



## **Department for Children and Families Placement Service Standards Manual**

**Effective: February 5, 2016**

All Residential/Group Home placement providers shall be licensed DCF Foster Care and Residential Facility Licensing and meet the DCF/PPS Placement Standards and requirements in the Child Welfare Handbook of Client Purchases in order to obtain a provider agreement with DCF.

Implementing a new facility or modifying a provider agreement for an existing facility requires an onsite review conducted by DCF regional staff. Providers may initiate the process by contacting their DCF regional office.

The list of the Regional Specialists is located at:

<http://www.dcf.ks.gov/services/PPS/Documents/Contract%20Information/ProviderAgreementServices.pdf>

### **A. Implementing a New Facility or Renewing/Changing a Provider Agreement:**

1. DCF regional staff shall assess the need for the type of service requested for a new facility and/or a change in services listed in an existing provider agreement.
2. DCF regional staff shall provide information to the provider including a copy of the DCF Placement Standards, Child Welfare Handbook of Client Purchases and contact information for DCF Foster Care and Residential Facility Licensing.
3. DCF regional staff shall provide technical assistance relative to the DCF Placement Standards and Child Welfare Handbook of Client Purchases.
4. DCF regional staff shall collaborate with KDOC-JS if the facility wants to serve juvenile offenders and child in need of care youth.
5. DCF regional staff shall conduct an initial on-site review of the facility to ensure compliance with the Placement Standards and the Child Welfare Handbook of Client Purchases. The on-site review shall include a tour of the facility, review of policy and procedures, human resource files and staffing patterns using the site review instrument. Ninety days after a new facility opens, or a change in services listed in an existing provider agreement is implemented, DCF regional staff shall return on site to review case records.

7. DCF regional staff shall provide technical assistance for compliance issues related to the Placement Standards and the Child Welfare Handbook of Client Purchases and provide a written site visit report of findings to the Provider.

8. The placement provider and DCF regional staff shall address any concerns prior to establishing a provider agreement. Program improvement activities for securing compliance shall be completed within 30 days.

9. The site visit report shall be maintained by DCF Regional Office who maintains the provider agreement and forwarded to the Provider.

**B. On-going Monitoring:**

The Child Welfare contractors for Family Preservation and Foster Care shall complete reviews annually. The purpose of the reviews is to maintain compliance with the DCF Placement Standards and Child Welfare Handbook of Client Purchases. The contractors shall provide reports containing the results of their on-site reviews to DCF on an annual basis.

Administrative desk reviews are conducted annually by DCF/PPS. The yearly desk reviews consists of an overall picture of the facility over the past year. The desk review report will summarize findings from the DCF Licensing Division incident reports, completed reviews from the Foster Care Contractor and a review of frequency of use as per DCF SCRIPTS. The report is shared with the DCF Licensing Division, The Foster Care Contractor, DCF PPS Administration and the facility being reviewed.

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## **Family Foster Home Descriptions**

### **Family Foster Home**

A foster home is a family home in which 24-hour care is provided to children who are in need of out of home placement to meet their safety and well-being needs. The home shall comply with DCF Foster Care and Residential Facility Licensing licensure requirements, and be sponsored by a licensed child placing agency. The foster family is an integral part of the team working with the child and birth family to achieve timely permanency for the child.

### **Satellite Family Foster Home**

Each satellite family foster home is sponsored by a licensed child placing agency with whom the child's referring agency subcontracts for child placement services.

### **Emergency Family Foster Home**

An emergency family foster home is a family home in which 24-hour care is provided on an emergency basis to children who are in need of out of home placement to meet their safety and well-being needs. The home shall comply with DCF Foster Care and Residential Facility Licensing licensure requirements, and be sponsored by a licensed child placing agency.

### **Maternity Foster Home**

A maternity foster home is a home in which 24-hour care is provided to a pregnant or postpartum youth and her child who is not a TANF recipient, who are in need of out of home placement to meet their safety and well-being needs. These homes shall comply with DCF Foster Care and Residential Facility Licensing licensure requirements, and be sponsored by a licensed child placing agency.

### **Specialized Family Foster Home**

Each specialized family foster parent is required to comply with DCF Foster Care and Residential Facility Licensing licensure requirements and the requirements of the sponsoring agency in regard to minimum number of in-service training hours to be obtained yearly. Specialized family foster parents are required to complete more annual in-service training than family foster parents due to specialized needs of the children/youth for whom they are providing care. Documentation of completion of in-service training hours shall be kept in the specialized family foster parent's file. The purpose of in-service training is to provide opportunities for the specialized family foster parent to increase their skills and parenting ability particularly with respect to the differences they may encounter in raising children with the developmental needs of the child to be placed and not born to them.

### **Relative Foster Home**

Twenty-four hour care in the home of a person related to the child. A KBI and DCF Child Abuse/Neglect Central Registry Check has been completed on all members of the family age 10 and over, and the child's referring agency has completed an assessment of the home to determine the child's safety and well-being needs will be met by placement in the relative's home. If DCF Foster Care and Residential Facility Licensing standards are met, relatives may receive financial assistance for the related child from the child's case management provider.

### **Kinship/Non-Related Kin Care**

Twenty-four hour care in a family home setting for not more than 30 days, on a one time basis, for a specific child with whom the kinship care provider has an existing supportive relationship with the child or the child's parent.

Informal Care/Kinship Care should be the first choice for placement when the child's family cannot provide adequate care. If the kin are not related to the child, they shall be required to meet DCF Foster Care and Residential Facility Licensing child care licensing standards and regulations in order to provide out of home services. To expedite placement of children with non-related kin, the requirement for the completion of PS-MAPP (the group process or Deciding Together) and the other training required prior to a child being placed in the home is waived. The non-related kin shall be required to complete the PS-MAPP curriculum and other pre-service training prior to licensure.

Prior to the child's placement, the Provider shall request from the local DCF Service Center a Child Abuse/Neglect Central Registry check on all members of the non-related kin family who are age 10 and over. The Provider shall also require the members of the family who are age 10 and over sign a statement, Declaration of No Prohibitive Offenses for DCF Foster Care and Residential Facility Licensing Licensure, indicating a check of the KBI criminal history database will not reveal any conviction for offenses, unless they have been expunged, which would prohibit DCF Foster Care and Residential Facility Licensing licensure. DCF Foster Care and Residential Facility Licensing shall complete the KBI criminal records check prior to issuing the temporary permit.

Immediately following placement, the Provider shall complete the family assessment and licensing packet. The packet shall be sent to DCF Foster Care and Residential Facility Licensing no later than 2 weeks after the child's placement. DCF Foster Care and Residential Facility Licensing shall review the packet and, if all requirements are met, issue a temporary permit by 30 days after the child's placement. The temporary permit remains in effect for 90 days from the date of issuance. This temporary license may be extended for one additional period not to exceed 90 days, to allow the kin time to complete PS-MAPP. No further extensions shall be granted. Non-related kin shall comply with all licensing requirements of DCF Foster Care and Residential Facility Licensing prior to a full foster home license being issued.

Case Management Providers shall negotiate a daily payment with the non-related kin providers to cover the cost of the child's room and board. They shall also provide the same level of supports and services which are provided to other resource families to ensure the child's needs are met and the placement remains stable.

Each child, newborn thru age 21, entering Kinship/Non-related Kin care shall have met criteria for this level of placement through use of a placement assessment tool utilized by DCF and the Child Welfare Community Based Service Provider staff. Each child being placed in Kinship/Non-related Kin care shall have an existing, supportive relationship with the Kinship/Non-related Kin care giver prior to placement. The relationship can be with the child or the parent.

## **General Program Requirements and Guidelines for all Family Foster Homes**

### **Section 1: General Program Requirements**

- Twenty-four hour care in a family home meeting DCF Foster Care and Residential Facility Licensing licensure requirements and sponsored by a licensed Child Placing Agency.
- Each family foster parent shall complete the PS-MAPP curriculum as a pre-service requirement
- Each family foster parent shall be at least 18 years of age at the time of application to DCF Foster Care and Residential Facility Licensing for licensure, and have been a member of the household for at least one year prior to application.
- Each family foster parent shall provide evidence of child care experience and knowledge of child care methods which will enable any child to develop his or her potential.
- The family foster home shall be licensed for a maximum of 4 foster children, not more than 2 of whom shall be under 18 months of age, with a total of 6 children in the home including the foster parents' own children under 16 years of age. Approval may be granted to care for 2 additional foster children in order to meet the needs of sibling groups or other special needs of foster children (K.A.R. 28-4-804).
- The family foster home shall meet the legal requirements of the community as to zoning, fire protection, water supply and sewage disposal.

### **Section 2: Services Provided in a Family Foster Home**

Services provided in a family foster home include: supervision, food, shelter, age appropriate daily living skills instruction, transportation, recreation, supporting parent/child interactions (when these have not been prohibited by the court), participation in development, and review of case plan tasks and objectives.

The daily schedule shall address the needs of the child and the use of time to enhance the child's physical, mental, emotional, and social development. Indoor and outdoor recreation shall be provided. All play equipment, books, and other materials shall be safe, clean, in good repair, and suitable to the developmental needs and interests of the child. The child shall attend school regularly and also have time for school and community activities. The child shall be provided opportunities to practice age appropriate daily living skills.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

### **Section 3: Criteria for Admission**

- Each child, newborn thru age 21 entering a Family Foster Home shall have met criteria for this level of placement through use of a placement assessment tool utilized by DCF and the Child Welfare Community Case Management Provider.
- A placement agreement shall be completed between the family foster parents or the home's sponsoring agency and the child's referring agency. A copy of the signed placement agreement shall be kept in the youth's file in the family foster home.

#### **Section 4: Accessing Outpatient Mental Health/Substance Use Disorder Services for a Child Residing in a Family Foster Home**

1. Child Welfare Case Management Provider's shall be responsible to complete a mental health and substance use disorder screen to determine each youth's need for further assessment in these areas.
2. If the mental health assessment indicates the need for outpatient mental health treatment services, the child shall receive the appropriate mental health services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will periodically assess the youth's progress and continued need for outpatient mental health treatment.
3. If the substance use disorder assessment indicates the need for outpatient substance use disorder treatment services, the child shall receive the appropriate substance use disorder services through an enrolled Medicaid provider through KanCare. The MCO assigned to the child through KanCare will periodically assess the youth's progress and continued need for outpatient substance use disorder treatment.
4. If the Mental Health assessment determines the youth may be in need of inpatient mental health or substance use disorder treatment, the youth shall receive a Psychiatric Residential Treatment Facility screen or, if the youth's sole diagnosis is substance use disorder, a referral shall be made to the MCO assigned to the youth.

#### **Section 5: Scope of Services**

**Supervision**– supervision will be provided by the foster parent or another appropriate care giver during the foster parent's absence.

**Food and Shelter**– nutritious meals and snacks will be provided, the home will meet the child's health and safety needs, each child has their own bed in a bedroom which meets DCF Foster Care and Residential Facility Licensing licensure requirements.

**Daily Living Skills Instruction**– age appropriate daily living skills instruction will be provided in such skill areas as: personal hygiene, laundry, meal preparation, shopping, cleaning, money management, and health.

**Transportation**– transportation will be provided to school and medical appointments. The foster family may also assist in transporting the child to social events, interactions with parents, court hearings and reviews, etc.

**Recreation**– sufficient time for recreation and for individual, school, and community activities shall be provided.

**Supporting parent/child interactions**– foster parents will assure each child is available for the scheduled parent/child interactions directed in the child's case plan. Foster parents may choose to make their home available for some of these interactions or accompany the child to the site for the interactions to provide mentoring support to the birth family.

**Participation in development and review of case plan tasks and objectives**– family foster parents are an integral part of the child's case planning team and are to be invited to participate in the development and review of the plan.

## **Section 6: Education**

Family foster parents are responsible to insure school age children attend school regularly, unless for an excused absence, and the children complete homework assignments. If the child will not be able to attend school due to illness or an appointment, the family foster parent is responsible to notify the school of this absence. The family foster parent will also communicate with the school in regard to the student's school progress and developing plans to address issues related to school performance.

## **Section 7: Child's Rights**

Each child residing in a foster family home shall have an opportunity for:

- privacy
- contact with their case manager without the family foster parent present
- recognition of the child's cultural and religious heritage
- taking personal items with them when they leave the foster home

### **Section 7.1: Forms of discipline not allowed in the Family Foster home include:**

- physical discipline, including hitting with the hand or any object
- restricting movement by tying or binding
- confining in a closet, box, or locked area
- withholding food, rest, or toilet use
- refusing access to the family foster home

## **Section 8: Record Keeping Requirements for the Family Foster Home**

### **Section 8.1: Child's File**

The family foster home shall maintain a file for each child in placement. The file shall contain the following information:

- Child's name and date of birth
- Name and address of the child's referring agency case manager/social worker
- Placement Agreement or Client Service Agreement (for child placed by DCF staff)
- Medical and surgical consents
- Medical and dental records
- Record of child's prescription and non-prescription medications and when administered
- Authorization for release of confidential information
- Log of significant incident reports

### **Section 8.2: 30-Day Progress Reports**

Thirty-day progress reports shall document child's adjustment in the home, school performance (if school age), medical, dental, vision, and mental health appointments, significant incidents reported, interactions with parents, and any other significant events or issues related to the child and the placement.

### **Section 8.3: Transfer of Child's Medical Records**

When a child leaves a family foster home to return home or moves to another out of home placement, the child's medical records shall be given to the child's referring agency to accompany the child.



## **Section 9: Family Foster Parent In-service Training**

Each family foster parent is required to comply with DCF Foster Care and Residential Facility Licensing licensure requirements and the requirements of the sponsoring agency in regard to minimum number of in-service training hours to be obtained yearly. Documentation of completion of the in-service training hours shall be kept in the family foster parent's file. The purpose of in-service training is to provide opportunities for the family foster parent to increase their skills and parenting ability particularly with respect to the differences they may encounter in raising children not born to them.

Training shall be related to one of the following topic areas:

- a) Developmental needs of the child to be placed
- b) Roles and relationships between the agency, foster parent, birth parent, and child
- c) Child management and discipline techniques
- d) Separation and the importance of the child's family
- e) Importance of the child's continued communication and contact with family
- f) Supportive services available to the child and to the foster family from the community
- g) Communication skills
- h) Constructive problem solving
- i) First aid, blood borne pathogens, CPR, medications
- j) Home safety
- k) Human sexuality, including the needs and behaviors of children who have been sexually or physically abused

## **Section 10: Reporting Abuse/Neglect**

All family foster parents are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

Abuse is any act or failure to act which results in death, physical harm, emotional harm, or which presents a likelihood of harm to a person under age 18. The broad definition of abuse includes physical abuse, emotional abuse, and sexual abuse. Neglect is any act or omission resulting in harm to a child or which presents a likelihood of harm. Neglect includes failure to provide food, clothing, shelter, safety, adequate levels of appropriate supervision, medical treatment, or education.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10.

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Neglect: Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

### **Section 11: Significant Incident**

A Significant Incident is an unanticipated event which does not rise to the level of a critical incident, but has the potential risk of a serious adverse outcome.

#### **Section 11.1 Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement. PPM 5245 shall be followed.
3. arrested for a juvenile offense
4. alleged abuse or neglect

5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy. See PPM 0513 D. 2.
10. birth. See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs
13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents must be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each foster family shall obtain on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

If the significant incident involves abuse or neglect the foster family shall also follow mandated reporting requirements.

## **General Program Requirements and Guidelines for Therapeutic Family Foster Home**

A Therapeutic Family Foster home is a family home in which 24-hour care is provided to children who are in need of out of home placement to meet their safety and well-being needs. The home shall comply with DCF Foster Care and Residential Facility Licensing licensure requirements, and be sponsored by a licensed child placing agency. The foster family is an integral part of the team working with the child and birth family in order to achieve timely permanency for the child.

### **Section 1: Therapeutic Family Foster Home**

The over-all purpose is to improve the mental health status, emotional, and social adjustment of youth who require out of home therapeutic placement. Placement in Therapeutic Foster Care (TFC) occurs to support the youth, allow the youth to function in a setting outside of an inpatient hospital, or prevent the inpatient placement of the youth.

The Kansas TFC standards are predicated upon the National Program Standards of the Foster Family- Based Treatment Association (<http://www.ffa.org>). The national standards indicate that TFC “is agency led and team oriented”. It is not simply the provision of higher payment and more training to foster parents for work with more difficult children or youth. Nor is it solely the addition of therapeutic resources external to the treatment foster home.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child’s health, safety, and best interests while at the same time encouraging the child’s emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

#### **Section 1.1: Goals and Objectives**

To facilitate youth reaching the optimal functioning and ability to reside in the community in the least restrictive environment.

Long term goals of the service are:

- Improve emotional, mental, and functional status of individuals receiving services;
- Reduce unplanned placement changes;
- Increase the youth’s ability to live safely, attend school, and be productive in an inclusive community environment;
- Increase the likelihood of a youth’s successful return to the family or the successful implementation of permanency planning; and
- If developmentally appropriate, increase the youth’s capacity for independent living.

### **Section 2: Description of Youth to Be Served**

Youth placed in Therapeutic Foster Care shall be in need of therapeutic intervention. Clinicians and others familiar with the youth shall document that the youth is at serious risk of placement in a highly structured residential treatment program, but that the youth has enough internal control to be served in a structured

family home environment by knowledgeable trained foster parents with the support of specialized behavioral management, school, and psychotherapy or behavioral therapy services.

These youths may exhibit well established patterns of behavior or conduct which are antisocial, oppositional, defiant, aggressive, abusive, impulsive, rebellious, self-defeating, or sometimes self-abusive. Youth with special medical needs or developmental disabilities may also require TFC if their behavior is such that specialized care is warranted. TFC eligible youth may also display a limited ability to delay gratification and show social and emotional immaturity. They may exhibit significant interpersonal relationship problems associated with such symptoms as withdrawal, aggressiveness, Asperger's or autistic patterns, or peculiar behaviors resulting in rejection by peers. They may have problems with substance use disorder, sexual acting out, running away, or destruction of property. Youth approved for Therapeutic Foster Care may also display poorly developed self-help or communication skills.

These youth's severe behavioral disturbances are primarily derived from environmental influences although some may exhibit patterns of mild to moderate mental illness. Various medical conditions may complicate the overall treatment picture. Affective disturbances will likely be prevalent as will be ADHD. Due to a history of severe physical, emotional, or sexual abuse, youth requiring TFC may avoid adult relationships, appear impersonal or detached, or exhibit serious oppositional tendencies. Sexual acting out associated with past sexual abuse will also likely be seen in the typical TFC setting. Youth appropriate for TFC referral are generally not an immediate danger to harm themselves. They may be potentially dangerous to others or property through their aggression and disregard for other's rights.

Youth in these circumstances require a high degree of supervision and intensive service. The youth may have received treatment in psychiatric institutions, higher levels of residential treatment, or they may be youth for which diversion from higher levels of treatment is recommended. They may be dually diagnosed youth who require a combination of support services and therapy to regain control of their physical actions.

TFC youth may exhibit severe interpersonal relationship difficulties, especially with peers. However, they shall be able to demonstrate at least some positive response to adults and authority. Bizarre or peculiar behaviors may be exhibited which are sometimes only understood when the underlying causes and dynamics of the behaviors are understood. Hyperactivity and a hyper-responsiveness to external stimulation will likely be seen in various cases. Periodically, these youth may need external controls placed upon them. Many of these youth may be placed on psychotropic medication to facilitate control of impulses, emotions, attention capacities, or activity levels.

Youth who are immediately dangerous to themselves or others shall not be referred to TFC. Conversely, youth who do not demonstrate a need for considerable supervision, support, psychotherapy, specialized school services, psychiatric services or an inability to function within their biological family environment, shall be helped in a less treatment intensive arrangement.

**NOTE: Therapeutic Foster Care services are limited to special needs children who are at eminent risk of placement in a psychiatric care, developmental disability care or residential facility or who are referred from such a facility.**

### **Section 3: General Program Description**

TFC providers shall demonstrate the clinical and administrative capacity to provide quality services by meeting the criteria listed below. The Licensed Child Placing Agency or the therapeutic family foster parents do not provide acute inpatient, psychiatric, or substance use disorder residential treatment. Each therapeutic family foster home shall meet DCF Foster Care and Residential Facility Licensing licensure requirements and shall be sponsored by a licensed child placing agency. The provider shall state whether

the services under the Provider Agreement will be carried out by the provider's staff, by subcontracted staff, or through cooperative agreements. The provider shall provide, as part of the application, copies of such agreements.

The provider shall agree that no more than two children will be cared for at any one time in each therapeutic foster home. Exceptions can be granted for the additional placement of siblings or stepsiblings of the TFC youth, provided that PPS the referring agency, and TFC program staff all agree that it is clinically good practice to do so and document the rationale for that decision in the TFC Program youth's case file. Services are to be provided to a small number of youth at a time in each therapeutic family foster home to insure that the children will achieve success with the goals outlined in the Treatment Plan.

Each child's treatment plan shall be reviewed every 90 days by the child's treatment team. The treatment team is composed of the Social Worker Case Coordinator, Case Coordinator Supervisor, child/youth, (if age appropriate), biological or adoptive parents (when appropriate), therapeutic family foster parents, and the therapist who is an enrolled KanCare Medicaid provider. CWCMP/DCF Case Managers, other Clinical Consultants, and educators working with the youth in the local school district are also considered to be an integral part of the treatment team. The review shall be documented in the child's case file.

Providers will use the National Standards of the Foster Family-Based Treatment Association (FFTA) as a guide in addition to standards given in this document. The Provider shall agree that prior to placement in Therapeutic Foster Care; the child will meet the criteria for placement, as determined by a score on the referring agency's placement screening tool and by meeting the general criteria for eligibility for placement in TFC.

#### **Section 4: Scope of Core Services**

The provider will operate and maintain a TFC program and conduct a program evaluation. Criteria for Therapeutic Foster Care are minimum requirements; exceeding the requirements does not automatically qualify providers for any other program designation. In addition, please refer to Section I of the National Standards for more clarification and discussion.

**Daily Living Services** - daily living services shall be provided and include the following:

- Room, board, child care, personal spending money, and school fees.
- Transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- Academic activities - assistance with school work, vocational training, and/or G.E.D. training.

**Situational Training-** to include but not limited to:

- Personal Hygiene – teaching about body cleanliness, use of deodorants and cosmetics, appropriate clothing, choosing clothing to fit individual and occasion, and keeping clothes neat and clean.
- Health - Identifying and understanding residents' health needs; securing and utilizing necessary medical treatment including preventive and health maintenance services; gaining information and education in health maintenance (including preventive measures, nutrition, menstruation, rest, cleanliness, family planning, drugs, sexually transmitted diseases, exercise, and motivation for meeting own health needs), maintaining contact with providers of health services (physician, nurse, clinic) and using outside Foster s for assistance (clinics, pharmacies, hospitals). KAN BE Healthy screening shall be provided according to the periodicity schedule and needed follow ups shall be completed.

- Consumer education for independent living- Budgeting, comparative buying, installment buying, avoiding risks, identifying illegal or excessive interest rates, use of credit, avoiding or dealing with debts, using checking and savings accounts, and paying taxes.

**Communication skills:**

The youth’s articulating thoughts and feelings through appropriate use of such skills as speech, writing, and use of the telephone.

**Home Management:**

Making the bed and changing linens, using the vacuum cleaner, dusting, organizing belongings, disposing of trash, cleaning all areas of the home, operating appliances, cooking complete meals, making simple repairs, who to call when a major repair is needed, being aware of the need for upkeep, handling emergencies, knowing first aid.

**Situational Guidance:**

Identifying and accepting strengths, developing patterns of acceptance and coping with authority figures, getting along with others, sharing responsibility, being considerate of others, developing friendships, knowing when to go home when visiting, recognizing or modifying attitudes toward self or others, responsible work attitudes, tolerance of verbal criticism, reactions to praise, punctuality, and attendance.

**Recreation:**

Participating in leisure time activities, learning how to spend leisure time, developing outside activities, managing time, finding recreation with little or no expense involved, finding community projects to take part in, participating in social groups, participating in sports and games, arts and crafts, and appreciating fine arts.

**Behavioral Health:**

Crisis management, social rehabilitation and counseling, Behavioral programming (including design, consultation and supervision), Counseling towards reunification with family (if appropriate), supportive counseling including the identification of behavioral and substance use disorder support services needed for successful transition into the community. If developmentally appropriate, services which develop increased capacity for independent living.

**Therapy:**

Individual and/or group therapy as well as psychosocial groups shall be provided as needed and indicated in the treatment plan for the individual youth. Therapy services are not part of the content of services for TFC, but rather are provided by an enrolled KanCare Medicaid provider. Therapeutic family Foster parents are expected to provide the basic day to day counseling the child needs in order to meet treatment goals. The case coordinator shall insure that individual or group therapy indicated by the treatment plan is implemented, reviewed as required, and modified as needed. The service delivered shall be documented in the individual’s case record, including date, place, amount of time, and names of the therapist providing the service. The therapy shall be directed towards helping the youth adjust to life in the therapeutic family Foster home, making the experience a period of continuing physical, mental, emotional growth and assist the youth to understand and accept his family relationships, interpersonal relationships and personal situations. The ultimate goal is to assist the youth to prepare to function effectively outside the therapeutic foster home setting.

**Tutoring:**

Tutoring for remedial purposes shall be provided as needed in addition to normal school work to assist youth to perform at his/her potential. Tutoring services shall be in accordance with need as indicated by

school staff. The service delivered shall be documented in the individual's case record including date, amount of time, and person who provided the service.

**Case Coordination:**

Responsibility for coordinating the youth's program and progress with the schools, employer, family, referring agency, therapist, and other appropriate community Foster s for each youth in residence shall reside with Case Coordinator.

**School/Work Liaison:**

The Licensed Child Placing Agency shall ensure routine communications between the staff and any educational program in which the youth is placed. This may include requesting and participating in the development of an Individual Education Plan for each resident. The necessity of the latter activity will be decided in conjunction with the worker assigned to each youth. The day to day school liaison activity may be the responsibility of the therapeutic foster home. These contacts shall be noted in the youth's case record.

**NOTE:** For youth in an employment program, similar contacts and services are to be provided in conjunction with the youth's employer when appropriate.

**Section 5: Treatment Plan Design**

The treatment program design includes a process for assuring appropriate services to a youth determined to be eligible for Therapeutic Foster Care services. The process includes:

- An initial screening by the case coordinator at the time of admission to the Therapeutic Foster Care Program (or prior to admission, if possible) to determine the needs of the youth.
- A master treatment plan to be developed within fourteen (14) days which includes input from the members of the treatment team and therapeutic family foster parents, as well as family involvement (unless contraindicated by legal constraints). Discharge planning shall be included in the master treatment plan in order to set goals which reflect youth, parent, and other community stakeholder input. Long term goals in the areas of physical /emotional health, family relations, daily living skills, academic and/or vocational skills, interpersonal interactions, and community relationships shall be addressed, according to the age appropriateness of the plan in relationship to the youth being served. Goals of treatment plan shall be described, treatment techniques or programs used to treat shall be identified, and time frames for reaching goals shall be defined. Persons responsible for individual goals of the treatment plan shall be identified and shall sign the plan, thus indicating their agreement to provide the service or treatment. The resident shall sign, if of sufficient cognitive ability to grasp the concept of the treatment plan. The Master treatment plan shall be reviewed, revised and documented in quarterly reports at least every 90 days by the TFC treatment team.

**Section 5.1: Case Coordinator responsibilities**

The primary case coordinator will:

- Develop the treatment plan in conjunction with the treatment team
- Coordinate and implement the treatment plan;
- Involve parents and family members in the treatment process, when appropriate;
- Coordinate treatment with other involved agencies;
- Provide training to therapeutic family Foster parents on the individualized treatment plan; and
- Observe and document implementation of each youth's individualized treatment plan, including the in-home treatment aspects utilized by the therapeutic foster parents.
- Be available to therapeutic family foster parents 24 hours per day for crisis consultation.



- Minimally, face to face consultation with therapeutic family foster parents and the child shall be provided one time per week during the first month of placement of a child. Thereafter, face to face consultation for therapeutic family foster parents and child shall be provided two times per month until the child completes the therapeutic foster care program. These, however, are minimal guidelines, and are in no way meant to reflect that only this level of support is required if there are severe problems that shall be addressed. The level of case coordinator contact shall be addressed in the Master Treatment Plan and shall be based upon the problems that are to be treated. Weekly contact by phone must be maintained with both the therapeutic family foster parents and the child regardless of the situation.

## **Section 6: Program and treatment planning, documentation and review**

The following shall be maintained in the case record for each youth.

### **Section 6.1: Initial Assessment**

Prior to placement in a TFC program, a youth's strengths and needs shall be assessed. The assessment shall include but not be limited to the following: (1). Reasons for referral to the TFC program; (2) Evaluation or assessment in the areas of physical health/medication needs, family relations, academic or vocational training, community life, interpersonal interactions, daily living skills and treatment needs. (3) Establishment of a score on the placement screening tool. These assessment results will be made available to the TFC program, shall be discussed with the therapeutic family Foster parents prior to agreement to accept the placement and shall be made a part of the TFC child case record.

### **Section 6.2: Master Treatment Plan**

Each youth residing in a therapeutic family foster home shall have a written treatment plan based on a thorough assessment, within 14 days of placement. Treatment Plans shall be signed by members of the treatment team and when possible the youth. The Treatment Team is composed of the Social Worker Case Coordinator, Case Coordinator Supervisor, child/youth, (if age appropriate), biological or adoptive parents (when appropriate), therapeutic family Foster parents, and the therapist who is an enrolled KanCare Medicaid provider. CWCMP/DCF Case Managers, other Clinical Consultants, and educators working with the youth in the local school district are also considered to be an integral part of the treatment team. **(NOTE: If the family is not involved in the treatment process, the reason for this shall be documented in the TFC file.)**

The name(s) of staff responsible for meeting the youth's needs shall be recorded on the treatment plan.

The Plan shall include the following:

- (1) Long term goals in the areas of physical health, family relations, and daily living skills; academic and/or vocational skills, interpersonal interactions, and community living;
- (2) Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas;
- (3) Specific plans for reaching the short term goals including services to be provided and frequency;
- (4) Estimated time for reaching short term goals.

The master treatment plan shall be reviewed and revised at least each 90 days. At that time a general written quarterly progress report shall be completed by the TFC program and therapist. Information obtained from the parent, guardian, referring agency and the youth shall be considered in the report and updated treatment plan.

### **Section 6.3: Weekly Progress Notes**

Therapeutic family foster parents and TFC program staff shall provide weekly input and feedback to the development, revision, and evaluation of the treatment plan as well as carry out the in-home strategies. Assessment documents shall be included in the case record. Weekly progress notes, written by the case coordinator and therapeutic family foster parents, shall be entered into the youth's chart, reflecting the delivery of services according to the treatment plan. This documentation shall address the youth's responses to treatment interventions and progress of the youth on individualized goals and objectives. The note shall include any significant events or significant incidents that occurred during the week and summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect actions to be taken to revise the plan for the youth.

### **Section 6.4: Permanency Planning**

Assessment and treatment of the child and family that focuses on opportunities for the child to have ongoing active and meaningful connections to the family, kin, relatives, and community. The goal for achieving permanency shall be coordinated with the referring agency and included in the treatment plan. The permanency plan shall include strategies and tasks to accomplish the strategies. Behaviors which place the child at risk for disruption, activities to prepare the child's family or kinship network for reunification, and the identification of other less restrictive living environments and preparing the child for transition to these settings shall be addressed. The National Standards indicate that "family involvement requires an unwavering commitment to promoting a service that is culturally competent and respectfully embraces cultural diversity. TFC programs actively support and enhance children's relationships with their parents, siblings and other family members throughout the period of placement regardless of the permanency goal."

### **Section 6.5: Discharge Summary/After Care Plan**

A discharge summary shall be completed at the time of the youth's discharge including delineation of aftercare plans and goals which the youth reached. While discharge planning shall begin at the time of placement in therapeutic foster care a written plan is still necessary. Written recommendations for aftercare shall be made and shall specify the nature, frequency, duration, and responsible parties for aftercare services.

### **Section 6.6: File Documentation**

A dated record of significant observations and occurrences involving each youth shall be maintained. The record shall include events which may affect the wellbeing of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it. The file shall also contain the Placement Agreement or Client Service Agreement (for child/youth referred by DCF staff).

### **Section 6.7: Health Records**

Records of medications shall be kept in each youth's case medical record and include: the name of the prescribing physician; the name of the medication; the dosage prescribed; the purpose of the medication; noted side effects; the date of the prescription; and the date of review at least every three (3) months. A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses and accidents shall be recorded. A current Kan-Be-Healthy shall be maintained by the TFC program on each youth. Allergies of any resident youth shall be displayed in a conspicuous place in the case file as well as in the medical section. The health record shall also contain a copy of the child/youth's current medical card and medical consent forms.

## **Section 6.8: Service Documentation**

Documentation of services provided shall include: who received the service; staff person providing the service; amount of time spent providing the service; what service was provided; when was the service provided; and where was the service provided. Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event

## **Section 6.9: Reports**

Quarterly Reports shall document progress on specific short-term treatment goals, describe significant revisions in goals and strategies, and specify any new treatment goals and strategies during the period covered. The quarterly progress reports shall summarize progress and note changes regarding long-term placement and treatment goals. The report will be signed by the Supervisor and Case Coordinator at least every 90 days. Information obtained from the parent, guardian, the referring agency, Case Coordinator, Supervisor, therapist(s) and the youth shall be considered in the report.

## **Section 7: Home Visits:**

When home visits are a part of the treatment plan, there shall be pre and post home visit contacts between the youth, their family and the therapeutic family foster parents or the agency program staff regarding the home visit. Because the goal of placement is return of the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth.

## **Section 8: Sponsoring Agency, Staff, and Therapeutic Family Foster Parent Qualifications**

### **Section 8.1: Sponsoring Agency**

The Sponsoring Agency shall be a Child Placing Agency licensed by DCF Foster Care and Residential Facility Licensing. There shall be social work staff designated by the Child Placing Agency to provide services to therapeutic family foster homes. The TFC Program shall meet the National Standards of Foster Family-Based Treatment Foster Care, in addition to the other standards listed in this document.

### **Section 8.2: Administrator**

There shall be an administrator with a minimum of a Bachelor's Degree in Social Services or Human Services, and at least two (2) years experience in administering a child welfare service delivery program or a related program commensurate with the size and complexity of the agency; a thorough understanding of philosophy, purpose, and policy of the agency; and the capacity to provide direction and leadership of the agency.

### **Section 8.3: Supervisor**

Each TFC program will designate supervisors for their Case Coordinators. Preferably a Supervisor will have a Master's degree in social work and a license to practice in the state of Kansas with a minimum of two years experience in the child placement field. However, a Master's degree in a related human service field can substitute for the advanced social work degree provided the Supervisor is licensed to practice in the state of Kansas and has three years of experience in the child placement field.

#### **Section 8.4: Case Coordinator**

Case Coordinators shall have a Master's degree in social work or in a related human service field and a license to practice in the state of Kansas. However, a Bachelor's degree with a license to practice in the state and at least two (2) years experience in child placement/foster care is acceptable.

#### **Section 8.5: Case Load Capacity**

Supervisors shall supervise no more than 5 Case Coordinators. Case Coordinators shall be assigned no more than 8 youth in TFC homes, although, in some circumstances, exceptions can be made for the case load to increase to 12. The case load shall be adjusted downward if a difficult client population requires more intensive support and contact or if the travel/distances impair the Case Coordinators ability to serve the needs of the youth or foster parents. The Case Coordinator shall supervise no more than 8 TFC homes.

#### **Section 8.6: Therapeutic Family Foster Parents**

- Shall be licensed as foster parents by DCF Foster Care and Residential Facility Licensing and be sponsored by a licensed child placing agency.
- Complete the PS Model Approach to Partnerships in Parenting (PS-MAPP) preparation program. This training shall be completed prior to placement of any child in the home.
- Shall receive, after the first year, a minimum of 24 hours, per parent in the home, of additional training annually. CPR and First Aid training does not count toward meeting the minimum 24 hours of annual training per parent in the home. This training shall, at a minimum, consist of: administration of medication; orientation to mandatory abuse/ neglect reporting; DCF disciplinary policies; the management of aggressive behaviors; grief/loss issues of children in care; special issues of working with children who have emotional/behavioral problems associated with abuse/neglect or traumatic brain injury; basic training in the concepts of the various diagnostic categories affecting children placed in TFC homes; training in working with biological/adoptive families regarding issues of reintegration or dealing with resolving issues within families that prevent children from living at home; as well as the provision of self-sufficiency or adult living transition skills for children who may not live with family members after treatment.
- In Service Training shall be on record for each therapeutic family foster parent and shall describe the professional development plan. It is preferred that the individuals chosen as therapeutic family Foster parents will be experienced foster parents, but exceptions can be made to allow "new" individuals to become TFC parents if they demonstrate exceptional parenting abilities. Please see Section III of the National Standards for more discussion regarding training for the TFC parents.
- Placements in each therapeutic family foster home may only be made by the Sponsoring Agency.
- Shall notify the Sponsoring Agency of any changes or impending changes in the household/family composition.
- Shall participate actively in the treatment plan and attend Case Planning Conferences as established by the Treatment Team.
- Shall obtain the Sponsoring Agency's permission to take a child in placement out of state or to move to another residence.
- Work with the schools regarding the education of the child and obtain free textbooks and lunches where applicable. If necessary, the therapeutic family foster parent shall become the Educational Advocate for foster children in the home, and attend all Individual Educational Plan conferences, and notify the Sponsoring Agency if there are suspensions or dismissals from school.
- Obtain needed medical/dental/psychiatric care for the child including the KanBeHealthy medical screenings. Medical information as required by licensing regulations shall be maintained by the foster parents.

- Incorporate the foster child into the family affording him/her the same privileges and responsibilities of other family members; appropriate to his/her age and abilities.
- Maintain appropriate renters/homeowners/household care insurance and furnish proof of coverage upon request to the Sponsoring Agency.
- Understand that the placing agencies cannot be held responsible for damages done to the therapeutic family foster parent's home, automobile, household furnishings, or other possessions, done by a foster child beyond that available in applicable insurance coverage.
- Utilize Respite Care and Foster Parent Support provided by the Sponsoring Agency.
- Complete Daily Behavioral Logs reflecting progress or lack thereof of the child in attaining the goals of the treatment plan.

### **Section 8.7: Therapeutic Family Foster Parent Support**

Sponsoring Agency shall provide intensive support, technical assistance and supervision to all therapeutic family foster parents. Respite care for the therapeutic family foster parents shall be planned on at least a monthly basis, and respite shall be provided both in planned situations and in crisis situations. Respite shall be provided in homes selected and trained using the same standards for therapeutic family foster parents. Support groups of therapeutic family foster parents shall be formed to help in the process of affirming and reinforcing the very central role the therapeutic family foster parents shall have in the treatment of severely emotionally disturbed youth.

### **Section 8.8: Staff Training**

Pre-Service and ongoing annual in-service training and support will be mandatory for all staff and respite foster parents working in the TFC program. Annual staff training records will be kept by the TFC program for review by DCF and DCF Foster Care and Residential Facility Licensing. Administrators, Supervisors, Case Coordinators and therapeutic family foster parents will complete the 30 hour PS MAPP training. Additional training shall, at a minimum, consist of: administration of medication; orientation to mandatory abuse /neglect reporting; DCF disciplinary policies; the management of aggressive behaviors; grief /loss issues of children in care; special issues of working with children who have emotional / behavioral problems associated with abuse /neglect or traumatic brain injury; basic training in the concepts of the various diagnostic categories affecting children placed in TFC homes; training in working with biological /adoptive families regarding issues of reintegration or dealing with resolving issues within families that prevent children from living at home; as well as the provision of self-sufficiency or adult living transition skills for children who may not live with family members after treatment.

### **Section 9: Child's Rights**

The staff of the Child Placing Agency and therapeutic family foster parents shall allow privacy for each child. The foster home's space and furnishings shall be designed and planned with respect for the child's right to privacy. The foster home's design shall also provide supervision according to the ages and needs of the children/youth in placement. Contacts between the child/youth and his/her parents or guardian shall be allowed while the child/youth is in care unless the rights of the parents have been terminated by court order or family contact is not in the child's best interest. The frequency of contact shall be determined by the needs of the child/youth and his/her family or guardian.

The Child Placing Agency shall have clearly written policies regarding visits, gifts, mail and telephone calls between the child/youth and his/her family, or guardian. These policies shall be made known to the child/youth and his/her family or guardian prior to admission. Youth shall be allowed to send and receive mail and have telephone conversations with family members or guardian unless the best interest of the youth or a court order necessitates restrictions. If restrictions on communications or visits are necessary

these shall be reviewed monthly by a psychiatrist, licensed psychologist or social worker with a master's degree in social work and the referring agency notified.

A youth shall be allowed to bring personal possessions to the therapeutic family foster home and may acquire others. Prior to admission, information shall be made available to the youth and their parents or guardian concerning what possessions a youth may bring to the foster home and the kinds of gifts they may receive.

### **Section 9.1: Discipline**

Discipline shall be consistent with the policies of DCF and shall not be physically or emotionally damaging. Only therapeutic family foster parents or substitute care providers, including respite providers, shall discipline children/youth placed in a TFC home.

#### **Children/youth shall not be:**

- Subjected to cruel, severe, unusual or unnecessary punishment.
- Subjected to remarks that belittle or ridicule them or their families.
- Denied food, mail or visits with their families as punishment.
- Punished by shaking, striking or spanking.
- Discipline or control shall fit the needs of each youth.

### **Section 10: Reporting Abuse/Neglect**

All foster parents are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

Abuse is any act or failure to act which results in death, physical harm, emotional harm, or which presents a likelihood of harm to a person under age 18. The broad definition of abuse includes physical abuse, emotional abuse, and sexual abuse. Neglect is any act or omission resulting in harm to a child or which presents a likelihood of harm. Neglect includes failure to provide food, clothing, shelter, safety, adequate levels of appropriate supervision, medical treatment, or education.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's

health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Neglect: Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

### **Section 11: Significant Incident**

A Significant Incident is an occurrence that requires the provider to make a response that is not a part of the program's ordinary daily routine.

#### **Section 11.1 Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

If the-significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each foster family shall obtain on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

If the significant incident involves abuse or neglect the foster family shall also follow mandated reporting requirements.



## **YOUTH RESIDENTIAL CARE II STANDARDS AND GENERAL GUIDELINES**

### **SECTION 1: GENERAL PROGRAM DESCRIPTION AND REQUIREMENTS**

A Youth Residential Care (YRC II) facility is a 24-hour group home or residential facility that meets the requirements of KAR 28-4-123-132 and KAR 28-4-268-280. It is a non-secure residential service designed to provide an environment that will enhance the youth's ability to achieve a higher level of functioning while avoiding future placement in a more highly structured treatment facility.

#### **Section 1.1: Services Provided in Youth Residential Care**

The range of services to be delivered by the YRC II facility to meet the variety of individual needs of the residents shall be well defined. The General Program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

1. goals of the program
2. resident behavioral treatment system
3. job descriptions (responsibilities, functions, and qualifications)
4. policies and procedures
5. daily living activities
6. health services
7. recreation activities
8. visitation policies

The purpose of placement in an YRC II is to improve the youth's decision making, coping skills, social skills, and to address any underlying problems which are affecting the youth, while teaching the youth how to handle their behaviors in order to transition successfully back into their family or community.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

### **SECTION 2: GENERAL STAFFING REQUIREMENTS**

Twenty-four hour care which has been licensed by DCF Foster Care and Residential Facility Licensing (K.A.R 28-4-268-280) as a group home or residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve.

- The administrator in a YRC II (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a Bachelors degree, prior administrative experience and a working knowledge of child development principles.
- The administrator in a YRC II (meeting group home standards K.A.R 28-4-268 (i)) not less than five nor more than ten persons) shall have at least a high school diploma or GED, prior administrative experience and a working knowledge of child development principles
- Program plan development, review, and case supervision are carried out by the YRC II Provider.

- The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education. The youth to case coordinator ratio in a YRC II is 1:16.
- Facility staff shall be trained to effectively meet the special needs of youth who require this level of care. Facility child care staff shall be at least 21 years of age with a minimum of three years age difference between the child care worker and oldest resident who can be admitted to the facility. Child care workers shall possess a high school diploma or GED.
- Staff ratio is 1:7 during waking hours and 1:10 during sleeping hours. There shall be 24-hour awake staff to insure child safety.

### **SECTION 3: CRITERIA FOR THE YOUTH'S ADMISSION**

#### **Population Served:**

- Population served is children and youth, ages 6 thru 21, who:
  - Have a well established pattern of behavior or conduct which is antisocial, oppositional, defiant, aggressive, abusive, impulsive or high risk in nature.
- Youth who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the youth's needs.
- Youth awaiting a PRTF screen may reside in a YRC II until the time of the screen.
- If a youth is in a YRC II awaiting a screen the screen shall be completed within 14 days, but shall be completed as soon as possible. If the youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the youth in a YRC II facility may have screened into a PRTF and be in the 14 day waiting period for a PRTF placement.
- Youth may step down to a YRC II from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

#### **Section 3.1: Placement Agreement**

A signed Placement Agreement shall be completed between the YRC II and the referring agency at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

#### **Section 4: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and

effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file.

## **SECTION 5: RESIDENTIAL CARE PROGRAM**

### **Section 5.1: Residential Care System**

Each YRC II shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the YRC's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed with the youth.

The YRC II facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference. Behavior management shall include rules governing:

1. interpersonal interactions with staff and peers
2. facility leave policies
3. school attendance and behavior while at school
4. verbal and physical aggression
5. allowable possessions
6. awakening and bedtime hours
7. leisure hours,
8. visitation policies
9. AWOL attempts
10. involvement in recreation and other activities
11. self-destructive behaviors
12. sexuality
13. communications with family and others outside the program
14. religious worship
15. involvement in therapies
16. theft, property destruction
17. behaviors resulting in mandatory removal from the program ~~and~~
18. behaviors at the program which could result in legal prosecution-

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to not only help the youth adjust to the residential facility but also to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

### **Section 5.2: Education Requirement**

All facilities shall have an education agreement letter with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This shall include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's

case record. Any accredited Kansas Virtual schooling program (on line schooling) shall be approved by the CWCMP Provider for each youth. Refer to PPM 3236.

### **Section 5.3: Scope of Services**

The provider shall write a policy and procedure manual for the operation of the YRC II facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The YRC II will provide a program for youth in the facility that covers the following program components:

**Daily Living Services:** Daily living services shall be provided and include the following:

1. room
2. board
3. child care
4. personal spending money
5. personal care needs
6. school fees
7. transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
8. academic activities
  - a. assistance with school work
  - b. vocational training, and/or
  - c. G.E.D. training.

**Situational Training-** to include but not limited to:

1. **Personal Hygiene:**
  - a. teaching about body cleanliness
  - b. use of deodorants and cosmetics
  - c. appropriate clothing
  - d. choosing clothing to fit individual and occasion
  - e. keeping clothes neat and clean
2. **Health:**
  - a. identifying and understanding residents' health needs
  - b. securing and utilizing necessary medical treatment including preventive and health maintenance services
  - c. gaining information and education in health maintenance including:
    - i. preventive measures
    - ii. nutrition
    - iii. menstruation
    - iv. rest
    - v. cleanliness
    - vi. family planning
    - vii. drugs
    - viii. sexually transmitted diseases
    - ix. exercise

- x. motivation for meeting own health needs
- d. maintaining contact with providers of health services (physician, nurse, clinic)
- e. using outside resources for assistance (clinics, pharmacies, hospitals)

**3. Consumer education for independent living:**

- a) budgeting
- b) comparative buying
- c) installment buying
- d) avoiding risks
- e) identifying illegal or excessive interest rates
- f) use of credit
- g) avoiding or dealing with debts
- h) using checking and savings accounts
- i) paying taxes

**4. Communication skills:**

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- a) speech
- b) writing
- c) use of the landline/cell telephones
- d) computer
- e) social networking
- f) internet

**5. Home Management:**

- a. making the bed and changing linens
- a) using the vacuum cleaner
- b) dusting
- c) organizing belongings
- d) disposing of trash
- e) cleaning all areas of the home
- f) operating appliances
- g) cooking complete meals
- h) making simple repairs
- i) who to call when a major repair is needed
- j) being aware of the need for upkeep
- k) handling emergencies
- l) knowing first aid

**6. Situational Guidance:**

- a) identifying and accepting strengths
- b) developing patterns of acceptance
- c) coping with authority figures
- d) getting along with others
- e) sharing responsibility
- f) being considerate of others
- g) developing friendships
- h) knowing when to go home when visiting
- i) recognizing or modifying attitudes toward self or others
- j) responsible work attitudes
- k) tolerance of verbal criticism

- l) reactions to praise
- m) punctuality
- n) attendance

**7. Recreation:**

- a) participating in leisure time activities
- b) learning how to spend leisure time
- c) developing outside activities
- d) managing time
- e) finding recreation with little or no expense involved
- f) finding community projects to take part in
- g) participating in social groups
- h) participating in sports and games
- i) arts and crafts
- j) appreciating fine arts

**Section 5.4: Initial Assessment**

When a youth enters the facility, the YRC II shall begin immediately assessing their strengths and needs including documentation and shall have a completed assessment within 7 days.

The assessment shall include but not be limited to the following:

1. Reasons for referral to the facility
2. Evaluation or assessment covering the following areas:
  - a) Physical health
  - b) Family relations
  - c) Academic or vocational training
3. Community life
4. Interpersonal interactions
5. Daily living skills as outlined in the scope of services listed above
6. Immediate service needs:-
  - a) Mental Health
  - b) Developmental
  - c) Dental
  - d) Medical
7. Involvement or exposure to Substance Use/disorder
8. Involvement or exposure to other trauma
9. Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assess with regards to most appropriate next placement.

Physical and mental health needs shall be coordinated with assigned CWCMP case manager and youth's assigned MCO.

**Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth Residing in a YRC II**

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The

MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

### **Section 5.6: Program Plan**

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter, including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CWCMP case manager shall be considered in the report.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. substance use service needs
  7. emotional/psychological health
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.
  1. Services to meet independent living goals.
  2. Specific plans for reaching the short-term goals including services to be provided and frequency.
  3. Estimated time for reaching short term goals.

- The youth shall sign and date the program plan indicating participation and input in the development of the plan.
- Updated information of the progress of the youth's goals shall be included.

YRCII staff shall participate in case plan conducted by CWCMP case manager.

### **Section 5.7: Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents, if applicable or guardian, and the placing agency shall be involved in planning the discharge of a resident from the facility.

A discharge summary and modifications to it shall be completed at the time of the youth's discharge, noted in the case file and forwarded to the CWCMP case management agency. This shall include delineation of after-care plans and goals which the youth have completed in the YRC II. Written recommendations for discharge shall be made and shall specify the nature, frequency, and duration of services the facility recommends for the youth.

### **Section 5.8: Case Coordination**

The YRC II's case coordinator has the responsibility for coordinating the youth's program and progress with the referring CWCMP case management agency, school, employer, family, and other appropriate community resources.

The Case Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans- and document in the youth file, when and what community resources have been contacted and utilized for services for the youth.

### **Section 5.9: Home Visits**

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including written pre and post documentation on the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's CWCMP case manager. Documentation in youth's file shall include who is transporting youth to and from family visits and observation of the youth's behavior during transportation.

## **SECTION 6: RESIDENT'S RIGHTS**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including



cell phone) calls, pictures and social networking between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 7: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 7.1: Time Out**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

#### **Application of time out:**

1. A resident in time out shall never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff shall monitor the resident while he or she is in time out.

### **Section 7.2: Emergency safety intervention / De-escalation techniques Managing Aggressive Behaviors**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.3 Emergency safety interventions/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in YRC II residential facilities.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian (if applicable) shall be oriented to the restraint policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.4: Reporting Abuse/Neglect**

All employees at the YRC II are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspects the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

-K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any other sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by, a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A 38-2224 (b) Violation of this section is a class B misdemeanor.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202.

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child,

or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

**Mental or Emotional Abuse:** Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

**Neglect:** Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 8: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a significant incident, but has the potential risk of a serious adverse outcome.

### **Section 8.1: Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement PPM 5245 shall be followed
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs
13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each YRC II provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 9: STAFF IN-SERVICE TRAINING**

### **Section 9.1 In-service Orientation Training**

Each facility shall have an in-service orientation training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Child care staff shall have completed 18 hours of in-service orientation training provided by the facility before they can work independently with youth.

The in-service orientation program shall provide written documentation that all staff are oriented to the following:

1. Facility policy and procedures manual
2. Facility emergency and evacuation procedures
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Facility discipline standards
6. Abuse/neglect mandatory reporting laws
7. Client record documentation policies and procedures
8. Policies and procedures for resident medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPR/First Aid within 3 months of employment
12. De-escalation techniques
13. Trauma based informed care

### **Section 9.2 Annual Service Training**

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial 18 hour orientation training program from the date of employment.

All YRC II direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating staff training, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Topics shall include but not be limited to:

1. CPR and First Aid (current not expired)
2. Blood borne pathogens
3. Medications
4. Emergency safety interventions
5. Substance use disorder patterns
6. Childhood and adolescent development (including developmental disorders)
7. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
8. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
9. De-escalation techniques/physical restraints techniques
10. Trauma based informed care

### **SECTION 10: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

**Record Retention:**

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

**Chart Documentation:**

A dated record of daily observations and significant occurrences involving each youth shall be maintained by each shift for each youth and maintained in each youth's individual file. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

**Weekly Progress Notes:**

Notes shall be completed by the case coordinator and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The case coordinator shall document specific services and activities they are providing to each youth.

**Health Records:**

Health Care and Records of residents shall meet the requirements of KAR 28-4-275. Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

**30 Day Progress Reports:**

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall be provided to the referring agency and a copy placed in the youth's file.

**Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CWCMP case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall

include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

## **EMERGENCY SHELTER STANDARDS AND GENERAL GUIDELINES**

### **SECTION 1: GENERAL PROGRAM DESCRIPTION AND REQUIREMENTS**

An Emergency Shelter provides twenty-four hour care that meets the requirements of K.A.R. 28-4-123-132 and K.A.R. 28-4-268-280. It has been licensed by DCF Foster Care and Residential Facility Licensing as a Group Boarding Home or Residential Center to cover the programming the facility will provide for the populations of children/youth whom the facility will serve.

#### **Section 1.1: Services Provided in an Emergency Shelter**

The purpose of placement in an Emergency Shelter is to ensure the youth has a short-term safe place to stay until a long-term placement for the youth can be found.

The range of services to be delivered by the Emergency Shelter shall be documented in the facilities program description. The general program description approved by DCF Prevention and Protection Services for each facility shall include but not be limited to the:

1. goals of the program
2. resident behavioral treatment system
3. job descriptions (responsibilities, functions, and qualifications)
4. policies and procedures
5. daily living activities
6. health services
7. recreation activities
8. visitation policies

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

#### **Section 1.2: Short Term Placement in an Emergency Shelter**

Youth shall not be placed in an emergency shelter for more than 30 days unless an extension is approved for a circumstance as indicated below:

- Extensions may only be requested by the referring agency. Extension requests and decisions for youth in DCF custody are managed by the child welfare case management provider case manager.
- Extensions to the 30 day emergency shelter stay will only be considered in the following circumstances:
  - If a youth is placed in an Emergency Shelter in the same school district from which they were previously attending and no alternative placement is available in the district. If the youth will be finishing the school term within 60 days of admission to the Emergency Shelter and movement of the youth would result in the loss of school credit.
  - The youth is awaiting an identified placement, which will be available within 45 days of admission to the Emergency Shelter.
  - A circumstance of substantially the same nature as above and it is in the best interest of the child or youth to request an extension.



## **SECTION 2: GENERAL STAFFING REQUIREMENTS**

Twenty-four hour care which has been licensed by DCF Foster Care and Residential Facility Licensing (KAR 28-4-268-280) as a group boarding home or residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve.

- The administrator of a residential center (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a Bachelor's degree, prior administrative experience and a working knowledge of child development principles.
- The administrator of a group boarding home (meeting group home standards K.A.R 28-4-268 (i)) not less than five nor more than ten persons) shall have at least a high school diploma, or its equivalent, prior administrative experience and a working knowledge of child development principles.
- Program plan development, review, and case supervision are carried out by the Emergency Shelter provider.
- Child care staff shall be at least 21 years of age, have at least a high school diploma or equivalent and shall practice accepted methods of child care. Staff shall be trained to effectively meet the special needs of youth who require this level of care.
- The facility shall be staffed appropriately to meet the needs of all the residents in their care. The staff ratio is 1:7 during waking hours and 1:10 during sleeping hours. To insure child safety, the Emergency Shelter facility will have awake staff 24 hours a day.

## **SECTION 3: CRITERIA FOR THE YOUTH'S ADMISSION**

### **Population Served:**

Population served is children and youth, ages birth thru 21, who:

- Need safety and a short term placement until a more appropriate stable placement can be found for the child/youth.
- Need Police Protective Custody.

Emergency Shelters are unique in their ability to accept youth who present a wide range of behavioral and health needs. Emergency Shelter's shall be trained in trauma informed care. Emergency Shelters are staffed and administered to serve all youth from the state agencies with whom they have provider agreements. Placements of youth shall only be denied in the most extreme circumstances, when the youth's safety or the safety of other residents in the Emergency Shelter cannot be assured.

### **Section 3.1: Placement Agreement**

A signed Placement Agreement shall be completed between the provider and the referring agency at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

Documentation shall be placed in the youth's file at the facility, including but not limited to:

1. The reason for the need of an extension for ES placement
2. Participants (names and title of position) in the discussion for the need for an extension, including who agreed upon the extension
3. The youth's updated plan of needed service(s) for the next 60 days, dated and signed by the appropriate parties.

#### **Section 4: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

1. Suicidal tendencies
2. Level of specialized needs (i.e. mental health, medical, etc.)
3. Displaying inappropriate sexual behaviors/victims of sexual abuse)
4. Gender
5. Age and/or maturity level
6. Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
7. Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file.

#### **SECTION 5: RESIDENTIAL CARE PROGRAM**

##### **Section 5.1: Residential Care System**

Emergency Shelter shall have a written program of consistent rules guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for behaviors shall be identified. Notation shall be made in the youth's file and signed by the youth that the rules, rewards and consequences have been discussed with the youth.

Each youth shall be oriented to the Emergency Shelter's behavior management system by a staff member during the admission or orientation process. The youth shall be given a written copy of the system to use as a reference and the Emergency Shelter shall post the behavior management system in a common area where the youth are able to easily access the system.

Behavior management shall include rules governing:

1. interpersonal interactions with staff and peers
2. facility leave policies
3. school attendance and behavior while at school
4. verbal and physical aggression
5. allowable possessions
6. awakening and bedtime hours
7. leisure hours, visitation policies
8. AWOL attempts
9. involvement in recreation and other activities
10. self-destructive behaviors
11. sexuality
12. communications with family and others outside the program
13. religious worship
14. involvement in therapies
15. theft

16. property destruction
17. behaviors resulting in mandatory removal from the program
18. behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to help the youth adjust to the residential facility and to daily life within society. A resource list shall be maintained by the facility of the available resources to meet the youth's need in the community.

### **Section 5.2: Education Requirement**

All facilities shall have an education agreement letter with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This shall include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record. Any accredited Kansas Virtual schooling program (on line schooling) shall be approved by the CWCMP Provider for each child. Refer to PPM 3236.

### **Section 5.3: Scope of Services**

The provider shall write a policy and procedure manual for the operation of the Emergency Shelter facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The ES will provide a program for youth in the facility that covers the following program components:

**Daily Living Services** - Daily living services shall be provided and include the following:

- room
- board
- child care
- personal spending money
- personal care needs
- school fees
- transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
- academic activities
  - a) assistance with school work
  - b) vocational training
  - c) G.E.D. training

**Situational Training-** to include but not limited to:

1. **Personal Hygiene** –
  - a) body cleanliness

- b) use of deodorants and cosmetics
- c) appropriate clothing
- d) choosing clothing to fit individual and occasion
- e) keeping clothes neat and clean

**2. Health –**

- a) identifying and understanding residents' health needs
- b) securing and utilizing necessary medical treatment including preventive and health maintenance services
- c) gaining information and education in health maintenance including:
  - i. preventive measures
  - ii. nutrition
  - iii. menstruation
  - iv. rest
  - v. cleanliness
  - vi. family planning
  - vii. drugs
  - viii. sexually transmitted diseases
  - ix. exercise
  - x. motivation for meeting own health needs
- d) maintaining contact with providers of health services (physician, nurse, clinic)
- e) using outside resources for assistance (clinics, pharmacies, hospitals)

**3. Consumer education for independent living-**

- a) budgeting
- b) comparative buying
- c) installment buying,
- d) avoiding risks
- e) identifying illegal or excessive interest rates
- f) use of credit
- g) avoiding or dealing with debts
- h) using checking and savings accounts
- i) paying taxes

**4. Communication skills:**

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- a) speech
- b) writing
- c) use of the telephone landline/cell
- d) computer
- e) social networking
- f) internet

**5. Home Management:**

- a) making the bed and changing linens
- b) using the vacuum cleaner
- c) dusting
- d) organizing belongings
- e) disposing of trash,
- f) cleaning all areas of the home
- g) operating appliances

- h) cooking complete meals
- i) making simple repairs
- j) who to call when a major repair is needed
- k) being aware of the need for upkeep
- l) handling emergencies
- m) knowing first aid

**6. Situational Guidance:**

- a) identifying and accepting strengths
- b) developing patterns of acceptance
- c) coping with authority figures
- d) getting along with others
- e) sharing responsibility
- f) being considerate of others
- g) developing friendships
- h) knowing when to go home when visiting
- i) recognizing or modifying attitudes toward self or others
- j) responsible work attitudes
- k) tolerance of verbal criticism
- l) reactions to praise
- m) punctuality
- n) attendance

**7. Recreation:**

- a) participating in leisure time activities
- b) learning how to spend leisure time
- c) developing outside activities
- d) managing time
- e) finding recreation with little or no expense involved
- f) finding community projects to take part in
- g) participating in social groups,
- h) participating in sports and games
- i) arts and crafts
- j) appreciating fine arts

**Section 5.4: Initial Assessment**

When a youth enters the facility, the ES shall begin immediately assessing their strengths and needs and shall have a completed assessment within 7 days. The assessment shall include but not be limited to the following:

1. Reasons for referral to the facility
2. Evaluation or assessment covering the following areas:
  - a) physical health
  - b) family relations
  - c) academic or vocational training
3. Community life
4. Interpersonal interactions
5. Daily living skills as outlined in the scope of services listed above
6. Immediate service needs:
  - a) mental health
  - b) developmental

- c) dental
- d) medical
- 7. Involvement or exposure to Substance Abuse/disorder
- 8. Involvement or exposure to trauma
- 9. Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assessed with regards to most appropriate next placement

Physical and mental health needs shall be coordinated with assigned CWCMP case manager and youth's assigned MCO.

### **Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth Residing in an Emergency Shelter**

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

### **Section 5.6: Program Plan**

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed and revisions made within 30 days of completion of initial program plan and each **30** days thereafter. This includes updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CWCMP case manager shall be considered in the report.

Program plan development, review, and case supervision are carried out by the Emergency Shelter provider.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. substance use service needs
  7. emotional/psychological health
  
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.
  1. Services to meet independent living goals.
  2. Specific plans for reaching the short-term goals including services to be provided and frequency.
  3. Estimated time for reaching short term goals.
  
- The youth shall sign and date the program plan indicating participation and input in the development of the plan.
  
- Updated information of the progress of the youth's goals shall be included.

Emergency Shelter staff shall participate in case planning conference conducted by CWCMP case manager.

#### **Section 5.7: Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents if applicable or guardian if applicable, and the placing agency shall be involved in planning the discharge of a resident from the facility.

A discharge summary and modifications to it shall be completed at the time of the youth's discharge, noted in the case file and forwarded to the CWCMP case management agency. This shall include delineation of after-care plans and goals which the youth have reached. Written recommendations for discharge shall be made and shall specify the nature, frequency, and duration or services the facility recommends for the youth.

#### **Section 5.8: Case Coordination**

Case Coordination and case supervision are carried out by the Emergency Shelter provider. The Emergency Shelter has the responsibility for coordinating the youth's program and progress with the referring CWCMP case management agency, school, employer, family, and other appropriate community resources.

Each ES shall outline the case coordination service delivery responsibilities for their facility. The ES will maintain a resource list of services to address the needs identified in Program Plans and documents when and what community resources have been contacted and utilized for services for the youth.

## **Section 5.9: Home Visits**

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including pre and post written documentation on the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's CWCMP case manager. Documentation in youth's file shall include who is transporting to and from family visits and observations of the youth's behavior after visitation.

## **SECTION 6: RESIDENT'S RIGHTS**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls, pictures and social networking between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission. Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 7: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 7.1: Time Out**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.



### **Application of time out**

1. A resident in time out shall never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff shall monitor the resident while he or she is in time out.

### **Section 7.2: Emergency safety intervention/De-escalation techniques Managing Aggressive Behaviors**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.3: Emergency safety intervention/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Emergency Shelter residential facilities.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent, if applicable or guardian, if applicable shall be oriented to the restraint policies of the facility and ~~must~~ shall sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.4: Reporting Abuse/Neglect**

All employees at the Emergency Shelter are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspects the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A. 38-2224 (b) Violation of this section is a class B misdemeanor.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion K.A.R. 30-46-10

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Neglect: Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially

diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 8: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a significant incident, but has the potential risk of a serious adverse outcome.

### **Section 8.1: Significant Incidents Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement PPM 5245 shall be followed
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs
13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each Emergency Shelter provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 9: STAFF IN-SERVICE TRAINING**

### **Section 9.1 In-service Orientation Training**

Each facility shall have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Child care staff shall have completed 18 hours of in-service orientation training provided by the facility before they can work independently with youth.

The in-service orientation program shall provide written documentation that all staff are oriented to the following:

1. Facility policy and procedures manual
2. Facility emergency and evacuation procedures
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Facility discipline standards
6. Abuse/neglect mandatory reporting laws
7. Client record documentation policies and procedures
8. Policies and procedures for resident medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPR/First Aid within 3 months of employment
12. De-escalation techniques
13. The handling of youth in trauma based informed care

### **Section 9.2 Annual Service Training**

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial 18 hours orientation training program from the date of employment.

All Emergency Shelter's direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating staff training, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training,

4. specify the number of training hours
5. date of the training

Topics shall include but not be limited to:

1. CPR and First Aid (current not expired)
2. Blood borne pathogens
3. Medications
4. Emergency safety interventions
5. Substance use disorder patterns
6. Childhood and adolescent development (including developmental disorders)
7. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
8. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse-
9. De-escalation techniques/physical restraints techniques
10. Trauma based informed care

### **SECTION 10: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

#### **Record Retention:**

Case records, including medical records, shall be maintained 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

#### **Health Records:**

Health Care records of residents shall meet the requirements of KAR-28-4-275.

Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

#### **Chart Documentation:**

A dated record of daily observations and significant occurrences involving each youth shall be maintained by each shift for each youth and maintained in each youth's individual file. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

**Weekly Progress Notes:**

Notes shall be completed by the case coordinator and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The case coordinator shall document specific services and activities they are providing to each youth.

**Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CWCMP case manager and be included in the program plan to be reviewed every 30 days. . The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

## **RESIDENTIAL MATERNITY CARE STANDARDS AND GENERAL GUIDELINES**

### **SECTION 1: GENERAL PROGRAM DESCRIPTION AND REQUIREMENTS**

A Residential Maternity Care (RMC) facility is a 24-hour group home or residential facility that meets the requirements of KAR 28-4-123-132 and KAR 28-4-268-280. It is non-secure residential services whose primary purpose is devoted to the maintenance and counseling of pregnant youth who need services related to their pregnancy, and planning and care for the unborn child through labor, delivery and postnatal care. RMC's providing care for pregnant youth shall meet the requirements of K.A.R. 28-4-279. RMC's providing care for post-partum youth and infants shall meet the requirements of K.A.R. 28-4-280.

#### **Section 1.1: Services Provided in Residential Maternity Care**

The range of services to be delivered by the RMC facility to meet the variety of individual needs of the residents shall be clearly defined. The General Program description approved by DCF Prevention and Protection Services shall include but not be limited to:

1. goals of the program
2. resident behavioral treatment system
3. job descriptions (responsibilities, functions, and qualifications)
4. policies and procedures
5. daily living activities
6. health services
7. recreation activities
8. visitation policies

The purpose of placement in a RMC is to improve the youth's decision making, coping skills, social skills, and to address any underlying problems which are affecting the youth, while teaching the youth how to handle their behaviors in order to transition successfully back into their family or community.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

### **SECTION 2: GENERAL STAFFING REQUIREMENTS**

Twenty-four hour care which has been licensed by DCF Foster Care and Residential Facility Licensing (KAR 28-4-268-280) as a residential center to cover the programming the facility will provide to the population of children/youth whom the facility will serve. RMC's providing care for pregnant youth shall meet the requirements of K.A.R. 28-4-279. RMC's providing care for post-partum youth and infants shall meet the requirements of K.A.R. 28-4-280.

- The administrator in a RMC (meeting residential center standards K.A.R 28-4-268 (t) more than 10 residents) shall have a Bachelors degree, prior administrative experience and a working knowledge of child development principles

- The administrator in a RMC (meeting group home standards K.A.R 28-4-268 (i)) not less than five nor more than ten persons) shall have at least a high school diploma or GED, prior administrative experience and a working knowledge of child development principles
- Program plan development, review, and case supervision are carried out by the RMC's Case Coordinator.
- The youth to case coordinator ratio in a RMC is 1:16
- The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling), nursing, or education.
- Facility staff shall be trained to effectively meet the special needs of youth who require this level of care.
- Facility child care staff shall be at least 21 years of age with a minimum of three years age difference between the child care worker and oldest resident who can be admitted to the facility.
- The staff ratio is 1:7. during waking hours and 1:10 during sleeping hours. There shall be 24-hour awake staff to insure child safety

### **SECTION 3: CRITERIA FOR THE YOUTH'S ADMISSION**

#### **Population Served:**

- Population served is pregnant or post-partum mothers thru age 21, who:
  - Display a need for more structure and supervision than provided in a family foster home due to behaviors which might include difficulty with authority figures, minor offenses, and difficulty in school.
  - And child who is not a recipient of TANF
- Youth who DO NOT meet the standard for Psychiatric Residential Treatment Facility (PRTF) admission, who are not in need of intensive treatment, and for whom family based services are not appropriate to meet the youth's needs.
- Youth awaiting a PRTF screen may reside in a RMC until the time of the screen.
- If a youth is in a RMC awaiting a screen the screen shall be completed within 14 days, but shall be completed as soon as possible. If the youth screens into a PRTF they can stay up to 14 days while awaiting a PRTF bed.
- No more than 50 percent of the youth in a RMC facility may have screened into a PRTF and be in the 14 day waiting period for a PRTF placement.
- Youth may step down to a RMC from a PRTF after the screener and treatment team have determined the youth no longer needs the level of care provided by a PRTF.

#### **Section 3.1: Placement Agreement**

A signed Placement Agreement shall be completed between the RMC and the referring agency, at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

#### **Section 4: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)



- Displaying inappropriate sexual behaviors/victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file

## **SECTION 5: RESIDENTIAL CARE PROGRAM**

### **Section 5.1: Residential Care System**

Each RMC shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the RMC's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The RMC facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference. Behavioral management shall include rules governing:

1. interpersonal interactions with staff and peers
2. facility leave policies
3. school attendance and behavior while at school
4. verbal and physical aggression
5. allowable possessions
6. awakening and bedtime hours
7. leisure hours
8. visitation policies
9. AWOL attempts
10. involvement in recreation and other activities
11. self-destructive behaviors
12. sexuality
13. communications with family and others outside the program
14. religious worship
15. involvement in therapies
16. theft, property destruction
17. behaviors resulting in mandatory removal from the program
18. behaviors at the program which could result in legal prosecution

When a youth decides not to attend religious worship or activities, alternative supervised activities shall be made available.

The overarching goals shall be to not only help the youth adjust to the residential facility but also to daily life within society. A resources list shall be maintained by the facility of the available resources to meet the youth's needs in the community.

## **Section 5.2: Education Requirement**

All facilities shall have an education agreement letter with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This shall include requesting and participating in the development of an Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record. Any accredited Kansas Virtual schooling program (on line schooling) shall be approved by the CWCMP Provider for each youth. Refer to PPM 3236.

## **Section 5.3: Scope of Services**

The provider shall write a policy and procedure manual for the operation of the RMC facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment and outdoor play space to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The RMC will provide a program for youth in the facility that covers the following program components:

**Daily Living Services** - Daily living services shall be provided and include the following:

1. room
2. board
3. child care
4. personal spending money
5. personal care needs
6. school fees
7. transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
8. academic activities
  - a) assistance with school work
  - b) vocational training, and/or
  - c) G.E.D. training

**Situational Training-** to include but not limited to:

- **Personal Hygiene:**
  - a) teaching about body cleanliness
  - b) use of deodorants and cosmetics
  - c) appropriate clothing
  - d) choosing clothing to fit individual and occasion
  - e) keeping clothes neat and clean
  
- **Health:**
  - a) identifying and understanding residents' health needs
  - b) securing and utilizing necessary medical treatment including preventive and health maintenance services
  - c) gaining information and education in health maintenance including:
    - i. preventive measures
    - ii. nutrition
    - iii. menstruation

- iv. rest
- v. cleanliness
- vi. family planning
- vii. drugs
- viii. sexually transmitted diseases
- ix. exercise
- x. motivation for meeting own health needs
- d) maintaining contact with providers of health services (physician, nurse, clinic)
- e) using outside resources for assistance (clinics, pharmacies, hospitals)
- f) outside resources for assistance (clinics, pharmacies, hospitals)

- **Consumer education for independent living:**

- a) budgeting
- b) comparative buying
- c) installment buying
- d) avoiding risks
- e) identifying illegal or excessive interest rates
- f) use of credit
- g) avoiding or dealing with debts
- h) using checking and savings accounts
- i) paying taxes

- **Communication skills:**

The youth's articulating thoughts and feelings through appropriate use of such skills as:

- a) speech
- b) writing
- c) use of the landline/cell telephones
- d) computer
- e) social networking
- f) internet

- **Home Management:**

- a) making the bed and changing linens
- b) using the vacuum cleaner
- c) dusting
- d) organizing belongings
- e) disposing of trash
- f) cleaning all areas of the home
- g) operating appliances
- h) cooking complete meals
- i) making simple repairs
- j) who to call when a major repair is needed
- k) being aware of the need for upkeep
- l) handling emergencies
- m) knowing first aid

- **Situational Guidance:**

- a) identifying and accepting strengths
- b) developing patterns of acceptance

- c) coping with authority figures
  - d) getting along with others
  - e) sharing responsibility
  - f) being considerate of others
  - g) developing friendships
  - h) knowing when to go home when visiting
  - i) recognizing or modifying attitudes toward self or others
  - j) responsible work attitudes
  - k) tolerance of verbal criticism
  - l) reactions to praise
  - m) punctuality
  - n) attendance
- **Recreation:**
    - a) participating in leisure time activities
    - b) learning how to spend leisure time
    - c) developing outside activities
    - d) managing time
    - e) finding recreation with little or no expense involved
    - f) finding community projects to take part in, participating in social groups
    - g) participating in sports and games
    - h) arts and crafts
    - i) appreciating fine arts

#### **Section 5.4: Initial Assessment**

When a youth enters the facility, the RMC shall begin assessing their strengths and needs immediately and have a completed assessment within 7 days of admission.

The assessment shall include but not be limited to the following:

1. Reasons for referral to the facility
2. Evaluation or assessment covering the following areas:
  - a) Physical health
  - b) Family relations
  - c) Academic or vocational training
3. Community life
4. Interpersonal interactions
5. Daily living skills as outlined in the scope of services listed above
6. Immediate service needs:
  - a) Mental Health
  - b) Developmental
  - c) Dental
  - d) Medical
7. Involvement or exposure to Substance Use/disorder
8. Involvement or exposure to other trauma
9. Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assess with regards to most appropriate next placement.

Physical and mental health needs shall be coordinated with assigned CWCMP and youth's assigned MCO.

### **Section 5.5: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth residing in a Residential Maternity Center**

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

### **Section 5.6: Program Plan**

Each youth residing in a residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document no needs were identified. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CWCMP case manager shall be considered in the report.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. substance use service needs
  7. emotional/psychological health
- Short term goals which will help a youth eventually reach his/her long term goals in each of the above areas.

1. Services to meet independent living goals.
  2. Specific plans for reaching the short-term goals including services to be provided and frequency.
  3. Estimated time for reaching short term goals.
- The youth shall sign and date the program plan indicating participation and input in the development of the plan.
  - Updated information of the progress of the youth's goals shall be included.

RMC staff shall participate in the case plan conducted by the CWCMP case manager.

### **Section 5.7: Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents, if applicable or guardian, and the placing agency shall be involved in planning the discharge of a resident from the facility.

A discharge summary and modifications to it shall be completed at the time of the youth's discharge, noted in the case file and forwarded to the CWCMP case management agency. This shall include documentation of after-care plans, and the goals which the youth has completed in the RMC. Written recommendations for discharge shall be made and shall specify the nature, frequency, and duration or services the facility recommends for the youth. The plan shall also document who the responsible parties are for aftercare services.

### **Section 5.8: Case Coordination**

The RMC's case coordinator has the responsibility for coordinating the youth's program and progress with the referring CWCMP case management agency, school, employer, family, and other appropriate community resources.

The Case Coordinator will maintain a resource base of services to address the needs identified in Individual Program Plans and document in the youth's file, when and what community resources have been contacted and utilized for services for the youth.

### **Section 5.9: Home Visits**

When home visits are a part of the program plan, there shall be pre and post home visit contacts between the youth, their family, and facility program staff regarding the home visit including written documentation pre and post regarding the home visit. Because the goal of placement is to return the youth to a family-like setting, it is important that home visits be carefully planned and executed in the best interests of permanency planning for the youth. All home visits shall be arranged through coordination with the child's CWCMP case manager. Documentation in youth's file shall include who is transporting youth to and from family visits and observation of the youth's behavior during transportation.

## **SECTION 6: RESIDENT'S RIGHTS**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide

supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls, pictures and social networking between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 7: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 7.1: Time Out**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

#### **Application of time out:**

1. A resident in time out shall never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff shall monitor the resident while he or she is in time out.

## **Section 7.2: Emergency safety intervention/ De-escalation techniques**

### **Managing Aggressive Behaviors**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.3 Emergency safety interventions/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in RMC residential facilities.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable) /guardian (if applicable) shall be oriented to the restraint policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 7.4: Reporting Abuse/Neglect**

All employees at the RMC are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspect the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.



K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A. 38-2224 (b) Violation of this section is a class B misdemeanor.

**Physical Abuse:** Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

**Sexual Abuse:** Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.S.A. 38-2202 and K.A.R. 30-46-10

**Mental or Emotional Abuse:** Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

**Neglect:** Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs

who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 8: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a significant incident, but has the potential risk of a serious adverse outcome.

### **Section 8.1: Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement. PPM 5245 shall be followed.
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs
13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each RMS provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 9: STAFF IN-SERVICE TRAINING**

### **Section 9.1 In-service Orientation Training**

Each facility shall have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Child care staff shall have completed 18 hours of in-service orientation training provided by the facility before they can work independently with youth.

The in-service orientation program shall provide written documentation that all staff are oriented to the following:

1. Facility policy and procedures manual
2. Facility emergency and evacuation procedures
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Facility discipline standards
6. Abuse/neglect mandatory reporting laws
7. Client record documentation policies and procedures
8. Policies and procedures for resident medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPR/First Aid within 3 months of employment
12. De-escalation techniques
13. The handling of youth in trauma based informed care.

### **Section 9.2 Annual Service Training**

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial 18 hour orientation training program from the date of employment.

All RMC direct care staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating staff training, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Topics shall include but not be limited to:

1. CPR and First Aid (current not expired)
2. Blood borne pathogens
3. Medications
4. Emergency safety interventions
5. Substance use disorder patterns
6. Childhood and adolescent development (including developmental disorders)
7. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
8. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
9. De-escalation techniques/physical restraints techniques
10. Trauma based informed care

## **SECTION 10: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

### **Record Retention:**

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

### **Chart Documentation:**

A dated record of daily observations and significant occurrences involving each youth shall be maintained by each shift for each youth and maintained in each youth's individual file. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

### **Weekly Progress Notes:**

Notes shall be completed by the case coordinator and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The case coordinator shall document specific services and activities they are providing to each youth.

### **Health Records:**

Health Care and Records of residents shall meet the requirements of KAR 28-4-275. Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

**30 Day Progress Reports:**

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall be provided to the referring agency and a copy placed in the youth's file.

**Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CWCMP case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

## **Transitional Living Program (TLP) Standards and General Guidelines**

### **SECTION 1: GENERAL PROGRAM DESCRIPTION**

Transitional living is designed for youth who are ready to enter a phase of care that will eventually transition them to independent living. Transitional living affords youth an opportunity to practice basic independent living skills in a variety of settings with decreasing degrees of supervision.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

#### **Section 1.1: Transitional Living Program (TLP)**

- Youth reside in apartments within one building or complex (contained apartments). Each youth shall be afforded sufficient bedroom space to insure adequate privacy, safety and security.
- The provider shall insure the environmental safety of the apartment is in compliance with local over sight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Service Access plan development, review, and case supervision are carried out by the Transitional Living provider.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.
- The provider shall provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider shall offer or arrange for strength-based interventions to address crisis and or daily living situations.
- The provider shall facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the referring agency.

### **SECTION 2: ADMISSION SKILLS REQUIREMENTS**

Prior to consideration for admission to any TLP service youth shall be able to demonstrate knowledge of basic life skills.

TLP services shall provide the opportunity to practice the skills necessary to live independently. These skills, at a minimum, shall include:

- Preparing meals
- Basic nutrition education
- Doing laundry

- Maintaining a clean, orderly, and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance
- Handling simple repairs
- How to call the landlord about problems
- Developing and following a budget
- Access to routine transportation (e.g., public transportation, carpool)
- Shopping, food preparation, food storage, and consumer skills

### **Section 2.1: General Requirements**

All youth in transitional living placements shall:

- Be at least 17 years of age
- Be working towards full or part-time employment
- Be working towards a diploma or equivalent (if not already obtained)
- Have demonstrated a basic knowledge of life skills
- Youth are required to maintain a savings account to be held in trust by the TLP.
- Youth shall deposit the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.
- The youth's planning team will determine the actual amount required to be deposited in trust. These monies are then available to the youth when they leave the TLP.

## **SECTION 3: TRANSITIONAL LIVING PROGRAM STAFFING**

Staff shall meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out.

### **Section 3.1: Administrator**

- Qualifications
  - The administrator shall have a Bachelor's degree and prior administrative experience.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
  - Shall have a working knowledge of adolescent development principles.
- Responsibilities
  - Shall be responsible for working with, supervising and training other staff (e.g., case coordinator, life coach) who are working with youth in the transitional living program.

### **Section 3.2: Case Coordinator**

- Qualifications
  - The Case Coordinator shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and a working knowledge of adolescent development principles. The youth to case coordinator ratio is 1:16.
  - Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Responsibilities

- Service Access plan development, review, and development of collaborations with community-based service providers.
- Shall be responsible for any direct supervision of youth as required.
- Shall inspect youth's apartment as needed to insure the safety and security of youth.
- Shall coordinate or provide alternative transportation as deemed necessary.
- Shall complete paperwork or reports to referring agency as required.
- Shall work in partnership with life coaches.

**Section 3.3: Life Coach**

- Qualifications
  - Life Coaches shall have at least a high school diploma or equivalent and have a working knowledge of adolescent development principles.
  - Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth served.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Responsibilities
  - Shall work shifts and or be on-call 24 hours a day on a rotating basis.
  - Shall be responsible for any direct supervision of youth as required.
  - Shall inspect youth's apartment as needed to insure the safety and security of youth.
  - Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving and decision making).
  - Shall monitor youth's daily life skills and provide appropriate feedback.
  - Shall work in partnership with the case coordinator.

**SECTION 4: STAFF IN-SERVICE TRAINING**

**Section 4.1 In-Service Orientation Training**

Each provider shall have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with youth in transitional living. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. Staff training , reflecting orientation or annual training
2. Name of trainer
3. Name of training
4. Specify the numbers of training hours
5. Date of the training

Staff shall have completed 18 hours of in-service training orientation training provided by the facility before they can work independently with the resident.

1. Agency policy and procedure manual
2. Facility emergency and evacuation procedures (non-scatter site only)
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Agency discipline standards
6. Abuse/neglect mandatory reporting laws
7. Resident record documentation policies and procedures



8. Policies and procedures for youth medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPF/First Aid within 3 months of employment
12. De-escalation techniques
13. Trauma based informed care

#### **Section 4.2 Annual Service training**

Each provider shall also have a written annual staff in-service training plan, which addresses the annual training needs of all staff having direct contact with youth. This annual training is beyond or in addition to the initial 18 hour orientation-training program.

All Transitional living staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file indicating training:

1. Staff training, reflecting orientation or annual training
2. Name of trainer
3. Name of training
4. Specify the numbers of training hours
5. Date of the training

Topics shall include but are not limited to:

1. CPR and First Aid (current not expired)
2. Blood borne pathogens
3. Medications
4. Emergency safety interventions
5. Substance use disorder patterns
6. Childhood and adolescent development (including developmental disorders)
7. Childhood and a psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
8. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
9. De-escalation techniques/physical restraints techniques
10. Trauma based informed care

#### **SECTION 5: PLACEMENTS**

Transitional living placements are offered through residential living arrangements where youth have the opportunity to practice independent living skills with decreasing degrees of care and supervision. The youth's case planning team, which shall include the youth, is required to determine the youth's readiness to enter this program by a review of the youth's current life skills proficiency. The youth may remain in this level of care until it is determined the youth is ready to transition to a transitional living placement or a fully independent living setting.

### **Section 5.1: Home Furnishings/Services**

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used, but shall be in good condition. The articles and supplies shall include, but are not limited to:

- A bed and bed linens;
- A dining table and chairs;
- Living or sitting room furniture;
- A stove and refrigerator;
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils);
- Basic cleaning supplies;
- Landline telephone;
- Utilities (e.g., water, trash, electricity, gas);
- Access to laundry services;
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day;
- Kitchen and bath linens;
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth shall be provided the opportunity to purchase these items when they are financially capable;
- Emergency transportation when routine transportation is not available;
- Administration, oversight of youth's trust;
- Financial guidance to youth (e.g., budgeting, consumer skills).

### **Section 5.2: Positive and Realistic Living Experiences**

Youth are further prepared for adulthood by being provided a realistic living experience, through transitional living placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions;
- Life skills practice while having access to staff for support and advice;
- Daily social contacts;
- Emotional adjustment to the difference between present living situation and previous ones;
- Practice living alone;
- Use of leisure time;
- Obtaining and using transportation to access needed resources.

These experiences shall also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

### **Section 5.3: Placement Supervision**

All youth in TLP placements shall have twenty-four (24) hour access to on-site program staff that is responsible for monitoring the activities of youth in their programs. Program staff shall develop a schedule for providing supervision with guidance based on a specific youth's maturity, acquired skills, and emotional status. The supervisory schedule shall be designed so that staff may observe that the youth is practicing healthy and responsible life skills and will be developed in collaboration with a youth's referring agency. This collaboration will determine the frequency and type of supervision/support provided to the youth.

## **Section 5.4 Placement Agreement**

A Placement Agreement shall be completed between the TLP and the referring agency at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

The initial service authorization period for a TLP stay will be for 90 days. Service extensions will be for a period of time not to exceed 60 days, and shall be approved by the youth's CWCMP case manager to ensure the youth is receiving the services they need to reintegrate into the community. The youth shall continue receiving services in the TLP facility as long as they continue to require this level of care as determined by the youth's CWCMP case manager.

## **Section 6: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Sex offender status (offenders/victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file.

## **Section 7: Service Supports**

Youth in transitional living placements may need access to supportive services including but not limited to the following categories:

- Mental health services
- Alcohol and substance use disorder treatment services
- Educational/vocational support services
- Individual counseling
- Sex Offender treatment services
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation

### **Section 7.1: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth residing in a TLP**

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider

shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

## **SECTION 8: SERVICE ACCESS PLANNING**

### **Initial Assessment:**

The admission service access request provided by the referring agency shall constitute the initial assessment.

### **Additional Assessments:**

The case coordinator or life skills coach may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

### **Plan requirements:**

Each youth residing in transitional living shall have a service access plan based on needs identified by the provider and the referring agency. Any assessment documents shall be included in the case record. The service plan shall be established by the end of 3 working days from admission. Service plans shall be updated whenever new needs are identified or when goals are met. Service plans shall be reviewed and revisions made at least every 30 days.

The service plan shall include:

- Long-term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. emotional/psychological health
- Short-term goals which help the youth reach his/her long-term goals in the areas identified above.
  1. Services to meet independent living goals
  2. Estimated time for reaching short-term goals.

3. The youth shall sign and date the service access plan indicating participation and input in the development of the plan
4. Updated information of the progress of the youth's goals shall be included

The service plan shall be reviewed, revised, and documented in a progress report at least every 30 days by the facility. Information obtained from the youth, parent, guardian, referring agency, employers or service providers shall be considered in the report.

### **Section 8.1: Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to transitional living. At a minimum, the youth, youth's parent, if applicable or guardian, if applicable and the referring agency shall be involved in planning the discharge of a youth. A discharge summary shall be completed at the time of the youth's discharge. This shall include goals that the youth has achieved and any identified plans for aftercare. Written recommendations for aftercare shall be made and shall specify the nature, frequency, and duration or services recommended for the youth. The plan shall also identify the parties responsible for specific aftercare services.

### **SECTION 9: RESIDENT'S RIGHTS**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file and reviewed at the 30 day case reviews. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 10: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 10.1: Time Out**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

#### **Application of time out:**

1. A resident in time out shall never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff shall monitor the resident while he or she is in time out.

### **Section 10.2: Emergency safety intervention/De-escalation techniques Managing Aggressive Behaviors:**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 10.3 Emergency safety interventions/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in TLP services.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian (if applicable) shall be oriented to the restraint policies of the facility and shall sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

#### **Section 10.4: Reporting Abuse/Neglect**

All employees at the TLP are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspects the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any other sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by, a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A 38-2224 (b) Violation of this section is a class B misdemeanor.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10.

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;

- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Neglect: Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 11: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a significant incident, but has the potential risk of a serious adverse outcome.

### **Section 11.1: Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement PPM 5245 shall be followed.
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs



13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each TLP provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 12: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

### **Section 12.1 Record Retention:**

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

### **Section 12.2: Chart Documentation**

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

### **Section 12.3: Weekly Progress Notes**

Notes shall be completed by the case coordinator and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The case coordinator shall document specific services and activities they are providing to each youth.

#### **Section 12.4: Health Records**

Health Care and Records of residents shall meet the requirements of KAR 28-4-275. Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

#### **Section 12.5: 15 and 30-Day Progress Reports**

Within the first 15 days of the youth's admission to the TLP the Case coordinator shall provide written placement recommendations to the youth's CWCMP case managers as well as an update on the youth's progress. This report shall be placed in the youth's file.

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall also be placed in the youth's file.

#### **Section 12.5: Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focus on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CWCMP case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

## **Community Integration Program (CIP) Standards and General Guidelines**

### **SECTION 1: GENERAL PROGRAM DESCRIPTION**

Community Integration is a service designed for youth who are ready to enter a phase of care, which will eventually transition them to independent living. Youth reside in apartments and are afforded the opportunity to practice independent living skills with decreasing degrees of supervision. Community Integration service is to prepare youth to become socially and financially independent from the program.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

#### **Section 1.1: General Requirements**

- Youth reside in apartments within one building or complex (contained apartments) or scatter site apartments. Each youth shall be afforded sufficient bedroom space to insure adequate privacy, safety and security.
- The provider shall insure the environmental safety of the apartment is in compliance with local over sight agencies such as HUD, Fire Marshall, Municipalities, Apartment Management, etc.
- Service Access plan development, review, and case supervision are carried out by the Community Integration Specialist.
- Services will be designed to work in collaboration with other community-based providers to develop a strong foundation of service and support access.
- Staff shall have experience, skill and knowledge in adolescent development, behavior management, child abuse and neglect, family dynamics, provision of community-based services, development of youth's strengths and assets, and positive youth development.
- The provider shall provide assistance to ensure that youth obtain the basic necessities of daily life.
- The provider shall offer or arrange for strength-based interventions to address crisis and or daily living situations.
- The provider shall facilitate development of support systems to increase the youth's interdependency within the community in which they reside.
- All services accessed shall be appropriate to the age, gender, sexual orientation, cultural heritage, developmental and functional level, as well as the learning ability of each youth.
- Admission requirements shall include a list of support service needs as identified by the referring agency.
- Youth is required to maintain a savings account into which the youth deposits the full or partial amount (depending upon their employment status) of their share of the monthly apartment rent and utilities.

### **SECTION 2: ADMISSION SKILLS REQUIRED**

Prior to consideration for admission to any Community Integration service youth shall be able to demonstrate the ability to perform basic life skills. These skills, at a minimum, shall include:

- Preparing meals

- Basic nutrition education
- Doing laundry
- Maintaining a clean, orderly and safe living space
- Living cooperatively with other housemates or neighbors
- Handling landlord/tenant complaints
- Controlling guests' behavior
- Handling basic maintenance
- Handling simple repairs
- How to call the landlord about problems
- Developing and following a budget
- Use of leisure time
- Obtaining and using transportation to access needed resources
- Identify safe and affordable housing
- Negotiate a lease
- Present oneself to a landlord
- Prevent actions that might lead to an eviction
- Understand landlord/tenant rights and responsibilities

### **Section 2.1: General Requirements**

All youth in community integration placements shall:

- Be at least 17 years of age
- Be working full or part-time
- Be working towards a diploma or equivalent (if not already obtained)
- Have demonstrated the ability to perform life skills

### **SECTION 3: COMMUNITY INTEGRATION PROGRAM STAFFING**

Staff shall meet the qualifications and responsibilities as set forth in this document. Written job descriptions shall be developed for all staff and maintained on site where personnel functions are carried out.

#### **Section 3.1: Administrator**

- Qualifications
  - The administrator shall have a Bachelor's degree and prior administrative experience.
  - Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
  - Shall have a working knowledge of adolescent development principles.
- Responsibilities
  - Shall be responsible for working with, supervising and training other staff (e.g., Community Integration Specialist) who are working with youth in the community integration program.

#### **Section 3.2: Community Integration Specialist**

- Qualifications
  - The Community Integration Specialist shall have at least a bachelor's degree in one of the human service fields (social work, psychology, human development and family life, criminal justice, counseling, nursing or education) and have a working knowledge of adolescent development principles.
  - Shall be at least twenty-one (21) years of age and at least three years older than the oldest youth

- o served.
- o Shall not be a person restricted from working with youth as defined by K.S.A. 65-516.
- Responsibilities
  - o Service Access plan development, review, and development of collaborations with community-based service providers.
  - o Shall be responsible for any monitoring of youth activities as required.
  - o Shall inspect youth's apartment as needed to insure the safety and security of youth.
  - o Shall coordinate or provide alternative transportation as deemed necessary.
  - o Shall complete paperwork or reports to referring agency as required.
  - o Shall work shifts and or be on-call 24 hours a day on a rotating basis.
  - o Shall be responsible for the day-to-day modeling of life skills (e.g., assertiveness, communication, conflict management, problem solving, and decision making).
  - o Shall monitor youth's daily life skills and provide appropriate feedback.
  - o Shall review bank statements, check stubs, etc. to insure youth's adherence to savings requirements

## **SECTION 4: STAFF IN-SERVICE TRAINING**

### **Section 4.1 In-Service Orientation Training**

Each provider shall have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with youth in a CIP. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. Staff training , reflecting orientation or annual training
2. Name of trainer
3. Name of training
4. Specify the numbers of training hours
5. Date of the training

Staff shall have completed 18 hours of in-service training orientation training provided by the facility before they can work independently with the resident.

1. Agency policy and procedure manual
2. Facility emergency and evacuation procedures (non-scatter site only)
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Agency discipline standards
6. Abuse/neglect mandatory reporting laws
7. Resident record documentation policies and procedures
8. Policies and procedures for youth medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPF/First Aid within 3 months of employment
12. De-escalation techniques
13. Trauma based informed care

## **Section 4.2 Annual Service training**

Each provider shall also have a written annual staff in-service training plan, which addresses the annual training needs of all staff having direct contact with youth. This annual training is beyond or in addition to the initial 18 hour orientation-training program.

All Transitional living staff shall have a minimum of 18 documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file indicating training:

6. Staff training, reflecting orientation or annual training
7. Name of trainer
8. Name of training
9. Specify the numbers of training hours
10. Date of the training

Topics shall include but are not limited to:

11. CPR and First Aid (current not expired)
12. Blood borne pathogens
13. Medications
14. Emergency safety interventions
15. Substance use disorder patterns
16. Childhood and adolescent development (including developmental disorders)
17. Childhood and a psychopathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
18. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse
19. De-escalation techniques/physical restraints techniques
20. Trauma based informed care

## **SECTION 5: PLACEMENTS**

Community Integration placements may be offered through a variety of residential living arrangements where youth have the opportunity to evidence independent living skills with decreasing degrees of supervision. Residential living arrangements may include apartments within one building or scattered site housing. Scattered site housing are dwellings (e.g., apartments, town homes, duplexes) that are typically located in the same neighborhood.

### **Section 5.1: Home Furnishings/Services**

The provider shall make available certain articles and supplies for furnishing the youths residence. The articles and supplies may be new or used, but shall be in good condition. The articles and supplies shall include, but are not limited to:

- A bed and bed linens
- A dining table and chairs
- Living or sitting room furniture
- A stove and refrigerator
- Kitchen furnishings (e.g., pots, pans, cooking and eating utensils)
- Basic cleaning supplies

- Landline telephone
- Utilities (e.g., water, trash, electricity, gas)
- Access to laundry services
- Food in sufficient quantity to provide at least three (3) nutritionally balanced meals per day (Food costs included in room and board, youth to be responsible for shopping and food preparation);
- Kitchen and bath linens
- Entertainment equipment (e.g., television, stereo, video games) are optional, if not provided, youth shall be provided the opportunity to purchase these items when they are financially capable
- Emergency transportation when routine transportation is not available
- Review of youth's financial records (e.g., bank statements, check stubs) to monitor youth's money management skills

### **Section 5.2: Positive and Realistic Living Experiences**

Youth are further prepared for adulthood by being provided a realistic living experience, through community integration placements in which they can take increasing responsibility for themselves. Elements of those living experiences include, but are not limited to, the following:

- Direct experience with the consequences of daily actions and decisions
- Life skills practice while having access to staff for support and advice
- Use emergency medical procedures
- Negotiating a rental agreement
- Practice in money management and budgeting
- Experience in shopping, food preparation, food storage, and consumer skills

These experiences shall also be tailored to a youth's current level of functioning. Additional experiences and opportunities may be introduced as a youth's skill level increases and more complex opportunities are desired.

### **Section 5.3: Placement Supervision**

All youth in community integration placements shall have twenty-four (24) hour telephone access to community integration staff and an alternate placement in the event the community integration placement is unsuccessful.

Community Integration staff shall evaluate, at a minimum, the youth's:

- Safety, health, and overall well-being;
- Ability to manage school and work responsibilities without daily supervision;
- Ability to follow program and landlord rules;
- Ability to use good judgment in daily activities; and
- Overall progress toward established goals and desired outcomes.

The frequency of contact may vary due to many factors (e.g., readiness for independence; living arrangements chosen; presence or availability of other adults; other factors unforeseen until after placement).

The following contact schedule, at a minimum, shall be utilized during the first eight (8) weeks in placement. In person contacts are to be in the youth's apartment.

- 1<sup>st</sup> Week                                      Daily Phone Contact and minimum of 1 in person contact

- 2<sup>nd</sup> through 4<sup>th</sup> Wks. Twice a Week Phone Contact and minimum of 1 in person contact
- 5<sup>th</sup> through 8<sup>th</sup> Wks. Once a Week Phone Contact and minimum of 1 in person contact
- After the eighth (8<sup>th</sup>) week, contact shall occur no less often than once a month and the Community Integration Specialist and referring agency shall reconvene to determine the necessity of the youth's continued placement.

#### **Section 5.4: Placement Agreement**

A Placement Agreement shall be completed between the CIP and the referring agency at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

#### **Section 5.5: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room, if the housing is shared, based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Displaying inappropriate sexual behaviors /victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file.

#### **SECTION 6: SERVICE/SUPPORTS**

Youth in community integration placements may need access to supportive services including but not limited to the following categories:

- Mental health services, including treatment to address sexual issues if needed
- Alcohol and substance use disorder treatment services
- Educational/vocational support services
- Individual counseling
- Pro-social recreational activities
- Preventative, routine and emergency health care
- Routine transportation

#### **Section 6.1: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth Residing in a CIP**



Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

## **SECTION 7: SERVICE ACCESS PLANNING**

### **Initial Assessment:**

The admission service access request provided by the referring agency shall constitute the initial assessment.

### **Additional Assessments:**

The Community Integration Specialist may administer life skills assessments as needed to further identify needs to be addressed in the service access plan.

### **Plan requirements:**

Each youth residing in a CIP shall have a service access plan based on needs identified by the provider and the referring agency. Any assessment documents shall be included in the case record. The service plan shall be established by the end of 3 working days from admission. Service plans shall be updated whenever new needs are identified or when goals are met. Service plans shall be reviewed and revisions made at least every 30 days.

The service plan shall include:

- Long-term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. emotional/psychological health
- Short-term goals which help the youth reach his/her long-term goals in the areas identified above.

1. Services to meet independent living goals
2. Estimated time for reaching short-term goals.
3. The youth shall sign and date the service access plan indicating participation and input in the development of the plan
4. Updated information of the progress of the youth's goals shall be included

The service plan shall be reviewed, revised, and documented in a progress report at least every 30 days by the facility. Information obtained from the youth, parent, guardian, referring agency, employers or service providers shall be considered in the report.

### **Section 7.1 Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to transitional living. At a minimum, the youth, youth's parent, if applicable or guardian, if applicable and the referring agency shall be involved in planning the discharge of a youth. A discharge summary shall be completed at the time of the youth's discharge. This shall include goals that the youth has achieved and any identified plans for aftercare. Written recommendations for aftercare shall be made and shall specify the nature, frequency, and duration or services recommended for the youth. The plan shall also identify the parties responsible for specific aftercare services.

### **SECTION 8: RESIDENT'S RIGHTS**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths file and reviewed at the 30 day review. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians, if applicable, concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 9: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 9.1: Time Out**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

#### **Application of time out:**

- (a) A resident in time out shall never be physically prevented from leaving the time out area.
- (b) Time out may take place away from the area of activity or from other residents.
- (c) Staff shall monitor the resident while he or she is in time out.

### **Section 9.2: Emergency safety intervention/De-escalation techniques Managing Aggressive Behaviors**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 9.3 Emergency safety interventions/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history.

The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in CIP services.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior and de-escalation techniques. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian (if applicable) shall be oriented to the restraint policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

#### **Section 9.4: Reporting Abuse/Neglect**

All employees at the CIP are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspects the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any other sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by, a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A 38-2224 (b) Violation of this section is a class B misdemeanor.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422 for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10.

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;

- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) Corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Neglect: Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) Failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 10: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a significant incident, but has the potential risk of a serious adverse outcome.

### **Section 10.1: Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement PPM 5245 shall be followed.
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs

13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)
17. death of child in care

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each CIP provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 11: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

### **Section 11.1 Record Retention:**

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

### **Section 11.2: Chart Documentation**

A dated record of daily observations and significant occurrences involving each youth shall be maintained. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

### **Section 11.3: Weekly Progress Notes**

Notes shall be completed by the Community Integration Specialist and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The Community Integration Specialist shall document specific services and activities they are providing to each youth.

#### **Section 11.4 Health Records**

Health Care and Records of residents shall meet the requirements of KAR 28-4-275. Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

#### **Section 11.5: 15 and 30-Day Progress Reports**

Within the first 15 days of the youth's admission to the CIP program the Community Integration Specialist shall provide written placement recommendations to the youth's CWCMP case managers as well as an update on the youth's progress. This report shall be placed in the youth's file.

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall also be placed in the youth's file.

#### **Section 11.6: Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's CWCMP case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.

## **SECURE CARE FACILITY**

### **STANDARDS AND GENERAL GUIDELINES**

#### **SECTION 1: GENERAL PROGRAM DESCRIPTION AND REQUIREMENTS**

A Secure Care facility is a 24-hour residential facility that meets the requirements of K.S.A. 38-2202 (bb) and K.A.R. 28-4-350 (u): defining a secure care facility. It also meets the requirements of K. A. R. 28-4-350-28-4-360 to provide twenty-four hour care in a DCF Foster Care and Residential Facility Licensing licensed secure care facility.

##### **Section 1.1 Services Provided in Secure Care**

A Secure Care facility is a 24-hour residential facility that meets the requirements of K.S.A. 38-2202 (bb) and K.A.R. 28-4-350 (u): defining a secure care facility. "Secure facility means a facility which is operated or structured so as to ensure that all entrances and exits from the facility are under the exclusive control of the staff of the facility, whether or not the person being detained has freedom of movement within the perimeters of the facility, or which relies on locked rooms and buildings, fences or physical restraint in order to control behavior of its residents. No secure facility other than a juvenile detention center shall be attached to or on the grounds of an adult jail or lock-up."

It also meets the licensing requirements of K. A. R. 28-4-350-28-4-360 to provide twenty-four hour care in a DCF CPA and Residential Facility Division secure care facility.

DCF requires foster parents and designated officials at child care institutions to apply the reasonable and prudent parenting standard. The standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while at the same time encouraging the child's emotional and developmental growth that a caregiver must use when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities.

#### **SECTION 2: GENERAL STAFFING REQUIREMENTS**

Twenty-four hour care which has been licensed by DCF Foster Care and Residential Facility Licensing (KAR 28-4-350-28-4-360) as a secure care facility.

- Each secure care center director shall have at least a master's degree in social work or a related field, or shall have a bachelor's degree in social work, human development and family life, psychology or education and a minimum of three years of supervisory experience within a child care agency.
- Facility staff shall meet the requirements of K.A.R. 28-4-353a. Facility child care staff shall be at least 21 years of age with a minimum of three years age difference between the child care worker and oldest resident who can be admitted to the facility. Child care staff shall have at least a high school diploma or its equivalent and shall also have a minimum of:
  1. three semester hours of college level study in adolescent development , psychology or a related subject
  2. Eight hours of orientation training before assuming supervisory responsibility of the residents.
  3. Staff shall have 32 hours of training before assuming independent supervisory responsibilities.
  4. All staff shall have 40 hours of training per year



5. One year of experience as a child care worker or house apparent in a facility serving youth of the same age.
- The facility shall be staffed appropriately to meet the needs of all the resident in their care. The staff ratio is 1:7 during waking hours and 1:11 during sleeping hours. There shall be 24-hour awake staff to insure child safety.

### **SECTION 3: CRITERIA FOR THE YOUTH'S ADMISSION**

Youth are admitted to the facility who have been placed in a secure care facility Per K.S.A 2260 (f) (2 -3). The court may authorize the custodian to place the child in a secure facility or juvenile detention facility, if the court determines that all other placement options have been exhausted or are inappropriate, based upon a written report submitted by the Secretary, if the child is in the Secretary's custody, or submitted by a public agency independent of the court and law enforcement, if the child is in the custody of someone other than the Secretary. The report to the court shall detail the behavior of the child and the circumstances under which the child was brought before the court and made subject to the order entered pursuant to subsection (a) of the CINC code.

The authorization to place the child in a secure facility or juvenile detention facility pursuant to this subsection shall expire 60 days, inclusive of weekend and legal holidays, after its issue. The court may grant extensions of such authorization for two additional periods, each not to exceed 60 days, upon rehearing pursuant to K.S.A. 38-2256, and amendments thereto.

#### **Section 3.1 Placement Agreement**

A signed Placement Agreement shall be completed between the Secure Care Facility and the referring agency at the time of placement. A copy of the signed Placement Agreement shall be kept in the youth's file at the facility.

The initial service authorization period for a Secure Care Facility stay will be for 60 days. The court may grant extensions of such authorization for two additional periods, each not to exceed 60 days, upon rehearing pursuant to K.S.A. 38-2256, and amendments thereto.

### **SECTION 4: RESIDENTIAL CARE PROGRAM**

#### **Section 4.1 Residential Care System**

Each Secure Care Facility shall have a written program of consistent rules and regulations guiding and governing the daily behavior of the youth under the care of the program. The behavior management system shall include a description of daily general routines of the program. The system of rules, rewards, and consequences for given behaviors shall be identified. Each youth shall be oriented to the Secure Care Facility's behavior management system by a staff member during the admission or orientation process. Notation shall be made in the youth's file and signed by the youth that the rules and regulations, rewards and consequences have been discussed with the youth.

The Secure Care Facility shall post the behavior management system in a common area where youth are able to easily access the system and the youth shall be given a written copy of the system to use as a reference.

The system shall include rules governing:

1. interpersonal interactions with staff and peers
2. facility leave policies
3. school attendance and behavior while at school,
4. verbal and physical aggression,
5. allowable possessions,
6. awakening and bedtime hours,
7. leisure hours,
8. visitation policies,
9. AWOL attempts,
10. involvement in recreation and other activities,
11. self-destructive behaviors,
12. sexuality,
13. communications with family and others outside the program,
14. religious worship,
15. involvement in therapies,
16. theft, property destruction,
17. behaviors resulting in mandatory removal from the program
18. behaviors at the program which could result in legal prosecution

Emphasis in the design of the secure care facility program is to be on addressing the youth's chronic running behaviors to eliminate current and future running behavior so the youth can be successful in a community non-secure setting.

#### **Section 4.2: Resident lodging**

In order to support the daily management and administration of residents, each residential provider shall develop an objective procedure regarding the physical housing of youth. Youth in a residential placement shall be assigned to a room based upon various factors, as identified by risk/needs assessment(s) in addition to other indicators. Factors to consider in assigning rooms shall include (but are not limited to):

- Suicidal tendencies
- Level of specialized needs (i.e. mental health, medical, etc.)
- Displaying inappropriate sexual behaviors/victims of sexual abuse)
- Gender
- Age and/or maturity level
- Program needs (substance use disorder, cognitive behavioral, independent living, etc.)
- Vulnerability to being victimized by others (i.e. physical stature)

While each youth will have an individualized program plan, assigning rooms based upon risk/need/responsivity factors will allow for a safer, more secure environment, as well as efficient and effective management of the living units. The youth's room assignment and how the decision was made shall be documented in the youth's file.

#### **Section 4.3: Education Requirement**

All facilities shall have an education agreement letter with a school district certified by the state board of education. The facility shall ensure routine communications between the staff and any educational program in which the youth is placed. This shall include requesting and participating in the development of an

Individual Education Plan for each resident when appropriate. These contacts shall be noted in the youth's case record. Any accredited Kansas Virtual schooling program (on line schooling) shall be approved by the CWCMP Provider for each child. Refer to PPM 3236.

#### **Section 4.4: Scope of Services**

The provider shall write a policy and procedure manual for the operation of the Secure Care Facility that will be reviewed and approved by DCF Prevention and Protection Services. The daily schedule shall address the needs of the residents and the use of time to enhance the resident's physical, mental, emotional, and social development. The facility shall provide supervised indoor and outdoor recreation so that every resident may participate. Age appropriate equipment to promote physical development and physical fitness shall be available. Age appropriate socialization shall be provided utilizing community resources to assist the youth in transitioning back into their community when appropriate.

The Secure Care will provide a program for youth in the facility that covers the following program components:

**Daily Living Services** - Daily living services shall be provided and include the following:

1. room
2. board
3. child care
4. personal spending money
5. personal care needs
6. school fees
7. transportation to appointments within a 60-mile radius; including to and from school, medical care, recreation, etc.
8. academic activities
  - a) assistance with school work
  - b) vocational training
  - c) G.E.D. training

**Situational Training** to include but not limited to:

1. **Personal Hygiene**
  - a. teaching about body cleanliness
  - b. use of deodorants and cosmetics
  - c. appropriate clothing
  - d. choosing clothing to fit individual and occasion
  - e. keeping clothes neat and clean
2. **Health**
  - a) identifying and understanding residents' health needs
  - b) securing and utilizing necessary medical treatment including preventive and health maintenance services
  - c) gaining information and education in health maintenance including:
    - i. preventive measures
    - ii. nutrition
    - iii. menstruation
    - iv. rest
    - v. cleanliness
    - vi. family planning
    - vii. drugs

- viii. sexually transmitted diseases
  - ix. exercise
  - x. motivation for meeting own health needs
  - d) maintaining contact with providers of health services (physician, nurse, clinic)
  - e) using outside resources for assistance (clinics, pharmacies, hospitals)
  - f) outside resources for assistance (clinics, pharmacies, hospitals)
3. **Consumer education for independent living-**
- a) budgeting
  - b) comparative buying
  - c) installment buying
  - d) avoiding risks
  - e) identifying illegal or excessive interest rates
  - f) use of credit
  - g) avoiding or dealing with debts
  - h) using checking and savings accounts
  - i) paying taxes
4. **Communication skills:** The youth's articulating thoughts and feelings through appropriate use of such skills as:
- a) speech
  - b) writing
  - c) use of the, landline/cell telephones
  - d) computer
  - e) social networking
  - f) internet
5. **Home Management:**
- a) making the bed and changing linens
  - b) using the vacuum cleaner
  - c) dusting
  - d) organizing belongings
  - e) disposing of trash
  - f) cleaning all areas of the home
  - g) operating appliances
  - h) cooking complete meals
  - i) making simple repairs
  - j) who to call when a major repair is needed
  - k) being aware of the need for upkeep
  - l) handling emergencies
  - m) knowing first aid
6. **Situational Guidance:**
- a) identifying and accepting strengths
  - b) developing patterns of acceptance
  - c) coping with authority figures
  - d) getting along with others
  - e) sharing responsibility
  - f) being considerate of others
  - g) developing friendships
  - h) knowing when to go home when visiting

- i) recognizing or modifying attitudes toward self or others
- j) responsible work attitudes
- k) tolerance of verbal criticism
- l) reactions to praise
- m) punctuality
- n) attendance

**7. Recreation:**

- a) participating in leisure time activities
- b) learning how to spend leisure time
- c) developing outside activities
- d) managing time
- e) finding recreation with little or no expense involved
- f) finding community projects to take part in
- g) participating in social groups
- h) participating in sports and games
- i) arts and crafts
- j) appreciating fine arts

**Section 4.5: Initial Assessment**

When a youth enters the facility, the Secure Care Facility shall begin immediately assessing their strengths and needs including documentation. The assessment shall include but not be limited to the following:

1. Reasons for referral to the facility
2. Evaluation or assessment covering the following areas:
  - a) Physical health
  - b) Family relations
  - c) Academic or vocational training
3. Community life
4. Interpersonal interactions
5. Daily living skills as outlined in the scope of services listed above
6. Immediate service needs:
  - a) Mental Health
  - b) Developmental
  - c) Dental
  - d) Medical
7. Involvement or exposure to Substance Use/disorder
8. Involvement or exposure to other trauma
9. Assessment of youth's self- injuring or suicidal attempts

Placement needs of the youth shall be assessed with regard to most appropriate next placement.

Physical and mental health needs shall be coordinated with assigned CWCMP case manager and youth's assigned MCO.

#### **Section 4.6: Accessing Outpatient Mental Health/Substance Use Disorder Services for Youth Residing in a Secure Care Facility**

Only Outpatient Mental Health/Substance Use Disorder services are allowed while a youth is residing in an out of home placement (excluding PRTF placement). If outpatient services are needed, the provider shall coordinate assessments and services through an enrolled Medicaid provider through KanCare. The MCO assigned to the youth through KanCare will determine the type, frequency and duration of services required to meet the individualized Mental Health/Substance Use Disorder needs of each youth.

Upon admission or during the course of the youth's stay, if the youth begins to exhibit behavior/needs which cannot be addressed by the placement or through outpatient services, the provider shall collaborate with the CWCMP case manager to obtain an appropriate screen/assessment to determine the level of services required.

If the youth is receiving Mental Health/Substance Use Disorder services from an enrolled Medicaid provider through KanCare, including a community mental health center or independent practitioner, at the time of admission, the youth may continue services by the same provider to maintain continuity of service.

Providers may employ, contract or otherwise partner with an enrolled Medicaid provider through KanCare to provide Outpatient Mental Health/Substance Use Disorder services to youth residing at the program.

Providers shall not prohibit the youth's ability to request or receive services from any willing provider who are enrolled Medicaid providers through KanCare.

#### **Section 4.7: Program Plan**

Each youth residing in a secure residential facility shall have a program plan that is based on a thorough assessment. Assessment documents shall be included in the case record. The program plan shall be established by the end of 14 days from admission and shall address the identified needs in the emotional, physical, educational, social, familial, and where appropriate independent living skill domains. Youth may not have identified needs in every domain. If so, document **"no needs were identified"**. Program plans shall be updated when new needs are identified or when program goals are met. Program plans shall be thoroughly reviewed and revisions made at the case review conferences within 30 days of completion of initial program plan and each 30 days thereafter including updated information of the progress of the youth's goals. Information obtained from the youth, parent, guardian, and CWCMP case manager shall be considered in the report.

The program plan shall include individualized services to match the youth's identified needs in the following areas:

- Long term goals in the areas of:
  1. physical health
  2. family relations
  3. daily living skills
  4. academic and/or vocational skills
  5. interpersonal relations
  6. substance use service needs
  7. emotional/psychological health
- Short term goals which will help a youth eventually reach his/her long term goals in each of the

above areas.

1. Services to meet independent living goals.
  2. Specific plans for reaching the short-term goals including services to be provided and frequency.
  3. Estimated time for reaching short term goals.
- The youth shall sign and date the program plan indicating participation and input in the development of the plan.
  - Updated information of the progress of the youth's goals shall be included.

Secure Care staff shall participate in case plan conducted by CWCMP case manager.

#### **Section 4.8: Discharge/Aftercare Plan**

Discharge planning shall begin upon admission of the youth to the facility. At a minimum, the resident, the resident's parents (if applicable) or guardian, and the placing agency shall be involved in planning the discharge of a resident from the facility. The discharge plan and modifications to it shall be noted in the case file. All releases shall be approved by the court of jurisdiction, or the designated authority.

A discharge summary and modifications to it shall be completed at the time of the youth's discharge, noted in the case file and forwarded to the CWCMP case management agency. This shall include delineation of after-care plans and goals which the youth have completed in the ES. Written recommendations for aftercare shall be made and shall specify the nature, frequency, and duration or services the facility recommends for the youth. The plan shall also document who the responsible parties are for aftercare services.

#### **Section 4.9: Case Coordination**

The Secure Care Facility has the responsibility for coordinating the youth's program and progress with the referring CWCMP case management agency, school, family, and other appropriate community resources. Each Secure Care facility shall outline the case coordination service delivery responsibilities for their facility.

The Case Coordinator will maintain a resource of services to address the needs identified in Individual Program Plans and document in the youth file, when and what community resources have been contacted and utilized for services for the youth.

#### **SECTION 5: RESIDENT'S RIGHTS:**

The staff of the facility shall allow privacy for each youth. The facility's space and furnishings shall be designed and planned with respect for the resident's right to privacy. The facility's design shall also provide supervision according to the ages and needs of the residents. Each resident shall have a quiet area where they can withdraw from the group when appropriate.

Contacts between the resident and their parents/guardian shall be allowed while the resident is in care unless the rights of the parents have been terminated by court order or family contact is not in the resident's best interest. The frequency of contact shall be determined by the needs of the resident and his/her family or guardians per program plan requirements.

The facility shall have clearly written policies regarding visits, gifts, mail, E-mail and telephone (including cell phone) calls pictures and social networking between the resident and their family, or guardian. These policies shall be made known to the resident and his/her family/guardian at or prior to admission.

Residents shall be allowed to send and receive mail and have telephone conversations with family members/guardians unless it is not in the best interest of the youth, the safety and security of facility, or if a court order necessitates restrictions.

If restrictions on communications or visits are necessary these shall be documented in the youths program plan and reviewed at the 30-day case reviews. The youth's CWCMP case manager shall be notified of any new restrictions to communications or visitation implemented by the facility prior to its implementation.

A resident shall be allowed to bring personal possessions to the facility and may acquire other possessions in accordance with the policies of the facility. Prior to admission, information shall be made available to the youth and their parents/guardians concerning what possessions a youth may bring to the facility and the kinds of gifts they may receive. Possessions, which a youth cannot have or receive at the facility, shall be specified in writing and distributed to the youth and their parents/guardians.

## **SECTION 6: BEHAVIOR MANAGEMENT**

Discipline at the facility shall be consistent and not be physically or emotionally damaging. Youth shall not be subjected to cruel, severe, unusual, or unnecessary punishment. Youth shall not be subjected to remarks that belittle or ridicule them or their families. Residents shall not be denied food, mail, telephone calls or visits with their families as punishment. Seclusion shall not be utilized as a disciplinary measure. Only staff members shall discipline residents.

### **Section 6.1 Time Out:**

A procedure used to assist the individual to regain emotional control by removing the individual from his or her immediate environment and restricting the individual to a quiet area or unlocked quiet room.

#### **Application of time out:**

1. Resident in time out shall never be physically prevented from leaving the time out area.
2. Time out may take place away from the area of activity or from other residents.
3. Staff shall monitor the resident while he or she is in time out.

### **Section 6.2 Emergency safety intervention / De-escalation techniques Managing Aggressive Behaviors**

De-escalation is a technique used during a potential crisis situation in an attempt to prevent a youth from causing harm to themselves, others and/or staff. De-escalation techniques shall be utilized for any activity required to diffuse a conflict or intense situation to ensure safety and calm the youth. Staff shall be trained in authorized, well-recognized de-escalation techniques programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent (if applicable)/guardian shall be oriented to the managing aggressive behaviors policies of the facility and shall sign a written acknowledgment of this orientation. This written acknowledgment shall be kept in the client's case record.

### **Section 6.3 Emergency safety interventions/Physical restraints**

An emergency safety intervention shall be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age, size, gender physical, medical, psychiatric condition, and personal history.



The use of emergency safety interventions shall be performed only through the use of nationally recognized restraint procedures applicable to this population designed to prevent a resident from harming self or others by exerting external control over physical movement.

Physical restraint is the application of physical force without any mechanical device, for the purpose of restricting the free movement of a resident's body. **Physical restraint shall be used only as last resort after all verbal de-escalation techniques have failed and when the resident is at-risk of harming themselves or others.**

Mechanical restraint is the use of mechanical devices to restrict the free movement of the resident's body, most often for purposes of preventing self-destructive behavior. **Mechanical restraints are not allowed in Secure Care residential facilities.**

Each facility shall have a written restraint policy and all staff shall be trained to provide safe physical restraints in the event of an emergency safety intervention. Staff shall be trained in authorized, well-recognized training programs for managing aggressive behavior. Staff training records shall be kept as part of the staff member's personnel file and shall be made available upon request. At the time of admission to a facility, the resident and parent/guardian shall be oriented to the restraint policies of the facility and shall sign a written acknowledgment or this orientation. This written acknowledgment shall be kept in the client's case record.

#### **Section 6.4 Reporting Abuse/Neglect**

All employees at the SC are mandated reporters. Mandated reporters shall report all witnessed or suspected abuse/neglect to the Kansas Protection Report Center (KPRC) at 1-800-922-5330 or the local Law Enforcement Agency.

The KPRC number shall be posted in a prominent place in the facility. Any employee of the facility who suspects the abuse/neglect of a resident within that facility is to notify the Director of the facility immediately, except in cases where the alleged perpetrator is the facility Director.

K.S.A. 38-2224 (a) No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any other sanction on, any employee because the employee made an oral or written report to, or cooperated with an investigation by, a law enforcement agency or the secretary relating to harm inflicted upon a child which was suspected by the employee of having resulted from the physical, mental or emotional abuse or neglect or sexual abuse of the child. K.S.A (b) Violation of this section is a class B misdemeanor.

Physical Abuse: Infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A. 38-2202

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include allowing, permitting, or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed, or depicted in obscene or pornographic material. Sexual abuse also shall include allowing, permitting or encouraging a child to engage in aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another. K.S.A. 38-2202 (See PPM 0160 or K.S.A. 21-6422

for Commercial sexual exploitation of a child, 21-5426 for aggravated human trafficking, and 21-5501 for sexual intercourse and sodomy definitions). Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion. K.A.R. 30-46-10

**Mental or Emotional Abuse:** Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

- 1) terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;
- 2) emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and
- 3) corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

**Neglect:** Acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include but, shall not be limited to:

- (1) failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child;
- (2) failure to provide adequate supervision of a child or to remove a child from a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or a likelihood of harm to the child; or
- (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202 (t)

## **SECTION 7: SIGNIFICANT INCIDENT**

A Significant Incident is an unanticipated event which does not rise to the level of a critical incident, but has the potential risk of a serious adverse outcome.

### **Section 7.1: Significant Incident Reporting**

Significant incidents are to be reported to the youth's CWCMP case manager and the youth's parent or guardian when appropriate per PPM 0513.

The following significant incidents shall be verbally reported immediately with a written report to the CWCMP case manager within 24 hours of the event (please refer to the following definitions for clarification):

Significant Incident involving a child in the custody of the Secretary include but are not limited to:

1. death of a parent/primary caregiver (provide date of death)
2. runaway or missing from placement PPM 5245 shall be followed.
3. arrested for a juvenile offense
4. alleged abuse or neglect
5. child is an alleged perpetrator or victim of a criminal assault of any kind
6. attempted suicide
7. serious physical illness
8. unanticipated medical attention that requires treatment beyond first aid
9. pregnancy See PPM 0513 D. 2.
10. birth See PPM 0513 D. 2.
11. emergency change in placement
12. use of illegal drugs
13. suspension of the license of a group or residential facility used by children
14. alleged victim of human trafficking
15. alleged perpetrator of animal abuse
16. other (document specifics)

If the significant incident involves abuse, neglect, or exploitation the facility shall also follow mandated reporting requirements.

All facilities shall have procedures for reporting significant incidents to administrative staff and recording significant incidents in the resident files. An administrative file of significant incidents shall be kept by facility and a copy of the significant incident shall be placed in the youth's file.

An administrative file shall be kept by the facility documenting significant incidents that is separate from the documentation in the youth's file.

Each Secure Care provider shall develop an internal process for obtaining on-call/emergency contact information for all CWCMP case managers in the event of an emergency or significant incident.

## **SECTION 8: STAFF IN-SERVICE TRAINING**

### **Section 8.1 In-service Orientation Training**

Each facility shall have an in-service orientation/training program for new employees, which is especially directed toward the initial training needs of staff working directly with residents. Documentation of completion of orientation training shall be kept in the staff member's personnel file.

The documentation shall be placed in a specific area in the staff's file, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Child care staff shall have completed 40 hours of in-service orientation training provided by the facility before they can work independently with youth.

The in-service orientation program shall provide written documentation that all staffs are oriented to the following:

1. Facility policy and procedures manual
2. Facility emergency and evacuation procedures
3. Emergency safety interventions (including management of aggressive or suicidal behavior and orientation to the facility's restraint policies and procedures)
4. The handling of blood borne pathogens
5. Facility discipline standards
6. Abuse/neglect mandatory reporting laws
7. Client record documentation policies and procedures
8. Policies and procedures for resident medication management
9. Resident rights
10. Confidentiality laws
11. Training in CPR/First Aid within 3 months of employment
12. De-escalation techniques
13. The handling of youth in trauma based informed care

### **Section 8.2 Annual Service Training**

Each facility shall also have a written annual staff in-service training plan which addresses the annual training needs of all staff having direct contact with residents. This annual training is beyond or in addition to the initial forty (40) hour orientation training program.

All secure care direct care staff, shall have a minimum of forty (40) documented clock hours of in-service training per year. Documentation shall be provided in each staff member's personnel record to include content, amount of time, trainer, and qualifications.

The documentation shall be placed in a specific area in the staff's file, indicating staff training, indicating:

1. staff training, reflecting orientation or annual training
2. name of trainer
3. name of training
4. specify the number of training hours
5. date of the training

Topics shall include but not be limited to:

1. CPR and First Aid (current not expired)
2. Blood borne pathogens
3. Medications
4. Emergency safety interventions
5. Substance use disorder patterns
6. Childhood and adolescent development (including developmental disorders)
7. Childhood and adolescent psycho-pathology (including such topics as effects of abuse/neglect, reactive attachment disorders, separation anxiety disorders, ADHD)
8. Childhood and adolescent sexuality issues, especially the effects of early sexual abuse-
9. De-escalation techniques/physical restraints techniques
10. Trauma informed care

Each program manager shall attend at least one training event per year away from the center in addition to the in service training conducted at the center.

## **SECTION 9: RECORD KEEPING REQUIREMENTS FOR THE FACILITY**

The record keeping requirements of KAR 28-4-272 shall be met by the facility. In addition, the following shall be kept by the facility.

### **Record Retention:**

Case records, including medical records, shall be maintained for 6 years from the date of the youth's discharge or until completion of an on-going audit and production of a final audit report, whichever is longer.

### **Chart Documentation:**

A dated record of daily observations and significant occurrences involving each youth shall be maintained by each shift for each youth and maintained in each youth's individual file. The record shall include events, which may affect the well-being of the youth. The record shall be available for review. Each report shall include the date and time of occurrence, the staff member and/or youth involved, the nature of the incident and the circumstances surrounding it.

### **Weekly Progress Notes:**

Notes shall be completed by the case coordinator and staff providing services. These notes shall be entered into the youth's chart, reflecting the delivery of services according to the program plan. This documentation shall address the youth's responses to interventions and the progress of the youth on individualized goals and objectives. The note shall include any significant events that occurred during the week and shall also summarize contacts with family members and other involved agencies. If an unmet need is identified, the note shall reflect the actions to be taken to revise the plan for the youth to meet that need. The case coordinator shall document specific services and activities they are providing to each youth.

### **Health Records:**

Health Care and Records of residents shall meet the requirements of KAR 28-4-275. Records of medications shall be kept in each youth's case medical record and include the:

1. name of the prescribing physician,
2. name of the medication
3. dosage prescribed
4. medication schedule
5. purpose of the medication
6. noted side effects
7. date of the prescription
8. date prescribed by a physician

A record of medication given, amount, date and time, and person dispensing shall be recorded. All doctor and dental visits, major illnesses, and accidents shall be recorded. Mental health appointments shall also be specifically documented in a youth's medical record. This provides for a complete Health record for the youth and their family, which documents the frequency of the youth's mental health treatment.

### **30 day Progress Reports:**

Thirty-day progress reports shall document progress on specific short-term goals, describe significant revisions in goals and strategies, and specify any new program goals and strategies during the period covered. The 30-day progress reports shall summarize progress and note changes regarding long-term placement and program goals and shall be provided to the referring agency and a copy placed in the youth's file.

**Permanency Planning:**

Includes the evaluation and design of an approach for the youth and family that focuses on opportunities for the youth to have ongoing active and meaningful connections with family, kin, relatives, and the community. The goal for achieving permanency shall be coordinated with the youth's— CWCMP case manager and be included in the program plan to be reviewed every 30 days. The permanency plan shall include strategies and tasks to accomplish the youth's goals. Behaviors which place the youth at risk for disruption, activities to prepare the youth's family or kinship network for reunification, identification of other less restrictive living environments and preparing the youth for transition to these settings shall be addressed.