

HEALTH CARE FACILITY REGULATION
SPECIALIZED CARE SECTION
2 PEACHTREE STREET N.W.
SUITE 31.447
ATLANTA, GA 30303-3142

APPLICATION FOR A LICENSE TO OPERATE A DRUG ABUSE TREATMENT AND EDUCATION PROGRAM

Pursuant to provision of O.C.G.A.26-5-1 et seq. Application is hereby made to operate the Drug Abuse Treatment and Education Program which is identified as follows (separate application required for each program location subject to licensure):

Section A. Identification

Type of Application: Initial____ Renewal____ Update/Change of status(explain):_____

Parent____ Sub-units (#)____ Branches(#)____(sep. applications required – attach)

Accreditation status: (optional) expiration date_____ type:_____

Name of Program	Phone
Program Street Address (where services provided)	City
	County
	Zip Code
Program Mailing Address	E-mail Address

Official Name of Governing Body

Administrator (appointed by Governing Body) Clinical Director On-site Manager

Section B. Ownership Information – Type of Ownership

Proprietary Profit	NonProfit	
____ Individual	____ State	____ Community Service Board
____ Partnership	____ County	____ Church
____ Corporation (Include copy of certificate of incorporation)	____ City	____ Corporation
____ Other (specify)_____	____ Hospital Authority	____ Other (specify)_____

List names and addresses of all owners above with five percent (5%) or more interest, or officers of a cooperation or partners of a partnership, as applicable (attach additional sheets if necessary):

Section C. Program Modalities Provided (check all located at program address section A)

Outpatient____ Amb. Detox____ Specialized Day Treatment____

Residential Beds: Transitional (#)____ Intensive (#)____ Detox____ w/food service____

Subunit____ Branch (part-time, a part of a full-time licensed prog.)____

Parent name & license#_____

(required for subunits and branches)

Populations served: male____ female____ maternity(approx. #)____

adult____ adolescent____ children____ age range____

Special Program(explain):_____

Section D. Personnel (assigned to program address section A):

	#full-time	#part-time	total hrs/wk
Counselor / Therapist / Social Worker (certified or licensed)	_____	_____	_____
Counselor (not licensed or certified)	_____	_____	_____
Consultants (specify type) _____	_____	_____	_____
Registered Nurses	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____
Administrative Personnel	_____	_____	_____
Program Director	_____	_____	_____
Medical Director (name) _____	_____	_____	_____
Other (specify) _____	_____	_____	_____

Section E. Program information for services provided at this location:

Number of hours each week that Drug Treatment & Education Services are scheduled: _____
 Hours each week that a physician, physician's assistant or nurse scheduled to be present: _____
 Specific days/hours of operation for the provision of Drug Treatment & Education: _____
 Minimum number of program staff present during operating hours: _____
 Current number of active Drug Treatment & Education Clients: _____
 Services other than Drug Treatment & Education provided at this location: _____

Section F. Required Attachments per O.C.G.A. Section 26-5-8:

Comprehensive Program Outline (include ASAM level/s provided at this location).
 Proof of compliance with laws for the handling and dispensing of drugs.
 Proof of compliance with applicable state & local health, safety, sanitation, building & zoning codes.

Section G. Certification:

I certify that this facility will comply will the Rules and Regulations for Drug Abuse Treatment and Education Programs.
 I understand that a license is non-transferable and must be returned to Healthcare Facility Regulation if a program closes, changes location or governing body. I certify that the above information is true to the best of my knowledge.

Signature of Principal Officer of Governing Body or Authorized Representative	Date of Signature
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Printed Name of Principal Officer of Governing Body or Authorized Representative	Title
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FOR STATE USE ONLY

Date Received: _____ Reviewed by: _____

Approved as: _____ Effective dates: _____

Section/Unit Director Approval/Comments: _____

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR A LICENSE TO OPERATE A DRUG ABUSE TREATMENT AND EDUCATION PROGRAM

No governing body shall operate a drug abuse treatment and education program in the state without first obtaining a license or provisional license-290-4.2.05. Completion and submission of the application form is required-290-4-2.07.

For specific definitions, procedures and requirements refer to the regulations (290-4-2). Answer all questions as of the date of application. If a significant change is anticipated please note and attach an explanation. Fill in all applicable blanks. Return the original to the Health Care Facility Regulation (HFRD-address at top of application). For any substantial delay in completing this form or questions contact HFRD, Specialized Care Unit at 404-657-5411.

DETAILED INSTRUCTIONS READ BEFORE COMPLETING APPLICATION

Section A. Identification

Type of Application (Check or complete all that apply):

Initial— first application for this program.

Renewal—a new application is required prior to each renewal survey.

Update/Change of Status—licenses are non-transferable for a change of location or governing body and must be returned to HFRD. Please describe changes (i.e. location, governing body, name of program, program modality). Attach additional information if necessary.

Parent/Subunits/Branches—if a program has Subunits or Branches (see Section C of these instructions and the rules for definitions), check Parent and fill in number of Subunits and/or Branches. Otherwise leave blank.

Accreditation status (optional): Include expiration date of current accreditation and type of accreditation.

Name of Program: Official name of the Drug Abuse Treatment and Education Program at this location. If part of a system or services, begin name with the name of the system.

Phone: Number including area code. Include fax number if available.

Street Address (where services provided): Include city, county and zip code. Complete on application only for each location/street address where treatment and education subject to licensure are provided. Branch (part-time) programs must complete a separate application (attach to parent's application) but must be licensed under the permit of a full-time program.

Program mailing address: Specify address where official mail is to be sent to the administrator of the program.

E-mail address: Include if correspondence is acceptable by e-mail.

Official Name of Governing Body: Official name of individual or organization that owns or is responsible for the program. CSB programs enter the official name of CSB.

Address of Governing Body: Location and mailing address of the Governing Body.

Administrator (appointed by Governing Body): Must be officially appointed by the governing body. Include title if different than Administrator (i.e. CEO).

Clinical Director: A licensed physician, licensed practitioner or a certified addiction counselor appointed by the governing body and responsible for all treatment provided.

On-site manager: The on-site clinician designated responsibility for the drug treatment and education provided at this location.

Section B. Ownership Information—Type of Ownership

Specify the type of legal ownership of the program by checking the applicable spaces. If other than the categories provided, check "other" and explain. Initial applications must include a copy of business license, IRS business tax identification number, proof of identity, certificate of occupancy, and for corporations a copy of the certification of incorporation.

Section C. Program Modalities Provided (check all located at program address)

Check all of the types of programs (as defined by the regulations) provided at the program's street address (section A).

Residential programs must specify the number of Transitional, Intensive, and Sub-acute Detox beds and whether the program provides food service (or it is contracted).

A Subunit is a separately licensed full-time program that is part of an organization with a designated main facility or Parent program.

A Branch is a part-time outpatient program (without the capacity to provide a drug abuse intake assessment and physical assessment at least 40 hours per week) that is part of a regional organization that includes a full-time licensed program. A Branch is licensed as a part of the full-time main licensed facility of an organization (Parent). Subunits and Branches must include the name and license number of the Parent program in the space provided. If a program offers special services for pregnant females check maternity and indicate approximate number of maternity clients.

Section D. Personnel (assigned to program address section A)

After each category record the number of staff scheduled to provide drug treatment and education at this location either full-time or part-time. If more than one type of program exists at this location, you can combine staff data or attached additional staffing information. Full-time is considered at least 40 hours per week. Total hrs/wk—record the total hours each week for each category of staff on-site. For personnel not listed, write in title/ profession (i.e. Physician) after "Consultants" for "Other" and enter full-time or part-time information and total hours on-site. Enter the name of the physician who oversees all medical services provided by the program in the space provided after Medical Director. This person may or may not be full-time or part-time at this site.

Section E. Program Information for services provided at this location

Answer questions regarding the drug abuse treatment and education provided at the program address section A. For new programs (not yet in operation) enter the planned level of services and note "planned". Part-time programs affiliated with a full-time program will be classified as a Branch but must complete the application form.

Section F. Required Attachments per O.C.G.A. Section 26-5-8

Comprehensive Program Outline (include ASAM level/s provided at this location). A description of the drug abuse treatment and education provided at this location and a copy of all required policies and procedures.

Proof of compliance with laws for the handling and dispensing of drugs. Copies of appropriate policies approved by the governing body are acceptable.

Proof of compliance with applicable state and local health, safety, sanitation, building and zoning codes. Copies of recent inspections by appropriate local or state authorities.

New or relocated programs also must attach Certificate of Occupancy.

Section G. Certification Signature of Principal Officer of Governing Body or their designee and date signed. Printed Name of Principal Official designee that signed form and title.

INDIVIDUAL TREATMENT PLAN FORM

NAME:

DATE OF FIRST REVIEW:

Identified Problem (See Assessment p.10)	Goal	Objective(s)	Review Date & Initials	Progress (none, some, achieved)	Completion Date & Initials
1.	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>			
2.	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>			
3.	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>			
4.	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>			

PERSONNEL RECORD CHECKLIST

The items below have been checked by the appropriate individual:

- 1. _____ Complete Orientation Checklist
- 2. _____ Director has contacted at least 2 references
- 3. _____ 10-year employment history
- 4. _____ Signed and dated Ethical Code of Conduct
- 5. _____ Copy of licenses/ certifications
- 6. _____ Director has conducted primary source verification
- 7. _____ Documentation of continuing education/ training forms
- 8. _____ Criminal Record Check
- 9. _____ Employment Contract (Contract Staff ONLY)
- 10. _____ Job Description
- 11. _____ Performance Evaluation Forms
- 12. _____ Completed IRS Form W-9 for Contract Staff ONLY
- 13. _____ Completed IRS Form W-4, I-9, and State Form G-4 (Employees ONLY)
- 14. _____ Negative TB test or chest X-Ray is in medical file
_____ Upon Hire
_____ 20____ _____ 20____ _____ 20____
_____ 20____ _____ 20____ _____ 20____
- 15. _____ Employee Drug Screen Upon Hire
- 16. _____ Name and contact information for PCP, including hospital to be taken to
in case of medical emergency: _____

APPLICATION INFORMATION NEEDED

1. Application form fill out
2. Copy of the business license
3. IRS business tax identification and proof of identity
4. Certificate of occupancy
5. Fire Safety Inspection
6. Program description (including ASAM levels)
7. Copy of all required policies and procedures

ORIENTATION CHECKLIST

NAME: _____

DATE OF ADMISSION: _____

- _____ Intake Assessment Form
- _____ Consent to Use and Disclose Information
- _____ Authorization(s) for Release of Information
- _____ Notice of Privacy Practices
- _____ Consent for Counseling
- _____ Financial Contract
- _____ Medical Assessment
- _____ IOP Attendance Schedule and Group Rules
- _____ Client Rights, Responsibilities and Complaints, Including Grievance Procedure
- _____ Information about Steppingstones To Recovery's Aftercare Services and 12-Step Support Groups
- _____ Information about family involvement in treatment
- _____ Information about individualized treatment planning
- _____ Tour of the facility, including smoking areas
- _____ Information about how to give input (open-door policy, suggestion box, satisfaction surveys...)

Client Signature

Date

Staff Signature

Date

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service		Definitions	ORS Category
II	Intensive Outpatient/Partial Hospitalization (General)	<p>Outpatient treatment in Level II involves a structured day or evening treatment program that may be offered before or after work or school, in the evening or on a weekend. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychological consultation, psychopharmacological consultation and 24-hour crisis services. They provide comprehensive biopsychosocial assessments and individualized treatment plans, which include problem formulation, treatment goals and measurable treatment objectives. In addition, they have active affiliations with other levels of care and can assist in accessing clinically necessary "wraparound" support services such as child care, transportation and vocational training.</p> <p>Beyond the essential services, many Level II programs provide psychopharmacological assessment and treatment, have the capacity to effectively treat patients with complex coexisting substance-related and mental health disorders, and the capacity to manage outpatient detoxification (see Dimension 1 criteria). Some also have the capacity to provide supplementary services such as child care, transportation and meals.</p> <p>Some programs also can provide overnight lodging for individuals who have problems related to such things as family or transportation but who do not need the supervision or 24-hour access to the treatment staff provided by a Level III program. Such structured day and evening treatment programs "unbundle" actual clinical treatment services from "around the clock" supervised living environments that include overnight sleeping capacity.</p>	Not Applicable
II.1	INTENSIVE OUTPATIENT	Intensive outpatient treatment (IOP) programs generally provide nine or more hours of structured programming per week, consisting primarily of counseling and education around alcohol and other drug problems. The patient's needs for psychiatric and medical services are addressed through consultation or referral arrangements. IOP differs from partial hospitalization (Level II.5) in the intensity of clinical services that are directly available: specifically, IOP has less capacity to effectively treat individuals who have substantial medical and psychiatric problems.	290-4-2-.23 Outpatient Drug Treatment
II.5	PARTIAL HOSPITALIZATIO N	<p>Partial hospitalization generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical and laboratory services, and thus are better able than Level II.1 programs to meet the patient's needs identified in Dimensions 1, 2 and 3, which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.</p> <p>Patients who meet Level III criteria in Dimensions 4, 5 or 6 and who would otherwise be placed in a Level III program may be considered for placement in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a jail, nursing home or other licensed health care facility, or supervised living situation.</p>	290-4-2-.22 Specialized Day Treatment 290-4-2-.23 Outpatient Drug Treatment
II-D	AMBULATORY DETOX.WITH EXTENDED ON- SITE MONITORING	<p>Level II-D is an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility, by trained clinicians who provide medically-supervised evaluation, detoxification and referral services. Such services are provided in regularly scheduled sessions. They are delivered under a defined set of policies and procedures or medical protocols. Outpatient services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's entry into ongoing treatment and recovery.</p> <p>Essential to this level of care is the availability of appropriately-credentialed and licensed nurses (R.N., L.P.N.) for monitoring of patients over a period of several hours each day of service.</p>	290-4-2-.19 Ambulatory Detoxification

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service	Definitions	ORS Category	
III	<p>Residential/ Inpatient Services (General)</p>	<p>Treatment in Level III involves services in the level of care described in the first edition of the ASAM Patient Placement Criteria as Level III. However, Level III has been expanded to add three clinically-managed levels of care—Levels III.1, III.3 and III.5—in addition to the original Level III, which is designated Level III.7. The decimal numbers indicate their relative positions on a scale of intensity of service that ranges from .1 to .9.</p> <p>The defining characteristic of all Level III programs is that they serve patients who need and, therefore, are placed in safe and stable living environments in order to develop sufficient recovery skills. These living environments may be in the same facility as the one in which the treatment services are provided. However, they may be separate facilities affiliated with the treatment services provider. In this case the relationship between living environment and treatment services must be sufficiently direct to allow specific aspects of the individual treatment plan to be addressed in both facilities. In part, the purpose of these programs is to demonstrate aspects of a positive recovery environment.</p> <p>The term "clinically-managed" is used to more accurately describe the nature of such programs. Patients appropriately placed in the clinically-managed levels of care have minimal problems with intoxication/withdrawal (Dimension 1) and minimal biomedical complications (Dimension 2); thus on-site physician services are not required. Such patients may have problems on DSM Axis II (Dimension 3) and will have significant deficits in the areas of treatment acceptance, relapse /continued use potential or recovery (Dimensions 4, 5, or 6), and thus are in need of interventions directed by trained addiction treatment staff. The patients have in common a need for case management services to facilitate their reintegration into the general community.</p> <p>Level III encompasses organized services staffed by designated addiction treatment personnel who provide a planned regimen of patient care in a 24-hour live-in setting. Such services adhere to defined sets of policies and procedures. They are housed in, or affiliated with, permanent facilities where patients can reside safely. They are staffed 24 hours a day. Mutual/self-help meetings generally are available on-site.</p>	<p style="text-align: center;">Not Applicable</p>
III.1	<p>CLINICALLY- MANAGED LOW INTENSITY RESIDENTIAL</p>	<p>The prime example of a Level III.1 program is the halfway house. Level III.1 offers low-intensity professional addiction treatment services at least 5 hours a week (or as specified by state licensure requirements). Treatment is directed toward applying recovery skills, preventing relapse, promoting personal responsibility and reintegrating the resident into the worlds of work, education, and family life. The services provided may include individual, group and family therapy. Mutual/self-help meetings usually are available on-site.</p> <p>Level III.1 care is best understood in its component parts. The professional addiction treatment services provided in this setting, when considered separately from the residential component and other concurrent services, are low-intensity outpatient services (Level I) focused on problems in applying recovery skills (Dimension 5). The other component is a structured recovery environment, staffed 24 hours a day. Interpersonal and group living skills generally are promoted in this level of care through the use of community or house meetings involving residents and staff. Level III.1 care is best understood in its component parts. The professional addiction treatment services provided in this setting, when considered separately from the residential component and other concurrent services, are low-intensity outpatient services (Level I) focused on problems in applying recovery skills (Dimension 5). The other component is a structured recovery environment, staffed 24 hours a day. Interpersonal and group living skills generally are promoted in this level of care through the use of community or house meetings involving residents and staff.</p> <p>When these components are provided together, Level III.1 care often is considered appropriate for residents who require time and structure to practice and successfully integrate their recovery skills.</p>	<p style="text-align: center;">290-4-2-.21 Residential Transitional</p>

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service	Definitions	ORS Category	
III.2-D	CLINICALLY-MANAGED RESIDENTIAL DETOX	<p>Level III.2-D: Clinically-Managed Residential Detoxification (sometimes referred to as "social setting detoxification") is an organized service that may be delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal. Clinically-managed residential detoxification is characterized by its emphasis on peer and social support.</p> <p>This level provides care for patients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. However, the full resources of a Level III.7-D, medically-monitored inpatient detoxification service, are not necessary.</p> <p>Some clinically-managed residential detoxification programs are staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to more appropriate levels of care.</p>	<p>290-4-2-.20 Residential Sub-acute Detoxification</p> <p>290-4-2-.19 Ambulatory Detoxification</p>
III.3	CLINICALLY-MANAGED MEDIUM INTENSITY RESIDENTIAL	<p>Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery. Interpersonal and group living skills generally are promoted in this level of care through community meetings involving residents and staff. Some individuals have such severe deficits in interpersonal skills and emotional coping skills that the treatment process is one of "habilitation" rather than "rehabilitation." Treatment of such patients is directed toward overcoming their denial of the presence and effects of addiction in their lives, as well as enhancing treatment acceptance and motivation, preventing continued use or relapse, and promoting eventual reintegration of the individual into the community. To achieve this, the individual is involved in a plan of continuing care to support recovery.</p> <p>With Level III.3 residents, the effects of addiction on the individual's life is so significant and the level of addiction-related impairment is so great that outpatient motivational strategies are not feasible or effective.</p> <p>Services generally are considered to be of medium intensity and are presented at a slower pace than in more intensive residential programs. Services may be provided in a purposely repetitive fashion, because of the special treatment needs of residents for whom Level III.3 services are considered medically necessary. Such residents often include elderly persons, those who are cognitively impaired or developmentally disabled, or individuals with such manifest chronicity and intensity of the primary addictive disease process that participation in a more intensive level of care will not allow sufficient time to integrate the lessons and experiences of treatment into their daily lives.</p> <p>Persons who are appropriately placed in Level III.3 care are characterized by their need for a slower paced treatment presentation because of mental health problems or reduced cognitive functioning (Dimension 3) or the chronicity of their illness (Dimensions 4 and 5). They also may be homeless, but that condition is not, of itself, sufficient for admission to this level of care.</p> <p>With increased staff training and nursing supervision, programs at this level of care also are able to address the needs of residents with slightly more severe medical or emotional/behavioral problems. For example, some residents may have biomedical conditions that otherwise would meet medical necessity criteria for placement in a nursing home or other medically-staffed facility. Such residents, who also have primary addiction treatment needs, may have their professional addiction care provided in a Level III.3 program, with the general medical condition (Dimension 2 comorbidity) providing the medical necessity for this level of service. Additional program descriptors and dimensional criteria are provided for these enhanced programs.</p> <p>Reintegration of Level III.3 residents into the community involves case management activities directed toward networking the residents into community-based ancillary or "wrap-around" services such as housing, vocational services, or transportation assistance to attend mutual self-help meetings or vocational activities after discharge.</p>	<p>290-4-2-.20 Residential Intensive</p>

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service	Definitions	ORS Category
III.5	<p>CLINICALLY-MANAGED MEDIUM/HIGH INTENSITY RESIDENTIAL</p> <p>High-intensity residential programs are designed to address significant problems with living skills. The prime example of Level III.5 care is the therapeutic community, which provides a highly structured recovery environment in combination with moderate- to high-intensity professional clinical services to support and promote recovery. Residents who are appropriately placed at this level of care generally can be characterized as having chaotic, unsupportive and often abusive interpersonal relationships, extensive treatment or criminal justice histories, with risk for continued criminal behavior, little or no work history or educational experience, and/or an anti-social value system.</p> <p>Level III.5 programs are characterized by their reliance on the treatment community as a therapeutic agent that introduces and enforces appropriate social values and behaviors, and by a focus on reintegration of the resident into the greater community, with a particular emphasis on employment and education. Treatment is specific to maintaining abstinence and preventing relapse but also vigorously promotes personal responsibility and positive character change. Token economies and other behavioral therapies sometimes are incorporated into these intense therapeutic milieus.</p> <p>Level III.5 care is accurately characterized by the intensity of the addiction treatment services and the highly structured program activity than by the intensity of medical services provided. In Level III.5 programs, the resident's activities are prescribed 24 hours a day until the resident demonstrates specified treatment progress.</p> <p>The defining characteristics of residents who are appropriately placed in Level III.5 programs are their emotional/behavioral conditions (Dimension 3) or their recovery environments (Dimension 6). They are likely to present with serious anti-social behaviors and/or to live in environments where substance use, crime, and unemployment are common. Assessment typically indicates significant deficiencies in the resident's behavior and functioning in all major life areas (educational, vocational, legal, familial, interpersonal, or financial), as well as the negative effects of the individual's alcohol or drug use on those areas. Some residents may have had no experience with a living environment conducive to healthy psychosocial development.</p> <p>With increased staff training and nursing supervision, programs at this level of care are able to address the medical needs of residents who have slightly more severe biomedical problems (Dimension 2). For example, some residents may have a biomedical condition that requires daily monitoring or administration of prescription medications. Some Level III.5 programs offer a full range of medical services.</p>	290-4-2-.20 Residential Intensive
III.7	<p>MEDICALLY-MONITORED INTENSIVE INPATIENT</p> <p>Level III.7 programs offer an organized service, staffed by designated addiction treatment personnel or addiction-credentialed physicians, that provides a planned regimen of 24-hour professionally directed evaluation, care and treatment for addicted patients in an inpatient setting. Such a service functions under a defined set of policies and procedures and has permanent facilities, including inpatient beds.</p> <p>Level III.7 care is delivered by an interdisciplinary staff to patients whose subacute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically-managed inpatient treatment service system are not necessary.</p> <p>The treatment delivered at Level III.7 is specific to the substance-related disorder, but the interdisciplinary team and the availability of support services also accommodate detoxification and/or intensive inpatient treatment of addiction and/or conjoint treatment of coexisting subacute biomedical and/or emotional/behavioral conditions that could jeopardize recovery. Patients who have a greater severity of illness in Dimension 1 (withdrawal), Dimension 2 (biomedical conditions) or Dimension 3 (emotional/behavioral complications) require use of more intensive staffing patterns and support services. For example, patients undergoing medical detoxification or chemical aversion therapy require more intensive medical and nursing care than do other patients at Level III.7.</p>	Not Applicable

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service	Definitions	ORS Category
III.5	<p>CLINICALLY-MANAGED MEDIUM/HIGH INTENSITY RESIDENTIAL</p> <p>High-intensity residential programs are designed to address significant problems with living skills. The prime example of Level III.5 care is the therapeutic community, which provides a highly structured recovery environment in combination with moderate- to high-intensity professional clinical services to support and promote recovery.</p> <p>Residents who are appropriately placed at this level of care generally can be characterized as having chaotic, unsupportive and often abusive interpersonal relationships, extensive treatment or criminal justice histories, with risk for continued criminal behavior, little or no work history or educational experience, and/or an anti-social value system.</p> <p>Level III.5 programs are characterized by their reliance on the treatment community as a therapeutic agent that introduces and enforces appropriate social values and behaviors, and by a focus on reintegration of the resident into the greater community, with a particular emphasis on employment and education. Treatment is specific to maintaining abstinence and preventing relapse but also vigorously promotes personal responsibility and positive character change. Token economies and other behavioral therapies sometimes are incorporated into these intense therapeutic milieus.</p> <p>Level III.5 care is accurately characterized by the intensity of the addiction treatment services and the highly structured program activity than by the intensity of medical services provided. In Level III.5 programs, the resident's activities are prescribed 24 hours a day until the resident demonstrates specified treatment progress.</p> <p>The defining characteristics of residents who are appropriately placed in Level III.5 programs are their emotional/behavioral conditions (Dimension 3) or their recovery environments (Dimension 6). They are likely to present with serious anti-social behaviors and/or to live in environments where substance use, crime, and unemployment are common. Assessment typically indicates significant deficiencies in the resident's behavior and functioning in all major life areas (educational, vocational, legal, familial, interpersonal, or financial), as well as the negative effects of the individual's alcohol or drug use on those areas. Some residents may have had no experience with a living environment conducive to healthy psychosocial development.</p> <p>With increased staff training and nursing supervision, programs at this level of care are able to address the medical needs of residents who have slightly more severe biomedical problems (Dimension 2). For example, some residents may have a biomedical condition that requires daily monitoring or administration of prescription medications. Some Level III.5 programs offer a full range of medical services.</p>	290-4-2-.20 Residential Intensive
III.7	<p>MEDICALLY-MONITORED INTENSIVE INPATIENT</p> <p>Level III.7 programs offer an organized service, staffed by designated addiction treatment personnel or addiction-credentialed physicians, that provides a planned regimen of 24-hour professionally directed evaluation, care and treatment for addicted patients in an inpatient setting. Such a service functions under a defined set of policies and procedures and has permanent facilities, including inpatient beds.</p> <p>Level III.7 care is delivered by an interdisciplinary staff to patients whose subacute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically-managed inpatient treatment service system are not necessary.</p> <p>The treatment delivered at Level III.7 is specific to the substance-related disorder, but the interdisciplinary team and the availability of support services also accommodate detoxification and/or intensive inpatient treatment of addiction and/or conjoint treatment of coexisting subacute biomedical and/or emotional/behavioral conditions that could jeopardize recovery. Patients who have a greater severity of illness in Dimension 1 (withdrawal), Dimension 2 (biomedical conditions) or Dimension 3 (emotional/behavioral complications) require use of more intensive staffing patterns and support services. For example, patients undergoing medical detoxification or chemical aversion therapy require more intensive medical and nursing care than do other patients at Level III.7.</p>	Not Applicable

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service	Definitions	ORS Category
III.7-D	<p>MEDICALLY-MONITORED INTENSIVE INPATIENT DETOX</p> <p>Level III.7-D: Medically-Monitored Inpatient Detoxification is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care. It sometimes is provided by overlapping with Level IV-D services (as a step down service) in a specialty unit of an acute care general or psychiatric hospital. Twenty-four hour observation, monitoring and treatment are available. However, the full resources of an acute care general hospital or a medically-managed intensive inpatient treatment program are not necessary.</p>	Not Applicable

ASAM Patient Placement Criteria-2 Levels of Service

ASAM PPC-2 Levels of Service		Definitions	ORS Category
IV	MEDICALLY- MANAGED INTENSIVE INPATIENT	<p>Level IV medically-managed intensive inpatient treatment is an organized service, staffed by designated addiction physicians or addiction credentialed clinicians. Level IV care involves a planned regimen of 24-hour medically-directed evaluation, care and treatment of substance-related disorders in an acute-care inpatient setting. Such a service functions under a defined set of policies and procedures and has permanent facilities that include inpatient beds.</p> <p>Level IV care requires an interdisciplinary staff to care for patients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available. The treatment is specific to substance dependence disorder; however, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any coexisting biomedical and emotional/behavioral conditions that need to be addressed and that could jeopardize recovery.</p> <p>Length of service varies with the severity of the patient's illness and his or her response to treatment.</p>	Not Applicable
IV-D	MEDICALLY- MANAGED INTENSIVE INPATIENT DETOX	<p>Level IV-D is an organized service delivered by medical and nursing professionals that provides for 24-hour medically-directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols.</p> <p>This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Twenty-four hour observation, monitoring and treatment are available.</p>	Not Applicable

Drug Abuse Treatment & Education Programs (DATEPs)



Training for Medicaid Rehab
Option Providers seeking state
licensure to provide outpatient
drug abuse treatment and
education

DRUG ABUSE TREATMENT AND EDUCATION PROGRAMS (DATEP)

O.C.G.A. § 26-5-1 et seq. requires entities that provide Drug Abuse Treatment and Education programs to be licensed by the Department of Human Resources (DHR). Within DHR, the Office of Regulatory Services is directly responsible for the licensing and periodic inspection of drug treatment programs in Georgia.

DRUG ABUSE TREATMENT AND EDUCATION PROGRAMS (DATEP)

- ❑ The Rules and Regulations for Drug Abuse Treatment and Education Programs, Chapter 290-4-2 are available at the ORS web site:

<http://ors.dhr.georgia.gov/portal/site/DHR-ORS/>

- ❑ On the welcome to ORS page, click on "Services" on the left of the page, then "Primary Health Care", and then "Drug Abuse Treatment Programs".

DO YOU REQUIRE A LICENSE?

An “Outpatient Drug Treatment Program” means a non-residential program staffed by professional and paraprofessional persons that provides drug treatment or therapeutic services, primarily counseling and other supportive services for drug dependent persons, and is not classified as another type of outpatient drug program.

DO YOU REQUIRE A LICENSE?

“Drug Dependent Person” means a person who is in imminent danger of becoming dependent upon or addicted to the use of drugs or who habitually lacks self-control as to the use of drugs or who uses drugs to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

ENTITIES NOT SUBJECT TO DATEP LICENSURE

- ❑ Licensed individual professionals operating in compliance with their state practice acts but who do not offer or purport to offer DATEPs;
- ❑ Organizations or persons that provide supportive services (i.e. residence, transportation, etc.) to drug dependent persons, but do not offer or purport to offer DATEPs. Support services under the direct control of licensed programs must be a part of the licensed program;
- ❑ Narcotic Treatment Programs which are licensed separately; and
- ❑ Licensed hospitals not operating separate and distinct drug abuse treatment programs.

ENTITIES NOT SUBJECT TO DATEP LICENSURE

- ❑ If a program provides DUI education only, they are approved by the **Division of Mental Health, Developmental Disabilities and Addictive Diseases** ; however, if a program also provides “treatment” it must be licensed (unless otherwise excluded from licensure)
- ❑ Programs that treat only adjudicated “Drug Court” clients may also be exempt from licensure

ENTITIES NOT SUBJECT TO LICENSURE

Facilities that only provide housing for persons, such as half-way houses or temporary shelters, are not subject to licensure as Residential Transitional Treatment Programs, unless the residence offers DATEP services or is a supportive service owned and/or controlled by a licensed program.

TYPES OF LICENSES

- ❑ Provisional License-generally issued for a period of 90 days to a program that has substantially complied with all requirements;
- ❑ Initial License– issued after the first inspection or during a period of provisional licensure if the program has achieved compliance with all requirements. Initial license is usually limited to a one year period; and
- ❑ Continuing License - renewal license becomes a continuing license unless suspended or revoked by the Department.

LICENSE IS NONTRANSFERABLE

A license to operate a program is nontransferable from one location to another or from one governing body to another. ORS must be notified and the license must be returned to the Department in the following cases: change in location, change in governing body, or program closure. A new license will be issued for changes in location and governing body.

PROGRAM MODALITIES

- This slide presentation is specifically designed for outpatient drug programs. If you plan to offer any of the following drug treatment modalities, contact ORS at 404-657-5550:
 - Residential Detoxification
 - Residential Intensive Treatment Program
 - Residential Transitional Treatment Program
 - Ambulatory Detoxification Program
 - Specialized Day Treatment Program

GETTING STARTED

- ❑ Complete the attached application form (instructions are attached to the application)
- ❑ Read chapters 1-11, 13-17, 23, and 25-28 of the rules and regulations. Please note that some parts of physical plant and safety do not apply to outpatient services and if you do not plan to administer medications, chapter 15 will not apply to your program. If you have any questions about completing the application or what parts of the rules apply to your program, contact ORS at 404-657-5550.

APPLICATION INFORMATION

“OWNERSHIP”

- ❑ Identify the name and type of “legal” ownership of the program:
 - Individual
 - Partnership
 - Corporation (Include copy of certificate of incorporation and names and addresses of owners or officers of a corporation or partners of a partnership must be attached to application.)

- ❑ Include: copy of business license;
- ❑ IRS tax identification number;
- ❑ Notarized form for proof of identify (attached)

APPLICATION INFORMATION CONTINUED

- ❑ Copy of the Fire Safety Inspection for program site;
- ❑ Copy of the Certificate of Occupancy for program site; and
- ❑ Copy of the description of the range of treatment and services provided by the program including which American Society of Addiction Medicine (ASAM) levels of care will be offered, and what services will be offered with community or contracted resources.

ADMINISTRATION (Chapter 9)

- ❑ The governing body must designate an administrator and a clinical director for the program. (The clinical director may serve as the administrator)
- ❑ Written policies and procedures must be developed and implemented to include at a minimum the following:
 - Program description;
 - Process for intake, assessment, admission, treatment planning, and evaluation of treatment;
 - Process for discharge summaries and aftercare plans;
 - Client rights and confidentiality of client records;
 - Appropriate use of behavior management and emergency safety interventions, and
 - Procedures for administering medications, if applicable.

ADMINISTRATION - Chapter 9 (CLIENT/PERSONNEL RECORDS)

- ❑ A DATEP written record for each client assessed and each client admitted to the program must be maintained by the program. For the lists of the required contents, refer to 290-4-2-.09(6) Client Records.
- ❑ Programs must maintain written records for each employee and administrator. For the lists of personnel record requirements, refer to 290-4-2-.09(7) Personnel Records.

ADMINISTRATION -Chapter 9

(Reports To The Department)

- Programs must report to ORS within 24 hours of serious client occurrences connected with the care provided by the DATEP:
 - accidents or injuries requiring medical treatment and/or hospitalization,
 - Deaths while in the DATEP;
 - Emergency safety interventions resulting in any injury requiring medical treatment beyond first aid; or
 - Copy of any child abuse reports filed with DFCS in accordance with the requirements of O.C.G.A. Sec. 19-7-5.

STAFFING- Chapter 10

- Programs are required to have sufficient types and numbers of staff to provide services offered to clients as outlined in their program description. At a minimum the following staff are required:
 - Qualified Clinical Director [See 290-4-2-.10(6) for qualifications]
 - Certified or licensed addiction counselor
 - GA licensed physician to oversee all medical services provided by program; and
 - A professional mental health consultant must be available for referral for psychiatric services.

STAFFING – Chapter 10

DATEP programs must provide staff orientation and training to include:

- Program description;
- Client rights, responsibilities, and complaints;
- Confidentiality;
- Employee's duties and responsibilities;
- Infection control ;
- Use of behavior management and safety interventions;
- HIV/AIDS;
- Reporting client progress; and
- Procedures for handling medical emergencies or incidents

PHYSICAL PLANT AND SAFETY

Chapter 11

Required approvals:

- ❑ All local applicable approvals: health, sanitation, building, zoning, and fire
- ❑ All buildings and grounds must be maintained in a safe manner and shall be clean and free from hazards

CLIENT REFERRAL, INTAKE, ASSESSMENT, AND ADMISSION

Chapter 13

- ❑ Only accept clients whose known needs can be met by the program
- ❑ Screen individuals before acceptance to determine if the client meets the program admission criteria
- ❑ Conduct a comprehensive substance abuse and psycho-social assessment on all clients
- ❑ Conduct a physical assessment on all clients (Can be done by a registered nurse or a Licensed Practical Nurse under the supervision of a RN or physician. See 290-4-2(1)(b)1. for physical assessment requirements.)

CLIENT RIGHTS – Chapter 25

- The following information must be documented in the client's record:
 - Consent for treatment
 - Program services and treatment
 - Specific condition that will be treated
 - Expected charges
 - Client's rights and responsibilities
 - The right to obtain information about treatment

CLIENT RIGHTS, CONT.

- Procedures for complaint and question resolutions
- Orientation
- Expected benefits
- Explanation of individualized treatment plan
- Identification of staff person that is expected to provide or coordinate treatment

CLIENT RIGHTS, CONT.

- Program rules
- Pregnant females shall be given priority for admission and services

INDIVIDUALIZED TREATMENT PLAN – Chapter 14

- ❑ A preliminary or initial treatment plan must be formulated within ten working days of admission.
- ❑ A complete treatment plan must be formulated by a multi-disciplinary team within 30 days of admission.
- ❑ Program must document the services received by the client on progress notes
- ❑ Random drug screens are required
- ❑ Plans must be reviewed and updated every 60 days

BEHAVIOR MANAGEMENT AND EMERGENCY SAFETY INTERVENTIONS – CHAPTER 26

- Programs are required to develop and implement policies and procedures on behavior management and must include:
 - The types and techniques of behavior management to be used which must be the least restrictive method;
 - Techniques must be administered by trained staff; and
 - Clients are generally not permitted to participate in the behavior management of other clients or to discipline other clients

BEHAVIOR MANAGEMENT AND EMERGENCY SAFETY INTERVENTIONS – CHAPTER 26

- ❑ If the DATEP uses emergency safety interventions (seclusion, manual holds, or mechanical restraints), policies and procedures must be developed and implemented to comply with 290-4-2-.26(2).
- ❑ If you have questions about the requirements in Chapter 26, please contact ORS at 404-657-5550.

MEDICATIONS

If the program plans to administer medications, please read 290-4-2-.15 and then contact ORS at 404-657-5550 for additional information.

QUALITY ASSURANCE-Chapter 16

- ❑ Written policies and procedures for ongoing quality assurance process must be established and implemented
- ❑ Identify areas of treatment problems to be addressed
- ❑ Establish and monitor criteria by which the quality and appropriateness of the treatment are to be measured
- ❑ Analyze the outcomes

QUALITY ASSURANCE, CONT.

- ❑ Make recommendations for change, as needed
- ❑ Monitor changes to ensure problem resolution
- ❑ Delegate the responsibility for administering the quality assurance process to a qualified staff person
- ❑ If the program provides medical services, include the medical director in the process

DISCHARGE SUMMARIES AND AFTERCARE PLANS –Chapter 17

- ❑ A discharge summary must be completed within 7 working days of discharge of clients who leave the program before completing treatment and within 10 working days for clients who complete treatment.
- ❑ Aftercare plans for continuing service and support must be developed prior to discharge for clients who complete treatment

INITIAL SURVEYS-ORGANIZING FOR ORS REVIEW:

- ❑ DATEP organizational chart
- ❑ DATEP program descriptions and treatment schedules
- ❑ DATEP employee records
- ❑ DATEP administrator/clinical director records
- ❑ DATEP policies and procedures
- ❑ DATEP client list
- ❑ DATEP client Records

SURVEY PROCESS-ON SITE

- The survey process consists of the following activities:
 - Entrance Conference – Introductions
 - Review of Process – tentative time frames
 - Documentation Review – personnel files, policies and procedures, medical records, program schedule
 - Staff Interviews – overview of program(s), verify qualifications and approach to treatment
 - Tour of Facility – to ensure compliance with space requirements for cleanliness and safety.

SURVEY PROCESS (con't)

- ❑ Surveyor findings will be shared with applicant/provider
- ❑ Provider has opportunity to provide and present additional information
- ❑ Surveyor will consider all information provided in determining whether compliance with intent of the rule is achieved
- ❑ All surveyor findings are reviewed by ORS management staff and findings resulting in deficiencies will be mailed to the facility within two weeks of survey date.

SURVEY PROCESS – CONT.

- ❑ Provider should receive inspection report within 14 days
- ❑ If there were deficiencies cited, the provider will be given instructions on how to submit a plan of correction (POC)
- ❑ The POC must include plan to correct, who is responsible for the correction, how the correction will be maintained and the date when the correction will be completed
- ❑ When the POC is completed, the administrator is required to sign and date the bottom of the inspection report and POC.

SURVEY PROCESS- (con't)

- ❑ If there are no deficiencies for initial survey, permit will be dated the day of the survey and the facility will receive a continuing license
- ❑ If there were deficiencies for initial survey (unless pervasive and/or serious), provisional permit will be issued and will be dated when acceptable POC is signed (POC must be promptly received in our office)
- ❑ If there were pervasive and/or serious deficiencies, follow-up site visit may be required before permit is issued
- ❑ A follow-up visit (FU) may be made for any deficiency.

RECEIPT OF PLAN OF CORRECTION (POC)

- ❑ An acceptable POC is required for all deficiencies cited;
- ❑ A POC must be returned to the office within 10 days of the receipt of the licensure report; and
- ❑ If the POC is not acceptable, the facility will receive a phone call to discuss what is not acceptable and additional information will be required.



QUESTIONS

404-657-5550

DISCLAIMER:

This is an unofficial copy of the rules that has been reformatted for the convenience of the public by the Department of Community Health. The official rules for this program are on record with the Georgia Secretary of State's office. The Secretary of State's website for reviewing the rules is <http://rules.sos.state.ga.us/cgi-bin/page.cgi?d=1>. Effort has been made to ensure the accuracy of this unofficial copy. The Department reserves the right to withdraw or correct text in this copy if deviations from the official text as published by the Georgia Secretary of State are found.

**Rules of Department of Community Health
(Successor agency to the Department of Human Resources
for these particular rules--see O.C.G.A. § 31-2-5)
Chapter 290-4-2
Rules and Regulations for Drug Abuse Treatment Programs**

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290-4-2-.01 Legal Authority. These rules are adopted and published pursuant to the Official Code of Georgia Annotated (O.C.G.A.) Sec. 26-5-1 *et seq.*
Authority O.C.G.A. Sec. 26-5-1 *et seq.* **History.** Original Rule entitled "Provisions" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975.
Repealed: New Rule entitled "Legal Authority" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.02 Title and Purposes. These rules shall be known as the Rules and Regulations for Drug Abuse Treatment and Education Programs. The purpose of these rules is to provide minimal requirements for the licensing and inspection of drug abuse treatment and education programs, not subject to regulation as licensed hospitals, or approved Emergency, Receiving, Evaluation and/or Treatment (ERET) services or licensed Narcotic Treatment Programs monitored by the State Methadone Authority.
Authority O.C.G.A. Sec. 26-5-1 *et seq.* **History.** Original Rule entitled "Definitions" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975.
Repealed: New Rule entitled "Title and Purposes" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.03 Definitions. In these rules, unless the context otherwise requires, the words and phrases set forth herein shall mean the following:

(a) "Ambulatory Detoxification Program" means a program for the medical management and other support for processes associated with the physical process of withdrawal from drugs in a non-residential setting. Persons treated in this setting are without unusual or significant medical risks or behavioral problems.

(b) "Behavior management" means those principles and techniques used by a facility to assist a client in facilitating self-control, addressing inappropriate behavior, and achieving positive outcomes in a constructive and safe manner. Behavior management principles and techniques shall be used in accordance with the client's treatment plan, written policies and procedures governing service expectations, treatment goals, safety, security, and these rules and regulations.

(c) "Branch" means a part-time (operating less than five days per week) substance abuse program at a site or location different from the location of the licensed program, yet which is operated as a part of the licensed program and is not separately licensed.

(d) "Department" means the Department of Human Resources or its successor.

(e) "Drug abuse treatment and education program" or "program" means any system of treatment or therapeutic advice or counsel provided for the rehabilitation of drug dependent persons and shall include programs offered in residential and/or nonresidential settings.

(f) "Drug dependent person" means a person who is in imminent danger of becoming dependent upon or addicted to the use of drugs or who habitually lacks self-control as to the use of drugs or who uses drugs to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

(g) "Drugs" means any substance defined as a drug by federal or Georgia law or any other chemical substance which may be used in lieu of a drug to obtain similar effects, with the exception of alcohol and its derivative.

(h) "Emergency safety interventions" means those behavioral intervention techniques that are authorized under an approved emergency safety intervention plan and are utilized by properly trained staff in an urgent situation to prevent a client from doing immediate harm to self or others.

(i) "Emergency safety intervention plan" means the plan developed by the facility utilizing a nationally recognized, Department approved, evidence-based, training program for emergency safety intervention. The plan shall clearly identify the emergency safety interventions staff may utilize and those that may never be used.

(j) "Final Adverse Finding" means 1) the issuance of a ruling by the Commissioner of the Department of Human Resources on any appeal from a decision of a state administrative law judge or hearing examiner pursuant to a contested case involving the imposition of a sanction; 2) when a decision of the state administrative law judge or hearing examiner becomes final by operation of law because no appeal is made to the Commissioner of the Department of Human Resources; 3) where the parties to a contested case dispose of the case by settlement; or 4) where a facility does not contest within the allotted time period a sanction imposed by the department.

(k) "Governing body" means the county board of health, the partnership, the corporation, the association, or the person or group of persons who maintains and controls the program and who is legally responsible for the operation.

(l) "Inspection" means any examination by the department or its representatives of a provider, including but not necessarily limited to the premises, staff, persons in care, and documents pertinent to initial and continued licensing so that the department may determine whether a provider is operating in compliance with licensing requirements or has violated any licensing requirements. The term inspection includes any survey, monitoring visit, complaint investigation, or other inquiry conducted for the purposes of making a compliance determination with respect to licensing requirements. Such examinations are generally unannounced.

(m) "License" means the official permit issued by the department which authorizes the holder to operate a drug abuse treatment and education program for the term provided therein.

(n) "Manual hold" means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a client's body. A manual hold does not include briefly holding the client without undue force to calm or comfort the client, holding the client by the hand or by the shoulders or back to walk the client safely from one area to another where the client is not forcefully resisting the assistance, or assisting the client in voluntarily participating in activities of daily living.

(o) "Mechanical restraint" means a device attached or adjacent to the client's body that is not a prescribed and approved medical protection device, and that he or she cannot easily remove, that restricts freedom of movement or normal access to his or her body.

(p) "Narcotic Treatment Program" means a program for chronic heroin or opiate-like drug users that administers narcotic drugs under physicians' orders either for detoxification purposes or for maintenance treatment in a rehabilitative context. This program is licensed according to rules promulgated by the department's State Methadone

Authority.

(q) "Outpatient Drug Treatment Program" means a non-residential program staffed by professional and paraprofessional persons that provides drug treatment or therapeutic services, primarily counseling and other supportive services for drug dependent persons, and is not classified as an ambulatory detoxification program or Specialized Day Treatment Program.

(r) "Parent program" means the licensed program that develops and maintains administrative controls of Subunits and Branches of the program.

(s) "Residential Sub-Acute Detoxification Program" means a residential program for drug dependent persons which includes the medical management and other support for processes associated with the physical withdrawal from drugs in a residential setting, staffed by professional and paraprofessional persons, which is not in a licensed hospital or approved ERET facility.

(t) "Residential Intensive Treatment Program" means a residential program staffed by professional and paraprofessional persons which provide highly structured treatment and therapeutic activities that focus on stabilization, abstinence, and skills required for recovery; are not classified as a residential sub-acute detoxification program.

(u) "Residential Transitional Treatment Program" means a residential program which provides therapeutic services to drug dependent persons, who are transitioning to the community or to other treatment modalities, and who, typically, lack a stable living situation and require variable levels of therapeutic services.

(v) "Seclusion" means the involuntary confinement of a client away from other clients, due to imminent risk of harm to self or others, in a room or an area from which the client is physically prevented from leaving.

(w) "Specialized Day Treatment Program" means a non-residential program for drug dependent persons staffed by professional and paraprofessional persons that provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method; it is not classified as an ambulatory detoxification or outpatient drug treatment program.

(x) "Special Program" means a program that provides therapeutic services to drug dependent persons which does not fit into existing program classifications.

(y) "Subunit" means a full-time program for drug dependent persons operated semiautonomously in a different location from the Parent program, which may provide different modalities of services, and must independently meet the licensing requirements and shall be separately licensed.

(z) "Time out" means a behavior management technique that involves the brief separation of a client from the group or setting where the client is experiencing some behavioral or emotional distress, not to exceed twenty (20) minutes, designed to deescalate the emotionally charged condition of the client. During "time-out" a client's physical freedom of movement is not restricted.

Authority O.C.G.A. Sec. 26-5-1 et seq. **History.** Original Rule entitled "Procedures for Granting and Revoking Licenses" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975. **Repealed:** New Rule entitled

"Definitions" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule of same title adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007

290-4-2-.04 Governing Body. Each licensed program shall have a clearly identified governing body. The chairperson or chief executive officer of the governing body shall complete a statement of responsibility on behalf of the governing body acknowledging the governing body's responsibility for the operation of the program in accordance with these rules in connection with any application for a license on a form provided by the department. If a program is individually owned, then the owner (s) will complete the statement of responsibility.

Authority O.C.G.A. Sec. 26-5-1 et seq. **History.** Original Rule entitled "Standards for Program Management" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975. **Repealed:** New Rule entitled "Governing Body" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.05 Licenses. No governing body shall operate a drug abuse treatment and education program in the state without first obtaining a license or provisional license. A licensed program may offer one or more of the program services described in these rules.

(a) License. A license will be issued, upon presentation of evidence satisfactory to the department, that the program is in compliance with these rules and all applicable federal and state laws for the handling and dispensing of drugs, and all state and local health, safety, (including fire, sanitation, building) and zoning requirements. A license shall remain in force and effect for a period determined by the department unless sooner suspended or revoked by the department. Such license shall describe each type of service and program that the licensee is authorized to provide. Any changes in authorized services and programs shall be reported to the department. The department will determine whether a new license is required.

(b) Provisional license. A provisional license may be issued for a period not to exceed 90 days to a program that has substantially complied with all requirements for a regular license. Provisional licenses shall be renewed at the discretion of the department only in cases of extreme hardship and in no case for longer than 90 days. The obligations and conditions of a provisional license shall be the same as those of a license unless otherwise provided for by the department. Such provisional license shall describe each type of service and program that the licensee is authorized to provide. Any changes in authorized services and programs shall be reported to the department. The department will determine whether a new license is required.

(c) Qualifications Requirement. In order to obtain or retain a license or provisional license, the administrator of the program and its employees must be qualified, as defined in these rules, to administer or work in a program. However, the department may require additional reasonable verification of the qualifications of the administrator and employees either at the time of application for a license or provisional license or at any time during the license period whenever the department has reason to believe that an administrator or employee is not qualified under these rules to administer or work in a program.

(d) License is nontransferable. A license or provisional license to operate a program is nontransferable for a change of location or governing body. Each license or provisional license shall be returned to the department in the following cases: changes in location, governing body, program closure or the license is suspended or revoked.

(e) Exclusions. The following types of entities are not subject to these specific rules:

1. Narcotic Treatment Programs which are licensed/monitored by the State Methadone Authority;
2. Licensed hospitals not operating separate and distinct drug abuse treatment programs as classified by the department;
3. Approved Emergency Receiving, Evaluation and/or Treatment (ERET) facilities which have been licensed or approved by the department and are not operating drug abuse treatment programs as classified by the department;
4. Licensed individual professionals operating in compliance with their state practice acts but do not offer or purport to offer "Drug Abuse Treatment and Education Programs.
5. Organizations or persons that provide supportive services (i.e. residence, transportation, and etc.) to drug dependent persons but do not offer or purport to offer "Drug Abuse Treatment and Educational Programs." Support services under the direct control of licensed programs must be a part of the licensed program.

Authority O.C.G.A. Secs. 26-5-6 to 26-5-11, 26-5-14, 31-2-4. **History.** Original Rule entitled "Client Care" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975. **Repealed:** New Rule entitled "Licenses" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.06 Accreditation. The department may issue a license to a program that provides proof of accreditation by an accreditation agency approved by the department, if the accreditation agency's requirements are substantially equivalent or more stringent than the requirements of these rules. The license may be issued without an on-site visit by the department, however, the department reserves the right to inspect accredited programs on a sample validation basis or whenever there is reason to believe that the requirements of these rules are not being met. Provided however, any denial, suspension, or revocation of such accreditation shall result in similar licensure actions, and the governing body shall be required to apply for a new license. For purpose of this rule, proof of accreditation shall require a copy of the program's most recent accreditation report together with any supplemental recommendations or reports. Such reports shall be submitted to the department whenever received by a program or whenever requested by the department.

Authority O.C.G.A. Secs. 26-5-6, 26-5-10, 31-2-4, 37-1-22, 37-7-3. **History.** Original Rule entitled "Program Modalities" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975. **Repealed:** New Rule of same title adopted. F. Nov. 18, 1992; eff. Dec. 8, 1992. **Repealed:** New Rule entitled "Accreditation" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.07 Applications.

(1) An application for a license to operate a drug abuse treatment and education program shall be submitted to the department on forms provided by the department, as well as requested updating information, and shall include assurances satisfactory to the department that the program is in compliance with all applicable federal and state laws for the handling and dispensing of drugs, with professional practice acts, and all state and local health, safety, sanitation, building, and zoning requirements.

(2) False or Misleading Information. An application for a license must be truthfully and fully completed. In the event that the department has reason to believe that an application has not been completed truthfully, the department may require additional verification of the facts alleged. The department may refuse to issue a license where false statements have been made in connection with an application or any other documents required by the department.

Authority O.C.G.A. Secs. 26-5-6, 26-5-8. **History.** Original Rule entitled "Enforcement" adopted. F. Nov. 17, 1975; eff. Dec. 7, 1975. **Repealed:** New Rule entitled "Applications" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.08 Inspections and Plans of Corrections.

(1) The department is authorized and empowered to conduct onsite inspections of any program to verify compliance with these rules. A program shall permit any authorized department representative to enter upon and inspect any and all program premises which, for the purposes of these rules, shall include access to all parts of the facility, staff, persons in care, and documents pertinent to initial and continued licensure, including but not limited to all clinical records maintained on clients. Failure to permit entry and inspection shall constitute noncompliance or violation of this rule and, subject to notice of an opportunity for a hearing, may result in the denial of any license applied for or the suspension or revocation of a license or provisional license. Inspections are generally unannounced, and may occur at any time the department deems necessary.

(2) If as a result of an inspection, violations of these licensing rules are identified, the program will be given a written report of the inspection which identifies the rules violated. The program must submit a written plan of correction in response to the report of inspection which states what the program will do when to correct each of the violations identified. The program may offer any explanation or dispute the findings of violations in the written plan of correction so long as an acceptable plan of correction is submitted within ten days of the receipt of the written report of inspection. Failure to submit an acceptable plan of correction may constitute cause for the department to deny a license or suspend or revoke a license.

Authority O.C.G.A. Secs. 26-5-6, 26-5-13, 26-5-14. **History.** Original Rule entitled "Inspections and Plans of Corrections" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.09 Administration.

(1) Program Purpose. A licensed program shall develop and implement written policies and procedures that specify its philosophy, purpose, and program orientation. Such policies and procedures shall identify the types of drug abusers and the ages of the clients that it serves, including referral sources. When the program serves persons with special needs, the description shall explain how these special needs will be met.

(2) Program Operations. A licensed program shall develop and implement written policies and procedures for operations to include:

(a) A description of the range of treatment and services provided by the program to be reviewed annually and updated as needed, specifying which American Society of Addiction Medicine (ASAM) levels of care will be offered, what services will be provided directly by the program, and what services are provided in cooperation with available community or contract resources;

(b) The process for intake, assessment, admission, treatment planning, and evaluation of treatment;

(c) Discharge summaries and aftercare plans;

(d) The protection of client's rights and confidentiality of client records;

(e) The appropriate use of behavior management and emergency safety interventions;
and

(f) When the program administers medications, policies and procedures related to medication administration.

(3) Administrator. The governing body of the program shall designate an administrator who shall be authorized to manage the program. The clinical director may serve as the administrator.

(4) Clinical Director. The governing body of the program shall designate a clinical director who is responsible for all treatment services provided.

(5) Finances. The governing body shall provide for the preparation of an annual budget and approve such budget. Copies of the current year's budget and expenditure records shall be maintained for examination and review by the department.

(a) The administrator and all persons authorized to receive and disburse operating funds shall be authorized by the governing body to do so.

(b) The program shall develop and implement a written schedule of client fees. The schedule shall identify all fees which are chargeable to clients and a copy of the schedule shall be provided to the client, or parent, or guardian, or responsible party upon request, during the admission process and subsequently upon request.

(c) A financial audit shall be completed annually by a certified public accountant or other qualified audit approved by the governing body.

(6) Client Records. A written record of each client assessed and each client admitted to the program must be maintained by the program.

(a) Contents. Each client record shall include all information necessary to monitor the client's condition and contain at least the following information:

1. Basic identifying information including name, address, telephone number, date of birth, sex, and race;

2. If applicable, the names, addresses, and telephone numbers of parents, or guardians, or responsible parties;

3. Persons to notify in case of an emergency if different from above;

4. The name of the client's attending physician, if any;

5. All records of screening and assessment, including a comprehensive psychosocial history;

6. If applicable, documentation of why the client was not admitted for treatment and suggested referrals given to client;

7. Written consent as required in rule .13 (c)1.;
8. Documentation of orientation as required in rule .13(c)2.;
9. Rights of the client (State and Federal) including confidentiality and signed by the client;
10. Individualized treatment plan and treatment notes (including drug administration records if applicable);
11. Results of laboratory tests, as appropriate;
12. Discharge summary and aftercare plan;
13. Any other records relating to the client's treatment and stay in the program such as written grievances, reports about discipline to include any use of emergency safety interventions if an incident resulting in injury occurs while the patient is at the program location, observations, etc.

(b) Confidentiality and Retention of Client Records. Written policies and procedures shall be established and implemented for the maintenance and security of client records specifying who shall supervise the maintenance of such records, who shall have custody of such records, and to whom records may be released, how they may be released and for what purposes they may be released. The department shall have access to all client clinical records for the purpose of determining compliance with licensure requirements. Confidentiality, release, and retention of client records must comply with 42 CFR, Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records.

(7) Personnel Records. A program shall maintain written records for each employee and the administrator. Each individual file shall include:

- (a) Identifying information such as name, address, telephone number, emergency contact person (s);
- (b) A ten year employment history or a complete employment history if the person has not worked ten years;
- (c) Records of applicable licenses, health requirements, and educational qualifications as required by these rules;
- (d) Date of employment;
- (e) The person's job description or statements of the person's duties and responsibilities;
- (f) Documentation of training and orientation required by these rules;
- (g) Any records relevant to the employee's performance including at least annual performance evaluations; and
- (h) The results of employment and criminal background checks conducted by the program prior to employment indicating that the employee has no history of violence or

abuse which would pose a risk to clients receiving services through the treatment program.

(8) Emergency Services. During non-operating hours, the program must make provisions for 24 hour emergency services or a telephone "hot line" to assist a client in a crisis situation. This information must be provided to the client upon admission.

(9) HIV/AIDS. A licensed program shall provide HIV/AIDS education, risk assessment and the provision of HIV counseling and testing, either directly or by referral.

(10) Priority Access. Written policies and procedures must be developed for providing priority in access to services and admissions to programs for drug dependent pregnant females.

(11) Drug-free work place. Written policies and procedures shall be established and implemented to provide for a drug-free work place. Pre-employment and ongoing random urine drug screens shall be utilized for all program employees. Each sample collected shall be screened for opiates, methadone, amphetamines, cocaine, benzodiazepines, THC and other drugs either as indicated by the department or the employer.

(12) Referral to Other Programs. Each program shall have a formal plan of cooperation with other programs in the state for referral of clients to allow for continuity of care for drug dependent persons or for emergency hospitalization. The licensed programs must have identified resources that would be available to continue the drug dependent person's care and to have worked out referral/transfer arrangements where appropriate.

(13) Reporting. Written summary reports shall be made to the Department of Human Resources, Office of Regulatory Services in a form acceptable to the Department within 24 hours (with a detailed investigative report to follow in five work days if not provided initially) regarding serious occurrences involving clients that happened either at the facility or were connected with the care that the client received at the facility, such as accidents or injuries requiring medical treatment and/or hospitalization; death; emergency safety interventions resulting in any injury requiring medical treatment beyond first aid; or any incident which results in any federal, state, or private legal action by or against the facility which affects any child or the conduct of the facility. However, legal action involving the juvenile justice system is not required to be reported.

(14) Child Abuse Reports. Whenever the program has reason to believe that a client who is a minor in care has been subjected to child abuse it shall cause a report of such abuse to be made to the child welfare agency providing protective services as designated by the Department of Human Resources (Division of Family and Children Services) or in the absence of such an agency to an appropriate police authority or district attorney in accordance with the requirements of O.C.G.A. Sec. 19-7-5. A copy of such report shall also be filed with the Office of Regulatory Services.

Authority O.C.G.A. Secs. 19-7-5, 26-5-5, 26-5-6. **History.** Original Rule entitled "Administration" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule of same title adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

290-4-2-.10 Staffing.

(1) The program shall have sufficient types and numbers of staff as required by these

rules to provide the treatment and services offered to clients and outlined in its program description.

(2) Staff subject to professional practice acts must be in compliance with the state practice acts.

(3) Counseling services are provided by individuals qualified by education, training, and experience to provide substance abuse counseling and who are licensed/certified if required by state practice acts.

(4) The medical responsibility for each client will be vested in a licensed physician who oversees all medical services provided by the program. Physician assistants or nurse practitioners may be utilized to the extent allowed by state practice acts.

(5) Each program shall have available professional mental health consultation to review selected cases and to provide assistance to the staff in client management or for referral for psychiatric services.

(6) The clinical director must be either a doctor of medicine licensed to practice in this state, or a licensed practitioner who is licensed to provide treatment, therapeutic advice or counsel for the rehabilitation of drug dependent persons in compliance with state practice acts, or a certified addiction counselor.

(7) For any employee hired after the effective date of these rules, employment and criminal background checks shall be conducted prior to employment, and only persons with no history of violence or abuse which would pose a risk to the clients in treatment shall be employed by the program.

(8) Staff Training and Orientation. Prior to working with clients, all staff who provide treatment and services shall be oriented in accordance with these rules and shall thereafter receive additional training in accordance with these rules.

(a) Orientation shall include instruction in:

1. The program's written policies and procedures regarding its program purpose and description; client rights, responsibilities, and complaints; confidentiality; and other policies and procedures that are relevant to the employee's range of duties and responsibilities, including the use of universal precautions for infection control, use of behavior management and emergency safety interventions, and information about HIV/AIDS;

2. The employee's assigned duties and responsibilities; and

3. Reporting client progress and problems to supervisory personnel and procedures for handling medical emergencies or other incidents that affect the delivery of treatment or services.

(b) Additional training consisting of a minimum of thirty (30) clock hours of training or instruction shall be provided annually for each staff member who provides treatment services to clients. Such training shall be in subjects that relate to the employee's assigned duties and responsibilities.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. **History.** Original Rule entitled "Staffing" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule of same title adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

290-4-2-11 Physical Plant and Safety.

(1) Required Approvals.

(a) A program shall be in compliance with all applicable local health, sanitation, building, and zoning requirements.

(b) A program shall be in compliance with all applicable laws and rules issued by the State Fire Marshall, the proper local fire marshal or state inspector, and shall have a certificate of occupancy if required.

(2) All buildings and grounds shall be constructed and maintained in a safe manner and in accordance with these rules.

(3) A program shall have appropriate and sufficient space to meet the programmatic needs of its clients, and carry out the program's array of services. Such space shall include areas conducive to privacy for counseling and group activities, reception/waiting areas, and bathrooms which assure privacy for collection of urine specimens.

(4) Sleeping Areas — Residential Programs.

(a) For residential programs initially licensed or expanded after the effective date of this rule, sleeping areas shall contain not less than 60 square feet of useable floor space per resident in multiple use bedroom and not less than 100 square feet of useable space in single bedrooms.

(b) Each resident shall be provided with his or her own personal space and furnishings for storage of clothes and personal belongings.

(c) Each resident shall be provided with his or her own personal bed and mattress. Clean sheets, pillows, and pillow cases, blankets or bed covering shall be provided and sheets and pillow cases shall be changed as needed, but at least weekly.

(d) Bedrooms shall be provided with outside ventilation by means of windows, air conditioners, or mechanical ventilation. All rooms that have windows that can be opened without special devices shall have insert window screens and the windows and screens must be in good repair.

(5) Lavatory and Bathing Facilities — Residential Programs.

(a) For residential programs initially licensed or expanded after the effective date of this rule, there shall be at least one lavatory (water basin and toilet) with hot and cold water for every six residents or fraction thereof. Lavatories that contain more than one toilet shall contain stalls for individual privacy. All lavatories shall be properly ventilated.

(b) For residential programs initially licensed or expanded after the effective date of this rule, there shall be at least one shower or bathtub with hot and cold water for every ten residents or fraction thereof. Bathtubs and shower stalls shall be equipped with non-slip

surfaces.

(6) Dining Area — Residential Programs. There shall be a separate furnished dining area for serving meals that contains not less than ten square feet of useable floor space for each resident being served.

(7) Climate Control and Pest Control — Residential Programs. A program shall be maintained at a temperature range of sixty-five degrees Fahrenheit (72 degrees if serving pregnant women, infants or small children) to eighty-two degrees Fahrenheit, depending on the season of the year. An effective pest control system shall be implemented and documentation on file as to actions taken.

(8) Off-site Residences. Programs which provide off-site residences as a part of their programs must ensure that the residences also meet the above requirements.

(9) Premises. All grounds, space, and facilities, both those within the program and those regularly used by residents as an integral part of the program, shall be kept clean and free from hazards to health and safety and from litter.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. **History.** Original Rule entitled "Physical Plant and Safety" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.12 Food Service.

(1) A residential program which provides food service shall provide each resident with meals and snacks of food groups and serving sizes which meet the nutritional guidelines of the United States Department of Agriculture. Meals and snacks shall be varied daily. Modified diets based on medical or religious reasons shall be served as needed.

(2) If required by the local county board of health, a residential program shall obtain a valid food service permit from the local county board of health. All residential programs providing food services shall meet the following requirements:

(a) Food shall be stored, prepared, and maintained in a safe and sanitary manner commensurate with generally accepted and recognized food service standards.

(b) There shall be designated and separate space for food preparation and storage.

(c) All perishable and potentially hazardous foods shall be refrigerated at a temperature of forty-five degrees Fahrenheit unless frozen. Freezer temperatures shall be maintained at zero degrees Fahrenheit or below.

(d) Food shall be in sound condition, free from spoilage and contamination and shall be safe for human consumption when served to residents.

(e) Food service equipment and preparation areas shall be kept clean and free of accumulation of dust, dirt, food particles, and grease deposits.

(f) When non-disposable dishes, glasses, and flatware are used, they shall be properly cleaned by pre-rinsing and scraping, washing, sanitizing, and drying.

(3) Where a residential program provides food services through contract or arranges for food services, the residential program shall require that food served be safe for human consumption and that the meals/snacks provided meet the nutritional guidelines of the United States Department of Agriculture.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6, 26-5-8. **History.** Original Rule entitled "Food Service" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.13 Client Referral, Intake, Assessment, and Admission.

(1) A program shall only accept referrals and shall only admit and retain clients whose known needs can be met by the program in accordance with its program purpose and description. Written policies and procedures for client referral, intake, assessment, and admission shall be established and implemented and shall include the following:

(a) Screening. All persons referred to the program or who present themselves for services shall be initially screened to determine if the prospective client appears to meet the program's admission criteria. Such screenings shall be done by a staff person who has been determined to be qualified by education, training, experience, and who are licensed/certified if required by state practice acts to perform such screenings. Screenings shall constitute an initial appraisal of the clients' dysfunctions and the types of services that appear needed. Persons whose needs can not be met by the program shall not be admitted and should be referred to other programs that provide appropriate services. A record (log) will be kept of persons not admitted and reason(s) for not admitting. The program has the discretion to use information on clinical evaluations done within thirty days.

(b) Assessment. All clients admitted to the program shall be evaluated by a staff person who has been determined to be qualified by education, training, and experience and who are licensed/certified if required by state practice acts to perform or coordinate the provision of such assessments. Such evaluations shall include a comprehensive assessment of the client's physical, emotional, behavioral, social, recreational, and educational status and needs. The program has the discretion to use current clinical information concerning a transitioning client from another licensed program, licensed hospital, or a state or federal agency, if there has not been a discontinuance in treatment.

1. Physical Assessment. At the time of admission, a preliminary physical assessment shall be done, at a minimum, by a Registered Nurse or Licensed Practical Nurse under the supervision of a RN or physician and shall include documentation of vital signs, appropriate screening tests for STD and TB, urine drug screens, a determination of whether the client requires a physical or psychiatric examination by a physician according to established protocols, and laboratory tests as clinically indicated. Laboratory tests required upon admission for clients in each program modality, in addition to those tests required for all modalities, will be determined by the programs and documented in their policy and procedures as to the criteria used to determine and specify which minimum lab tests are to be done for each modality. Other lab tests may be required by the physician as clinically indicated. If an examination by a physician is indicated, arrangements shall be made for such an examination as appropriate. The assessment shall also include circumstances leading to admission, mental status, support system, psychiatric and medical history, risk assessment for HIV, history of use of drugs, including the age of onset, duration, patterns, and consequences of use, family history of drug use, route of administration and previous treatment. If a client has been referred for

treatment from another facility, the results of a physical examination and laboratory tests from the other facility may be documented and used to assess physical status, provided that such physical examination was done within six months of admission, and there has been no significant change in the physical status of the client. Further assessments or laboratory tests may be required depending upon the modality of treatment needed or the client's changing condition.

2. Psycho-social assessment. At the time of admission or as soon as clinically appropriate (but no longer than ten working days), a comprehensive psycho-social assessment shall be done and shall document personal and social history, including current relationships, educational status, living arrangements, social habits, employment status, legal status and related areas.

(c) Admission.

1. Consent. Except as otherwise authorized by law, no person shall be admitted for treatment without written authorization from the client and parent, guardian, or responsible party, if applicable. The following information must be explained by a trained staff person to the client and other consenters, and documented in the client's file.

(i) The program's services and treatment;

(ii) The specific condition that will be treated;

(iii) The expected charges for services including any charges that might be billed separately;

(iv) The Client's Rights and Responsibilities;

(v) The rights of consenters to obtain information about the client's treatment, etc.; and

(vi) The procedures for complaint and question resolution.

2. Orientation. The program shall provide orientation to clients admitted for treatment within 24 hours of admission or at such time that the client appears able to hear and respond to requests, but in no event later than 72 hours after admission. Orientation shall be done by a staff person who has been determined to be qualified by education, training, and experience to perform the task. The following information must be explained to the client, and documented in the client's file.

(i) The expected benefits of the treatment that the client is expected to receive;

(ii) An explanation of individualized treatment planning;

(iii) The client's responsibilities for adhering to the treatment plan and the consequences of non-adherence;

(iv) The identification of the staff person that is expected to provide treatment or coordinate the treatment;

(v) Program rules including requirements for conduct and the consequences of

infractions;

(vi) Client's Rights, Responsibilities, and Complaints;

(vii) The program's policies for use of behavior management and emergency safety interventions when necessary; and

(viii) Policies and procedures for visiting hours and communications with persons outside the program, if a residential program.

(2) Drug dependent pregnant females shall be given priority for admission and services when a program has a waiting list for admissions.

Authority O.C.G.A. Secs. 26-5-2, 26-5-5, 26-5-6. **History.** Original Rule entitled "Client Referral, Intake, Assessment and Admission" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule of same title adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

290-4-2-.14 Individual Treatment Planning. A program must develop and implement a complete individualized treatment plan for each client. Such treatment plans shall be modified and updated as necessary, depending upon the clients' needs.

(a) Preliminary Treatment Plan. An initial treatment plan will be formulated at the time of admission after assessment (within a minimum of ten working days) and will include the initial treatment recommendation for the client. The initial treatment plan may be documented in the program notes.

(b) Complete Treatment Plan. The complete treatment plan must be comprehensive, formulated by a multi-disciplinary team with the input of the client, approved by the clinical director, completed within thirty days from admission, and shall contain sufficient information about the client's expected treatment including:

1. Descriptions of the client's problems and needs;
2. Measurable goals and desired outcomes that are to be attained by the client, which include both long term goals and short term objectives leading to these goals;
3. The interventions and services that the program will provide to help the client achieve the individual goals and desired outcomes;
4. The expected course of treatment; and
5. Identification of the staff person who will provide treatment or coordinate the treatment.

(c) Progress Notes. A program shall document the services received by the client and document chronologically observations of the client's clinical course of treatment which includes the client's response to treatment and progress towards achieving individual goals and desired outcomes. Progress notes shall be documented by the staff members assigned primary responsibility for the client's care, and shall be legible and recorded in the client's plan. Progress notes shall be recorded as applicable;

1. At the end of each shift in the client's medical record for residential detoxification

programs;

2. Following any contact with a client undergoing ambulatory detoxification or narcotic treatment;
3. At least weekly for substance abuse treatment residences;
4. Daily for day treatment programs;
5. Whenever there are face-to-face contacts with the client for outpatient drug treatment programs;
6. Whenever the client is observed to engage in a behavior which may effect a change in the treatment plan; and
7. Immediately following the use of any emergency safety intervention with the client.

(d) Random urine drug screens are required for each client, the frequency of which is determined by the program in order to determine its effectiveness. Clinical directors electing to rely upon presumptive urinalysis results for client management must demonstrate adequate access to definitive qualitative laboratory analysis for use when necessary.

(e) Plan Reviews. Plans shall be reviewed and updated, as needed, by the staff member who has primary responsibility for coordinating or providing for the care of the client. Reviews shall be done whenever necessary as indicated by the client's needs or at least every thirty (30) days for residential and sixty (60) days for outpatient.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. **History.** Original Rule entitled "Individual Treatment Planning" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule of same title adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

290-4-2-.15 Medications. If a program administers medications, written policies and procedures for prescription, administration and security of medications shall be established and implemented. Such policies and procedures shall include the following:

(a) Medications are prescribed by a physician, and/or other practitioners as allowed by state law, and the risks and benefits of the prescribed medication are explained to the client (and parent, guardian, or responsible party if applicable) by the physician or a staff person who has been delegated responsibility in writing by the physician to explain the risks and benefits. Documentation of such explanations of risks and benefits must be maintained by the program.

(b) The program may have written pre-medication screening protocols which are completed and approved by the physician. Such protocols shall include an assessment as required in rule .13 (1)(b).

(c) Unless self-administered, all medications are administered by a physician, physician's assistant, or nurse.

(d) Any medications prescribed, administered or self-administered under supervision are documented on an individual medication administration record that is filed with the

individual treatment plan, unless maintained as a clinical record at the client's bedside or in the medication room in a residential detoxification setting. The record must include:

1. Name of medication;
2. Date prescribed;
3. Dosage;
4. Frequency;
5. Route of administration;
6. Date and time administered; and
7. Documentation of staff administering medication or supervising self-administration.

(e) Adverse drug reaction and errors are reported to a physician immediately and corrective action is initiated. The adverse reaction or error is recorded in the drug administration record and the individual treatment plan, and all persons who are authorized to administer medication or supervise self-medication are alerted.

(f) All medications shall be stored under lock and key when not being administered or self-administered.

(g) Program staff shall adhere to all federal and state laws and rules regarding controlled substances.

Authority O.C.G.A. Secs. 26-5-6. **History.** Original Rule entitled "Medications" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.16 Quality Assurance. Written policies and procedures for an ongoing quality assurance process shall be established and implemented. Such process shall identify areas of treatment or treatment problems to be addressed; establish and monitor criteria by which the quality and appropriateness of the treatment are to be measured; analyze the outcomes; make recommendations for change, as needed; and monitor changes to ensure problem resolution. Responsibility for administering and coordinating the quality assurance process shall be delegated to a staff person who has been determined to be qualified by education, training, and experience to perform such tasks. If the program provides medical services, the medical director shall be actively involved in the process.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. **History.** Original Rule entitled "Quality Assurance" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.17 Discharge Summaries and Aftercare Plans. A program must complete an individualized discharge summary for all clients discharged and also an aftercare plan for continuing services and support for those clients who complete their course of treatment.

(a) Discharge Summary. A discharge summary shall be completed within seven working days of discharge for clients who leave the program before completing treatment. A summary shall be completed by the person who has primary responsibility for coordinating or providing for the care of the client, and it shall include a final assessment of the client's status at the time of discharge, summary of progress towards treatment goals, and the reasons the client was discharged prior to completing treatment. For those

who complete treatment, the discharge summary must be completed within ten working days and must include aftercare plans.

(b) Aftercare Plans. Aftercare plans for continuing services and support shall be developed and completed prior to discharge for clients who complete treatment. The plan shall be completed by the person who has primary responsibility for coordinating or providing for the care of the client, and it shall include a final assessment of the client's status at the time of discharge, summary of progress towards treatment goals, a description of what services and supports the client is expected to need following discharge, and a description of potential barriers to overcome to maintain a drug free life style. The client must participate in aftercare planning, and if applicable, parents, or guardians, or responsible persons must participate whenever feasible.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. **History.** Original Rule entitled "Discharge Summaries and Aftercare Plans" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.18 Residential Sub-acute Detoxification Programs. Programs offering residential sub-acute detoxification programs must meet the rules listed in this subsection (.18), in addition to the general rules set forth.

(a) The program shall establish and implement written policies and procedures that address how the program manages the medical and detoxification services that it provides. The program shall operate 24 hours a day.

(b) Staffing. Treatment is provided by qualified medical staff and other professionals who are qualified by education, training, experience, and who are licensed/certified if required by state practice acts to perform detoxification services that meet the needs of clients.

1. Medical Staff. The medical staff is headed by a medical director who is licensed to practice medicine in Georgia, and all other medical staff are licensed to practice in Georgia. The medical director must approve all medical policies and procedures, including assessment tools, treatment protocols, and emergency procedures. Such policies and procedures shall include provisions for an effective infection control program.

2. Director of Nursing. A licensed registered nurse determined qualified by education, training, and experience to supervise nursing services for detoxification shall be designated as the Director of Nursing.

3. Medical Coverage.

(i) Physician coverage shall be provided in accordance with the treatment protocol. At a minimum, there shall be on call physician coverage 24 hours a day, and a physician must be on site daily as medically indicated.

(ii) Nursing coverage shall be provided in accordance with clients needs as determined by the number and condition of client population. At a minimum, there shall be one registered or licensed practical nurse awake and on duty on premises 24 hours per day to respond to client needs.

4. Other Medical Services.

(i) Diagnostic Services. Clinical laboratory services and x-ray services shall be provided in accordance with the Department of Human Resources' Rules for Licensure of Clinical

Laboratories, Chapter 290-5-29, and Rules for X-Ray, Chapter 290-5-22.

(ii) Emergency Medical Services. The program's medical policies and procedures include provisions for the delivery of emergency medical services, which services are either provided directly or through an established procedure specifying how emergency services will be accessed.

(iii) Pharmaceutical Services. Pharmaceutical services are offered through a licensed pharmacy service in the community or by the program's own licensed pharmacist.

(c) Treatment — Assessment. Admission Assessment of clients shall be performed by a physician, nurse practitioner, physician's assistant, or registered nurse. If an assessment is done by other than a physician, then the assessment must be communicated to physician by telephone prior to the client's admission. The assessment must include:

1. Drug history including past detoxification episodes, and current use of drugs and medications;
2. Causes that triggered the present need for services;
3. Descriptions of medical risks and any behavioral or emotional problems.
4. Taking and documentation of vital signs; and
5. Determination of whether or not a physical and/or psychiatric examination by a physician is needed immediately and arrangements for such examination, if the assessment was done by a registered nurse. If the assessment is done by a physician, nurse practitioner or physician's assistant, it will include a physical examination.
6. Laboratory tests will be ordered as indicated, but at a minimum will include: CBC, RPR, urinalysis (routine and microscopic). TB screening and urine drug screens.

(d) Treatment — Admission. Clients are admitted to treatment by physician's orders only following assessment and determination that the medical, emotional, and behavioral status of the client justifies admission. The initial detoxification care plan must be documented in the record and may be initiated by the order of the physician following admission.

(e) Treatment.

1. Within twenty-four hours of admission, or the next normal business day if admission occurred on a weekend or holiday, the client must be seen by a physician, nurse practitioner, or physician's assistant if the assessment required by rule .13(1)(b) and subparagraph (3) above was done by a registered nurse. If a physical examination is needed, such examination shall be done at that time.
2. Within 48 hours of admission, a complete Detoxification Care Plan shall be developed by a registered nurse, physician's assistant, or physician. If not done by a physician, the development of the plan shall be supervised and signed by a physician. Any changes to the plan must be documented in the plan and reviewed and signed by the physician. The plan shall address the nursing and medical procedures needed to stabilize the client and to

manage the withdrawal.

3. In addition to medical management, the program shall provide the client substance abuse counseling and support by staff who are determined qualified by training, education, experience, and who are licensed/certified if required by state practice acts to provide such services. Such services shall be provided to clients as soon as it is determined that they can benefit from such services but no later than within three work days of admission.

4. A discharge summary and aftercare plan, if applicable, shall be completed in accordance with rule .17.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Residential Sub-acute Detoxification Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.19 Ambulatory Detoxification Programs. Programs offering outpatient ambulatory detoxification services must meet the rules listed in this subsection (.19) in addition to the general rules set forth.

(a) The program shall establish and implement written policies and procedures that address how the program manages the medical and detoxification services that it provides. The program shall be open and operate five days a week with on-call physician coverage as outlined below.

(b) Staffing. Treatment is provided by qualified medical staff and other professionals who are qualified by education, training, experience, and who are licensed/certified if required by state practice acts to perform detoxification services that meet the needs of clients.

1. Medical Staff. The medical staff is headed by a medical director who is licensed to practice medicine in Georgia, and all other medical staff are licensed to practice in Georgia. The medical director must approve all medical policies and procedures, including assessment tools, treatment protocols, and emergency procedures.

2. Medical Coverage. There shall be a physician, nurse practitioner, physician's assistant, registered nurse, or licensed practical nurse with at least two years of substance abuse experience under RN supervision on duty during all hours of operation to provide or supervise client treatment and assess individual clients as needed. Each physician employed by the program is determined qualified by training, education, and experience to manage detoxification treatment and assumes responsibility for the medical services provided by the staff.

3. On-Call Coverage. A staff physician shall provide 24-hour, on-call coverage when the program is closed or a physician is not present on the premises.

4. Other Medical Services.

(i) Diagnostic Services. Clinical laboratory services and x-ray services shall be provided in accordance with the Department of Human Resources' Rules for Licensure of Clinical Laboratories, Chapter 290-5-29, and Rules for X-Ray, Chapter 290-5-22.

(ii) Emergency Medical Services. The program's medical policies and procedures include arrangements for the delivery of emergency medical services.

(iii) Pharmacy Services. Pharmaceutical services are provided through a licensed pharmacy in the community or the program's own licensed pharmacist.

(c) Treatment — Assessment. Admission Assessment of client shall be performed by a physician, nurse practitioner, physician's assistant or a registered nurse. If an assessment is done by other than a physician, then the assessment must be communicated to a physician by telephone prior to the client's admission. The assessment must include:

1. Drug history including past detoxification episodes, and current use of drugs and medications;
2. Causes that triggered the present need for services;
3. Descriptions of medical risks and any behavioral or emotional problems;
4. Taking and documentation of vital signs;
5. Determination of whether or not a physical and/or psychiatric examination by a physician is needed immediately, and arrangements for such examinations, if indicated, if the assessment was done by a registered nurse; and
6. Determination that the prospective client appears to have the needed support and supervision from family members and others to benefit from ambulatory treatment.
7. Laboratory tests will be ordered as indicated, but at a minimum will include: CBC, RPR, urinalysis (routine and microscopic), TB screening and urine drug screens.

(d) Treatment — Admission. Clients are admitted to treatment by physicians' orders only following assessment and determination that the medical, emotional, and behavioral status of the client and his or her support systems are adequate to justify admission to an ambulatory program. Persons treated in ambulatory detoxification settings are without unusual or significant medical or behavioral problems that would pose a significant risk to the safe completion of an ambulatory detoxification program. The initial detoxification care plan must be documented in the record and may be initiated by the order of the physician following admission.

(e) Treatment.

1. Within twenty-four hours of admission, or the next normal business day if admission occurred on a weekend or holiday, the client must be seen by the physician, nurse practitioner, or physician's assistant if the assessment required by rule .13(1)(b) and subparagraph (3) above was done by a registered nurse. If a physical examination is needed, such examination shall be done at that time.

2. Within 48 hours of admission, a Detoxification Care Plan shall be developed by a registered nurse, physician's assistant, or the physician. If not done by a physician, the development of the plan shall be supervised and signed by a physician. Any changes to the plan must be documented in the plan and reviewed and signed by the physician. The plan shall address the nursing and medical procedures and monitoring activity needed to stabilize the client and to manage the withdrawal.

3. For the length of the detoxification care plan and while on medication, the client shall be required to visit the program at least once a business day for a check of vital signs and monitoring of medication by one of the medical staff.

4. In addition to medical management services, the program shall provide the client counseling and support by staff who are determined qualified by training, education, experience, and who are licensed/certified if required by state practice acts to provide such services. Such services shall be provided to clients as soon as it is determined that they can benefit from such services but no later than within three work days of admission.

5. A discharge summary and an aftercare plan, if applicable, shall be completed in accordance with rule .17.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Ambulatory Detoxification Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.20 Residential Intensive Treatment Programs. Such residences provide services for clients with significant substance abuse impairment, and who, typically, have not progressed in a less intensive setting, or lack supports and require a highly structured and specialized environment, or are transitioning from detoxification. In addition to the general rules set forth, programs offering residential intensive treatment programs shall meet the requirements of this subsection (.20).

(a) Client intake, assessment, and admission; individual treatment planning; and discharge and aftercare, if applicable, shall be done in accordance with rules .13, .14, and .17. Additional admission requirements, including laboratory tests, may be required by facility policy and/or determination of the medical/clinical director.

(b) A program shall provide a minimum of eight hours per day of various therapeutic services designed to enable the client to function without substance abuse. Such services shall be provided by persons who have been determined qualified by education, training, experience, and who are licensed/certified if required by state practice acts to render such services that meet the needs of clients.

(c) There shall be sufficient types and numbers of staff members on duty in the residence to provide for safe supervision of clients whenever clients are present.

(d) Provisions shall be made for mandatory education of children in care in accordance with O.C.G.A. Sections 20-2-690 et seq. or its successor statute.

(e) A program shall have a written agreement with a physician for the provision of medical care.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Residential Intensive Treatment Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.21 Residential Transitional Treatment Programs. Such residences provide services on an intermediate basis for clients characterized as chronic substance abusers who are transitioning to the community or to other treatment modalities, and who, typically, lack a stable living situation and require variable levels of therapeutic services. Facilities that only provide housing for persons, such as half-way houses or temporary shelters, are not subject to licensure as residential transitional treatment programs, unless the residence offers treatment services or is a supportive service owned and/or controlled by a licensed program. In addition to the general rules set forth, programs offering residential transitional treatment programs shall meet the requirements of this subsection (.21).

(a) Client intake, assessment, and admission; individual treatment planning; and discharge and aftercare shall be done in accordance with rules .13, .14 and .17. Additional admissions requirements, including laboratory tests, may be required by facility policy and/or determination of the medical/clinical director. The program has the discretion to use physical and psycho-social assessment information from another licensed program, licensed hospital, or a state or federal agency, if the client is transitioning directly from another program.

(b) The program shall provide at least five or more hours per week of therapeutic services designed to enable the client to function without substance abuse. Such services shall be rendered by persons who have been determined qualified by training, education, experience, and who are licensed/certified if required by state practice acts to render such services.

(c) There shall be sufficient types and numbers of staff members on duty in the residence to provide for safe supervision of clients whenever clients are present.

(d) Provisions shall be made for mandatory education of children in care in accordance with O.C.G.A. Sections 20-2-690 et seq. or its successor statute.

(e) A program shall have a written agreement with a physician for the provision of medical care.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Residential Transitional Treatment Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.22 Specialized Day Treatment Programs. Specialized day treatment programs emphasize continued abstinence, development of social support network and necessary lifestyle changes, educational skills, vocational skills, social and interpersonal skills, the understanding of addictive disease, and the continued commitment to a recovery program. The program provides structured treatment or therapeutic services, utilizing activity schedules as part of its operational method, i.e. plans or schedules of days or times of day for certain activities. The programs utilize methods, materials, settings, and outside resources that are appropriate to the development levels and ages of clients, and, age appropriate. These programs are provided over a period of several weeks or months and often follow detoxification or residential services. They may also utilize group and/or individual counseling and/or therapy. Such programs shall provide:

(a) Client intake, assessment, and admission; individual treatment planning; and discharge and aftercare shall be done in accordance with rules .13, .14, and .17. Additional admissions requirements, including laboratory tests, may be required by facility policy and/or determination of the medical/clinical director.

(b) Treatment must be provided by persons determined to be qualified by training, education, experience, and who are licensed/certified if required by state practice acts to render such services that meet the needs of the clients.

(c) Provisions shall be made for mandatory education of children in care in accordance with O.C.G.A. Sections 20-2-690 et seq. or its successor statute.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Specialized Day Treatment Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.23 Outpatient Drug Treatment Programs. Outpatient drug treatment programs provide a variety of treatment and therapeutic services intended to enable clients to function drug free and to learn social and psychological skills. Typically, these include services such as psychosocial assessment; group, individual, and family counseling; supportive counseling; substance abuse education; and therapeutic recreational activities. Such services shall be provided in part outside normal business hours so that clients who work or go to school can attend. Such programs shall provide:

(a) Client intake, assessment, and admission; individual treatment planning; and discharge and aftercare shall be done in accordance with rules .13, .14, and .17.

(b) Treatment must be provided by persons determined to be qualified by training, education, experience, and who are licensed/certified if required by state practice acts to render such services that meet the needs of the clients.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Outpatient Drug Treatment Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.24 Special Programs. Structured programs that do not fit into existing program classifications but meet the requirements of these rules will be licensed as Special Programs. These programs may be part of other licensed programs or may be individually licensed.

Authority O.C.G.A. Secs. 26-5-5, 26-5-6. History. Original Rule entitled "Special Programs" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997.

290-4-2-.25 Client's Rights, Responsibilities, and Complaints. A program shall establish and implement written policies and procedures regarding the rights and responsibilities of clients, and the handling and resolution of complaints. At a minimum, the program must ensure that it's clients enjoy the rights and responsibilities listed herein.

(a) Such policies and procedures shall include a written notice of rights and responsibilities which shall be provided to each client and parent, guardian, or responsible party, if applicable, when the client receives orientation. The required notice shall contain the following items:

1. Right to a humane treatment or habilitation environment that affords reasonable protection from harm, exploitation, and coercion;
2. Right to be free from physical and verbal abuse;
3. Right to be free from the use of physical restraints and seclusion unless it is determined that there are no less restrictive methods of controlling behavior to reasonably insure the safety of the client and other persons:
4. Right to be informed about plan of treatment and to participate in the planning, as able;
5. Right to be promptly and fully informed of any changes in the plan of treatment;
6. Right to accept or refuse treatment, unless it is determined through established authorized legal processes that the client is un-able to care for himself or is dangerous to himself;
7. Right to be fully informed of the charges for treatment;

8. Right to confidentiality of client records;
9. Right to have and retain personal property which does not jeopardize the safety of the client or other clients or staff and have such property treated with respect;
10. Right to converse privately, have convenient and reasonable access to the telephone and mails, and to see visitors, unless denial is necessary for treatment and the reasons are documented in the client's treatment plan;
11. Right to be informed of the program's complaint policy and procedures and the right to submit complaints without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time;
12. Right to have access to their own client records and to obtain necessary copies when needed;
13. Right to receive a written notice of the address and telephone number of that state licensing authority, i.e. the department, which further explains the responsibilities of licensing the program and investigating client complaints which appear to violate licensing rules;
14. Right to obtain a copy of the program's most recent completed report of licensing inspection from the program upon written request. The program is not required to release a report until the program has had the opportunity to file a written plan of correction for the violations as provided for in these rules; and

(b) Such policies and procedures shall also include provisions for clients and others to present complaints, either orally or in writing, and to have their complaints addressed and resolved as appropriate in a timely manner.

Authority O.C.G.A. Secs. 26-5-6. **History.** Original Rule entitled "Client's Rights, Responsibilities, and Complaints" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997

290-4-2-.26 Behavior Management and Emergency Safety Interventions.

(1) Behavior Management.

(a) The program shall develop and implement policies and procedures on behavior management. Such policies and procedures shall set forth the types of clients served in accordance with its program purpose, the anticipated behavioral problems of the clients, and appropriate techniques of behavior management for dealing with such behaviors.

(b) Program staff shall be made aware of each client's known or apparent medical and psychological conditions and family history, as evidenced by written acknowledgement of such awareness, to ensure that the staff have adequate knowledge to deliver safe and healthy care to the client.

(c) Behavior management policies and procedures shall incorporate the following minimum requirements:

1. Behavior management principles and techniques shall be used in accordance with the individual treatment plan and written policies and procedures governing service expectations, treatment goals, safety, security, and these rules and regulations.

2. Behavior management shall be limited to the least restrictive appropriate method, as described in the client's treatment plan pursuant to Rule .14(a), (b) 1-5 and in accordance with the prohibitions as specified in these rules and regulations.

(d) Behavior management techniques shall be administered by trained staff and shall be appropriate for the client's age, intelligence, emotional makeup and past experience. The following forms of behavior management shall not be used by program staff with client's receiving services through the program:

1. Assignment of excessive or unreasonable work tasks;
2. Denial of meals and hydration;
3. Denial of sleep;
4. Denial of shelter, clothing, or essential personal needs;
5. Denial of essential program services;
6. Verbal abuse, ridicule, or humiliation;
7. Manual holds, chemical restraints, or mechanical restraints not used appropriately as emergency safety interventions;
8. Denial of communication and visits unless restricted in accordance with Rule .13(2.);
9. Corporal punishment;
10. Seclusion or confinement of a client in a room or area which may reasonably be expected to cause physical or emotional damage to the client; or not used appropriately as an emergency safety intervention; and
11. Seclusion or confinement of a client to a room or area for periods longer than those appropriate to the client's age, intelligence, emotional makeup and previous experience, or confinement to a room or area without the supervision or monitoring necessary to ensure the client's safety and well-being.

(e) Clients shall not be permitted to participate in the behavior management of other clients or to discipline other clients, except as part of an organized therapeutic selfgoverning program in accordance with accepted standards of clinical practice that is conducted in accordance with written policy and is supervised directly by designated staff.

(f) Programs shall submit to the Department electronically or by facsimile a report within 24 hours whenever the program becomes aware of an incident which results in any injury to a client requiring medical treatment beyond first aid that is received by a client as a result of or in connection with any behavior management.

(g) All forms of behavior management or emergency safety interventions used by staff shall also be documented in case records in order to ensure that such records reflect

behavior management problems.

(h) The program shall take appropriate corrective action when the program staff become aware of or observe the use of prohibited forms of behavior management, as specified in sections .26(1)(d) 1. through 10. Documentation of the incident and the corrective action taken by the program shall be maintained in the case records of the client.

(2) Emergency Safety Interventions.

(a) Emergency safety interventions may be used only by staff trained in the proper use of such interventions when it can be reasonably anticipated from a client's behavioral history, that a client may require the use of emergency safety interventions to keep either the client or others safe from immediate physical harm, and less restrictive means of dealing with the injurious behavior have not proven successful or may subject the client or others to greater risk of injury.

(b) Program staff working with such client shall be trained in emergency safety interventions utilizing a nationally recognized training program in emergency safety interventions which has been approved by the Department.

(c) Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the client's ability to breathe or has been determined to be inappropriate for use on a particular client due to a documented medical or psychological condition.

(d) The program shall have written policies and procedures for the use of emergency safety interventions, a copy of which shall be provided to and discussed with each client (as appropriate taking into account the client's age and intellectual development) and the client's parents and/or legal guardians prior to or at the time of admission. Emergency safety interventions policies and procedures shall include:

1. Provisions for the documentation of an assessment at admission and at each annual exam by the client's physician, a physician's assistant, or a registered nurse with advanced training working under the direction of a physician, or a public health clinic which states that there are no medical issues that would be incompatible with the appropriate use of emergency safety interventions on that client. Such assessment and documentation must be re-evaluated following any significant change in the client's medical condition; and

2. Provisions for the documentation of each use of an emergency safety intervention including:

- (i) Date and a description of the precipitating incident;
- (ii) Description of the de-escalation techniques used prior to the emergency safety intervention, if applicable;
- (iii) Environmental considerations;
- (iv) Names of staff participating in the emergency safety intervention;

- (v) Any witnesses to the precipitating incident and subsequent intervention;
- (vi) Exact emergency safety intervention used;
- (vii) Documentation of the 15 minute interval visual monitoring of a client in seclusion;
- (viii) Beginning and ending time of the intervention;
- (ix) Outcome of the intervention;
- (x) Detailed description of any injury arising from the incident or intervention; and
- (xi) Summary of any medical care provided.

3. Provisions for prohibiting manual hold use by any employee not trained in prevention and use of emergency safety interventions.

(e) Emergency safety interventions may be used to prevent runaways only when the client presents an imminent threat of physical harm to self or others, or as specified in the individual treatment plan.

(f) Program staff shall be aware of each client's medical and psychological conditions (e.g. obvious health issues, list of medications, history of physical abuse, etc.), as evidenced by written acknowledgement of such awareness, to ensure that the emergency safety intervention that is utilized does not pose any undue danger to the physical or mental health of the client.

(g) Clients shall not be allowed to participate in the emergency safety intervention of other clients.

(h) Immediately following the conclusion of the emergency safety intervention and hourly thereafter for a period of at least four hours where the client is with a staff member, the client's behavior will be assessed, monitored, and documented to ensure that the client does not appear to be exhibiting symptoms that would be associated with an injury.

(i) At a minimum, the emergency safety intervention program that is utilized shall include the following:

1. Techniques for de-escalating problem behavior including client and staff debriefings;
2. Appropriate use of emergency safety interventions;
3. Recognizing aggressive behavior that may be related to a medical condition;
4. Awareness of physiological impact of a restraint on the client;
5. Recognizing signs and symptoms of positional and compression asphyxia and restraint associated cardiac arrest;
6. Instructions on how to monitor the breathing, verbal responsiveness, and motor control of a client who is the subject of an emergency safety intervention;

7. Appropriate self-protection techniques;
8. Policies and procedures relating to using manual holds, including the prohibition of any technique that would potentially impair a client's ability to breathe;
9. Agency policies and reporting requirements;
10. Alternatives to restraint;
11. Avoiding power struggles;
12. Escape and evasion techniques;
13. Time limits for the use of restraint and seclusion;
14. Process for obtaining approval for continual restraints and seclusion;
15. Procedures to address problematic restraints;
16. Documentation;
17. Investigation of injuries and complaints;
18. Monitoring physical signs of distress and obtaining medical assistance; and
19. Legal issues.

(j) Emergency safety intervention training shall be in addition to the annual training required in Rule .10(8)(b) and shall be documented in the staff member's personnel record.

(k) All actions taken that involve utilizing an emergency safety intervention shall be recorded in the client's case record showing the cause for the emergency safety intervention, the emergency safety intervention used, and, if needed, approval by the clinical director, the staff member in charge of casework services, and the physician who has responsibility for the diagnosis and treatment of the client's behavior.

(l) Programs shall submit to the Department electronically or by facsimile a report, in a format acceptable to the Department, within 24 hours whenever the program becomes aware of an I incident which results in injury to a client requiring medical treatment beyond first aid that is received by a client as a result of or in connection with any emergency safety intervention.

1. For any program with a licensed capacity of 20 clients or more, any 30-day period in which three or more instances of emergency safety interventions of a specific client occurred and/or whenever the program has had a total of 10 emergency safety interventions for all clients in care within the 30-day period; and

2. For any program with a licensed capacity of less than 20 clients, any 30-day period in which three or more instances of emergency safety interventions of a specific client

occurred and/or whenever the program has had a total of five instances for all clients in care within the 30-day period.

(m) Programs shall submit a written report to the program's clinical director on the use of any emergency safety intervention immediately after the conclusion of the intervention and, if the client is a child or has an assigned legal guardian, shall further notify the client's parents or legal guardians regarding the use of the intervention. A copy of such report shall be maintained in the client's file.

(n) At least once per quarter, the program, utilizing a master agency restraint log and the client's case record, shall review the use of all emergency safety interventions for each client and staff member, including the type of intervention used and the length of time of each use, to determine whether there was a clinical basis for the intervention, whether the use of the emergency safety intervention was warranted, whether any alternatives were considered or employed, the effectiveness of the intervention or alternative, and the need for additional training. Written documentation of all such reviews shall be maintained. Where the program identifies opportunities for improvement as a result of such reviews or otherwise, the program shall implement these changes through an effective quality improvement plan.

(o) No later than March 31, 2007 and ongoing thereafter, all program staff who may be involved in the use of emergency safety interventions, shall have evidence of having satisfactorily completed a nationally recognized training program for emergency safety interventions to protect clients and others from injury, which has been approved by the Department and taught by an appropriately certified trainer in such program.

(p) Manual Holds.

1. Emergency safety interventions utilizing manual holds require at least one trained staff member to carry out the hold. Emergency safety interventions utilizing prone restraints require at least two trained staff members to carry out the hold.

2. Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the client's ability to breathe or has been determined to be inappropriate for use on a particular client due to a documented medical or psychological condition.

3. When a manual hold is used upon any client whose primary mode of communication is sign language, the client shall be permitted to have his or her hands free from restraint for brief periods during the intervention, except when such freedom may result in physical harm to the client or others.

4. If the use of a manual hold exceeds 15 consecutive minutes, the clinical director or his or her designee, who possesses at least the qualifications of the clinical director and has been fully trained in the program's emergency safety intervention plan, shall be contacted by a two-way communications device or in person and determine that the continuation of the manual hold is appropriate under the circumstances. Documentation of any consultations and outcomes shall be maintained for each application of a manual hold that exceeds 15 minutes. Manual holds shall not be permitted to continue if the restraint is determined to pose an undue risk to the client's health given the client's physical or mental condition.

5. A manual hold may not continue for more than 30 minutes at any one time without the consultation as specified in subparagraph (4) of this subparagraph, and under no circumstances may a manual hold be used for more than one hour total within a 24-hour period.

6. If the use of a manual hold on a client reaches a total of one hour within a 24-hour period, the staff shall reconsider alternative treatment strategies, document same, and consider notifying the authorities or transporting the client to a hospital or mental health facility for evaluation.

7. The client's breathing, verbal responsiveness, and motor control shall be continuously monitored during any manual hold. Written summaries of the monitoring by a trained staff member not currently directly involved in the manual hold shall be recorded every 15 minutes during the duration of the restraint. If only one trained staff member is involved in the restraint and no other staff member is available, written summaries of the monitoring of the manual hold shall be recorded as soon as is practicable, but no later than one hour after the conclusion of the restraint.

(q) Seclusion.

1. If used, seclusion procedures in excess of thirty (30) minutes must be approved by the clinical director or designee. No client shall be placed in a seclusion room in excess of one (1) hour within any twenty-four(24) hour period without obtaining authorization for continuing such seclusion from the client's physician, psychiatrist, or licensed psychologist and documenting such authorization in the client's record.

2. A seclusion room shall only be used if a client is in danger of harming himself or herself or others.

3. A client placed in a seclusion room shall be visually monitored at least every fifteen (15) minutes.

4. A room used for the purposes of seclusion must meet the following criteria:

(i) The room shall be constructed and used in such ways that the risk of harm to the client is minimized;

(ii) The room shall be equipped with a viewing window on the door so that staff can monitor the client;

(iii) The room shall be lighted and well-ventilated;

(iv) The room shall be a minimum fifty (50) square feet in area; and

(v) The room must be free of any item that may be used by the client to cause physical harm to himself/herself or others.

5. No more than one client shall be placed in the seclusion room at a time.

6. A seclusion room monitoring log shall be maintained and used to record the following information:

- (i) Name of the secluded client;
- (ii) Reason for client's seclusion;
- (iii) Time of client's placement in the seclusion room;
- (iv) Name and signature of the staff member that conducted visual monitoring;
- (v) Signed observation notes; and
- (vi) Time of the client's removal from the seclusion room.

Authority O.C.G.A. Secs. 26-5-14, 26-5-15, 26-5-16, 50-13-18. **History.** Original Rule entitled "Enforcement and Penalties" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule entitled "Behavior Management and Emergency Safety Interventions" adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007

290-4-2-.27 Enforcement and Penalties.

(1) When the Department finds that any applicant for any license fails to fulfill the requirements of these rules, the Department may, subject to notice and opportunity for a hearing, refuse to grant any license (denial); provided, however, that the department shall not be required to hold a hearing prior to taking such action.

(2) When the Department finds that any licensed program violates any requirements of this chapter, the Department may, subject to notice and opportunity for a hearing, suspend or revoke any license.

(a) The Department may suspend any license for a definite period calculated by it as the period necessary for the facility to implement long-term corrective measures and for the facility to be deterred from lapsing into noncompliance in the future. As an alternative to suspending a license for a definite period, the Department may suspend the license for an indefinite period in connection with the imposition of any condition or conditions reasonably calculated to elicit long-term compliance with licensing requirements which the program must meet and demonstrate before it may regain its license.

(b) The Department may revoke any license, subject to notice and opportunity for hearing, when it determines that the facility is non-compliant with rules and regulations or sanctions previously imposed. If the sanction of license revocation is finally imposed, as defined by a final adverse finding, the Department shall effectuate it by requiring the program to return its license to the department.

1. Notification of Action: The program shall notify clients and clients' representatives and family units of the Department's actions to revoke the license or seek an emergency suspension of the program's license to operate.

2. The official notice of the revocation or emergency suspension action and any final resolution, together with the Department's complaint intake phone number and website address, shall be provided to current and prospective clients and to their representatives and family units.

3. The program shall ensure the posting of the official notice at the program location in

an area that is visible to the clients and to the clients' family units and representatives.

4. The program shall ensure that the official notice continues to be visible to the clients and to the clients' representatives and family units throughout the pendency of the revocation and emergency suspension actions, including any appeals.

5. The program shall have posted at the program location in an area that is readily visible to the clients and to the clients' representatives and family units any inspection reports that are prepared by the Department during the pendency of any revocation or emergency suspension action.

6. It shall be a violation of these rules for the program to permit the removal or obliteration of any posted notices of revocation, emergency suspension action, resolution, or inspection survey during the pendency of any revocation or emergency suspension action.

7. The Department may post an official notice of the revocation or emergency suspension action on its website or share the notice of the revocation or emergency suspension action and any information pertaining thereto with any other agencies that may have an interest in the welfare of the patients in care at the program.

8. If the sanction of license suspension is finally imposed, as defined by a final adverse findings, the department shall effectuate it by requiring the program to return its license to the department. Upon the expiration of any period of suspension, and upon a showing by the program that it has achieved compliance with licensing requirements, the department shall reissue the program a license. Where the license was suspended for an indefinite period in connection with conditions for the reissuance of a license, once the program can show that any and all conditions imposed by the department have been met, the department shall reissue the program a license.

(3) If the Department identifies a violation of these rules, where an opportunity to correct is permissible, the Department shall provide written notice specifying the rule(s) violated and setting a time, not to exceed ten (10) working days, within which a program may file an acceptable written plan of correction. If such plan of correction is determined not acceptable to the Department because it does not adequately correct the identified violation, the Department will advise the program that the plan of correction is not acceptable. The Department may permit the program to submit a revised plan of correction.

(a) The program shall comply with an accepted plan of correction.

(b) Where the Department determines that either the program has not filed an acceptable plan of correction or has not complied with the accepted plan of correction, the Department may initiate an adverse action to enforce these rules.

(4) All actions to enforce the Rules and Regulations for Drug Abuse Treatment and Education Programs shall be administered in accordance with Chapter 13 of Title 50 of the Official Code of Georgia Annotated, the "Georgia Administrative Procedure Act," the Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6, and O.C.G.A. §26-5-1 et seq.. Any request for a hearing in response to any enforcement action undertaken pursuant to this chapter shall be in writing and must be submitted to

the Department no later than ten (10) calendar days from the date of receipt of any written notice of intent by the Department to impose an enforcement action setting forth the proposed action or actions and the basis therefore. The Department's notice of intent to impose an enforcement action shall be made within ninety days after an application is submitted or within 90 days of when the grounds for the actions are discovered.

(5) The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared a public health emergency.

Authority O.C.G.A. Secs. 26-5-6, 26-5-14 to 26-5-16, 31-2-4, 50-13-18. **History.** Original Rule entitled "Waivers and Variances" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule entitled "Enforcement and Penalties" adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007

290-4-2-.28 Waivers and Variances. The department may, in its discretion, grant waivers and variances of specific rules upon application or petition being filed on forms provided by the department. The department may establish conditions which must be met by the program in order to operate under the waiver or variance granted. Waivers and variances may be granted in accordance with the following considerations:

(a) Variance. A variance may be granted by the department upon a showing by the applicant or petitioner that the particular rule or regulation that is the subject of the variance request should not be applied as written because strict application of the rule would cause undue hardship. The applicant or petitioner must also show that adequate standards affording protection for the health, safety and care of clients exist and will be met in lieu of the exact requirements of the rule or regulations in question.

(b) Waiver. The department may dispense entirely with the enforcement of a rule or regulation by granting a waiver upon a showing by the applicant or petitioner that the purpose of the rule or regulation is met through equivalent standards affording equivalent protection for the health, safety and care of clients.

(c) Experimental Variance or Waiver. The department may grant waivers and variances to allow experimentation and demonstration of new and innovative approaches to delivery of services upon a showing by the applicant or petitioner that the intended protections afforded by the rule or regulation which is the subject of the request are met and that the innovative approach has the potential to improve service delivery.

Authority O.C.G.A. Secs. 26-5-6, 31-2-4. **History.** Original Rule entitled "Severability" adopted. F. Sept. 18, 1997; eff. Oct. 8, 1997. **Repealed:** New Rule entitled "Waivers and Variances" adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

290-4-2-.29 Severability. In the event that any rule, sentence, clause or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portions thereof. The remaining rules or portions thereof shall remain in full force and effect, as if such rule or portions thereof so determined, declared or adjudged invalid or unconstitutional were not originally a part of these rules.

Authority O.C.G.A. Sec. 26-5-6. **History.** Original Rule entitled "Severability" adopted. F. Jan. 4, 2007; eff. Jan. 24, 2007.

INITIAL DRUG TREATMENT AND EDUCATION
FACILITY CHECKLIST

FACILITY: _____

Please check that you have each of the required items below. Please have a copy of each item ready for the initial licensure inspection. Include this checklist with your application.

___ 1. A copy of the Business License (if required by local Government)

___ 2. IRS Business Tax Identification Proof of Identity

___ 3. Certificate of Occupancy (if required by local Government)

___ 4. Fire Safety Inspection. (if required by local Government)

___ 5. Program description (including ASAM levels)

___ 6. Governing Board

___ 7. Current Budget

___ 8. Current Organizational Chart

___ 9. Pest Control Contract

___ 10. Sanitation Contract

___ 11. Current Client list

___ 12. Staff list with title

SIGNATURE _____

By signing this form, I verify that the above items are ready for inspection.

TITLE _____

DATE _____