted a time limit as it is based on resident individual needs and service plans. The Department determined that the rule is written sufficiently. No changes were made to the rule based on this comment.

270. Comment: Commenter #3 recommended the inclusion of a requirement of resident and family input in the service plan in Section 8(E)(4).

Response: Section 5(K), Core Licensing Requirements, Service plans, already has sufficient language to include the parents and other significant persons involved in the resident’s life. No changes were made to the rule based on this comment.

271. Comment: Commenter #3 recommended the following revision to Section 8(E)(5)(a): “Behavioral and/or rehabilitative therapies, the specific modality to be described in the resident’s service plan. The plan must be individualized, and must be the most appropriate plan designed to help the resident progress quickly and successfully to a less restrictive level of care. Therapy must include at a minimum, the following;”

Response: The Department finds that the language in Section 5(K), Core Licensing Requirements, Service plans, is sufficient. No changes were made to the rule based on this comment.

272. Comment: Commenter #16 stated that her organization believes the medical director requirement in Section 8(E)(7)(a), of Level 2 facilities should have special training in the treatment of youth. The commenter recommended changing the personnel qualifications of the medical director to the following: "A medical director is responsible for overall program implementation, individualized service planning, interventions, and key decision-making regarding a resident's treatment. The medical director must be either: Board Certified or Board Eligible psychiatrist specifically in Child and Adolescent Psychiatry; or ABA Certified Psychologist and Pediatrician."

Response: The Department encourages providers to seek medical directors with this experience. However, adding this requirement to the rule is not feasible at this time due to the consideration of added costs to providers. No changes were made to the rule based on this comment.

273. Comment: Commenter #3 recommended the following revision to the rule by adding Section 8(E)(9)(c), “Trauma informed care and child development.”
Response: The Department finds that the language in Section 5(K), Core Licensing Requirements, Service plans is sufficient. No changes were made to the rule based on this comment.

275. **Comment:** Commenter #3 recommended the following revision to Section 8(E)(10)(b), “The resident’s natural supports, including family or legal guardian, school personnel, and community providers, must be considered in the development of the discharge plan. The resident’s family or legal guardian must be involved in the development of the discharge plan, as must the resident;”

**Response:** Based on this comment, the Department has amended this renumbered Section 8(D)(10(b) of the rule to read, “The resident and the resident’s natural supports…”

276. **Comment:** Commenter #3 recommended the following revision to the rule by adding Section 8(E)(10)(f), “appropriate discharge services in place.”

**Response:** Section 5(L)(2)(c) addresses safe and appropriate discharge. No changes were made to the rule based on this comment.

277. **Comment:** Commenter #2 is concerned about the “host” of restraints, as well as isolation and seclusion included in the proposed Section 8(E)(11). The commenter is concerned that a resident can be restrained indefinitely with administrative approval every two hours. The commenter noted that in the rule, isolation can last up to two hours and added that no isolation should ever occur for youth longer than two hours. The commenter encouraged the time limits be adjusted for children less than 12 years old, to no more than 30 minutes. Commenter #3 stated that restraints should be used sparingly as they are retraumatizing for many children.

**Response:** The Department reviewed this comment and determined that the current language included adequately describes the process by including administrative approval every two hours. The rule does not state that seclusion and restraints can be administered infinitely. The length of time of the intervention are treatment based and can only be ordered by a physician, physician assistant or other licensed practitioner. No changes were made to the rule based on this comment.

278. **Comment:** Commenter #10 stated that the proposed rule includes a statement that the use of restraints and seclusions at Level 2 facilities may be employed only in an emergency in Section 8(E)(11); yet, there is no such clarification for Level 1 facilities in Section 8(D). The commenter stated that the use of restraint and seclusion is traumatic, regardless of facility level. The commenter stated that seclusion and restraint at a Level 1 Facility should only be employed at the approval of doctor, physician assistant or other licensed practitioner. The commenter stated that seclusion and restraint should not be implemented for non-emergencies, and that their use should be monitored for the effects on a child. The commenter added that there is no reason that the standards for use of restraint and seclusion that are set forth in the Proposed Rule 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Section 107, Psychiatric Residential Treatment Facilities (107.08-02) should not also apply to Level 1 facilities. The commenter stated that there is no mention in the rule of these additional safeguards on the use of seclusion and restraint for any type of facility.

**Response:** As a result of this comment, the Department has added more detail on the use of restraints to the core licensing standards in Section 5(O)(8) through 5(O)(12). These changes include more detail regarding the use of restraints, acknowledgment, monitoring, documentation and debriefing after the use of restraints. The Department continues to only allows seclusion in secured capacity facilities as described in Sections 8 (D) and 8(E) of this rule.

279. **Comment:** Commenter #16 stated that her organization is concerned about the inclusion in Section 8(E)(11) of the use of seclusion and restraints in the proposed Level 2 Facility. The commenter recommended that the Department include in the final rulemaking an expectation that programs will collect seclusion and restraint data
and to measure against national benchmarks. The commenter added that without these measurements and standards to work toward minimizing the use of seclusion and restraints, the commenter feared that the State may be moving backwards in our standards of care for treatment of youth. Commenter #2 requested that the following be added to the list of reporting requirements for all restraints, seclusions and isolations:

- Documentation of the beginning and ending time of each restraint, isolation or seclusion;
- Total time of the restraint, isolation or seclusion;
- Description of prior events and circumstances immediately before the restraint, isolation, or seclusion was employed;
- Less restrictive interventions tried prior to the use of restraint, isolation, or seclusion. If none used, explain why;
- The behavior that justified the use of restraint, isolation, or seclusion;
- A detailed description of the restraint, isolation, or seclusion used;
- Staff person(s) involved, their role in the use of restraint, isolation, or seclusion and their certification, if any, in an approved training program;
- Description of the incident including the resolution and process of returning to program, if appropriate;
- If resident or staff sustained bodily injury, the date and time of medical personnel notification and treatment administered, if any; and
- Date, time, and method of parent or guardian notification.

Response: The Department believes that this information extends beyond what is necessary for the licensing of children’s residential care facilities. No changes were made to the rule based on this comment.

280. Comment: Commenter #3 recommended the following revision to Section 8(E)(11)(a); “When the intervention is necessary to protect the resident from causing harm to self or others and to prevent further serious disruption that significantly interferes with others’ treatment. Restraint or seclusion must not be utilized solely to address the comfort, convenience, or anxiety of staff, or as a form of coercion, discipline, or retaliation, and “The commenter also stated that, “restraint and seclusion cannot be used to prevent disruption!”

Response: As a result of this comment, the Department amended the rule in the renumbered Section 8(D)(11)(a) as recommended by the commenter.

281. Comment: Commenter #3 recommended the following revision to the rule by adding Section 8(E)(11)(f), “The facility shall keep data on its use of restraint and seclusion, and work to identify trends and decrease use of these emergency, non-therapeutic interventions.”

Response: Facilities are keeping data on the use of restraints and seclusion. The Department finds that it is not necessary to add this requirement to the licensing rule. No changes were made to the rule based on this comment.

282. Comment: Commenter #3 stated that protection around the use of restraint and seclusion are important and useful and should be implemented in all settings in which these interventions are permitted in Section 8(E)(12) through (20).

Response: The Department has added, in its response to Comment #278, more detail on the use of restraints to the core licensing standards in Section 5(O)(8) through 5(O)(12). Although seclusion is still only allowed in secured capacity facilities within Sections 8(D) and 8(E), the additional language in Section 5(O) includes more detail on the use of restraints, acknowledgment, monitoring, documentation and debriefing after the use of restraints.

283. Comment: Commenter #3 recommended the following revision to Section 8(E)(19)(d), “Staff involved in the use of restraint and seclusion that results in injury to a resident or staff must meet with supervisory staff and
evaluate the circumstances that caused the injury and develop a plan to prevent future restraint and seclusion injuries.”

Response: The Department finds that the rule is sufficient, as written. No changes were made to the rule, based on this comment.

284. Comment: Commenter #6 stated that the Maine Department of Education is in favor of the proposed rule change for children’s residential care facilities, particularly the new (level 1 and 2 secured) residential service in Sections 8(D) and 8(E). The commenter stated that the advantages include: providing services to unserved students in Maine that are in extend stays in hospital emergency rooms awaiting a placement; providing an appropriate level of service to Maine students currently in inappropriate placements because there is no existing step down program to provide continuity of services in a less restrictive manner because there is no other programming option available at the time of sentencing; potential to bring Maine children that are currently placed out-of-state; and the expansion of services available to Maine children to better meet their mental health needs, as close to their home community as possible; and increasing the workforce in Maine and providing fiscal efficiency, saving Maine taxpayers’ money.

Response: No changes to the rule are necessary based on this comment.

SUMMARY OF CHANGES RESULTING FROM COMMENTS AND THE ASSISTANT ATTORNEY GENERAL:

Changes made per recommendation from the Assistant Attorney General are italicized. Additional changes were made to keep consistency with current law (statutes and other rules), address limitations on authority, and achieve clarity based on AAG review.

1. Section 2(A): removed the definition of chemical restraint. Replaced the term chemical restraint with PRN psychotropic medication throughout the rule.
2. Section 2(A): removed the definition of child.
3. Section 2(A): revised the definition of children’s residential care facility to refer to the statute for exclusions to the definition.
4. Section 2(A): added a definition of dangerous situation.
5. Section 2(A): clarified the definition of Department or DHHS.
6. Section 2(A): revised the definition of education program to remove reference to a sub-section of Section 8 that was removed after AAG review.
7. Section 2(A): clarified the definition of emergency safety situation.
8. Section 2(A): amended the definition of interactive telecommunication system to add, “Telephonic telehealth may be used when no other means are available and if appropriate to the service.”
9. Section 2(A): amended the definition of isolation to add, “where egress is allowed”.
10. Section 2(A): clarified the definition of mechanical restraint.
11. Section 2(A): removed “passive” from the definition of passive physical restraint.
12. Section 2(A): fixed the grammar in the definition of relatives.
13. Section 2(A): added definition of positive support strategy
15. Section 2(A): added definition of physical prompt.
16. Section 2(A): clarified the definition of residential treatment facility with secure capacity.
17. Section 2(A): removed the definition of critical incident; 2(A)(13), and replaced it with a definition of reportable events.
18. Section 2(A): removed the definition of serious injury.
19. Section 2(A): added to the definition of seclusion, “seclusion can be accomplished by locking (locked seclusion) which means a door is locked, barred or held shut by staff. Seclusion includes when egress from solitary, involuntary confinement is physically prevented by staff in any way.”

20. Section 2(A): replaced “substance abuse” with “substance use disorder” in this section and throughout the rule.

21. Section 2(A): updated the definition of time out.

22. Section 3(A)(2): replaced "has" with "must have".

23. Section 3(A)(7)(f): removed the requirement stating that the governing authority must review and accept the results of licensing surveys and any associated plans of correction.

24. Section 3(A)(7)(i): removed the requirement that stated that the governing body is required to complete an annual written evaluation of the performance of the administrator.

25. Section 3(A)(7)(i): increased Department notification from within two business days to within two weeks for any legal proceedings related to a facility’s provision of services.

26. Section 3(A)(7)(j): amended this requirement to state, “that when the governing authority is made aware that abuse and neglect of a resident has occurred, that these instances are appropriately reported as per Section 5(G)(1),” and also added, “and that reporting procedures exist that are transparent and accessible to residents and employees.”

27. 3(A)(7)(j)(a): moved this section for clarity to 3(A)(7)(i)(a).

28. Section 3(C)(1)(a): updated this section of the rule to clarify that the administrator must notify the Department within the required timeframes of any reportable events either through OCFS if required to do so electronically, or to the Department if not required to provide electronic notification.

29. Section 3(C)(1)(d): added, “Must have the authority to cooperate with Department inspections and investigations”.

30. Section 3(D)(1): added to the annual program evaluation that, “the process must include family and resident interviews.”

31. Section 3(D)(1)(d): added, “responses and outcomes” as part of an annual program evaluation for grievances and complaints.

32. Section 3(D)(1)(e): changed, “summary of incident reports” to “summary of reportable events.”

33. Section 4(A)(1)(a): changed “must be void” to “will be considered void by the Department.”

34. Section 4(A)(1)(b)(xiii): clarified this section by adding, “Grievances “and/or formal complaint processes”.


36. Section 4(A)(1)(b)(xii): eliminated, “including record storage and access and evidence of the bond or other financial instrument that covers the costs associated with the close of business.”


38. Section 4(A)(1)(b)(xiii)(17): replaced the name of the policy and procedure required for initial licensure from, “critical incident” to “reportable events.”


40. Section 4(A)(1)(b)(xiv): replaced “an” with “Statement that the...”; deleted “must be” and replaced with “is”.

41. Section 4(A)(1)(c): removed, “Whenever a children’s residential care facility has made timely and sufficient application for renewal of a license, the existing license must not expire until the status of the application has been finally determined by the Department” for clarity as it is addressed in Section 4(A)(1)(c)(iii).

42. Section 4(A)(1)(c): Added for clarity, “Failure to submit a renewal application prior to the expiration will result in the expiration of the license.”

43. Section 4(A)(1)(c)(ii): clarified what is meant by documentary information by adding, “including but not limited to, a change in policies, a change in the organizational chart, or a change in programming.”

44. Section 4(A)(1)(c)(iii): added the word “only” to, “A license may be renewed only if a completed application is received by the Department at least 60 days prior to the license expiration date.”
45. Section 4(A)(1)(xiv) added, “Statement that the education program provided in a licensed children’s residential care facility must be approved by the Maine Department of Education with oversight provided by the school administrative unit in which the institution must be located, or any adjoining unit.”

46. Section 4(A)(1)(d): added, “A waiver must be granted before it is effective.”

47. Section 4(A)(2)(a) & (b) clarified inspections to mean Department’s right of entry and fire inspections.


49. Section 5(B)(7)(a): reworded this section for clarity.

50. Section 5(D): renamed this section “Inspections and Investigations” from “Inspections”.

51. Section 5(D)(1)(d): added to this section, “The Department may interview the resident’s guardian as necessary.”

52. Section 5(D)(2)(a): removed, “Complainants have immunity from civil or criminal liability when the complaint is made in good faith.” As the Department does not have the authority to grant immunity civil or criminal liability.

53. Section 5(D)(2)(b): added the Department’s toll-free numbers for Child and Adult Protective Services.

54. Section 5(D)(2)(c): amended the rule to add that the grievance procedure must be written “in a way that is accessible and understandable to all residents”

55. Section 5(E)(1)(d): revised this section to add clarity for non-discrimination in providing services.

56. Section 5(E)(2)(a): amended the rule to change timeframe of notification of closure from 30 days to at least 60 days prior to the closure date.

57. Section 5(E)(2)(c): amended the rule to state that notification must occur one to five business days after the governing authority has made a determination to close.

58. Section 5(E)(3): changed “child abuse” to “resident abuse”.

59. Section 5(E)(4): updated this section of the rule to clarify and to update it from “Critical incident response” to “Reportable event” policy.

60. Section 5(E)(4)(b): added internal reference to Section 5(G)(4)(b).

61. Section 5(E)(6)(a): updated this section to read, “Ensure that any resident not required to attend school is either offered the opportunity to be gainfully employed or be enrolled in a training program geared to the acquisition of suitable employment or necessary life skills.”

62. Section 5(E)(6)(b): clarified the types of chores that are similar to a family experience by adding, “These assignments include gardening, cleaning or similar household chores. Residents must be paid if the resident is doing anything other than chores consistent with the age of the resident.”

63. Section 5(E)(7)(a): amended “unsafe” to, “potentially high risk” and included examples of potentially high risk activities, including, zip lining, horseback riding or swimming.

64. Section 5(E)(8): added Routine and emergency healthcare policy.

65. Section 5(E)(9): revised this section to replace “children and adults ages 18 through 21” to “all residents”.

66. Section 5(E)(19): revised this section by adding, “document its efforts” and “unless contraindicated”.

67. Section 5(F)(1)(b): amended this section to state that agency texts and e-mails to be used as electronic documents, “when available and made part of the electronic health record” and to allow for electronic signatures as an acceptable form of documentation.

68. Section 5(F)(2)(x): added a requirement for the reporting of adult abuse, neglect and exploitation.

69. Section 5(F)(3)(e)(ii): removed the requirement that the marital status of the parents of a resident must be contained in the resident’s record.

70. Section 5(F)(3)(f): in keeping with the replacement of critical incidents within this rule, updated this section and changed critical incident to significant occurrence.

71. Section 5(G)(2)(a): amended to change “Documentation will be maintained in the facility” to “Documentation will be maintained within the facility’s record system.”

72. Section 5(G)(2)(a): amended this section of the rule to include the toll free numbers for Adult Protective Services and Child Protective Services.

73. Section 5(G)(3)(c): added “Change in administrator” as a reporting requirement to be consistent with Section 3(C)(1).

74. Section 5(G)(5): amended this section of the rule to clarify the reporting requirements of a reportable event.
75. Section 5(G)(5)(c): for clarity revised this section to read, “At a minimum, the facility must notify the Department and the resident’s legal guardian that a reportable event has occurred.”

76. Section 5(H)(1)(a): removed “See 22 M.R.S. § 4011-A;

77. Section 5(H)(1)(b): clarified the correct office of the Department for the reporting of a violation of resident rights.

78. Section 5(H)(1)(l): removed the term, “common areas” to clarify this section of the rule. Reworded the language of the rule for clarity to read, “….endanger the health and safety of a resident or others.”

79. Section 5(H)(1)(l)(ii): added that “routine or regularly scheduled safety sweeps of common areas do not require documentation.”

80. Section 5(H)(1)(o): amended this section for clarity and renamed this section from, “Rights regarding transfer and discharge in residential care” to “Right to discharge planning.”

81. Section 5(I)(3)(b): amended to read, “As part of the admission orientation, the facility must provide the following in an accessible format:”

82. Section 5(I)(3)(b)(i): for clarity amended this section of the rule to clarify that a facility’s rules must be provided to each resident during the admission orientation and be “signed and dated by the resident if they are able to sign or the resident’s guardian if the resident is unable to sign.”

83. Section 5(I)(3)(c): removed the terms “referring agency” and “placing agency.”

84. Section 5(J)(1)(a): clarified to state that it is the resident who drives the assessment process and that, “if possible, the resident, legal guardian and family must be interviewed as part of the assessment process.”

85. Section 5(K)(1): added to this section that a service plan is reviewed every 90 days and in accordance with Section 5(K)(9).

86. Section 5(K)(3): changed “clinical consultant” to “clinician.”

87. Section 5(K)(5)(b): added to this section of the rule that measurable goals must be written in a language that the resident and family can understand.

88. Section 5(K)(5)(e): clarified this section to state that the development of discharge criteria begins, “from the time of admission.”

89. Section 5(K)(5)(j): added, “Any objection to the service plan that the resident or family expresses must be documented.”

90. Section 5(K)(6): removed the requirement that the service plan must be signed by a representative of the referring agency. Revised the language in this section for clarity regarding who signs the service plan.

91. Section 5(K)(7): amended this section from a copy of the service plan must be “received” to “were offered” to the resident and legal guardian.

92. Section 5(K)(9): amended this section to state “The facility must coordinate with treatment team members to periodically review and update each resident’s service plan, in a language that the resident and family can understand.”

93. Section 5(K)(9)(c): added, “This review includes the consideration of less restrictive alternatives.”
101. Section 5(K)(11): amended to include the resident’s and family’s input, perspective and ideas, when developing a crisis plan.
102. Section 5(K)(11)(c): added to this section that a crisis plan is reviewed after each use to, “guide staff response in a situation of full crisis or serious risk of harm to self or others.”
103. Section 5(M)(1)(b): added that information provided to the resident regarding health, personal care and hygiene “as appropriate and accessible to the resident.”
104. Section 5(M)(1)(f): to provide more clarity regarding access to medical care, removed, “when the resident is ill” from “receipt of timely competent medical care when the resident is ill and necessary follow-up medical care.”
105. Section 5(M)(5): removed the requirement that facilities must have a medical director.
106. Section 5(N)(4): replaced “direct access worker” with “CRMA”.
107. Section 5(N)(5)(a)(ii): updated the language of this section to state “Orders from the medical provider who prescribed the medication regarding notification of missed doses.”
108. Section (5)(N)(5)(b): In reference to notifying providers who prescribe medication, of a missed dose medication error, “per their orders of notification.”
109. Section 5(N)(7)(a) & (c). removed the requirement that the key to a locked cabinet must be carried by the person on duty. The requirement that sample medications be stored in accordance with the facilities policies was also removed for clarity.
110. Section 5(N)(15): regarding the legal guardian’s consent to medication, added, “If consent is verbal or if the guardian is unavailable to obtain written consent, then the facility must document consent and ensure that written consent is received within 30 days.”
111. Section 5(N)(16): added, “A resident of any age on any psychotropic medication should, when possible, give informed consent, and be consulted and monitored for input, progress, and side effects.”
112. Section 5(N)(17)(b): added to this section, “and whenever possible, a conversation with…”
113. Section 5(N)(18): clarified and removed from this section, the requirement that two staff persons must witness the third refusal of psychotropic medication by a resident, so as to consider the third refusal, the revoking of consent by the resident for the psychotropic medication.
114. Section 5(N)(19): added, regarding PRN medications, “when possible, the resident’s input should be part of the plan for PRN use.” Added “(Pro Re Nata-PRN)”.
115. Section 5(N)(19)(b): for clarity removed, “by the authorized licensed practitioner to notify the licensed practitioner earlier.”
116. Section 5(N)(19)(e): added, “PRN medication shall not be used as a drug/chemical restraint (emergency safety intervention).”
117. Section 5(N)(19)(e): replaced “or” in the phrase “drug or chemical restraint” with a “/”.
118. Section 5(O): added to consequences, “natural and logical.”
119. Section 5(O)(2): removed the term, “passive” when referring to restraints.
120. Section 5(O)(2)(a): added, restraints may be used if a resident is threatening to inflict harm to staff, residents “or others.”
121. Section 5(O)(2)(c): removed this section.
122. Section 5(O)(3): clarified the prohibited practices section in regard to behavior management.
123. Section 5(O)(4): clarified seclusion.
124. Section 5(O)(4): added “Rights of” before the word “Recipients”.
125. Section 5(O)(6): removed, “Chemical restraint means the administration of psychotropic medication for the exclusive purpose of sedation of a resident.”
126. Section 5(O)(6): added in reference to the use of PRN psychotropic medications, “Facilities must adhere to CRMA Curriculum guidelines and with Section 5(N) of this rule.”
128. Section 5(O)(7)(b): replaced, “considered” with “attempted.”
129. Section 5(O)(7)(c): clarified this section by removing, “preventing egress by” and adding “in a way that does not physically prevent egress by the resident.”
130. Section 5(O)(8) through 5(O)(12): Added more detail on the use of restraints including their use, acknowledgment, monitoring, documentation and debriefing after the use of restraints.

131. Section 5(P)(1)(c): added “or staff”.


133. Section 5(P)(22)(g): corrected the grammar.

134. Section 5(P)(26): clarified that only law enforcement entering a facility in an official capacity, “may carry weapons.”

135. Section 6(A)(1), 6(B)(1)(a) and (b): clarified these section by adding references to the Maine Background Check Center Act.

136. Section 6(A)(11): removed the section requiring a medical statement prior to employment from the rule.

137. Section 6(B)(1)(C): clarified the rule by changing “for operating under the influence” to “related to operating under the influence.”

138. Section 6(B)(3)(e) and (f): for clarity combined these two sub-sections and moved them to 6(B)(4).

139. Section 6(B)(4): added “and must complete the waiver process pursuant to the Maine Background Check Center Act and rules promulgated under that Act.”

140. Section 6(C)(1): added, “Training must be done by individuals qualified by education, training and experience.”

141. Section 6(C)(2): amended to clarify that volunteers and interns are not required to be trained in the use of restraints. Clarified training requirements.

142. Section 6(C)(2)(h) and 6(C)(4)(m): changed “child” to “resident”.

143. Section 6(C)(2)(k): added “rights of residents” training.

144. Sections 6(C)(4) and 6(C)(5): amended to distinguish which trainings are required annually and biennially for full and part time employees.

145. Section 6(D)(1): amended by changing, “clinically indicated” to “clinically appropriate”.

146. Section 6(D)(3) and (5): clarified that teleservices and distant site practitioners are not allowed for secure facilities, “except for family counseling”.

147. Sections 6(D)(5): added, “or other qualified professionals as indicated in the residential service plan” to qualified distant site practitioners.

148. Section 6(E)(6): removed the requirement for a quality improvement review for independent contractors.

149. Section 7(B)(6): changed “exception” to “variance”.

150. Section 7(D)(1): removed a provision regarding uniforms.

151. Section 7(I)(3): clarified this section to read, “Transportation accessibility. The operator of any vehicle transporting residents must be informed of any resident’s transportation access needs. The facility will provide appropriate transportation for the accessibility needs of residents.”

152. Section 7(J)(1): added, “All plans and communication/notification systems will be updated annually and have primary and alternative means for communication/notification.”

153. Section 7(J)(1)(d): added, “and entities providing services to the facility in emergencies and residents’ physicians.”

154. Section 7(J)(1)(g): removed, “including specialized training as necessary for the evacuation of residents and persons with disabilities;”.

155. Section 7(J)(1)(i): replaced “service recipients” with “residents” and added “during and after emergencies”.

156. Section 7(J)(1)(j): added, “including volunteer emergency health care providers”.

157. Section 7(J)(1)(k): added “or” before the word “exercise”.

158. Section 7(J)(1)(m): added, “Provision of necessities such as food and water to residents and staff for both sheltering in place and evacuation plans.

159. Section 7(J)(1)(n): added, “alternate sources of energy to maintain temperatures for living and food safety, lighting, alarm and sprinkler systems, and sewage/waste disposal”.

160. Section 7(J)(2)(a): added, “including delegation of authority and succession plans”.

161. Section 7(J)(2)(e): added, “including state emergency preparedness officials of occupancy needs and any ability to assist other Children’s Residential Care Facilities”.

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162. Section 7(J)(6)(a) and (b): added language about emergency preparedness for Level 2 facilities.
163. Section 7(J)(6)(c): clarified this section by adding, “care must be taken to ensure that all residents’ individuals needs are accommodated in evacuation plans.”
164. Section 7(J)(7): added “and reportable events”.
165. Section 8(A)(1), (2) and (3): clarified the timeframes for the completion of the initial service plan, the service plan and service plan review.
166. Section 8(A)(3): clarified the requirement for the frequency of resident notes.
167. Section 8(A)(6): reduced the number of clinical supervision hours required, two hours for full-time staff and one hour for part-time staff.
168. Section 8(C): removed this section from the rule.
169. Section 8(D)(7): removed the requirement that only secure capacity facilities, Level 1 and Level 2, can use PRN psychotropic medications.
170. Section 8(D)(9): amended this section of the rule to clarify that personnel must receive annual training on “all restraint techniques used.”
171. Section 8(D)(11): added that residents and families must be included in weekly service plan team meetings whenever possible.
172. Section 8(E)(7): added, “licensed or certified in Maine”.
173. Section 8(E)(10)(b): added “the resident” and the resident’s natural supports.
174. Section 8(E)(11)(a): removed, “and to prevent further serious disruption that significantly interferes with others’ treatment.”
175. Section 8(E)(11)(e): for clarity, amended this section to read, “Restraint and seclusion must not be used simultaneously.”
176. Section 8(E)(13)(a)(iv): removed this section from the rule as PRN psychotropic medications are adequately covered in other sections of the rule.