CHAPTER 75-03-17
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

75-03-17-01. Definitions.

1. "Accredited" means to be accredited and in good standing by an independent, not-for-profit accreditation organization approved by the United States department of health and human services and the department, including the commission on accreditation of rehabilitation facilities, the joint commission, and the council on accreditation.

2. "Active treatment" means a strength based, culturally competent, and medically appropriate treatment designed to meet immediate needs with specific outcome and return to the family or another less restrictive community setting as soon as clinically possible and when treatment in a facility is no longer medically necessary.

3. "Aftercare" means followup support and services provided to a resident and family after discharge from a facility.

4. "Applicant" means the entity requesting licensure as a psychiatric residential treatment facility for children under this chapter.

5. "Child", "children", or "resident" means a person or persons under the age of twenty-one.

6. "Clinical supervision" means the oversight responsibility for individual treatment plans and individual service delivery.

7. "Condition" means a violation of the requirements of any applicable law or regulation.

8. "Department" means the department of human services.

9. "Diagnostic assessment" means a written summary of the history, diagnosis, and individual treatment needs of a person with a mental illness using diagnostic, interview, and other relevant assessment techniques.

10. "Discharge planning" means the multidisciplinary process that begins at the time of admission that identifies the child's and family's needed services and supports upon discharge.

11. "Employee" means an individual compensated by the facility to work, including contracted service providers who conduct onsite training, treatment groups, individual therapy, or other facility services.

12. "Family-driven" means the family has a primary decisionmaking role in the care of its own children.

13. "Individual person-centered treatment plan" means a youth-guided and family-driven written plan of intervention, treatment, and services that is developed under clinical supervision on the basis of a diagnostic assessment.

14. "Initial license" means a license for a new facility that is in effect for one year.

15. "Nonemployee" means an individual, including a volunteer or student intern, who is not compensated by the facility.

16. "Person with a mental illness" means an individual with an organic, mental, or emotional disorder that substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations. "Person with a mental illness" does not include an individual with intellectual disabilities of significantly subaverage general intellectual functioning that originates during the developmental period and is associated with impairment in adaptive behavior, although an individual who has intellectual disabilities may also be an individual who has a mental illness. A substance use disorder does not per se constitute mental illness, although an individual who has a substance use disorder may also be an individual who has a mental illness.

17. "Psychiatric residential treatment facility for children" or "facility" means a facility or a distinct part of a facility that provides to children and adolescents a total, twenty-four-hour, therapeutic environment integrating group living, educational services, and a clinical program based upon a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. The services are available to children in need of and able to respond to active psychotherapeutic intervention and who cannot be effectively treated in their own family, in another home, or in a less restrictive setting. The facility must be in compliance with requirements for psychiatric residential treatment facilities under 42 U.S.C. 1396d [Pub. L. 89-97; 79 Stat. 351] and title 42, Code of Federal Regulations, subpart D, part 441 and subpart G, part 483.

18. "Residential treatment" means a twenty-four-hour a day program under clinical supervision in a community residential setting other than an acute care hospital, for the active treatment of persons with mental illness.

19. "Sentinel event" means any serious injury or trauma to a resident, death of a resident, or inappropriate sexual contact.

20. "Serious injury" means any significant impairment of the physical condition of the child as determined by qualified medical personnel. This includes burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

21. "Serious risk of harm" means a substantial likelihood of:

    a. Suicide, as manifested by current suicidal threats, attempts, or significant depression creating immediate risk of suicide;

    b. Killing or inflicting serious bodily harm to self or another person, as manifested by current act; or

    c. Substantial deterioration in physical health or substantial injury, disease, or death based on current poor self-control or judgment.

22. "Special treatment procedures" are defined as follows:

    a. "Drug used as a restraint" means any drug that:

        (1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;

        (2) Has a temporary effect of restricting the resident's freedom of movement; and

        (3) Is not a standard treatment for the resident's medical or psychiatric condition.

    b. "Emergency safety interventions" means the use of restraint or seclusion as an immediate response to an emergency safety situation.

    c. "Emergency safety situation" means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.

    d. "Mechanical restraint" means any device attached or adjacent to the resident's body that the resident cannot easily remove that restricts freedom of movement or normal access to the resident's body.

    e. "Personal restraint" means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort the resident, or holding a resident's hand to safely escort a resident from one area to another.

    f. "Physical escort" means the temporary touching or holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a resident who is acting out to walk to a safe location.

    g. "Restraint" means a personal restraint, mechanical restraint, or drug used as a restraint.

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

    i. "Timeout" means the voluntary option of a resident to move to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

23. "Tier 1 mental health professional" means a licensed psychiatrist, licensed psychologist, licensed physician or a physical assistant, or an advanced practice registered nurse.

24. "Trauma-informed" means an understanding of the prevalence of traumatic experiences in a child who receives mental health services and of the profound neurological, biological, psychological, and social effect of trauma and violence on the child being treated.

25. "Youth-guided" means a child has the right to be empowered, educated, and given a decisionmaking role in the care of the child's own life.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; July 1, 2012; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-01, 25-03.2-03

75-03-17-02. Procedures for licensing.

1. **Application.** An application for license or for renewal as a facility must be submitted to the department. The department shall determine the suitability of the applicant for licensure under this chapter. The application must contain any materials the department may require, including:

   a. A comprehensive list and description of the program plan which includes:

      (1) A plan demonstrating compliance with this chapter;

      (2) A copy of current accreditation certification, accreditation letter, and findings report;

      (3) The facility's organizational chart;

      (4) The treatment modalities offered, including milieu therapy, family therapy, psychopharmacology, and psychotherapy;

      (5) Prohibited treatment modalities; and

      (6) The services provided directly by the facility and those provided by other community resources, including special education as required by law and contracted services.

   b. A copy of all policies and procedures as required by this chapter with a detailed plan for their implementation.

   c. A list of licensed professionals employed or to be employed by or contracting with the facility.

2. **License contents.** The license to operate a psychiatric residential treatment facility for children must specify:

   a. The name of the licensee;

   b. The premises for which the license is applicable;

   c. The number of children who may reside at the facility at any one time;

   d. The date of expiration of the license;

   e. The facility license number; and

   f. The name of the accreditation body.

3. **Initial license and license renewal.**

   a. An initial license for a new facility is in effect for one year. Subsequent licenses shall be renewed at least once every two years, either through a full onsite license review or the facility may receive deemed status, at the discretion of the department.

   b. The license is valid only on the premises indicated and is not transferable.

c. License renewals are based on the outcomes of the department's licensure reviews, the facility's ongoing compliance with the licensure rules set forth in this chapter, and the facility's accreditation standings. The facility must list the department as a confidential inquiry for the accrediting body on their accreditation intent to survey prior to each accreditation review. If the accrediting body determines a facility to not be in good standing, the facility shall report that determination to the department within five working days after the facility has learned of that determination.

d. A facility shall submit a license renewal application on a form required by the department to the department licensor fifteen days prior to the date the department has notified the facility will be the date the facility's licensure review will begin.

4. **Provisional license.** The department may issue a provisional license, effective for up to ninety days, to a facility that has failed to comply with any of the standards of this chapter or with any other state law or regulation, compliance with which is required for licensure. The facility will have thirty days from the issuance of the provisional license to submit a written plan of correction for the department's review and approval. The department may perform an onsite followup visit to assure that the standards have been met by the facility.

   a. The department may renew a provisional license if the licensee demonstrates to the department that it has made progress towards compliance and can be fully compliant within the next ninety days. A provisional license may be renewed but may not exceed one hundred eighty consecutive days.

   b. When a facility operating under a provisional license notifies the department that it has corrected its deficiencies, the department must ascertain whether all deficiencies have been corrected. Upon finding compliance and sustainability, the department shall issue an unrestricted license for the balance of the licensing period.

   c. The department may apply restrictions to a provisional license to limit the number of children in residence or the ages of the children in residence while the provisional license is in effect.

5. **License display.** A facility shall display its license in a conspicuous place within the facility.

6. **Notice of change.** A facility shall notify the department in writing at least thirty days before any of the following changes occur:

   a. Transfer of or change in ownership.

   b. Transfer of operating rights, including a lease of the facility where the lessor retains no control of the operation or management of the facility.

   c. Change in the name of the facility.

7. **Denial and revocation of a license.** Failure to comply with any of the standards of this chapter or other state law or regulation is cause for refusal or revocation of a license. Conviction of an offense by an owner or operator of a facility does not disqualify the facility from licensure unless the department determines that the offense has a direct bearing upon a person's ability to serve the public as an owner or operator of a psychiatric residential treatment facility for children, or that, following conviction of any offense, the person is not sufficiently rehabilitated under section 12.1-33-02.1.

8. **Appeal.** An applicant may appeal a license denial or a department decision not to allow an increase or decrease in bed capacity in accordance with North Dakota Century Code chapter 28-32 and North Dakota Administrative Code chapter 75-01-03.

9. **License report procedures.**

   a. Within thirty days of an onsite review of a facility, the department shall send a license report to the facility that was reviewed.

   b. A license report must contain a description of the programs and services reviewed, strengths, concerns, recommendations, and conditions.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-02, 25-03.2-03, 25-03.2-05

75-03-17-03. Organization and administration.

1. **Governing body.** The applicant must have a governing body that designates or assigns responsibility for the operation, policies, program, and practice of the facility. The governing body shall:

   a. Define:

      (1) The facility's philosophy;

      (2) The facility's purpose;

      (3) The facility's function;

      (4) The geographical area served by the facility;

      (5) The ages and types of children accepted for care by the facility; and

      (6) The clinical disorders addressed by the facility's program;

   b. Ensure that all policies and procedures required by this chapter are in writing and on file at the facility and are accessible to all employees, family members, and residents;

   c. Develop a records retention policy and procedures consistent with state and federal law;

   d. Assure that all vehicles transporting children are:

      (1) Subject to routine inspection and maintenance;

      (2) Licensed by the state motor vehicle department;

      (3) Equipped with seatbelts for every passenger;

      (4) Equipped with a first-aid kit and a fire extinguisher;

      (5) Carrying no more individuals than the manufacturer's recommended maximum capacity;

      (6) Disability accessible where appropriate; and

      (7) Driven by an individual who holds a valid driver's license, of a class appropriate to the vehicle driven, issued by the driver's jurisdiction of residence; and

   e. Obtain sufficient insurance, including:

(1) Liability insurance covering bodily injury, property damage, personal injury, professional liability; and

(2) Automobile or vehicle insurance covering property damage, comprehensive, collision, uninsured motorist, bodily injury, and no fault.

2. **Quality improvement.** The applicant and facility shall implement a quality improvement program. The applicant and facility shall submit the quality improvement program and evaluations of the program to the department for review at a minimum of every six months. The applicant shall create policies and procedures and have them in place to implement its facility's quality improvement program. The facility must monitor and evaluate the quality and appropriateness of care of children, and identify performance indicators that will be monitored to assess the program's effectiveness. The quality improvement program must include:

   a. A plan for child and employee safety and protection;

   b. A method to evaluate personnel performance and the utilization of personnel;

   c. A plan to ensure the facility accesses and maintains copies of the current license of all employees, contract workers, and consultants when relevant for that person's role or function;

   d. A system of credentialing, granting, and withholding employee privileges;

   e. A method to review and update policies and procedures assuring the usefulness and appropriateness of policies and procedures;

   f. A method to review the appropriateness of admissions, care provided, and employee utilization;

   g. A plan for the review of individual treatment plans that ensures compliance with paragraph 3 of subdivision b of subsection 3 of section 75-03-17-05;

   h. A plan for program evaluations that includes measurements of progress toward the facility's stated goals and objectives; and

   i. A method to evaluate and monitor standards of resident care.

3. **Outcomes and data collection.** The department shall require a facility to engage in data management practices to collect and report outcomes every six months. Data collection efforts will offer facilities a continuous quality improvement process that measures and monitors the safety, wellbeing, and service delivery provided to children in placement. Facilities must have written policy to identify a plan to implement, collect, and measure outcomes data requirements. The policy must also include how a facility will respond to identified data outcomes by utilizing one or more facility improvement plans every six months.

4. **Children's case records.** The facility shall establish and implement policies and procedures to ensure the facility maintains a confidential record for each child which must be current and reviewed monthly. Each record must contain:

   a. An application for service;

   b. A social history;

   c. A release of information and medical treatment consent form signed by a person who may lawfully act on behalf of the child and any consent for the use of psychotropic medications as required under subdivision d of subsection 10 of section 75-03-17-07;

d. The name, address, and telephone number of individuals to be contacted in an emergency;

e. Reports on medical examinations, including immunizations, any medications received, allergies, dental examinations, and psychological and psychiatric evaluations which occurred prior to the placement;

f. An explanation of custody and legal responsibility for the child and relevant court documents, including custody or guardianship papers;

g. Documentation on all medical examinations, including immunizations, all medications received, allergies, dental examinations, and psychological and psychiatric evaluations received during placement;

h. Documentation of medical care given during placement as a result of an admission to the hospital or inpatient care, including:

(1) Hospitalization admission and discharge records to include history and physical;

(2) Medications administered, with the quantity, directions, physician's name, date of issue, and name of the pharmacy indicated; and

(3) Significant illnesses or accidents;

i. Records of the annual medical examination required under section 75-03-17-07; and

j. A written agreement between a person who may lawfully act on behalf of the child and the facility and a record that the person who acted on behalf of the child received a copy. The agreement must include:

(1) A statement as to who has financial responsibility;

(2) How payments are to be made to cover the cost of care;

(3) Which items are covered by the normal or regular facility charges for care;

(4) Medical arrangements, including the cost of medical care;

(5) Visiting arrangements and expectations;

(6) Arrangements for clothing and allowances;

(7) Arrangements for therapeutic leave;

(8) Regulations about gifts permitted;

(9) Arrangements for participation by the person who acted on behalf of the child through regularly scheduled interviews with designated employee;

(10) The facility's policy on personal monetary allowance to be provided to the child at the facility;

(11) Records of special treatment orders; and

(12) Educational arrangements agreed upon discharge.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10

Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-04. Admissions.

1. A child may be admitted to a psychiatric residential treatment facility for children if:

   a. The child has been diagnosed by a psychiatrist or psychologist as suffering from a mental illness or emotional disturbance;

   b. The child's situation meets the definition of serious risk of harm; and

   c. A less restrictive setting cannot meet the immediate treatment need.

2. The facility shall provide a short-term, intense, focused mental health treatment program to promote successful return of the child to the community with specific outcomes of the mental health services to include the child returning to the family or another less restrictive community living situation as soon as clinically possible.

3. Every facility shall have specific admission policies that describe which professional staff have admission authority. Admissions must occur emergently and planned. Diagnostic assessment and plan of care must document immediate need for inpatient psychiatric residential services.

4. A tier 1 mental health professional must complete an assessment of a child upon admission to a facility.

5. The facility shall grant or deny admission within three business days of receipt of a completed application.

6. If admission is denied, the facility shall indicate the reason in writing to the individual or referral source making the application for placement, including recommendations for services and supports available to the child and family.

7. No child may be denied admission to a facility on the basis of race, color, creed, religion, or national origin.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-06

75-03-17-05. Diagnosis and treatment while at the facility.

1. **Duties of the facility.** The facility shall:

   a. Provide for a medical, psychiatric, and psychological assessment of each child no later than seventy-two hours after admission;

   b. Immediately include family and custodians in the active treatment;

   c. Involve the families and the person who may lawfully act on behalf of the child in the person-centered treatment plan;

   d. Provide daily therapy and programming that are individually tailored to meeting a child's need and in sufficient volume to resolve immediate inpatient need. Therapies must include individual and family components to facilitate rapid return of the child to a family setting;

e. Provide ongoing and consistent individual therapy utilizing evidence-based models of care for psychiatric residential treatment facilities for children. Individual therapy must focus on providing the child skills they need to be successful in their home and community;

f. Complete a diagnostic assessment, completed by a licensed psychiatrist, no less than seventy-two hours after admission that includes:

(1) A psychiatric history;

(2) A mental status examination, including an assessment of suicide;

(3) Psychosocial, including family history; and

(4) Complete set of diagnosis and recommendations for immediate treatment; and

g. Ensure therapeutic leave such as weekend overnight visits or day passes with family must be documented in the child's case file and be tied to family therapy and therapeutic goals of the child and family, or it must be documented in the child's case file why weekend overnight visits or day passes are not tied to therapy and therapeutic goals of the child and family.

2. **Specialists.** The facility shall provide a sufficient number of qualified psychiatric professionals to meet the resident needs. Each facility shall provide a minimum of one-half hour per week per bed of psychiatry time, one hour per week per bed of family therapy time, and two hours per week per bed of individual therapy time. Each facility shall provide twenty-four-hour nursing, which may include a combination of onsite or on-call hours.

3. **Individual person-centered treatment plan.**

a. The facility shall develop and implement an individual person-centered treatment plan that includes the child's input giving the child a voice and a choice in the treatment planning and interventions used. The plan must be based upon a comprehensive interdisciplinary diagnostic assessment, which includes the role of the family, identifies the goals and objectives of the therapeutic activities and treatment and it must be developed by an interdisciplinary team. The plan must provide a schedule for accomplishing the therapeutic activities and treatment goals and objectives, and identify the individuals responsible for providing services to children consistent with the individual person-centered treatment plan. Clinical supervision for the individual person-centered treatment plan must be accomplished by full-time or part-time employment of or contracts with a licensed psychiatrist, a licensed psychologist, a licensed clinical social worker, or a nurse who holds advanced licensure in psychiatric nursing. Clinical supervision must be documented by the clinical supervisor cosigning individual person-centered treatment plans and by entries in the child's record regarding supervisory activity. The child, and the person who lawfully may act on the child's behalf, must be involved in all phases of developing and implementing the individual person-centered treatment plan. The child may be excluded from planning if excluding the child is determined to be in the best interest of the child and the reasons for the exclusion are documented in the child's plan.

b. The plan must be:

(1) Based on a diagnosis using the current diagnostic and statistical manual of mental disorders and a biopsychosocial assessment;

(2) Developed within three business days of admission; and

(3) Reviewed at a minimum every fourteen days and updated or amended to meet the needs of the child by the interdisciplinary team.

c. The person-centered treatment plan must identify:

(1) Treatment goals that are short term and intense, focused on successful return to home and community;

(2) Time frames for achieving the goals;

(3) Goals that are achievable and measurable;

(4) The individuals responsible for coordinating and implementing child and family treatment goals;

(5) Therapeutic intervention or techniques or both for achieving the child's treatment goals;

(6) The projected length of stay and discharge plan; and

(7) Referrals made to other service providers based on treatment needs, and the reasons referrals are made.

4. **Solicitation of funds.** A facility may not use a child for advertising, soliciting funds, or in any other way that may cause harm or embarrassment to a child or the child's family. A facility may not make public or otherwise disclose by electronic, print, or other media for fundraising, publicity, or illustrative purposes, any image or identifying information concerning any child or member of a child's immediate family, without first securing the child's written consent and the written consent of the person who may lawfully act on behalf of the child. The written consent must apply to an event that occurs no later than ninety days after the date the consent was signed and must specifically identify the image or information that may be disclosed by reference to dates, locations, and other event-specific information. Consent documents that do not identify a specific event are invalid to confer consent for fundraising, publicity, or illustrative purposes. The duration of an event identified in a consent document may not exceed fourteen days.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-06. Special treatment procedures.

A facility shall have written policies and procedures regarding implementation of special treatment procedures. Special treatment procedures must be therapeutic and meaningful interventions and may not be used for punishment, for the convenience of employees, or as substitute for therapeutic programming. Upon admission, the facility shall inform the child and the person who may lawfully act on behalf of the child of the facility policy on restraint and seclusion procedures during an emergency safety situation. The facility shall provide education to the children, providing each child the opportunity to express the child's opinion and educating the child on alternative behavior choices to avoid the use of special treatment procedures. Alternatives to behaviors must be documented in each child's individual person-centered treatment plan. The health, safety, and well-being of children receiving care and treatment in the facility must be properly safeguarded. A physician shall review the use of special treatment procedures.

1. Timeout. Employees shall supervise the use of timeout procedures at all times, and shall document the use of timeout procedures in the child's file. The use of the resident's bedroom for timeout is prohibited.

2. Physical escort. Employees shall supervise the use of physical escort procedures at all times and shall document the use of physical escort in the child's file.

3. Physical restraints.

    a. Physical restraints must be ordered by a psychiatrist or other physician, a licensed psychologist, a licensed clinical social worker, or a nurse who holds advanced licensure in psychiatric nursing. Staff authorized to order physical restraint must be trained in the use of emergency interventions. A psychiatrist or other physician, a licensed psychologist, a licensed clinical social worker, or a nurse who holds advanced licensure in psychiatric nursing must review and sign the order within forty-eight hours after the ordered physical restraint. Physical restraints may be imposed only in emergency circumstances and must be used with extreme caution to ensure the immediate physical safety of the child, an employee, or others after all other less intrusive alternatives have failed or have been deemed inappropriate;

    b. All physical restraints must be applied by employees who are certified in the use of restraints and emergency safety interventions; and

    c. The facility shall have established protocols that require:

        (1) Entries made in the child's file as to the date, time, employee involved, reasons for the use of, and the extent to which physical restraints were used, and which identify less restrictive measures attempted;

        (2) Notification within twelve hours of the individual who lawfully may act on behalf of the child; and

        (3) Face-to-face assessment of children in physical restraint completed by a psychiatrist or other physician, a licensed psychologist, a licensed clinical social worker, a nurse who holds advanced licensure in psychiatric nursing, or other licensed health care professional or practitioner who is trained in the use of safety, emergency interventions. The face-to-face assessment must be documented in the child's case file and include assessing the mental and physical well-being of the child. The face-to-face assessment must be completed as soon as possible, and no later than one hour after the initiation of physical restraint or seclusion.

4. Seclusion. Seclusion must be ordered by a psychiatrist or other physician, a licensed psychologist, a licensed clinical social worker, or a nurse who holds advanced licensure in psychiatric nursing. Staff authorized to order seclusion must be trained in the use of emergency interventions. A psychiatrist or other physician, a licensed psychologist, a licensed clinical social worker, or a nurse who holds advanced licensure in psychiatric nursing must review and sign the order within forty-eight hours after the ordered seclusion. Seclusion may be imposed only in emergency circumstances after all other less intrusive alternatives have failed or have been deemed inappropriate. Seclusion is to be used with extreme caution, and only to ensure the immediate physical safety of the child, an employee, or others. A child's bedroom may not be used for seclusion. If seclusion is indicated, the facility shall ensure that:

    a. The proximity of the employee allows for visual and auditory contact with the child at all times;

    b. Employees conduct assessments of the child every fifteen minutes and document the assessments in the child's case file;

c. The seclusion room is not locked, or is equipped with a lock that only operates with an employee present such as a push-button lock that only remains locked while it is being pushed;

d. All nontherapeutic objects are removed from the area in which the seclusion occurs;

e. All fixtures within the room are tamperproof, with switches located outside the room;

f. Smoke-monitoring or fire-monitoring devices are an inherent part of the seclusion room;

g. Security mattresses used are made of fire-resistant material;

h. The room is properly ventilated;

i. Notification of the individual who lawfully may act on behalf of the child is made within twelve hours of a seclusion and is documented in the child's case file;

j. A child under special treatment procedures is provided a similar diet that other children in the facility are receiving;

k. No child remains in seclusion:

(1) For more than four hours in a twenty-four-hour period; and

(2) Without physician approval;

l. Seclusion is limited to the maximum time frame per episode for fifteen minutes for children aged nine and younger and one hour for children aged ten and older; and

m. Face-to-face assessment of children in seclusion is completed by a psychiatrist or other physician, licensed psychologist, a licensed clinical social worker, a nurse who holds advanced licensure in psychiatric nursing, or other licensed health care professional or practitioner who is trained in the use of safety, emergency interventions. The face-to-face assessment must be documented in the child's case file and include assessing the mental and physical well-being of the child. The face-to-face assessment must occur no later than one hour after the initiation of seclusion.

5. Within twenty-four hours of each use of seclusion or physical restraint, the facility shall conduct a face-to-face discussion which includes the child and all employees involved in the emergency intervention, except when the involvement of a particular employee may jeopardize the wellbeing of the child, and which:

a. Evaluates and documents in the child's case file the well-being of the child served and identifies the need for counseling or other therapeutic services related to the incident;

b. Identifies antecedent behaviors and modifies the child's individual person-centered treatment plan as appropriate; and

c. Analyzes the incident and identifies needed changes to policy and procedures, employee training, and strategies that could have been used by an employee, by the child, or by others which could prevent the future use of seclusion or physical restraint.

6. Within twenty-four hours after the use of physical restraint or seclusion, all employees involved in the emergency safety intervention, and appropriate supervisory and administrative employees, shall conduct a debriefing session that includes, at a minimum a review and discussion of:

a. Precipitating factors to the emergency situation;

b. Alternative techniques that might have prevented the use of physical restraint or seclusion;

c. The procedures, if any, that employees are to implement to prevent any recurrence of the use of physical restraint or seclusion; and

d. The outcomes of the intervention, including any injuries that may have resulted from the use of the physical restraint or seclusion.

7. Employees shall document in the child's record both the face-to-face discussion and debriefing sessions identified in subsections 5 and 6 and the names of employees involved, employees excused, and any changes to the child's treatment plan as a result of the face-to-face discussion and debriefing. The facility also shall document that the person who may lawfully act on behalf of the child was notified.

8. Special treatment procedure training. Each facility must have policies and procedures regarding annual training in the use of all special treatment procedures listed in this section, which comply with the standards set forth by the facility's accrediting body.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 50-11-03, 50-11-03.2

75-03-17-07. Medical care.

The facility shall institute policies and procedures to address the medical care for each child during placement at the facility, including:

1. **Medical examination.** Each child must have a medical examination within thirty days prior to admission or within seventy-two hours of admission.

2. **Immunizations.** Each child must have current immunizations as required by North Dakota Century Code section 23-07-17.1.

3. **Medical care arrangements.** A facility shall make arrangements with a physician for medical care of each child.

4. **Annual medical examination.** Each child shall have a medical examination at least annually.

5. **Employee instruction.** The facility shall train employees what medical care, including first aid, may be given by employees without specific orders from a physician. The facility shall instruct employees how to obtain further medical care and how to handle emergency cases.

6. **Hospital admission.** Each facility shall institute policies and procedures regarding transfers and discharges from an admission to the hospital. A facility's policies and procedures must include arrangements made with a hospital for the admission of children from the facility in the event of serious illness or an emergency.

7. **Hospitalization or death reports.** A facility shall report all hospitalizations immediately to an individual who lawfully may act on behalf of the involved child. The facility shall report any death immediately to the department, an individual who lawfully may act on behalf of the child, a law enforcement agency, and the county coroner. The facility shall document these contacts in the involved child's case file.

8. **Prescription labels.** The facility shall obtain prescribed medications on an individual prescription basis and labeled according to state and federal rules.

9. **Administration of medications.**

a. The facility shall institute policies and procedures for guidance in the administration of all medications. Medications must be administered by a designated employee who is medication-certified. All medications must be labeled and stored in a locked cabinet, with the keys for the cabinet kept under the supervision of the designated employee assigned to administer the medications. The medication cabinet must be equipped with separate cubicles, plainly labeled with each child's name.

b. The facility shall return medications belonging to a child to the person who lawfully may act on behalf of the child upon discharge, or the designated person in charge of medication storage shall dispose of the medications according to the facility's policies and procedures for the disposal of medications. The facility's policies and procedures for the disposal of medications must be in accordance with state and federal requirements for the disposal of medications.

c. The facility may possess a limited quantity of nonprescription medications. The medications must be ordered by a physician and administered under the supervision of medication-certified employee.

d. (1) The facility shall obtain written consent, including via electronic mail, or shall obtain verbal consent witnessed by another person, from a person who lawfully may act on behalf of the child prior to administering:

(a) A newly prescribed medication to the child except in an emergency situation;

(b) A psychotropic medication; or

(c) A medication dosage or dosage range change.

A person who lawfully may act on behalf of the child who receives medication must be informed of benefits, risks, and the potential side effects of all prescribed medication. The facility shall obtain written consent within fourteen days verifying verbal consent received. The facility shall document and file all consents in the child's case file.

(2) The facility shall institute policies and procedures governing the use of psychotropic medications, which require documentation in the case file justifying the necessity and therapeutic advantages for the child receiving psychotropic medication. Documentation must reflect that a trauma screening has been completed and that the symptomology that the psychotropic medication is attempting to treat is not more effectively treated through therapeutic interventions that specifically address symptomology related to trauma.

e. Upon admission, when a new psychotropic medication is prescribed, and when a psychotropic medication is discontinued, a child's psychotropic medication regime must be reviewed by the attending psychiatrist every seven days for the first thirty days and every thirty days thereafter. Additionally, the facility's nursing staff shall complete an involuntary movement assessment prior to the start of, or a change in the dose of, a psychotropic medication. An involuntary movement assessment must be repeated every three months, or sooner if determined necessary, following completion of the initial involuntary movement assessment to monitor the child for side effects of the psychotropic medication.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10

Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-08. Dental care.

Each child shall have an annual dental examination. If a child has not had an examination in the twelve months prior to admission, an examination must be scheduled within ninety days of admission.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-09. General health.

1. **Sleep.** Each child must receive enough sleep for the child's age at regular and reasonable hours, and under situations conducive to rest.

2. **Personal hygiene.** The facility shall educate children on age-appropriate hygiene.

3. **Bathing facilities.** The facility shall maintain properly and keep clean toilet facilities.

4. **Personal articles.** The facility shall ensure that each child has a toothbrush, comb, and an adequate supply of towels, washcloths, and personal toiletry articles.

5. **Daily diet.** The facility shall provide food that meets all dietary needs for each child's daily nutritional requirements, including special dietary needs, such as food allergies and diabetes.

6. **Clothing.** Each child shall have clothing for the child's exclusive use. The clothing must be comfortable and appropriate for current weather conditions.

7. **Play.** The facility shall provide safe, age-appropriate equipment for indoor and outdoor play. The facility shall provide safety instructions on all equipment prior to the child participating in the activity.

8. **Services.** The facility shall provide education on general health and promote positive healthy activities, such as sufficient therapeutic treatment, and educational, recreational, and leisure activities.

9. **Spirituality.** The facility shall make a reasonable effort to make opportunities available for children to attend spiritual ceremonies within the area in which the facility is located, giving reasonable consideration to requests by the child or a person with lawful authority to act on behalf of the child. The facility shall respect the spiritual beliefs of the child and the child's family.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-10. Education and training.

1. **Public education.** Any primary or secondary program offered by a facility must be in compliance with standards established by the department of public instruction. The facility shall ensure that children comply with all state school attendance laws.

2. **Employee training.** The facility shall provide quarterly training to employees which is relevant to address the changing needs of the milieu and according to the requirements of the facility's accrediting body.

a. All employees on duty must have satisfactorily completed annual training on current first aid, therapeutic crisis intervention or crisis prevention intervention, suicide awareness and prevention training, standard precautions as used by the centers for disease control and prevention, training on institutional child abuse and neglect to include reporting requirements and prohibition of employer retaliation for reporting, and cardiopulmonary resuscitation training and have on file at the facility a certificate of satisfactory completion prior to having direct contact with residents. A certificate must be provided to each employee demonstrating their competencies in cardiopulmonary resuscitation on an annual basis and therapeutic crisis intervention on a semi-annual basis. An employee who is in orientation status and who is in the process of completing the required trainings and background check may be allowed to job shadow with an employee who the facility has deemed to be an experienced and competent employee to supervise during orientation status. The facility ensures that employees who are in orientation status are always under the supervision of experienced employees and are not left alone with the children until all required training and background check has been completed.

b. Each employee must be able to recognize the common symptoms of illnesses of children, signs and symptoms of an overdose, and to note any marked physical defects of children. The facility shall ensure a sterile clinical thermometer and a complete first-aid kit are available.

3. **Discipline.** A facility shall create a trauma-informed culture that promotes respect, healing, and positive behaviors and which minimizes the use of restrictive behavior management interventions to the extent possible. Discipline must be constructive or educational in nature and follow the discipline guidelines of the facility's accrediting body. A facility shall adopt and implement written policies and procedures for discipline and behavior management consistent with the following:

   a. Only employees of the facility may prescribe, administer, or supervise the discipline of children. Authority to discipline may not be delegated to children or nonemployees.

   b. A child may not be slapped, punched, spanked, shaken, pinched, roughly handled, struck with an object, or receive any inappropriate physical treatment.

   c. Verbal abuse and derogatory actions or remarks about the child, the child's family, religion, or cultural background may not be used or permitted.

   d. A child may not be locked in any room.

   e. The facility shall develop and implement a youth-guided, family-driven plan of discipline as part of the child's person-centered treatment planning, emphasizing the use of positive behavior supports and therapeutic interventions, that promote an effective means of discipline. Daily documentation must reflect whether the interventions are effective and if they need revising.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-11. Children as employees prohibited.

Children may not be solely responsible for any major phase of the facility's operation or maintenance, including cooking, laundering, housekeeping, farming, or repairing.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008.
General Authority: NDCC 25-03.2-10

Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-12. Discharge.

1. Discharge planning for each child must begin during the admission process. The facility shall develop an evolving discharge plan within seven days of admission that identifies the child's and family's needed services and supports upon discharge and include the discharge plan in the treatment plan. The facility's interdisciplinary team shall review the discharge plan every fourteen days at the same time as the treatment plan review. The facility's interdisciplinary team shall update or amend the discharge plan to meet the needs of the child.

2. Prior to discharge, the facility shall complete a discharge plan, coordinate community services required for the child to return to the home, and provide information for aftercare services with each child's family, school, and community to ensure continuity of care. The discharge plan must address and include:

   a. Psychiatric, medical, educational, psychological, social, behavioral, developmental, and chemical dependency treatment needs;

   b. The reason for discharge;

   c. A progress report, including an update on the child's psychiatric care and treatment recommendations;

   d. An assessment of community-based service needs for the child and family;

   e. A statement that the discharge plan recommendations have been reviewed with the child and the person who lawfully may act on behalf of the child;

   f. The name and title of the individual into whose care the child was discharged.

3. The discharge committee shall review and approve each anticipated discharge thirty days before the discharge and provide the completed discharge plan to the custodian at least seven days before the anticipated discharge.

4. At least seven days prior to discharge a team meeting involving the child, the person who lawfully may act on behalf of the child, the facility treatment team, and related community services providers must take place to ensure the continuity of services consistent with the child's treatment needs after discharge. As part of the discharge planning requirements, facilities shall:

   a. Identify a prescribing provider in the community and schedule an outpatient visit;

   b. Ensure the child has a seven-day supply of needed medication and a written prescription for medication to last through the first outpatient visit in the community with a prescribing provider; and

   c. Include documentation of the medication plan and arrangements for the outpatient visit in the medical records in the child's case file. If medication has been used during the child's treatment in the facility but is not needed upon discharge, the reason the medication is being discontinued must be documented in the medical records in the child's case file.

5. The discharge committee shall review and approve each discharge from a facility prior to the discharge. The discharge committee must include the following:

   a. Tier 1 mental health professional;

   b. Attending therapist;

c. Assigned social worker;

d. Facility nurse;

e. Facility educator;

f. Facility residential staff; and

g. A person who lawfully may act on behalf of the child.

6. The facility shall assist the child and the person who lawfully may act on behalf of the child in preparing for the transition from residential treatment to return the child home, to a foster family, adoptive family, an institution, or to the home of relatives.

7. The facility treatment team shall develop a discharge plan that ensures appropriate appointments are scheduled, based on the child's needs and input from the person who lawfully may act on behalf of the child, as part of the post discharge plan. Appointments must support continuity of care addressing needs for individual therapy, psychiatric services and educational services, and other services or supports that may be appropriate. The facility treatment team shall provide a copy of the plan to the person who lawfully may act on behalf of the child and a copy must remain in the chart.

8. If a discharge is not anticipated at least thirty calendar days ahead of time, the discharge is considered unplanned and the facility shall:

   a. Hold a discharge planning meeting involving the child, custodian, parent, guardian, facility treatment team, additional family members, and any other relevant parties. This meeting must allow relevant parties time to review the discharge plan and aftercare engagement strategies while discussing services needed to best meet the needs of the child; and

   b. Create and provide in writing a finalized discharge and aftercare plan to the custodian and parent or guardian at least seven days before the child's discharge.

9. A child's discharge from the facility may not be based on the child's need for short-term inpatient treatment at a psychiatric facility.

10. The facility may not discharge a child without community-based support services in place. If a child does not have a home or safe place for discharge, the facility shall work with the legal custodian or placing agency to implement a safety plan for the child until a safe place is available.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-13. Responsibility for notification - Elopement of children.

When a facility confirms that a child's whereabouts are unknown, the facility shall immediately notify law enforcement officials and the individual who may lawfully act on behalf of the child. The child's return must be reported immediately to law enforcement and the individual who may lawfully act on behalf of the child. The facility shall institute policies and procedures for responding to the elopement of children from the facility.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014.

General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-14. Employee health qualifications.

1. All employees, including nonemployees, must be in good health and physically and mentally capable of performing assigned tasks.

2. All employees must have a health screening that includes a test for tuberculosis, performed by or under the supervision of a physician not more than one year prior to or thirty days after employment. The individual performing the screening shall sign a report indicating the presence of any health condition that would create a hazard to children of the facility or other employees.

3. Unless effective measures are taken to prevent transmission, an employee or nonemployee suffering from a serious communicable disease shall be isolated from other employees, nonemployees, and children of the facility who have not been infected.

4. Information obtained concerning the medical condition or history of an employee must be collected and maintained on forms and in medical files separate from other forms and files and must be treated as a confidential medical record.

5. The facility shall develop a policy regarding health requirements for nonemployees that addresses tuberculin testing.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-04, 25-03.2-07

75-03-17-15. Staff-to-child ratio.

1. The ratio of employee to children must meet the standards of the facility's accredited body and be included in the facility's policies and procedures. The facility shall follow the employee-to-child ratio set by its accrediting body, or the ratios set forth in this subsection, if the ratios set forth in this subsection require a greater number of employee to children than the ratios set by the accrediting body. The employee-to-child ratio on the premises during waking hours Monday through Friday is dependent on the needs of the children and the requirements of the individual person-centered treatment plans, but may not be less than:

   a. Two employees present who are qualified to provide direct care for one to six residents.

   b. Three employees present who are qualified to provide direct care for seven to nine residents.

   c. Four employees present who are qualified to provide direct care for ten to twelve residents.

   d. Five employees present who are qualified to provide direct care for thirteen to sixteen residents.

2. On evenings, nights, weekends, and holidays, during non-programming hours, the ratio of employees to children is dependent on the needs of the children and the requirements of the individual person-centered treatment plans. Additionally, the ratio of employee-to-children must meet the minimum standards of the accrediting body but may not be less than two employees on premises qualified to provide direct care. The facility shall implement a policy that if there is an emergency, and additional employees are not available to respond to the

facility within fifteen minutes, the facility will call for law enforcement or emergency medical assistance.

3. All night employees must be awake and within hearing distance of children. Employees shall perform bedroom checks at a minimum of every fifteen minutes to assure that each sleeping child is in that child's assigned room and is safe.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; July 1, 2014; April 1, 2016.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-16. Personnel policies and employee and nonemployee files.

1. The facility shall have clearly written personnel policies. The policies must be made available to each employee and nonemployee and must include:

   a. An employee training and development plan;

   b. Procedures for reporting suspected child abuse and neglect for employees and nonemployees;

   c. Procedures for employee evaluation, disciplinary actions, and termination;

   d. A prohibition of sexual contact between employees and nonemployees and children in accordance with the Prison Rape Elimination Act of 2003 [Pub. L. 108-79];

   e. Procedures for employee grievances;

   f. Both oral and written instructions regarding employee and nonemployee responsibility for preserving confidentiality;

   g. Evaluation procedures that include a written evaluation following the probationary period for new employees and at least annually thereafter; and

   h. A plan for review of the personnel policies and practices with employee and, as appropriate, nonemployee, participation at least once every three years, or more often if necessary.

2. The facility shall maintain an individual file on each employee. The file must include:

   a. The application for employment including a record of previous employment and the applicant's statement in answer to the question, "Have you been convicted of a crime?";

   b. Annual performance evaluations; or

   c. Annual professional development and training records consisting of name of presenter, date of presentation, topic of presentation, and length of presentation;

   d. The following required training certificates:

      (1) First-aid training;

      (2) Cardiopulmonary resuscitation and automated external defibrillator;

      (3) Nonviolent crisis intervention;

      (4) Suicide prevention training;

(5) Evidence-based treatment modalities; and

(6) Trauma training;

e. Evidence of the employee having read the law requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the facility's written child abuse and neglect procedures;

f. Results of background checks for criminal conviction record, motor vehicle operator's license record, as applicable, and child abuse or neglect record;

g. Any other evaluation or background check deemed necessary by the administrator of the facility; and

h. Documentation of the status of any required license or qualification for the position or tasks assigned to the employee.

3. The facility shall maintain an individual file on each nonemployee. The file must include:

a. Personal identification information;

b. Results of background checks for criminal conviction record, motor vehicle operator's license record, as applicable, and child abuse or neglect record;

c. Description of duties;

d. Orientation and training records consisting of name of presenter, date of presentation, topic of presentation, and length of presentation; and

e. Evidence of the nonemployee having read the law requiring the reporting of suspected child abuse and neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the facility's written child abuse and neglect procedures.

4. The facility shall adopt a policy regarding the retention of employee and nonemployee files.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-16.1. Child abuse and neglect reporting.

1. All facility employees and nonemployees, upon hire and annually thereafter, shall certify having read the law requiring the reporting of suspected child abuse or neglect, North Dakota Century Code chapter 50-25.1, and having read and received a copy of the facility's written child abuse and neglect reporting procedures.

2. The facility shall adopt written policies and procedures requiring employees and nonemployees to report cases of suspected child abuse and neglect. The procedures must include the following statements:

"All employees and nonemployees shall comply with North Dakota Century Code chapter 50-25.1, child abuse and neglect. Therefore, it is the policy of this facility that an employee or nonemployee who knows or reasonably suspects that a current resident or former resident receiving aftercare services whose health or welfare has been, or appears to have been, harmed as a result of abuse or neglect, that employee or nonemployee shall immediately report this information to the department.

Failure to report this information in the prescribed manner constitutes grounds for dismissal from employment or placement of nonemployee and referral of the employee or nonemployee to the office of the state's attorney for investigation of possible criminal violation."

3. The facility's policies and procedures must address:

   a. To whom a report is made;

   b. When a report must be made;

   c. The contents of the report;

   d. The responsibility of each individual in the reporting chain;

   e. The status of an employee or nonemployee who is the alleged perpetrator subject of a report pending assessment, administrative proceeding, or criminal proceeding;

   f. The discipline of an employee or nonemployee who is the perpetrator subject of a confirmed decision or a determination that institutional child abuse or neglect is indicated, up to and including termination; and

   g. The status and discipline of an employee or nonemployee who fails to report suspected child abuse or neglect.

4. The facility shall cooperate fully with the department throughout the course of any assessment or investigation of any allegation of child abuse or neglect made concerning care furnished to a resident. The facility shall, at a minimum, provide the assessors, investigators, or reviewers with all documents and records available to the facility and reasonably relevant to the assessment or investigation, and shall permit confidential interviews with employees, nonemployees, and residents. Internal facility interviews and investigations are not permitted to occur concurrent with a department assessment or law enforcement investigation. A facility may use risk reduction techniques to ensure safety and security of employees, nonemployees, and residents. In the case of an indicated determination, the facility shall notify the department licensing administrator, in writing, of the corrective action the facility has taken, or plans to take, to comply with any resulting recommendations from the state child protection team. The facility shall make assurances that revised facility practice will reduce the risk of the incident reoccurring. The facility shall respond within thirty days of receiving written notification of the determination.

History: Effective September 1, 1998; amended effective April 1, 2008; April 1, 2014; April 1, 2016; April 1, 2022; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-16.2. Criminal conviction - Effect on operation of facility or employment by facility.

1. A facility operator may not be, and a facility may not employ, in any capacity that involves or permits contact between the employee, contracted service providers, or nonemployee and any child cared for by the facility, an individual who is known to have been found guilty of, pled guilty to, or pled no contest to:

   a. An offense described in North Dakota Century Code chapter 12.1- 16, homicide; 12.1-17, assaults - threats - coercion - harassment; 12.1-18, kidnapping; 12.1-27.2, sexual performances by children; or 12.1-40, human trafficking; or in North Dakota Century Code section 12.1-20-03, gross sexual imposition; 12.1-20-03.1, continuous sexual abuse of a child; 12.1-20-04, sexual imposition; 12.1-20-05, corruption or solicitation of minors; 12.1-20-05.1, luring minors by computer or other electronic means; 12.1-20-06,

sexual abuse of wards; 12.1-20-07, sexual assault; 12.1-22-01, robbery; 12.1-22-02, burglary, if a class B felony under subdivision b of subsection 2 of that section; 12.1-29-01, promoting prostitution; 12.1-29-02, facilitating prostitution; 12.1-31-05, child procurement; 14-09-22, abuse or neglect of a child;

b. An offense under the laws of another jurisdiction which requires proof of substantially similar elements as required for conviction under any of the offenses identified in subdivision a; or

c. An offense, other than an offense identified in subdivision a or b, if the department determines that the individual has not been sufficiently rehabilitated.

(1) The department will not consider a claim that the individual has been sufficiently rehabilitated until any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction, has elapsed.

(2) An offender's completion of a period of five years after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent conviction, is prima facie evidence of sufficient rehabilitation.

2. A facility shall establish written policies, and engage in practices that conform to those policies, to effectively implement subsection 1.

3. The department has determined the offenses enumerated in subdivisions a and b of subsection 1 have a direct bearing on the individual's ability to serve the public in a capacity involving the provision of foster care to children.

4. In the case of a misdemeanor simple assault described in North Dakota Century Code section 12.1-17-01, or equivalent conduct in another jurisdiction which requires proof of substantially similar elements as required for conviction, the department may determine that the individual has been sufficiently rehabilitated if five years have elapsed after final discharge or release from any term of probation, parole, or other form of community corrections or imprisonment, without subsequent charge or conviction. The department may not be compelled to make such determination.

5. The department may discontinue processing a request for a criminal background check for any individual who provides false or misleading information about the individual's criminal history.

6. An individual is known to have been found guilty of, pled guilty to, or pled no contest to an offense when it is:

a. Common knowledge in the community;

b. Acknowledged by the individual; or

c. Discovered by the facility, authorized agent, or department as result of a background check.

7. The facility shall require a fingerprint-based criminal background check and child abuse or neglect index be completed for each employee and nonemployee.

8. The facility shall make an offer of employment to an employee or an offer of placement to a nonemployee conditional upon the individual's consent to complete required background checks. While awaiting the results of the required background checks, a facility may choose to provide training and orientation to an employee or nonemployee. However, until the approved

background check results are placed in the employee or nonemployee file, the employee or nonemployee shall only have supervised interaction with any child cared for by the facility.

9. A facility shall establish written policies specific to how the facility will proceed if a current employee or nonemployee is known to have been found guilty of, plead guilty to, or pled no contest to an offense.

10. If a prospective employee has previously been employed by one or more group homes, residential child care facilities, or facilities, the facility shall request a reference from all previous group home, residential child care facility, and facility employers regarding the existence of any determination or incident of reported child abuse or neglect in which the prospective employee is the perpetrator subject.

11. The facility shall perform a background check for reported suspected child abuse or neglect each year on each facility employee. Each employee, including direct care staff, supervisors, administrators, administrative, and facility maintenance staff, shall complete a department-approved authorization for child abuse and neglect background check form no later than the first day of employment and annually thereafter to facilitate the background checks required under this subsection.

12. The department may excuse a person from providing fingerprints if usable prints have not been obtained after two sets of prints have been submitted and rejected. If a person is excused from providing fingerprints, the department may conduct a nationwide name-based criminal history record investigation in any state in which the person lived during the eleven years preceding the signed authorization for the background check.

13. A facility shall establish written policies and engage in practices that conform to those policies, to effectively implement this section.

History: Effective April 1, 2016; amended effective July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-17. Facility employee.

1. The facility's employees shall include:

   a. An executive director who has a bachelor's degree in a behavioral science, or a bachelor's degree in any field and two years of experience in administration;

   b. A program director who has a master's degree in social work, psychology, or in a related field with two years of professional experience in the treatment of children suffering from mental illnesses or emotional disturbances;

   c. Facility care employees who are at least twenty-one years of age and have sufficient training and demonstrated skills experience to perform assigned duties;

   d. A sufficient number of qualified psychiatric professionals, employed or contracted, to meet the resident needs; and

   e. Educators, where onsite education is provided.

2. Nonemployees may be used to augment and assist other employees in carrying out program or treatment plans. Nonemployees shall receive orientation training regarding the program, employees, and children of the facility, and the functions to be performed.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2016; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-18. Safety, buildings, and grounds.

1. **Compliance with fire, sanitation, and zoning standards.** An applicant shall demonstrate compliance with applicable state or local fire, sanitation, and zoning standards. The premises to be used must be in fit, safe, and sanitary condition and properly equipped to provide good care and treatment.

    a. Fire. For fire safety, the facility shall meet the applicable life safety standards established by the city. If the city has not established life safety standards, the facility shall comply with chapter 21 of the Life Safety Code of the national fire protection association, 1985 edition, and amendments thereto.

        (1) Compliance is shown by submitting the written report of an authorized fire inspector, following an initial or subsequent inspection of a building which states the:

            (a) Rated occupancy and approval of the building for occupancy; or

            (b) Existing hazards, and recommendations for correction which, if followed, would result in approval of the building for occupancy.

        (2) All electrical and heating equipment must be approved by underwriters laboratories, incorporated, or another nationally recognized testing laboratory.

    b. Sanitation. Compliance with sanitation standards is shown by submitting a statement prepared by a licensed environmental health professional or authorized public health officer, following an initial or subsequent annual inspection, that the building's plumbing, sewer disposal, water supply, milk supply, and food storage and handling comply with the applicable rules of the state department of health and the department of environmental quality.

    c. Zoning. Compliance with zoning requirements is shown by submitting a statement prepared by the appropriate county or municipal official having jurisdiction that the premises are in compliance with local zoning laws and ordinances.

2. **Safety.** Safety requirements of a facility must include:

    a. Prohibition of smoking on the premises;

    b. Procedures for water safety where swimming facilities are on the grounds;

    c. A copy of the Red Cross manual on first-aid measures, or a book of its equivalent, and first-aid supplies;

    d. Prohibiting a child's possession and use of any firearms while at the facility;

    e. Advising children of emergency and evacuation procedures upon admission and thereafter every two months;

    f. Training in properly reporting a fire, in extinguishing a fire, and in evacuation from the building in case of fire. Fire drills must be held monthly. Fire extinguishers must be provided and maintained throughout each building in accordance with standards of the state fire marshal; and

g. Telephones with emergency numbers posted by each telephone in all buildings that house children.

3. **Buildings and grounds.** The facility must have sufficient outdoor recreational space, and the facility's buildings must meet the following standards:

a. Bedrooms. Each child must have eighty square feet [7.43 square meters] in a single sleeping room, and sixty square feet [5.57 square meters] per individual in a multiple occupancy sleeping room; the child's own bed, and bed covering in good condition; and a private area to store the child's personal belongings. A facility may not permit more than two children in each sleeping room; children to sleep in basements or attics; nonambulatory children to sleep above the first floor; and a child to share a bedroom with a child of the opposite sex.

b. Bathrooms. The facility's bathroom facilities must have an adequate supply of hot and cold water; be maintained in a sanitary condition; have separate toilet and bath facilities for male and female children, and employees; and have one bathroom that contains a toilet, washbasin, and tub or shower with hot and cold water for every four children.

c. Dining and living rooms must have suitably equipped furnishings designed for use by children within the age range of children served by the facility.

d. The facility shall provide sufficient space for indoor quiet play and active group play.

e. The facility shall provide adequate heating, lighting, and ventilation.

f. Employee quarters must be separate from those of children, although near enough to assure proper supervision of children.

g. A facility shall provide a quiet area for studying.

h. A facility shall lock all outbuildings on the property at all times when not in use by facility employees.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; April 1, 2016.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-07

75-03-17-19. Interstate compact on the placement of children.

1. The facility shall comply with the interstate compact on the placement of children and the interstate compact for juveniles.

2. All placements from any state which has not adopted the interstate compact on the placement of children or the interstate compact on juveniles must comply with all North Dakota laws and rules prior to the arrival of a child at a facility.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-06

75-03-17-20. Rights and obligations of the applicant.

1. **Right to apply for license.** An applicant has the right to apply to receive a license to operate a facility under this chapter.

2. **Entry and inspection.**

a. The department may evaluate a facility's compliance with this chapter at any time through:

(1) An announced or unannounced onsite review; or

(2) A request for written documentation verifying compliance.

b. The applicant shall allow authorized representatives of the department to enter any of the applicant's buildings or facilities to determine the extent to which the applicant is in compliance with the rules of the department, to verify information submitted with an application for licensure or license renewal, and to investigate complaints. Inspections must be scheduled for the mutual convenience of the department and the facility unless the effectiveness of the inspection would be substantially diminished by prearrangement.

3. **Access to records.** The applicant shall allow duly authorized representatives of the department to inspect the records of the applicant, to facilitate verification of the information submitted with an application for licensure, and to determine the extent to which the applicant is in compliance with the rules of the department.

4. **Denial of access to facilities and records.** Any applicant or licensee which denies access, by the authorized representative of the department, to a facility or records for the purpose of determining the applicant's or licensee's state of compliance with the rules of the department shall have its license revoked or application denied.

5. **License refusal or revocation.** Failure to comply with any of the standards of this chapter or other state law or regulation is cause for refusal or revocation of a license. Conviction of an offense by an owner or operator of a facility does not disqualify the facility from licensure unless the department determines that the offense has a direct bearing upon a person's ability to serve the public as an owner or operator of a psychiatric residential treatment facility for children or that, following conviction of any offense, the person is not sufficiently rehabilitated under North Dakota Century Code section 12.1-33-02.1.

6. **Appeal.** An applicant may appeal a license denial in accordance with North Dakota Century Code chapter 28-32 and North Dakota Administrative Code chapter 75-01-03.

7. **Deemed status.** The department may recognize "deemed status" for those providers who are accredited by nationally recognized bodies who review and certify providers of psychiatric residential treatment services for children. When applying for licensure or licensure renewal, proof of accreditation or "deemed status" in the form of the accreditation agency's most recent review and certification must be submitted to the department. "Deemed status" means status conferred on a facility accredited by a national accreditation body based on standards that exceed the standards set forth in these licensure rules.

History: Effective December 1, 1989; amended effective September 1, 1998; April 1, 2008; April 1, 2014; July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-02, 25-03.2-03, 25-03.2-07, 25-03.2-08, 25-03.2-09

75-03-17-21. Increase or decrease in the number of licensed beds in a facility.

1. A facility may not increase or decrease bed capacity without approval of the department. A facility requesting a bed capacity change shall submit a request to the department licensor. To qualify for an increase, a facility must:

a. Be in compliance with this chapter.

b. Submit a plan for the use of its beds.

2. The department shall review the facility's request and may approve or deny the request considering the programming need for the beds and the number of beds available.

History: Effective April 1, 2014.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03.1

75-03-17-22. Incident and sentinel event reporting.

1. The facility shall have a written policy outlining the documentation of incidents that occur while the resident is in placement. The policy must include:

   a. A description of an incident as an unplanned occurrence that resulted or could have resulted in injury to an individual or damage to property, specifically involving the public, residents, or agency employees and nonemployees; incidents involving law enforcement, including in the case of a runaway, criminal activity, behavior resulting in harm to others, or restraint injury; and incidents involving outbreak of a serious communicable disease, harassment, violence, and discrimination; and

   b. Notification must be made to the custodian and parent or guardian immediately or no more than twelve hours;

2. The facility shall have a written policy outlining the documentation of sentinel events that occur while the resident is in placement. The policy must include:

   a. A description of a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury not related to the natural course of a resident's illness or underlying medical condition, including any process variation for which a reoccurrence would carry a significant chance of a serious adverse outcome, trauma to a resident, attempted suicide by the resident, or inappropriate sexual contact; and

   b. Notification must be made to the custodian and parent or guardian, and the department immediately or no more than twelve hours;

3. Documentation of an incident or sentinel event must be completed and placed in the resident's record. The report must include:

   a. Resident's name, age, and sex;

   b. A description of the incident or event;

   c. The date, time, and location of the incident or event;

   d. The name of each employee or nonemployee involved;

   e. Methods used to address the resident's behavior, including duration of each intervention;

   f. Detailed description of the technique or approach engaged with the resident at the time of the incident or event;

   g. Results achieved from methods used to address resident behavior; and

   h. Injuries received by either the resident, employee, or nonemployee in using physically enforced separation or restraint, how the injuries occurred, and any medical care provided;

4. The facility shall maintain a log of written reports of incidents involving residents;

5. Direct care staff must be given time at the beginning of each shift to be informed of or review incident reports occurring since their last shift; and

6. Employees, nonemployees, and residents must be given time to debrief the incident with clinical staff.

History: Effective July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-10

75-03-17-23. Conditions.

1. The department may require immediate correction of a condition that threatens the life or safety of a resident.

2. The facility shall submit to the department a plan of corrective action within thirty days of receiving the licensure visit report. The facility shall be allowed sixty days after the plan of corrective action is submitted to and approved by the department to implement the plan and satisfy the conditions.

3. The department may conduct another onsite review before issuing the license after a facility has developed a plan of corrective action.

4. If the facility does not satisfy a condition or develop a plan of corrective action to satisfy the condition within the time frames allowed, the department may impose a ninety-nine-day suspension of the facility's license. At the end of the ninety-nine-day suspension, if the condition has been corrected, the department may issue a one-year provisional license to the facility. If the facility has not corrected the condition, the department may revoke the facility's license.

5. Upon written request by the facility and upon showing a need for an extension created by circumstances beyond the control of the facility and documentation that the facility has diligently pursued correction of the condition, the department may grant extensions of time to correct conditions.

6. A facility which has had its license revoked is prohibited from submitting a new application to the department for consideration for a license for any facility during the three hundred sixty-five days following a license revocation.

History: Effective July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-10

75-03-17-24. Variance.

Upon written application and good cause shown to the satisfaction of the department, the department may grant a variance regarding a specific provision of this chapter upon such terms as the department may prescribe, except no variance may permit or authorize a danger to the health or safety of any resident cared for by the facility and no variance may be granted except at the discretion of the department. A facility shall submit a written request to the department justifying the variance. A refusal to grant a variance is not subject to appeal.

History: Effective July 1, 2022.
General Authority: NDCC 25-03.2-10
Law Implemented: NDCC 25-03.2-03, 25-03.2-10