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November 15, 2006 --SENT BY E-MAIL AND POST

Ms. Margaret Walsh, Director
Office of Human Rights
Department of Mental Health, Mental Retardation
and Substance Abuse Services
PO Box 1797
Richmond, VA 23219

Dear Ms. Walsh:

Thank you for the opportunity to provide Comment on the current *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation, or Substance Abuse Services (12 VAC35 -115-10 et seq.)*. The Virginia Board for People with Disabilities is an important partner in policy and planning for effective and meaningful systems change and is representative of many, but certainly not all, constituent groups involved in and profoundly affected by systems change decisions.

In submitting these formal Comments, the Board is fulfilling state and federal legislative mandates as well as the agency's mission and strategic vision for people with disabilities. Under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402, the DD Act), the Board is directed to "support and conduct activities to eliminate barriers to access and use of community services by individuals with developmental disabilities, [and to] enhance systems design and redesign..." (Sec.125).

Under the Virginians with Disabilities Act (*Code of Virginia*, Title 51.5, the VDA), the Board is directed "to advise the Secretary of Health and Human Resources and Governor on issues and problems of interest to persons with disabilities" (§51.5-33). The Board's mission statement is "to improve the lives of people with disabilities by providing a voice for their concerns", and finally, its strategic vision includes a strong commitment to community inclusion to ensure that individuals with disabilities "be given equal opportunity to achieve independence, contribute to society, and enjoy full inclusion into educational, economic, political, social, and cultural life of the community".

**Virginia Board for People with Disabilities
Public Comment on VAC Chapter 115**

The Board is making both general Comments and specific recommendations for text revisions, both of which are in the attached document. We fully support the efforts of your office to ensure the dignity, rights, and freedoms of all persons with mental, cognitive, or substance abuse disorder. We believe that our Comments and recommendations will further enhance the quality of life for persons with disabilities.

Once again, we appreciate the opportunity for input.

Sincerely,

Heidi Lawyer

Heidi Lawyer

Lisbet Ward

Lisbet Ward

Cc: The Honorable Marilyn Tavenner
Secretary of Health and Human Resources

Gail Jaspen
Deputy Secretary of Health and Human Resources

James Reinhard, M.D., Commissioner
Dept. of Mental Health, Mental Retardation and Substance Abuse Services

12 VAC 35-115: Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers of Mental Health, Mental Retardation, or Substance Abuse Services

General Comments:

The Board recognizes and appreciates the efforts of the Office of Human Rights to protect individuals being served by MHMRSAS providers. The Board is deeply concerned about the protection of human, civil and legal rights of individual with disabilities, with a focus on those with developmental disabilities. Quality assurance and safety provisions are key to successful community living and for those who remain in facilities. In that light, we would like the department reconsider the organizational structure for abuse and neglect investigations and implement a similar structure to that of the Office of Human Rights in which the human rights advocates report to the State Director of Human Rights in the Central Office who reports directly to the Commissioner. This avoids the conflict of interest that arose when the human rights advocates were directly employed by the facility. This same practice should be in place for abuse and neglect investigatory staff. We also recommend that the Office of Human Rights be required to post all substantiated cases of abuse or neglect for all providers, including facilities (more detail later in this document).

With respect to human rights advocacy, individuals receiving services must have reasonable access to the Human Rights Advocates, which requires realistic ratios of individuals to advocates. The Board recommends that the Office of Human Rights determine appropriate “caseloads” for advocates to ensure access and adequate levels of support. The Board would support budgetary efforts to expand the number of human rights advocates statewide.

The Board also has concerns regarding the level of oversight for and training of the Local Human Rights Committees (LHRCs). Anecdotal reports received by the Board indicate that significant variations may exist in the manner in which they function and in their interpretation of these regulations. We recommend a consistent statewide training program at mandatory time intervals for all LHRC members.

Another general issue identified by the Board pertains to references to “written” notices, consent, and documents throughout the regulation. Individuals served by, or potentially served by, MHMRSAS providers may have sensory or physical impairments that require alternative forms of communication such as American Sign Language, Braille, or assistive technology; or may have cognitive impairments that require adjustment in the language used for documents and signs or the way in which messages are imparted. Clear recognition of the necessity of adapting communications to the needs of such individuals is critically important and, therefore should be reflected in the language of these regulations. The Board recommends that “in writing” be accompanied by the phrase, “or in alternative form of communication appropriate to the individual’s needs”.

A number of such changes are included below, but we are unlikely to have caught every reference.

As you will see in our specific Comments, the Board recommends that the regulatory language in Part III, 12 VAC35-115-50, *Dignity*, and 115-100, *Restrictions on Freedoms of Everyday Life*, promote practices by service providers that support individual self-determination to the full extent possible in keeping with accepted clinical practices. At focus groups statewide, which were conducted during the past year by the Human Services Research Institute (HSRI) under a grant project coordinated by the VCU Partnership for People with Disabilities, individuals with disabilities complained that too often staff kept them from living the life that they wanted. Specifically, individuals described “an array of rules that controlled their actions”, with which they did not agree or “felt were downright ‘silly’.” Examples cited by the focus group participants included, but were not limited to, restrictive rules on dating, phone use, eating, use of free time, mandatory group “outings”, etc. Review of services by the Office of Human Rights should include private interviews with individuals to ascertain the extent to which such restrictions occur.

A significant Board recommendation involves inclusion of “Microboards” and “Circles of Support” as accepted means of providing assistance for decision-making to individuals with disabilities. Definitions for each of these terms are provided for that section of the regulation. Although these entities are a relatively new in the Commonwealth, they have been found to be successful in enabling individuals to thrive in their communities by truly being in charge of their daily decisions.

PART I. GENERAL PROVISIONS.

IMPORTANT FORMAT NOTE: Because the draft document provided for Comment necessarily contains text that is stricken-through and underlined (representing the department’s proposed changes), the Board’s recommendations are in blue type (in the electronic copy and in one original copy submitted to DMHMRAS). New text is underlined and italicized; deleted text is stricken-through and italicized.

Only regulatory provisions on which Comment is being made are included in this document. Other regulatory provisions on which the Board is not Commenting may be included when necessary to understand the context of a recommended change. The numbering of each section is consistent with the numbering in the regulatory draft provided by the department.

12VAC 35-115-10—Authority and Applicability

Comment: Minor language change suggested for grammatical purposes.

D. These regulations apply to individuals under forensic status and individuals committed to the custody of the ~~commissioner~~department as sexually violent

predators, except to the extent that the commissioner may determine these regulations are not applicable to them. The exemption must be in writing and based solely on the need to protect individuals receiving services, employees, or the general public. The commissioner shall give the State Human Rights Committee (SHRC) chairperson prior notice of all exemptions; Thereafter, The commissioner shall submit and shall provide the written exemption to the State Human Rights Committee (SHRC) SHRC for its information. The commissioner shall give the SHRC chairperson prior notice regarding all exemptions. Such These exemptions shall be time limited and services shall not be compromised.

12VAC35-115-20. Policy

Comment: No changes

12VAC35-115-30. Definitions.

Comments: The Board is recommending changes to several definitions and the addition of two new definitions: Microboards and Circles of Support. These terms will be utilized again in the Substitute decision-makers portion of the regulations. We recommend revision as follows:

“Authorized representative” means a person *or persons* permitted by law or these regulations to authorize the disclosure of information, to consent to treatment and services, or participation in human research. The decision-making authority of an authorized representative recognized or designated under these regulations is specific to the designating provider. Legal guardians, attorneys-in-fact, health care agents appointed pursuant to §54.1-2983, *Microboards duly incorporated under the laws of the Commonwealth, or Circles of Support* may have decision-making authority beyond any specific provider.

Comment: The following Comment, noted in the Board’s earlier response to the licensure regulations, relates to these regulations as well. As we noted, the Board is concerned about the definitions of *Behavior Management* and *Behavioral Treatment*. These definitions should be in sync with best practices and with person-centered values. The definition of Behavior Management is overly broad and is unclear. Second, Behavioral Treatment and Positive Behavioral supports are viewed as being synonymous. The preferred terminology is Positive Behavioral Support. The Board also believes there should be one term used, either Behavioral Support Plan or Positive Behavioral Support plan. Staff should be trained in the terminology used to avoid confusion. We recommend revision as follows:

“Behavioral management supports” means those principles and methods employed by a provider to help an individual receiving services to achieve a positive outcome and to address and correct inappropriate *challenging* behavior in a constructive and safe manner *in accordance with current best practice manuals and professional standards for positive behavioral supports.* ~~Behavior management principles and methods must be employed in accordance with the~~

~~individualized service services plan and written policies and procedures governing service expectations, treatment goals, safety, and security. [This is guidance. Should not be part of definition.]~~

Comment: Eliminate definition of Behavioral treatment plan, functional plan or behavioral support plan and replace with definition of Positive Behavioral Supports (See below).

~~"Behavioral treatment program plan, functional plan, or behavioral support plan" means any set of documented procedures that are an integral part of the interdisciplinary treatment plan and are developed on the basis of a comprehensive assessment of the individual as well as systemic data collection, such as a functional assessment, for the purpose of assisting an individual receiving services to achieve any or all of the following:~~

- ~~1. Improved behavioral functioning and effectiveness;~~
- ~~2. Alleviation of symptoms of psychopathology; or [3. Reduction and/or improvement of serious behaviors that are injurious to self or others or that interfere significantly with community involvement and integration.~~

~~A behavioral treatment program can also be referred to as a behavioral treatment plan or behavioral support plan.~~

Comment: Add definition of Circle of Support.

"Circle of Support" means a group of 3 or more people who have been designated by the individual with a disability to assist him or her to accomplish personal life goals and to support the individual in making decisions and, if so designated, act as a substitute decision-maker. "

Comment. The Board recommends the following reorganization of the consent definition.

~~"Consent" means the voluntary and expressed agreement of an individual or that individual's legally authorized representative if the individual has one—given freely and without undue inducement, any element of force, fraud, deceit, or duress, or any form of constraint or coercion—to specific services. Consent may be expressed through any means appropriate for the individual, including verbally, through physical gestures or behaviors, in Braille, through ~~or~~ American Sign Language, in writing, or through other methods. Informed consent is needed to disclose information that identifies an individual receiving services. Informed consent is also needed before a provider may provide treatment to an individual which poses risk of harm greater than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations, tests, or treatments, or before an individual participates in human research. Informed consent is required for surgery, aversive treatment, electroconvulsive treatment, and use of psychoactive medications. Consent to any action for which consent is required under these regulations must be voluntary. To be voluntary, the consent~~

~~must be given by the individual receiving services, or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or any form of constraint or coercion. To be informed, consent must be based on disclosure and understanding by the individual or legally authorized representative, as applicable, of the following kinds of information:~~

No change to the strike-throughs in #1-9 (a-d).

Comment: No changes to definitions of “Department”, “Director”, or “Discharge plan.”

Comment: Eliminate redundancy in definition of disclosure.

“Disclosure” means the release by a provider of information identifying an individual *by a provider*.

Comment: No changes to definitions of “Emergency”, or “Exploitation.”

Comment: Recommend the following changes/reorganization of the definition of “Habilitation.” “Habilitation” ~~refers to~~ means the provision of *individualized* services conforming to professionally acceptable practices, that enhance the strengths of, teach functional skills to, or reduce or eliminate ~~problematic~~ *challenging* behaviors of an individual receiving services in a manner that ~~These services occur in an environment that~~ suits the individual's needs, responds to his preferences, and promotes social interaction and appropriate adaptive and communicative behaviors. ~~In order to be considered sound and therapeutic, habilitation must conform to current acceptable professional practice.~~

Comment: No changes to the definitions of “health care operations”, “Health plan”, “Historical research.”

Comment: Recommend the addition of the word “professional” as it relates to the definition of “Human Research.

“Human research” means any systematic investigation ~~that uses human participants who may be exposed to potential physical or psychological injury if they participate and which departs from established and accepted therapeutic methods appropriate to meet the participants' needs, including research~~ development, testing, and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized *professional* knowledge. Human research shall ~~not be conducted in compliance with §§ 32.1-162.16 through 32.1-162-20 and 37.1-24.01 of the Code of Virginia, and 12VAC35-180-10 et seq., or any applicable federal policies and regulations~~ deemed to include research exempt from federal research regulations pursuant to 45 C.F.R. § 46.101(b).

Comment: No changes to the definitions of “Human rights advocate”, or “Individual.”

Comment: The Board recommends the following changes to the definition of an “Individualized Services Plan”.

“Individualized Services Plan (ISP)” means a comprehensive and regularly updated written plan of action to meet the needs and preferences of an individual. An ISP describes measurable goals and objectives and expected outcomes of services and is designed to meet the needs of a specific individual. The term ISP includes treatment plan, functional plan, habilitation plan, or plan of care.

Consider replacing with:

"Individualized services plan (ISP)" means a comprehensive and regularly updated written plan that includes but is not limited to an individual's treatment plan, functional plan, habilitation plan, or plan of care that meets the needs and preferences of an individual and describes the measurable goals, objectives and expected outcomes

Comment: In the definition of “Informed Consent”, ensure consistency with the definition of “consent” with respect to being offered freely and in various formats. In addition, the Board believes that the importance of the concept of informed consent requires that the definition be more comprehensive in its nature in order to differentiate informed consent from general consent. The current proposed definition in the regulations is:

“Informed consent” means the voluntary written agreement of an individual, or that individual’s authorized representative to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research. To be voluntary, informed consent must be given freely and without undue inducement, any element of force, fraud, deceit, or duress, or any form of constraint or coercion.

We recommend replacing the definition above with the following more comprehensive definition:

“Informed consent” means the voluntary written agreement of an individual—or that individual’s authorized representative—to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research, *following the provision of:*

- 1. a fair and reasonable explanation of proposed treatment or service, including any adverse consequences and risks to be expected;*
- 2. the benefits that can be reasonably expected from the treatment or service;*

3. any alternate procedures that may be equally advantageous and a description of any benefits and side effects;
4. an offer to answer any questions about the procedure, treatment, or service; and
5. notification that the individual may refuse or withdraw consent and discontinue the treatment or service at any time.

Informed consent must be given freely and without undue inducement, any element of force, fraud, deceit, or duress, or any form of constraint or coercion. Consent may be expressed through any means appropriate for the individual, including verbally, through physical gestures or behaviors, in Braille, through or American Sign Language, in writing, or through other methods.

Comment: No change to the definition of “Inspector general”.

Comment: With respect to the definition of “Investigating authority”, the Board has significant concern that an investigating authority directly associated with a provider may be approved to conduct investigations of that same provider. Investigations should be conducted by an impartial, independent investigator, unaffiliated with the provider. The Board recommends review of this regulation and procedure.

"Investigating authority" means any person or entity with the legal authority and independent responsibility to conduct investigations of abuse and neglect. ~~that is approved by the provider to conduct investigations of abuse and neglect.~~

Comment: The Board recommends broadening the definition of “Licensed professional” to any licensed professional.

“Licensed professional” means a physician, licensed clinical psychologist, licensed professional counselor, licensed clinical social worker, licensed or certified substance abuse treatment practitioner, or certified psychiatric nurse specialist, and any other professional licensed or certified by the Commonwealth of Virginia

Comment: The Board recommends adding minor language regarding the purpose of the Local Human Rights Committee (LHRC) within the definition.

"Local Human Rights Committee (LHRC)" means a group of at least five people who are appointed by the State Human Rights Committee to monitor and address human rights issues in a specified jurisdiction. See 12VAC35-115-250 D for membership and duties.

Comment: Minor wording change recommended to the definition of “Mechanical restraint.”

“Mechanical restraint” means the use of any mechanical device that restricts the freedom of movement or voluntary functioning of an individual’s limb or a

portion of his body and that does not allow when the individual does not have the option to remove the device.

Comment: The Board recommends adding the following definition of Microboard which will be referred to later in the regulations under Substitute Decision-making.

“Microboard” means an organization, incorporated under the laws of the Commonwealth, whose mission and scope is to develop, provide and oversee the delivery of services and supports, within a formal organizational structure, to an individual who requires assistance in decision-making.

Comment. The board recommends a minor language change in the definition of “Neglect” to account for new creative options such as Microboard and Circles of Support, which could involve more than one person but is not necessarily considered a “program.” In addition, since the term individual is defined, this term should be consistently used when referring to the service recipient.

"Neglect" means ~~the failure by an individual~~ a person or persons, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to provide do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of a person an individual receiving care or treatment for mental illness, mental retardation, or substance abuse. See ~~37.1-1-§ 37.2-100~~ of the Code of Virginia.

Comment. The Board believes that the reference to the statute in the definition of “Next friend” is sufficient and the stricken language is not necessary.

“Next friend" means a person ~~whom a provider may appoint designated by a~~ director in accordance with ~~12VAC35-115-70 B 9 e-12VAC35-115-146~~ to serve as the ~~legally~~ authorized representative of an individual who has been determined to lack capacity to ~~give consent or authorize the disclosure of identifying information,~~ when required under these regulations.

Comment: Minor wording suggestions

“Peer on peer harm” means a physical act or verbal expression by an individual against or to another individual that results in harm to that individual or his property. Harm includes hitting and/or threatening behavior by an individual who has with the means to carry out the threat. Incidents of harm shall be investigated as potential neglect pursuant to 12VAC35-115-50 D3.

Comment: Add Definition of Person-Centered Planning

“Person-Centered Planning” means a process-oriented approach which focuses planning on the needs of the individual with a disability, puts the individual in charge of defining the direction for their lives, and does not base planning on system needs or services that may or may not be available to them.

Comment: Add Definition for Positive Behavioral Support (PBS). Using language from the national Association for PBS (www.abps.org/PBSTopics.htm), one definition would be:

“Positive Behavioral Support (PBS)” means a set of research-based strategies used to decrease problem or challenging behaviors (such as self-injury, aggression, property destruction, pica, and intrusive behaviors) by teaching new skills and making changes in a person’s environment and to increase the social, personal, and professional quality of life for the individual and others. PBS involves changing situations and events that people with problem or challenging behaviors experience in order to reduce the likelihood that problem behaviors will occur.

Comment: Minor clarification wording in the definition of “Protection and advocacy agency.”

"Protection and advocacy agency" means the state agency designated under the federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and the Developmental Disabilities (DD) Act. The protection and advocacy agency *for the Commonwealth* is the ~~Department for the Rights of Virginians with Disabilities (DRVD)~~ Virginia Office for Protection and Advocacy (VOVA).

Comment: No changes to the definition of “Program rules”, “Provider”, or Psychotherapy notes.”

Comment: Minor changes to the definition of “Research review committee” in order to incorporate the purpose into the definition.

"Research review committee" or "institutional review board" means a committee of professionals ~~that provides~~ that provides complete and adequate review of research activities in order to safeguard the rights and welfare of participants in human research. ~~The~~ committee shall be sufficiently qualified through maturity, experience, training, and diversity of its members, including consideration of race, gender, and cultural background, to promote respect for its advice and counsel ~~in safeguarding the rights and welfare of participants in human research.~~ (See ~~37-1-24.01~~ § 37.2-402 of the Code of Virginia and 12VAC35-180-110 et seq.)

Comment: Regarding the definition of “Restraint”, the Board does not support the routine use of restraint but recognizes that there may be emergency situations in which

other interventions have not worked and in which immediate action is necessary. We would like the definition to be clear regarding its use solely-when there is imminent risk of harm and, thus, believe that this concept bears repetition in each of the sub-definitions. In light of this we are proposing some modifications to the definition and also suggest that some parts of this definition are really for guidance as to use vs. definitional and should be moved to a later section of the regulation.

"Restraint" means the use of an approved mechanical device, medication, physical intervention or hands-on hold, ~~or pharmacological agent to involuntarily prevent an individual receiving services from moving his body to engage in a behavior that places him or others at imminent risk of harm and to deescalate a dangerous situation.~~ The term includes restraints used for behavioral, medical, or protective purposes. There are three kinds of restraints:

1. Mechanical restraint means the use of an approved mechanical device that cannot be removed by the individual to restrict the freedom of movement or functioning of a limb or a portion of an individual's body when that individual's behavior places him or others at imminent risk.
2. Pharmacological restraint means the use of a medication that is administered involuntarily for the emergency control of an individual's behavior when that behavior places the individual or others at imminent risk and when the administered medication is not a standard treatment for the individual's medical or psychiatric condition.
3. Physical restraint, (also referred to as manual hold), means the use of a physical intervention or hands-on hold to prevent an individual from moving his body in order to engage in a behavior that places him or others at imminent risk.

The following section is guidance vs. definition. The Board recommends that it be moved to **12VAC35-115-110**.

Restraints may be used for the following behavioral, medical, or protective purposes:

1. A restraint used for "behavioral" Behavioral purposes means the use of using an approved a physical hold, a psychotropic psychotropic medication, or a mechanical device that is used for the purpose of controlling to control behavior or involuntarily restricting restrict the freedom of movement of the an individual in an instance when all of the following conditions are met: (i) in which there is an imminent risk of an individual harming himself or others, including staff there is an emergency; (ii) when nonphysical interventions are not viable; and (iii) when safety issues require an immediate response.
2. A restraint used for "medical" Medical purposes means the use of an using a physical hold, medication, or mechanical device approved mechanical or physical hold to limit the mobility of the individual for medical, diagnostic, or surgical purposes, such as routine dental care or radiological procedures and related post-procedure care processes, when the use of such device the restraint is not a standard the accepted clinical practice for the individual's condition.

~~3. A restraint used for "protective" Protective purposes means the use of using a mechanical device to compensate for a physical or cognitive deficit when the individual does not have the option to remove the device. The device may limit an individual's movement, for example, bed rails or a gerichair, and prevent possible harm to the individual (e.g., bed rail or gerichair) or it may create a passive barrier, such as a helmet, to protect the individual (e.g., helmet).~~

Comment: No changes to the definition of “Restriction, “Seclusion”, or “Serious injury.”

Comment: We recommended including the term “assessment” as an important aspect of the definition of “Services.”

"Services" means mental health, mental retardation and substance abuse assessment, care, treatment, training, habilitation, or other supports, including medical care, delivered by a provider.

Comment: Minor wording change to the definition of “Services record.”

"Services record" means all written information that a provider keeps about an individual who receives services.

Comment: No changes to the definition of State Human Rights Committee (SHRC).

Comment: With respect to the definition of “Time out”, the Board believes there should be differentiation between time out that is used to address a challenging behavior when less restrictive alternatives have failed and time out that is used by the individual as a strategy to self calm or reduce stress.

~~"Time out" means assisting an individual to regain emotional control by removing the individual from his immediate environment to a different, open location until he is calm or the problem behavior has subsided~~ (1) the involuntary removal of an individual by a staff person from a situation or location source of reinforcement to a different, open location for a specified period of time or until the problem behavior has subsided for the purpose of discontinuing or reducing the frequency of future challenging problematic behavior; or (2) the voluntary removal by the individual of his/herself from the current environment to an agreed upon environment in order to self calm or reduce immediate stress.

Comment: Minor wording changes recommended to the definition of “Treatment”, consistent with terminology used in other parts of the regulation.

"Treatment" means the individually planned, ~~sound,~~ clinically appropriate, and therapeutic interventions that are intended to improve or maintain functioning of an individual ~~receiving services~~ in those areas that show impairment as the result

of mental ~~disability, substance addiction illness,~~ mental retardation, substance use (alcohol or other drug dependence or abuse) disorders, or physical impairment. In order to be considered clinically appropriate sound and therapeutic, the treatment must conform to current acceptable professional practice.

PART II. ASSURANCE OF RIGHTS.

12VAC35-115-40. Assurance of rights.

Comment: No changes to Section 115-40 (A).

Comment: In Section B, additional language recommended to ensure that needs for alternate formats or explanations are met.

B. Individuals are entitled to know what their rights are under these regulations; therefore, providers shall take the following actions:

(no changes to B (1-4)-change recommended to B(5-6) and addition of B (7)

5. Display and provide information as requested by the protection and advocacy agency (VOPA) director that informs individuals of their right to contact the protection and advocacy agency.
6. Display and provide written notice of rights, which shall be at the reading level and in the languages ~~the~~ most frequently used languages by individuals served.
7. Upon request, provide the notice in alternate formats and explain the rights to individuals in the mode of communication most effective for those who request such explanation.

Comment: Minor grammatical change to Section C.

C. Every individual ~~receiving services~~ has a right to seek ~~informal~~ resolution of and to file a human rights complaint. Any individual ~~receiving services~~ or anyone acting on his behalf who thinks that a provider has violated any of his rights under these regulations may file a complaint and get help in filing the complaint in accordance with Part IV-Part V (12VAC35-115-150 et seq.) of this chapter.

Comment: No change to Section D.

PART III.

EXPLANATION OF INDIVIDUAL RIGHTS AND PROVIDER DUTIES.

12VAC35-115-50. Dignity.

Comment: No change to 115-50 (A)

Comment: In Section 115-50 (B), New # 1, New #7 are designed to ensure maximum self-determination; a reordering of other provisions recommended.

B. In receiving all services, each individual has the right to

1. Receive services in an environment that: meets the individual's needs; responds to his preferences; is person-centered and directed; and promotes participation in community and social activities that enhance personal growth and full community participation to the maximum extent.

2. Be protected from harm including abuse, neglect, and exploitation.

~~3.~~ Use his preferred or legal name.

The use of an individual's preferred name may be limited when a licensed professional makes the determination that the use of the name will result in demonstrable harm or have significant negative impact on the program itself or the individual's treatment, progress, and recovery. The director shall inform the individual and human rights advocate of the reasons for any restriction prior to implementation and the reasons for the restriction shall be documented in the individual's services record. The need for the restriction shall be reviewed by the treatment team every month and documented in the services record.

~~3.~~ 4 Have help in learning about, applying for, and fully using any public service or benefit to which he may be entitled. These services and benefits include ~~but are not limited to~~ educational or vocational services, housing assistance, services or benefits under Titles II, XVI, XVIII, and XIX of the Social Security Act, United States Veterans Benefits, and services from legal and advocacy agencies.

~~4.~~ 5. Have opportunities to communicate in private with lawyers, judges, legislators, clergy, licensed health care practitioners, ~~legally~~ authorized representatives, advocates, the ~~Inspector General~~ inspector general, and employees of the protection and advocacy agency.

~~5.~~ 6. Be provided with general information about program services and policies in a manner easily understood by the individual.

7. Exercise maximum self-determination regarding daily routines, such as bedtime and meals, social relationships and other activities, consistent with

sound therapeutic practices, the individual's ISP, and applicable laws and regulations.

Comment: Re Section 115-50 (C), we recommend several language revisions/additions with a continued focus on respect for the individual as well as some reorganization. We also recommend separating the concept of personal privacy and private storage space as they are different issues. With respect to "e" below, formerly "d", the Board understands the cost implications of this recommendation and that current providers will have to be grandfathered. We believe that any new residence or place of treatment should be fully air conditioned. In addition, we believe that these rights should be updated to reflect modern modes of communication such as e-mail.

C. In services provided in residential and inpatient settings, each individual has the right to:

1. Have sufficient and suitable clothing for his exclusive use.
2. Receive a nutritionally adequate, varied, and appetizing *meals that are diet* prepared and served under sanitary condition, served at appropriate times and temperatures, and consistent with any individualized diet program *and the individual's preferences, including cultural and religious preferences as they affect diet.*
3. Live in a *humane, safe, and sanitary, and humane physical* environment that gives each individual, at a minimum:
 - a. *Reasonable privacy, including private visits with friends, family members, or others of the individual's choice. Privacy shall be afforded to the individual except when the provider has documented a potential threat of abuse, a threat to the individual or others' safety, or when disallowed as part of an individual's treatment plan based upon standard accepted clinical practices.*
 - b. Private storage space;*
 - b.-c.* An adequate number ~~and design~~ of private, operating toilets, sinks, showers, and tubs *that are designed to accommodate/address individuals' physical needs;*
 - e.-d.* Direct outside air provided by a window that opens ~~or by an air conditioner;~~
 - f.e.* Room temperatures that are comfortable year round and compatible with health requirements, to include but not be limited to *an air conditioning system or at a minimum, air conditioning in all sleeping areas.*
 - d. f.* Windows or skylights in all major areas used by individuals; and
 - e.-g.* Clean air, free of bad odors; ~~and.~~

4. Practice a religion and participate in religious services subject to their availability, provided that such services are not dangerous to ~~self~~ the individual or others and do not infringe on the freedom of others.
 - a. Religious services or practices that present a danger of bodily injury to any individual or interfere with another individual's religious beliefs or practices may be limited.
 - b. Participation in religious services or practices may be reasonably limited by *the provider if such participation is inconsistent with the individual's ISP or significantly affects the activities of others in a demonstrated negative manner. Any restriction on religious activity participation shall be documented and include justification for such restriction.* ~~in accordance with other general rules limiting privileges or times or places of activities.~~
5. Have paper, pencil and stamps provided free of charge for at least one letter every day upon request, *if an individual does not have adequate personal funds. ~~If an individual has funds for clothing and to buy paper, pencils, and stamps to send a letter every day, the provider does not have to pay for them.~~*
6. ~~Have~~ Communicate privately with any person by *mail, or e-mail if the individual has access to a computer,* and have help in writing or reading mail as needed.
 - a. *A provider shall not open or read mail or e-mail unless the individual has asked them to do so. Whenever this occurs, it must be documented. If the individual has requested ongoing assistance with opening and reviewing mail, the request shall be documented at least monthly.*
 - ~~a.~~ b. An individual's access to mail *or e-mail* may be limited if (i) the provider has *reasonable cause to believe that the mail or e-mail contains illegal material or may contain anything dangerous materials;* or (ii) *in the judgment of a licensed professional, the individual's communication with another person or persons will result in demonstrable harm to the individual's mental health.* If so, the director may open *but not read* the mail *or e-mail* ~~but not read it,~~ in the presence of the individual.
 - c. The director shall inform the individual and human rights advocate of the reasons for any restriction prior to implementation and the reasons for the restriction shall be documented in the individual's services record. The need for the restriction shall be reviewed by the treatment team *or professional staff* every month and documented in the services record.
7. Communicate privately with any person by ~~mail or telephone,~~ *or personally-owned cell phone,* and ~~get~~ have help in doing so. Use of the telephone may be limited to certain times and places to make sure that other individuals have equal access to the *public* telephone and that they can eat, sleep, or participate in an activity without being disturbed.

No changes recommended to 115-50 (C)7(a-c)

Comment: In 115-50 (C)8 the Board recommends inserting the word “only” as emphasis on visitor restriction. The Board is aware of instances in which the provider has not allowed an individual to have a visitor for purposes of the provider’s convenience. With respect to (C)8(b), not all settings (such as group homes) have “treatment” teams and so a generic word would be preferred or the addition of the term “staff”.

8. Have or refuse visitors.

a. An individual’s access to visitors may be limited or supervised *only* when, in the judgment of a licensed professional: the visits result in demonstrable harm to the individual or significantly affect the individual’s *or others’* treatment; or when the visitors are suspected of bringing contraband or threatening harm to the individual *or others* ~~in any other way.~~

b. The director shall inform the individual and the human rights advocate of the reasons for any restriction prior to implementation, and the restriction shall be documented in the individual’s services record. The need for the restriction shall be reviewed by the treatment *or staff* team every month and documented in the services record.

No changes recommended to 115-50(C)8(c) or (C)9.

Comment: In 115-50 (D), the Board suggests modifying language in several places to ensure that the responsibilities of providers are clear, particularly with respect to protection of the individual. A new 115-50 (D)3(c) is added. Of particular concern to the Board is the conduct of impartial investigations. How impartiality is determined is unclear. Currently, the only provision is that the investigator is not involved in the issues at hand. For a provider/director to handpick the individual who will conduct the investigation is a conflict of interest. In addition, while we recognize that this is common practice, having providers evaluate one another is clearly problematic. A provider may have a very challenging time finding fault with a fellow provider knowing that provider may next be conducting an investigation on his/her operations/services. The entire investigatory process should be revamped to ensure clear impartiality and independence of the investigator.

D. The provider's duties.

No changes to (D)1-2

3. Providers shall assure the following relative to abuse, neglect, and exploitation:

a. Policies and procedures governing harm, abuse, neglect, and exploitation of individuals receiving their services shall require that, *as a condition of his or her involvement with the provider, employment or volunteering,* any employee, volunteer, consultant, or student who knows of or has reason to believe that an individual may have been abused, neglected, or exploited at

any location covered by these regulations, shall immediately report this information directly to the director.

b. The director shall immediately take necessary steps to protect the individual ~~receiving services~~ until an investigation is complete. This *shall* ~~may~~ include at least one of the following actions and any other action as deemed appropriate.

(1) Direct the employee or employees involved to have no further contact with the individual. In the case of incidents of peer-to-peer harm, protect the individuals from the aggressor in accordance with sound therapeutic practice and these regulations.

(2) Temporarily reassign or transfer the employee or employees involved to a position that has no direct contact with individuals receiving services.

(3) Temporarily suspend the involved employee or employees pending completion of an investigation.

c. In the case of incidents of peer-to-peer harm, protect the individuals from the aggressor in accordance with sound therapeutic practice and these regulations.

e. d. The director shall immediately notify the human rights advocate and the ~~legally individual's~~ authorized representative, ~~as applicable~~. In no case shall notification ~~exceed~~ be later than 24 hours ~~from~~ after the receipt of the initial allegation of abuse, neglect, or exploitation.

~~d. e.~~ In no case shall the director punish ~~or~~ or retaliate against an employee, volunteer, consultant, or student for reporting an allegation of abuse, neglect, or exploitation to an outside entity.

e. f. The director shall initiate an impartial investigation within 24 hours of receiving notification. The investigation shall be conducted by an impartial independent investigator ~~person~~ with training and experience in the knowledge, skills, and abilities necessary to conduct effective investigations and who is not involved in the issues under investigation or an employee of the provider.

(1) The investigator shall make a final report to the director or the investigating authority and to the human rights advocate within 10 working days of appointment. Exceptions to this timeframe may be requested and approved by the department if submitted prior to the close of the sixth day.

(2) The director or investigating authority shall, based on the investigator's report and any other available information, decide whether the abuse, neglect or exploitation occurred. Unless otherwise provided by law, the standard for deciding whether abuse, neglect, or exploitation has occurred is preponderance of the evidence.

(3) If abuse, neglect, or exploitation occurred, the director shall take any action required to protect the individual and other individuals. All actions must be documented and reported as required by 12VAC35-115-230.

(4) In all cases, the director shall provide his written notice decision, including actions taken as a result of the investigation, within seven working days following completion of the investigation ~~of the decision and all actions taken~~ to the individual or individual's legally authorized representative, the human rights advocate, investigating authority and the involved employee or employees. If needed, the decision shall be provided to the individual in alternate format and/or explained in the mode of communication or language most effective for the individual.

(5) If the individual affected by the alleged abuse, neglect, or exploitation or his legally authorized representative is not satisfied with the director's actions, he or his legally authorized representative, or anyone acting on his behalf, may file a petition for an LHRC hearing under 12VAC35-115-180. This process shall be clearly explained in the mode of communication and language most appropriate to the individual's functional abilities.

No changes to 115-50 (D)3 (f-h)

12VAC35-115-60. Services.

Comment: Recommend minor grammatical change in 115-60(A)

A. Each individual receiving services shall receive ~~those~~ services according to law, regulations, and sound therapeutic practice.

Comment: In 115-60(B), additional language is designed to eliminate cancellation of medical appointments without justification and documentation. The Board is aware of situations in which medical appointments have been cancelled or rescheduled for the provider's convenience and to the detriment of the individual.

B. The provider's duties.

No change to 115-60(B) 1-3

4. Providers shall assign a specific person or group of persons to carry out each of the following activities:

a. Medical, mental health, and behavioral screenings and assessments, as applicable, upon admission and during the provision of services;

i) With the exception of emergency situations or unforeseen circumstances outside of the provider's control, the scheduled medical, mental health appointments shall not be cancelled.

ii) If an unforeseen circumstance or emergency requires cancellation of a scheduled appointment, the cancellation and its justification shall be documented in the individual's record, and the appointment shall be rescheduled immediately.

No change to 115-60(B)4 (b-d)

No changes to 115-60(B) 6-7

8. Providers shall ensure that the entries in an individual's services record are at all times authentic, accurate, complete, timely, ~~and~~ pertinent, and meet professional standards.

12VAC35-115-70. Participation in decision making and consent.

Comment: Minor language changes in various parts of this section. More substantively, we recommend that sections 115-70 (A) 2(a) (1-8) be eliminated from this section since they are included in the definition. The qualifications regarding informed consent (proposed definition provided earlier repeated below for convenience) are integral to the concept of consent being "informed" and therefore should remain a part of the definition. Without the qualifications, the definition is not meaningful.

No change to 115-70(A)1

Regarding 115-70(A)2, the following is recommended:

2. Give or not give informed consent to receive or participate in treatment or services that pose a risk of harm ~~greater than ordinarily encountered in daily life~~ and to participate in human research except research that is exempt under §37.2-162.17. Informed consent is always required for ~~surgery~~, surgical procedures, electroconvulsive treatment, or use of psychotropic medications.

~~a. To be informed, consent for any treatment or service must be based on disclosure of and understanding by the individual or his authorized representative of the following information:~~

~~(1) An explanation of the treatment, service, or research and its purpose~~

~~(2) When proposing human research, the provider shall describe the research and its purpose; explain how the results of the research will be disseminated and how the identity of the individual will be protected; and explain any compensation or medical care that is available if an injury occurs;~~

~~(3) A description of any adverse consequences and risks associated with the research, treatment, or service; [covered in 2]~~

~~(4) A description of any benefits that may be expected from the research, treatment, or service; [covered in 2]~~

~~(5) A description of any alternative procedures that might be considered, along with their potential side effects, risks, and benefits;~~

(6) Notification that the individual is free to refuse or to withdraw his consent and to discontinue participation in any treatment, service, or research requiring his consent at any time without fear or reprisal against or prejudice to him;

(7) A description of the ways in which the individual or his authorized representative can raise concerns and ask questions about the research or treatment to which consent is given; and

(8) When the provider proposes human research, an explanation of any compensation or medical care that is available if an injury occurs.

The definition proposed earlier which would cover the areas above is as follows.

Informed consent” means the voluntary written agreement of an individual—or that individual’s authorized representative—to surgery, electroconvulsive treatment, use of psychotropic medications, or any other treatment or service that poses a risk of harm greater than that ordinarily encountered in daily life or for participation in human research, following the provision of:

1. a fair and reasonable explanation of proposed treatment or service, including any adverse consequences and risks to be expected;
2. the benefits that can be reasonably expected from the treatment or service;
3. any alternate procedures that may be equally advantageous and a description of any benefits and side effects;
4. an offer to answer any questions about the procedure, treatment, or service; and
5. notification that the individual may refuse or withdraw consent and discontinue the treatment or service at any time.

Informed consent must be given freely and without undue inducement, any element of force, fraud, deceit, or duress, or any form of constraint or coercion. Consent may be expressed through any means appropriate for the individual, including verbally, through physical gestures or behaviors, in Braille, through ~~or~~ American Sign Language, in writing, or through other methods appropriate to the individual’s needs.

Comment: Re 115-70 A(2)8(b-c) – A(3-4), minor changes are recommended as follows:

b. Evidence of informed consent shall be documented in an individual’s services record and indicated by the signature of the individual or his authorized representative on a designated form ~~or~~ and the ISP.

c. Informed consent for electroconvulsive treatment requires the following additional components:

- (1) Informed consent shall be in writing, documented on a form that shall become part of the individual’s services record. This form shall:

- (a) Specify the maximum number of treatments to be administered during the series;
 - (b) Indicate that the individual has been given the opportunity to view an instructional video presentation about the treatment procedures and their potential side effects, *risks and benefits*; and
 - (c) Be witnessed in writing by a person not involved in the individual's treatment who attests that the individual has been counseled and informed about the treatment procedures and potential side effects, *risks and benefits* of the procedures.
 - (2) Separate consent, documented on a *distinct separate* consent form, shall be obtained for any treatments *that will* exceeding the maximum number of treatments indicated on the initial consent form.
 - (3) Providers shall inform the individual ~~receiving services~~ or his authorized representative that: the individual may obtain a second opinion before receiving electroconvulsive treatment; and the individual is free to refuse *consent* or *later* withdraw his consent and to discontinue participation at any time without fear of reprisal against or prejudice to him. The provider shall document such notification in the individual's services record.
 - (4) *For any individual under age 18 years, b*Before initiating electroconvulsive treatment ~~for any individual under age 18 years~~, two qualified child psychiatrists must concur with the treatment. The psychiatrists must be trained or experienced in treating children or adolescents and not directly involved in treating the individual. Both must examine the individual, consult with the prescribing psychiatrist, and document their concurrence with the treatment in the individual's services record.
3. Have an authorized representative make decisions for him in cases where the individual *has been determined* to lack capacity to consent or authorize the disclosure of information.
- a. If an individual who has an authorized representative who is not his legal guardian objects to the disclosure of specific information or a specific proposed treatment or service, the director shall immediately notify the human rights advocate and authorized representative. A petition for LHRC review of the objection may be filed under 12 VAC 35-115-200.
 - b. If the authorized representative objects or refuses to consent to a specific proposed treatment or service for which consent is necessary, the provider shall not institute the proposed treatment, except in an emergency in accordance with 12 VAC 35-115-70.
4. Be accompanied, except during forensic evaluations, by someone whom the individual trusts as his representative when he participates in services planning, assessments, and evaluations, including discussions and evaluations of the individual's capacity to consent, and discharge planning.

COMMENT: In 115-70 (B), Provider duties, the board recommends several changes in language to ensure that providers honor individual preferences.

B. The provider's duties.

No changes to 115-70(B)1

2. Providers shall ask the individual to express his preferences about decisions regarding all aspects of services that affect him and *shall honor these preferences unless contraindicated in the individual's ISP.*

No changes to 115-70(B) 3-4

COMMENT: Move 115-70(B) 6 below to 5 (e) as it is a component of the same process. Minor language changes recommended. Add new #7 and change subsequent numbers if new #7 is adopted. Clarify in #8 that payment is for services received while the individual was in treatment or residence. In #9 (C) clarify that the admission refers to a state training center. Delete language regarding denial of discharge from a state Training Center. The current certification regulation for admission to Training Centers is so broad, that the only real criteria are having a diagnosis of mental retardation and assessment of need for ICF-MR level of care. Whenever a person wants community placement, initiation of the discharge process should be immediate. The level of care needed in the community would be part of the discharge planning by the CSB.

5. Providers may initiate, administer, or undertake a proposed treatment without the consent of the individual or the individual's authorized representative in an emergency. All emergency treatment or services and the facts and circumstances justifying the emergency shall be documented in the individual's services record within 24 hours of the treatment or services.

a. Providers shall immediately notify the authorized representative of the provision of treatment without consent during an emergency.

b. Providers shall continue emergency treatment without consent beyond 24 hours only following a review of the individual's condition and if a new order is issued by a professional who is authorized by law and the provider to order treatment.

c. Providers shall notify the human rights advocate if emergency treatment without consent continues beyond 24 hours.

d. Providers shall develop and integrate treatment strategies into the ISP to address and prevent future emergencies to the extent possible following provision of emergency treatment without consent.

e. In the event that the treatment lasts more than 24 hours, the provider shall—Providers shall obtain and document in the individual's services record the consent of the individual's informed consent individual or his authorized representative to continue any treatment initiated in an emergency that lasts longer than 24 hours after the emergency began.

6. Providers shall provide Program Rules to individuals in writing, or in alternative form of communication appropriate to the individual's needs and explained to the individual in a manner that will ensure that they understand the

expectations placed upon them. ~~included in a handbook or policies.~~ Alternative formats and modes of communication include but are not limited to large print, Braille, picture communication, American Sign language, writing, or other methods.

7. Providers shall make available information, or access to information, about inclusive recreational, civic, and social activities or resources available in the community; and shall promote, to the extent appropriate to the individual's ISP and services, the individual's participation in community life.

7. 8. Providers may provide treatment in accordance with a court order or in accordance with other provisions of law that authorize such treatment or services including the Health Care Decisions Act (§54.1-2981 et seq.). The provisions of these regulations are not intended to be exclusive of other provisions of law but are cumulative (e.g. see § 54.1-2970 of the Code of Virginia).

8. 9. Providers shall respond to an individual's request for discharge according to requirements set forth in statute and shall make sure that the individual is not subject to punishment, reprisal, or reduction in services because he makes a request. However, if an individual leaves a service against medical advice, any subsequent billing of the individual *for services received prior to discharge* by his private third party payer shall not constitute punishment or reprisal on the part of the provider.

No changes to 115-70(B)9(a-b). Following change recommended to 155-70(B)9(c)

c. Certified admissions. If an individual certified for admission *to a state Training Center* under § 37.2-806 of the *Code of Virginia* requests discharge, the director, *or designee*, shall contact the individual's Community Services Board to initiate discharge planning. ~~shall determine whether the individual continues to meet the criteria for admission. If the director denies the request for discharge, the individual and the individual's authorized representative shall be notified in writing of the reasons for the denial and of the individual's right to seek relief in the courts. The request and the reasons for denial shall be included in the individual's services record.~~

12VAC35-115-80. Confidentiality.

COMMENT: The Board supports this section as written.

12VAC35-115-90. Access to and ~~correction~~ amendment of services records.

Comment: The Board is comfortable with the access to and amendment of services records provisions in this regulation but has a few very minor language suggestions under Section C (formerly Section B, providers duties)

No changes to 115-90(A-B)

B-C. The provider's duties.

No changes to 115-90(C)1-3

~~6-4.~~ If an individual asks to challenge, ~~correct~~amend, or explain any information contained in his services record, the provider shall investigate and file in the services record a written report concerning the individual's request.

a. If the report finds that information in the services record is incomplete, inaccurate, not pertinent, not timely, or not necessary, the provider shall:

(1) Either mark that part of the services record clearly to say so, or else remove that part of the services record and file it separately with an appropriate cross reference to indicate that the information was removed.—;

(2) Not disclose the original services record without separate specific ~~consent~~authorization or legal authority (e.g., if compelled by subpoena or other court order).—;

(3) Request Obtain the individual's identification of and agreement to have the provider notify the relevant persons of the amendment; and

(4) With the individual's consent, promptly notify in writing all persons who have received the incorrect information and all persons identified by the individual that the services record has been corrected ~~and request that recipients acknowledge the correction.~~

12VAC35-115-100. Restrictions on freedoms of everyday life.

COMMENT: Several recommendations are made regarding language changes that will enhance the personal freedom and self-determination of individuals receiving services. As community services increase and as the department and its providers embrace the concepts of person centered planning and positive behavioral supports, there will and should be much greater opportunities for personal choice and decision-making.

A. From admission until discharge from a service, each individual is entitled to:

1. Enjoy all the freedoms of everyday life that are consistent with his need for services, his protection, and the protection of others,—and that do not interfere with his services or the services of others. These freedoms include ~~the following:~~ but are not limited to:

a. Freedom to move within the service setting, its grounds, and the community.—;

b. Freedom to communicate, associate, and meet privately with anyone the individual chooses.—;

c. Freedom to have and spend personal money.—;

- d. Freedom to see, hear, or receive television, radio, books, and newspapers, whether privately owned or in a library, ~~or~~ public area of the service setting, or any other public setting;
 - e. Freedom to keep and use personal clothing and other personal items;
 - f. Freedom to use recreational facilities and enjoy the outdoors; ~~and~~
 - g. Freedom to make purchases in canteens, vending machines, or appropriate retail establishments consistent with his preference. ~~stores selling a basic selection of food and clothing. And~~
 - h. Freedom to determine his own activities and personal schedule to the maximum extent feasible consistent with personal preference and goals.
 - i. Freedom to fully participate in any other activities of community life, consistent with the civil and legal rights of free citizens.
2. Receive services in that setting and under those conditions that are least restrictive of his freedom.
- B. The provider's duties.
1. Providers shall encourage each individual's participation in normal activities and conditions of everyday living and support each individual's freedoms.
 2. Providers shall not limit or restrict any individual's freedom more than is needed to achieve a therapeutic benefit, to maintain a safe and ~~orderly~~ clean environment, or to intervene in an emergency.
 3. Providers shall not impose any restriction on an individual unless the restriction is justified and carried out according to these regulations. If a provider imposes a restriction, except as provided in 12 VAC 35-115-50, the following conditions shall be met:
 - a. A qualified professional involved in providing services has, in advance, assessed and documented all possible alternatives to the proposed restriction, taking into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs, ability to function independently level of independence, and promotion of everyday life facilitation of self-determination.
 - 3-4. Providers may develop and enforce written program rules of ~~conduct~~, but only if the rules do not conflict with these regulations or any individual's services plan, ~~and the rules are~~ needed to maintain a safe and ~~orderly~~ clean environment.

No changes to 115-100(B) 5

C35-115-110. Use of seclusion, restraint, and time out.

COMMENT: The Board strongly concurs with 115-110(A) below and believes that the use of seclusion, restraint or involuntary time out should be extremely limited. These interventions should be considered strategies of last resort and should be employed only in emergency situations in which there is imminent danger of harm to the individual or to others or, in the case of protective restraint, when all other less restrictive options have been attempted and have not been successful. In order to proactively prevent the use of seclusion, restraint, or involuntary time out, individuals should have behavioral support plans which identify challenging behaviors as well as the positive interventions that can and should be used to eliminate or reduce the behavior and to develop more positive methods of communicating frustration. All members of the individual's treatment or staff team should have a copy of the behavioral support plan and be trained in its implementation. There are states and providers that have completely eliminated the use of seclusion and restraint. Virginia should continue to move in this direction. The Board recommends several language changes to the relevant regulation and has revised language from the "Definitions" section and moved it to section under 115-110(B)1-3 below.

A. Each individual is entitled to be completely free from any unnecessary use of seclusion, restraint, ~~and~~ or time out.

B. Restraints may be used for the following behavioral, medical, or protective purposes:

1. A restraint used for behavioral purposes restricts freedom of movement for the purpose of ensuring the individual's safety or the safety of others in an emergency situation when there is imminent risk of harm to the individual or others; when non-physical interventions are not viable; and when an immediate response to the situation is required. Restraint shall not be part of an individual's Behavioral Support plan.
2. A restraint used for Medical purposes limits the mobility of the individual for medical, dental, diagnostic, or surgical services, including but not limited to, routine dental care or radiological procedures and related post-procedure care processes, when use of the restraint is not ~~a~~ standard the ~~accepted~~ clinical practice for the individual's condition. Prior to using restraints for medical purposes, the provider shall work with the individual's staff team to determine if a positive behavioral support intervention can be utilized to reduce or eliminate the need for medical restraint. Alternatives that were considered and found to be unsuccessful shall be documented.
3. The purpose of a protective restraint is to compensate for a significant physical or cognitive deficit and to prevent a documented risk of harm to the individual or to protect the individual (for example, bed rails or a gerichair or helmet). The need for protective restraint should be

documented as should less restrictive alternatives that were considered and/or attempted and determined to be unsuccessful.

COMMENT: In 115-110(B)1, the individual should be part of developing the “emergency” plan. As written, the provision reads as though the discussion is on which restrictive intervention is preferred rather than a proactive behavioral support plan. Specific criteria for release from restraint should be established and documented rather than a broad criteria of “when he/she calms down.” The requirements for restraint should apply to all types of restraint, not just mechanical restraint.

B. The provider's duties.

1. Providers shall meet with the individual or his authorized representative upon admission *to the service* to discuss the individual’s preferred interventions *in the event that his behaviors or symptoms become a danger to self or others; and under what circumstances, if any, the intervention may include seclusion, restraint, or time out. ~~it become necessary to use seclusion, restraint, or time out.~~*
2. Providers shall: *(i) document the circumstances under which seclusion, ~~and~~ restraint and time out are to be used that include the individual’s preferences; (ii) document all known contraindications to the use of seclusion, time out, or any form of physical or mechanical restraint, including medical contraindications and a history of trauma, in the individual’s services record; and (iii) shall flag ~~and~~ the record ~~shall be flagged~~ to alert and communicate this information to staff.*
3. Only residential facilities for children that are licensed under the Regulations for Providers for Mental Health, Mental Retardation and Substance Abuse Residential Services for Children (12 VAC 35-45-10 et seq.) and inpatient hospitals may use seclusion. *The use of seclusion in the case of a minor shall be used only in an emergency situation and shall not be a component of a behavioral support plan.*

No Comment on items 115-110(B)4-11.

12. Providers shall ensure that review and approval by a qualified professional for the use or continuation of restraint is documented in the individual’s services record. Approval for the use of restraint may not be given on an as needed basis. Documentation includes:
 - a. Justification for any restraint;
 - b. Time-limited approval for the use or continuation of restraint; ~~and~~
 - c. ~~Behavioral~~ Specific criteria for release from restraint; *and*
 - e. d. Any physical or psychological conditions that would place the individual at greater risk during restraint.
13. Providers may use seclusion or mechanical restraint for behavioral purposes only in an emergency and only if a qualified professional involved in providing services to the individual has, within one hour of the initiation of the procedure:

- a. Conducted a face-to-face assessment of the individual placed in seclusion or *mechanical* restraint and documented why alternatives to the proposed use of seclusion and *mechanical* restraint have not been successful in changing the behavior or were not attempted, taking into account the individual's medical and mental condition, behavior, preferences, nursing and medication needs, and ability to function independently;
- b. Determined that the proposed seclusion or *mechanical* restraint is necessary to protect the individual or others from harm, injury, or death;
- c. Documented in the individual's services record the specific reason for the seclusion or *mechanical*-restraint;
- d. Documented in the individual's services record the behavioral criteria that the individual must meet for release from seclusion or *mechanical* restraint; and
- e. Explained to the individual, in a way that he can understand, *to include alternate communication formats where necessary*, the reason for using *mechanical* restraint or seclusion, the criteria for its removal, and the individual's right to a fair review of whether the mechanical restraint or seclusion is permissible.

COMMENT: The Board is concerned about the time limits for restraint of children. We recognized that these time limits are an improvement upon previous policy and practice. The Board does not have sufficient expertise to have knowledge of whether these timeframes are consistent with best practice and standards in other states but wanted to express its caution in this area, particularly with respect to young children. In addition, we believe that with the development and implementation of appropriate positive behavioral support plans based on properly conducted functional behavioral analysis, the usage of seclusion and restraint can be significantly diminished. The Board has not referenced all instances but recommends that wherever the term behavioral treatment is referenced, that term be changed to behavioral support.

14. Providers shall limit each approval for seclusion or restraint for behavioral purposes ~~or seclusion~~ *to specific instances in which lesser restrictive intervention has not worked and each episode shall be limited to no longer than it takes for the individual to meet the specific criteria established for release up to a maximum of:*
 - a. ~~to~~ four hours for individuals age 18 and older.
 - b. ~~to~~ two hours for children and adolescents ages 9 through 17, and
 - c. ~~to~~ one hour for children under age 9.

Comment: No Comment on items 115-110(B)15-16. In 115-110(B)17-18, the term behavioral treatment should be replaced with the term positive behavioral support plan or behavioral support plan and references to functional behavioral analysis should be

included. In addition, this regulatory section should be clear that restraint is only to be used when data-based positive behavior supports have been tried and have failed.

17. Providers may use restraint or time-out in a positive behavioral support behavioral treatment plan to address behaviors that present an immediate danger to the individual or others, but only after a qualified professional has conducted a detailed and systemic analysis of the behavior and the situations in which the behavior occurs. functional behavioral analysis to include but not be limited to: the antecedents to the behavior, the environments, situations, and times, in which the behavior occurs, and the communicative function of the behavior and the professional has determined that safety cannot be achieved with the use of positive interventions and that no lesser restrictive alternative will be effective. This determination shall be reevaluated at least every 6 months.

a. Providers shall develop any behavioral treatment-support plan involving the use of restraint or time-out for behavioral purposes according to its policies and procedures, which ensure that:

(1) Behavioral treatment-support plans are initiated, developed, carried out, and monitored by professionals who are qualified by expertise, training, education, or credentials to do so.

(2) Behavioral treatment support plans include-emphasize nonrestrictive procedures and environmental modifications that (i) address the communicative function of the targeted behavior and seek to replace it with a more acceptable means of communication and (ii) the individual's preferences for interventions as identified in the ISP.

(3) Behavioral treatment support plans are submitted to and approved by an independent review committee comprised of professionals with training and experience in applied behavior analysis and/or positive behavioral supports who have assessed the technical adequacy of the plan and data collection procedures.

b. Providers shall document in the individual's services record ~~that~~ the lack of success, or probable success, of less restrictive procedures attempted and that the risks associated with not using restrictive procedures not treating the behavior are greater than any risks associated with the use of restraint. This documentation must reflect trials of less restrictive procedures employed within an appropriately developed, data-based positive behavioral support plan and not an assumptions that the less restrictive procedures will not work.

c. Prior to the implementation of any behavioral support treatment plan involving the use of restraint or time-out, the provider shall obtain approval of the LHRC. If the LHRC finds that the plan violates or has the potential to violate the rights of the individual, the LHRC shall notify and make recommendations to the director.

d. Behavioral support treatment plans involving the use of restraint or time-out shall be reviewed quarterly by the independent review committee and by the LHRC to determine if the use of restraint has resulted in improvements in functioning of the individual.

18. Providers may not use seclusion in a behavioral ~~support~~ treatment plan.

12VAC35-115-120. Work.

COMMENT: For consistency, the term “consumer in 115-120 (B) should be replaced with the term “individual.” No change recommended to 115-120(A).

B. The provider's duties.

4. If vocational training, extended employment services, or ~~supportive~~ supported employment services are offered, providers shall establish procedures for documenting the decision on employment and training and the methodology for establishing the individual's ~~consumer~~ wages. Providers shall give a copy of the procedures and information about possible consequences for violating the procedures to all individuals and their ~~legally~~ authorized representatives.

12VAC35-115-130. Research.

COMMENT: No change recommended to 115-130(A). Additional language recommended for protection of the individual in 115-130(B).

B. The provider's duties.

1. Providers shall ~~get~~ obtain prior, written, informed consent of the individual or his ~~legally~~ authorized representative before any individual begins to participate in human research unless the research is exempt under §32.1-162.17.
2. Providers shall comply with all other applicable state and federal laws and regulations regarding human research, including the provisions under Chapter 5.1 ('32.1-162.16 et seq.) of Title 32.1 of the Code of Virginia and the regulations ~~promulgated~~ adopted under ~~that statute~~ §37.2-402.
3. Providers shall ~~solicit~~ obtain consultation and review by and approval from an institutional review board (IRB) or research review committee prior to ~~participation in human research~~ performing or participating in a human research protocol. Documentation of this review and approval must be maintained and made available upon request by the individual or his authorized representative.
4. Prior to participation by individuals in any human research project, the provider All providers shall inform and provide a copy of the IRB or review committee approval to the Local Human Rights Committee-LHRC before an individual receiving services may participate in any human research project. Once the research has been initiated, the provider shall and provide update the LHRC periodically updates on the status of the individual's participation.

12VAC35-115-140. Complaint and fair hearing.

COMMENT: The Board supports this section as written.

PART IV
SUBSTITUTE DECISION MAKING

COMMENT: The concept of substitute decision-making is a critical one. As more people with cognitive or intellectual disabilities move into the community, there will be a need for additional decision-making supports. The Board continues to support creative options that enable people with significant disabilities to live as independently as possible and to exercise maximum self-determination. It is the Board's position that the least restrictive alternatives should be employed when determining whether an individual needs a guardian or substitute decision-maker. Individuals are not necessarily unable to make their own decisions simply because they have mental retardation, developmental disabilities, mental illness, or substance abuse issues. Until determined otherwise, it should be presumed that individuals are able to make their own choices and decisions. Some individuals can make some but not all choices (i.e., they may be able to make choices about who to live with, where to live, what to eat, but not about undergoing a medical procedure or managing their finances). Individuals should be supported to make the decisions they are able, and substitute decision-makers, to the maximum extent possible, should respect the individual's preferences in areas in which they are making the decision. These regulations should reflect the tenor of least restrictive alternative for decision-making.

12VAC35-115-145. Determination of capacity to give consent or authorization.

COMMENT: We recommend a broad review of the methods by which capacity evaluations are conducted for persons with mental retardation and developmental disabilities. The seriousness of the implications of being determined incapacitated are such that the department should develop clear guidelines with respect to the scope and nature of an appropriately conducted capacity evaluation. To avoid conflict of interest, capacity evaluations should be independent and should not be conducted by an evaluator working for or affiliated with a provider. In 115-145(A)5(c) below, the provision, combined with the provision in 12VAC 35-115-200 provides that the LHRC is responsible for determining which evaluation will control when there are two evaluations that disagree with one another. Members of the LHRC are not qualified to make such a decision and this provision should be removed and another more appropriate process implemented. The Board does not have specific recommendations for this process at present.

A. If the capacity of an individual to consent to treatment, services, or research, or authorize the disclosure of information is in doubt, the provider shall obtain an *independent* evaluation from a professional who is qualified by expertise, training, education, or credentials and *who is* not directly involved with the individual *or the provider* to determine whether the individual has capacity to consent or to authorize the disclosure of information.

1. Capacity evaluations shall be obtained for all individuals who may lack capacity, even if they requested that an authorized representative be designated or agree to submit to a recommended course of treatment.
2. In conducting this evaluation, the professional may seek Comments from a professionals involved in the individual's care ~~representative accompanying the individual~~ pursuant to 12VAC-35-115-70A4 about the individual's capacity to consent or authorize disclosure.
3. Providers shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information and the need for a substitute decision maker whenever: (i) the individual's condition warrants, or (ii) the individual requests such a review₇. *Once a determination has been made that the individual lacks such capacity, the provider shall have the individual's capacity evaluated* at least every six months, and at discharge, except for individuals receiving acute inpatient services.

a. If the individual's record indicates that the individual is not expected to obtain or regain capacity, *the provider shall have the individual's capacity reevaluated and documented annually-that it has reviewed the individual's capacity to make decisions and* to determine whether there has been any change in that capacity.

b. Providers of acute inpatient services shall determine the need for an evaluation of an individual's capacity to consent or authorize disclosure of information whenever the individual's condition warrants or at least at every treatment team meeting. Results of such reviews shall be documented in the treatment team notes and communicated to the individual and the authorized representative *in mode of communication that is appropriate and effective for the individual.*

4. Capacity evaluations shall be conducted in accordance with accepted standards of professional practice and shall indicate: (i) the specific type or level of decision for which the individual's capacity is being evaluated (e.g., medical, treatment planning) and *shall indicate* (ii) what specific type of decision the individual has or does not have the capacity to make. *Decision-making supports should be person-centered and least restrictive to the liberty of the individual. Consideration should be given to administration of a capacity evaluation that will address ability to provide both general and informed consent.*

5. If the individual or his family objects to the results of the qualified professional's determination, the provider shall immediately inform the human rights advocate.

- a. If the individual or family member wishes to obtain an independent evaluation of the individual's capacity, he may do so at his own expense and within reasonable timeframes consistent with his circumstances. If the individual or family member cannot pay for an independent evaluation, the individual may request that the LHRC consider the need for an independent evaluation pursuant to 12 VAC 35-115-200 (B). The provider shall take no action for which consent or authorization is required, except in an emergency, pending the results of the independent evaluation. The provider shall take no steps to designate an authorized representative until the independent evaluation is complete.
- b. If the independent evaluation is consistent with the provider's evaluation, the provider's evaluation is binding, and the provider shall implement it accordingly.
- c. If the independent evaluation is not consistent with the provider's evaluation, the matter shall be referred to the LHRC for review and decision [under the procedures set forth in 12 VAC 35-115-200\(A\)2](#) et seq. of this chapter.

12VAC35-115-146. Authorized representatives, [Microboards, and Circles of Support.](#)

COMMENT: With creative community living options growing, it is critical that the human rights regulations recognize and support these opportunities for maximum independence. Thus we are recommending incorporation in 115-145 of the support systems created through the microboard and circle of support models, defined earlier. A microboard is a legal entity and thus should be qualified as a substitute decision-maker.

- A. When it is determined, in accordance with 12 VAC-35-115-145, that an individual lacks the capacity to consent or authorize the disclosure of information, the provider shall recognize and obtain consent or authorization for those decisions for which the individual lacks capacity from the following:
1. An attorney-in-fact who is currently empowered to consent or authorize the disclosure under the terms of a durable power of attorney;
 2. A health care agent appointed by the individual under an advance directive or power of attorney in accordance with the laws of Virginia; or
 3. A legal guardian of the individual, or if the individual is a minor, a parent with legal custody of the minor or other person authorized to consent to treatment pursuant to § 54.1-2969 (A); or
 4. [A Microboard duly incorporated under the laws of the Commonwealth of Virginia.](#) .

B. If an attorney-in-fact, health care agent, or legal guardian, *or Microboard* is not available, the director shall designate a substitute decision-maker as authorized representative in the following order of priority:

1. The individual's family member. In designating a family member, the director shall select the best qualified person, if available, according to the following order of priority unless, from all information available to the director, another person in a lower priority is clearly better qualified. The director shall ask the individual and if the individual expresses a preference for one family member over another in the same category, the director shall designate that family member, unless there is a compelling clinical reason not to do so.

- a. a spouse,
- b. an adult child,
- c. a parent,
- d. an adult brother or sister,
- e. any other relative of the individual.

2. Next friend of the individual. If no other person specified above is available and willing to serve as authorized representative, a provider may *nominate designate* a next friend of the individual, *to the LHRC for review and finding. A next friend can be an individual or a Circle of Support. The nomination of the next friend shall include sufficient information for a decision to be made. If the next friend is an individual, the LHRC will ~~After a review and finding by the LHRC~~ determine that the proposed next friend has, for a period of six months within two years prior to the designation either:*

- a. Shared a residence with the individual; or
- b. Had regular contact or communication with the individual and provided significant emotional, personal, financial, spiritual, psychological, or other support and assistance to the individual.

If the next friend is a Circle of Support, the Circle shall designate a liaison to the LHRC and the provider, and the Circle shall agree to regular contact or communication with the individual and the provision of personal, financial, spiritual, psychological, or other support or assistance to the individual. The liaison of the Circle shall not be a provider currently working with the individual.

3. In addition to the conditions set forth in subdivision 2,:

- a. The LHRC shall conduct a criminal background check on the nominated next friend; and*
- b. the ~~individual~~ the nominated next friend must have no objection to the proposed next friend being designated as the authorized representative.*

COMMENT: While we do not have substitute language, the practice cited below in 115-146 (C) should be strongly discouraged due to the potential for conflict of interest. The ability of the individual to complain about services being provided by a relative is impaired by the caregiver relationship and dependence on that individual. If maintained, there should be a stronger accountability requirement to ensure that the authorized representative is acting in the best interests of the individual and consistent with his preference.

C. No director, employee, or agent of a provider may serve as an authorized representative for any individual receiving services delivered by that provider unless the authorized representative is a relative or the legal guardian. When a provider, or the director, an employee, or agent of the provider is also the individual's guardian, the provider shall assure that the individual's preferences are included in the services plan and that the individual can make complaints about any aspect of the services he receives.

Comment: No changes in 115-146 (D-F). Minor change recommended to 115-146(G) to protect individuals who are not acting in the individual's best interest.

G. Conditions for removal of an authorized representative: Whenever an individual has regained capacity to consent as indicated by a capacity evaluation or clinical determination, the director shall immediately remove any authorized representative designated pursuant to 12 VAC-35-115-146 B1 or B2, notify the individual and the authorized representative, and ensure that the services record reflects that the individual is capable of making his own decisions. Whenever an individual with an authorized representative who is his legal guardian has regained his capacity to give informed consent, the director shall use the applicable statutory provisions to remove the authorized representative. (See § 37.2-1012 of the *Code of Virginia*.) Powers of attorney and health care agents' powers should cease of their own accord when a clinician has determined that the individual is no longer incapacitated.

1. The director shall remove the authorized representative designated pursuant to 12 VAC 35-115 146 B 1 or 2 if the authorized representative becomes unavailable, unwilling, or unqualified to serve *or is clearly acting against the best interests or express preferences of the individual*.. The individual or the advocate may appeal the director's decision to remove an authorized representative to the LHRC under the procedures set out at 12 VAC-35-115-180, and the LHRC may reinstate the authorized representative if it determines that the director's action was unjustified.
2. Prior to any removal under this authority, the director shall notify the individual of the decision to remove the authorized representative, of his right to request that the LHRC review the decision, and of the reasons for the removal decision. This information shall be placed in the individual's services record. If the individual requests, the director shall provide him with a written statement of the facts and circumstances

upon which the director relied in deciding to remove the authorized representative.

The LHRC may recommend the removal of a next friend pursuant to 12VAC35-115-200 when the next friend is not acting in accordance with the individual's best interests *and expressed preferences*

3. The director may otherwise seek to replace an authorized representative recognized pursuant to 12VAC35-115-146 who is an attorney-in-fact currently authorized to consent under the terms of a durable power of attorney, a health care agent appointed by an individual under an advance directive, *a Microboard duly authorized under the laws of the Commonwealth*, a legal guardian of the individual, or, if the individual is a minor, a parent with legal custody of the individual, only by a court order under applicable statutory authority.

PART IV-PART V

COMPLAINT RESOLUTION, HEARING, AND APPEAL PROCEDURES.

12VAC35-115-150. General provisions.

COMMENT: Several language/organizational changes recommended for clarity in 115-150.

A. The parties to any complaint are the individual and the director. *Each party can designate someone to represent him.* ~~also have anyone else to represent him during resolution of the complaint resolution.~~

B. ~~Meetings, reviews, and hearings will generally be closed to other people unless the individual making the complaint requests that other people attend or if an open meeting is required by the Virginia Freedom of Information Act. To protect the confidentiality of the individual, meetings, reviews, and hearings are closed to other people except under the following circumstances:~~

(1) When the individual making the complaint requests that the meeting, hearing, or review be open to other people.

(2) When an open meeting is required under the Virginia Freedom of Information Act (§2.2-3111 of the Code of Virginia)

C. ~~1.~~ The LHRC and SHRC may conduct a closed hearing to protect the confidentiality of persons who are not a party to the complaint, *even if the individual requests an open hearing*, but only if a closed meeting is otherwise allowed under the Virginia Freedom of Information Act (~~2.2-3700 et seq.~~ § 2.2-3711 of the Code of Virginia).

D. ~~2.~~ If any person alleges that implementation of an LHRC recommendation would violate the individual's rights or those of other individuals, the person

may file a petition for a hearing with the SHRC, according to 12VAC35-115-210.

Comment: No changes to 115-150(C-H) other than required renumbering. These sections would now be 115-150(E-J).

12VAC35-115-170. ~~Formal complaint~~ *Complaint resolution process.*

COMMENT: Reporting a violation of rights should be required not optional. In addition, it is critical throughout the complaint resolution process that the procedures be explained to the individual in a manner that the individual can understand. This explanation should reoccur at each step of the process. The use of the term “chosen representative” throughout this section is confusing and too similar to the term “authorized representative.” A different term should be used to reflect that this is the person representing the individual during the complaint proceeding. In addition, there should be provision for emergency or extenuating circumstances with respect to the complaint timeline.

~~A. B. Step 1:~~ Anyone who believes that a provider has violated an individual's rights under these regulations shall ~~may~~ report it to the director ~~and or~~ or the human rights advocate, ~~or either of them,~~ for resolution.

No changes to 115-170(A) 1-2

- ~~3. If the human rights advocate concludes, after an initial investigation, that there is substantial risk that serious and irreparable harm will result if the complaint is not resolved immediately, the human rights advocate shall inform the director, the provider, the provider's governing body, and the LHRC. Steps 2 through 6 below shall not be followed. Instead, the LHRC shall conduct a hearing according to the special procedures for emergency hearings in 12VAC35-115-190.~~

The human rights advocate or director or his designee shall discuss the report with the individual and notify the individual of his right to pursue a complaint through the process established in these regulations. The individual shall be given the choice of pursuing the complaint through the informal or formal complaint process. *The steps in the informal and formal complaint process shall be thoroughly explained to the individual using the mode of communication most effective to the individual, including using alternate formats as needed. The human rights advocate, director, or his designee shall ask the individual if he understands the complaint process and the choice that he has before asking the individual to choose how he wishes to pursue the complaint. If the individual does not make a choice the complaint shall be managed through the informal process.*

No changes to 115-170(A)4

5. The following steps apply if the complaint is pursued through the formal process:

~~C. Step 2~~ Step 1: The director or his designee shall try to resolve the complaint by meeting ~~within 24 hours of receipt of the complaint~~ with the individual, any representative the individual chooses, the human rights advocate, and others as appropriate within 24 hours of receipt of the complaint or the next business day if that day is a weekend or holiday. ~~, and by conducting an investigation if necessary.~~ The director or his designee shall conduct an investigation of the complaint, if necessary.

~~D. Step 3~~ Step 2: The director or his designee shall give the individual and the person the individual has chosen to represent him during the complaint process, ~~his chosen representative~~ a written preliminary decision and, where appropriate, an action plan for resolving the complaint, within 10 working days of receiving the complaint. Along with the action plan, the director or designee shall provide written notice to the individual about the time frame for the individual's response pursuant to Step 3 of this subdivision and a statement the complaint will be closed if the individual does not respond. This decision, the action plan, and the written notice, shall be provided in alternate format if appropriate and explained to the individual in the mode of communication effective for him.

~~E. Step 4~~ Step 3: If the individual ~~is not satisfied at this step~~ disagrees with the director's preliminary decision or action plan, he can respond to the director within ~~5~~ five working days after receiving the ~~director's or the designee's written preliminary decision and action plan.~~ This response shall be in writing or in alternative form of communication appropriate to the individual's need. If the individual has not responded within five working days the complaint will be closed unless there are emergency or extenuating circumstances beyond the control of the individual which prevent a timely response (e.g., an unexpected hospitalization).

~~F. Step 5~~ Step 4: ~~The~~ If the individual disagrees with the preliminary decision or action plan the director shall investigate further as appropriate and shall make a final decision regarding the complaint. The director shall forward a written copy of his final decision and action plan to the individual, the person representing the individual during the complaint process, ~~his chosen representative,~~ and the human rights advocate within ~~10~~ five working days after the director ~~received~~ receives the individual's written response. Along with the action plan, the director shall provide written notice to the individual about the time frame for the individual's response pursuant to Step 5 of this subdivision and a statement that if the individual does not respond that the complaint will be closed unless there are emergency or extenuating circumstances beyond the control of the individual which prevent a timely response (e.g. an unexpected hospitalization). The decision, the action plan, and the written notice, shall be provided in alternate format if appropriate and explained to the individual in the mode of communication effective for him.

~~G. Step 6~~ Step 5: If the individual is ~~not satisfied~~ disagrees with the director's final decision or action plan, he may file a petition for a hearing by the LHRC, using the procedures prescribed in 12VAC35-115-180. The human rights advocate shall thoroughly explain the steps in the hearing process to the individual using the mode of communication most effective to the individual, including using alternate formats as needed. The human rights advocate shall ask the individual if he understands the hearing/appeal process. If the individual has accepted the relief offered by the director, the matter is not subject to further review.

No changes to 115-170(B)

12VAC35-115-180. Local Human Rights Committee hearing and review procedures.

COMMENT: As noted above, we recommend changing the term “chosen” representative, ensuring that procedures are explained through the processes, and that a communication mode effective to the individual is used.

No changes to 115-180(A)

B. Step 1: The individual or his authorized representative must file the petition ~~must be filed for a hearing with the chairperson of the LHRC~~ within 10 working days of the director's action or final decision ~~for which there is a~~ on the complaint.

1. The petition for hearing must be in writing. It should contain all facts and arguments surrounding the complaint and reference any section of the regulations that the individual believes the provider violated.
2. The human rights advocate or any person the individual chooses may help the individual in filing the petition. If the individual chooses a person other than the human rights advocate to help him, the individual and the person he chooses to have assist him ~~his chosen representative~~ may request the human rights advocate's assistance in filing the petition.

No changes to 115-180(C-D)

E. Step 4: The LHRC shall hold a hearing within ~~15~~ 20 working days of receiving the petition.

1. The parties shall have at least five working days' notice of the hearing.
2. The director or his ~~chosen representative~~ designee shall attend the hearing.
- ~~3.~~ 3-4. The individual or ~~legally his~~ authorized representative, ~~as applicable,~~ making the complaint shall attend the hearing.
- ~~4.~~ At the hearing, the parties and their designees, including any person the individual has chosen to represent him and their a individual's representing the parties ~~have~~ have the right to present witnesses and other evidence and the opportunity to be heard.

No changes to 115-180(F)

G. Step 6: Within five working days of receiving the LHRC's findings and recommendations, the director shall give the individual, the *person representing the individual*, ~~individual's chosen representative~~, the human rights advocate, the governing body, and the LHRC a written action plan he intends to take to respond to the LHRC's findings and recommendations. Along with the action plan, the director shall provide written notice to the individual about the time frame for the individual's response pursuant to Step 7 (12VAC35-115-180 H) and a statement that if the individual does not respond that the complaint will be closed. *The action plan written notice, shall be provided in alternate format if appropriate and explained to the individual in the mode of communication effective for him.* The plan shall not be implemented for five working days after it is submitted, unless the individual ~~receiving services~~ agrees to its implementation sooner.

H. Step 7: The individual, his chosen representative, the human rights advocate, or the LHRC may object to the action plan within five working days by stating ~~what the objection is~~ and what the director can do to resolve the objection *except that the five day response time can be extended if there are emergency or extenuating circumstances beyond the control of the individual which prevent a timely response (e.g. an unexpected hospitalization).*

No changes to 115-180(H)

12VAC35-115-190. Special procedures for emergency hearings by the LHRC.

COMMENT: Provisions should be made for alternate forms of communication. In addition, the following changes are recommended to 115-190.

No changes to 115-190(A-C)

D. ~~Step 4:~~ If the individual or the human rights advocate objects within 24 hours to the LHRC findings or recommendations or to the director's action plan, the LHRC shall conduct a full hearing within five working days of the objection, following the procedures outlined in 12VAC35-115-180. This objection shall be in writing *or in alternative form of communication appropriate to the individual's needs.*

No changes to 115-190(E)

12VAC35-115-200. Special procedures for LHRC reviews involving consent and authorization.

COMMENT: As noted in our comments under 115-145, members of an LHRC are not qualified to make a determination of which evaluation will control when there are two conflicting evaluations. A third independent evaluation should be obtained or a court determination sought.

No changes under 115-200(A)1. Under 115-200(A)2, we recommend the following:

2. If an individual or his family member has obtained an independent evaluation of the individual's capacity to ~~give any informed consent to treatment or participation services or to participate in human research under 12VAC35-115-70, or authorize the disclosure of information under 12VAC35-115-90,~~ and the opinion of that evaluator conflicts with the opinion of the provider's evaluator, the LHRC may be requested to decide whether the individual's personal consent is required for any treatment or participation in research which evaluation will control. *To facilitate its review, the LHRC shall ask that a physician or licensed clinical psychologist, not employed by the provider, evaluate the individual at the provider's expense, and give a third opinion about his capacity to consent to treatment or authorize information.*

a. *If the LHRC agrees that the final determination is that the individual lacks the capacity to consent to treatment or services, or authorize disclosure of information, the director may begin or continue treatment or research, or disclose information, but only with the appropriate consent or authorization of the authorized representative. The LHRC shall advise the individual of his right to appeal this determination to the SHRC under 12VAC35-115-210.*

b. *If the final determination is that the individual does not lack capacity LHRC does not agree that the individual lacks the capacity to consent to treatment or services, or authorize disclosure of information, the director shall not begin any treatment, research, or disclose information with the individual's consent or authorization, or shall take immediate steps to discontinue any actions begun without the consent or authorization of the individual. The director may appeal to the SHRC under 12VAC35-115-210 but may not take any further action until the SHRC issues its opinion.*

No changes to 115-200(A)3 or 115-200(B).

12VAC35-115-210. State Human Rights Committee appeals procedures.

COMMENTS: Suggestions on Section 115-210 section are consistent with those throughout the document, reflecting the need for alternate forms of communication and explanation of the appeal process. In addition, we recommended that notice to the Office of the Inspector General of an appeal take place at the same time as notice to the SHRC.

A. Any party may appeal to the ~~State Human Rights Committee~~ SHRC if he is not satisfied with any of the following:

1. An LHRC's final findings of fact and recommendations following a hearing—;
2. A director's final action plan following an LHRC hearing—;

3. An LHRC's final decision regarding the capacity of an individual to consent to treatment, services, or research, or authorize disclosure of confidential information; or
4. An LHRC's final decision concerning whether consent or authorization is needed for the director to take a certain action.

The human rights advocate shall thoroughly explain the steps in appeal process to the individual using the mode of communication most effective to the individual, including using alternate formats as needed. The human rights advocate shall ask the individual if he understands the appeal process.

The steps for filing an appeal are provided in subsections B through I of this section.

- B. Step 1: Appeals shall be filed in writing or in alternative form of communication appropriate to the individual's needs, with the SHRC by a party within 10 working days of receipt of the final action.
 1. The appeal shall explain the reasons the final action is not satisfactory.
 2. The human rights advocate or any other person may help in filing the appeal. If the individual chooses a person other than the human rights advocate to help him, he and the person he has chosen to represent him during the appeal his ~~chosen representative~~ may request the human rights advocate's help in filing the appeal.
- C. Step 2: If the director is appealing, the individual may file a written statement with the SHRC within five working days after receiving a copy of the appeal. This statement shall be accepted in the individual's primary mode of communication if the individual is not able to respond in writing. If the individual is appealing, the director shall file a written statement with the SHRC within five working days after receiving a copy of the appeal.
- D. Step 3: Within 5 working days of noting or being notified of an appeal, the director shall include a complete record of the LHRC hearing to the SHRC and shall send notification of the appeal to the office of the inspector general. The record shall include at a minimum:

COMMENT: The Board believes that hearing the appeal at its next scheduled meeting could be detrimental to the individual since it could be 3 months before the committee meetings. The Board recognizes that it is difficult to gather a statewide committee but believes the individuals' needs should be prioritized and recommends changing the timeframe back to the original 20 working days which is approximately 30 calendar days. We also recommend that there be a specific time frame for sending a case back to the LHRC. In Section G, no new language is recommended, but we recommend separating the paragraphs for purposes of clarity and consistency with the format in Section I.

- E. Step 4: The SHRC shall hear the appeal within 20 working days at its next scheduled meeting after the ~~chair~~ chairperson receives the appeal.

1. The SHRC shall give the parties at least 10 working days' notice of the appeal hearing.
2. The following rules govern appeal hearings:
 - a. The SHRC shall not hear any new evidence.
 - b. The SHRC is bound by the LHRC's findings of fact subject to subdivision 3 of this subsection.
 - c. The SHRC shall limit its review to whether the facts, as found by the LHRC, establish a violation of these regulations and a determination of whether the LHRC's recommendations or the action plan adequately address the alleged violation.
 - d. All parties and their representatives shall have the opportunity to appear before the SHRC to present their position and answer questions the SHRC may have.
 - e. ~~The SHRC will shall notify the Inspector General inspector general of the appeal.~~
3. If the SHRC decides that the LHRC's findings of fact are clearly wrong or that the hearing procedures employed by the LHRC were inadequate, the SHRC may ~~either~~:
 - a. Send the case back to the LHRC for another hearing to be completed no later than 20 working days a time period specified by the SHRC; or
 - b. Conduct its own fact-finding hearing. If the SHRC chooses to conduct its own fact-finding hearing, it may appoint a subcommittee of at least three of its members as fact finders. The fact-finding hearing shall be conducted within 30 working days of the SHRC's initial hearing.

In either case, the parties shall have 15 working days' notice of the date of the hearing and the opportunity to be heard and to present witnesses and other evidence. All necessary reasonable accommodations for the individual shall be made in order to ensure the individual's ability to participate fully in the proceedings.

F. Step 5: Within 20 working days after the SHRC appeal hearing, the SHRC shall submit a report, its findings of fact, if applicable, and recommendations to the commissioner and to the provider's governing body, with copies to the parties, the LHRC, and the human rights advocate. Upon request, the human rights advocate shall explain the report and the findings of fact and recommendations to the individual.

G. Step 6: Within 10 working days after receiving the SHRC's report, in the case of appeals involving a state facility, the commissioner shall

submit an outline of actions to be taken in response to the SHRC's recommendations.

In the case of appeals involving CSBs and private providers, both the commissioner and the provider's governing body shall each outline in writing the action or actions they will take in response to the recommendations of the SHRC. They shall also explain any reasons for not carrying out any of the recommended actions. Copies of their responses shall be forwarded to the SHRC, the LHRC, the director, the human rights advocate, and the individual.

H. Step 7: If the SHRC objects in writing to the commissioner's or governing body's proposed actions, or both, their actions shall be postponed. The commissioner or governing body, or both, shall meet with the SHRC within 20 working days at its next regularly scheduled meeting to attempt to arrange a mutually agreeable resolution.

I. Step 8: In the case of services provided directly by the department, the commissioner's action plan shall be final and binding on all parties. However, when the SHRC believes the commissioner's action plan is incompatible with the purpose of these regulations, it shall notify the board, the protection and advocacy agency, and the ~~Inspector General~~ inspector general.

In the case of services delivered by all other providers, the action plan of the provider's governing body shall be reviewed by the commissioner. If the commissioner determines that the provider has failed to develop and carry out an acceptable action plan, the commissioner shall notify the protection and advocacy agency and shall inform the SHRC ~~what of the~~ sanctions the department will impose against the provider.

J. Step 9: Upon completion of the process outlined above, the SHRC shall notify the parties and the human rights advocate of the final outcome of the complaint. Further appeal rights, if any, including the right to file a civil case in a court of competent jurisdiction shall be explained to the individual in his primary mode of communication.

~~PART VI~~ PART VI

VARIANCES

12VAC35-115-220. Variances.

COMMENT: The Board recommends that notice of variances be published in local newspapers. Most citizens do not have access to or do not regularly read the Virginia Register of Regulations. We recommend a new Section I relating to notification.

No changes to 115-220 (A-C)

D. When the SHRC receives the application and the LHRC's report, the SHRC shall do the following:

1. Invite oral or written statements about the application from the applicant director, LHRC, advocate, and other interested persons by publishing the request for variance in the next issue of the Virginia Register of Regulations and in *the primary newspaper in the locality in which the variance is being requested.*
2. Notify the ~~Inspector General~~ inspector general of the request for variance.
3. After considering all available information, prepare a written decision deferring, disapproving, ~~or~~ modifying, or approving the application. All variances shall be approved for a specific time period and must be reviewed at least annually.
 - a. A copy of this decision including conditions, time frames, circumstances for removal, and the reasons for the decision shall be given to the applicant director, the commissioner or governing body, ~~where appropriate, the State Human Rights Director~~ state human rights director, the human rights advocate, any person commenting on the request at any stage, and the LHRC.
 - b. The decision and reasons shall also be published in the next issue of the Virginia Register of Regulations.

E. Directors shall implement any approved variance in strict compliance with the written application as amended, modified, or approved by the SHRC.

F. Providers shall develop policies and procedures for monitoring the implementation of any approved variances *and documenting the impact of the variance on the individuals being served.* These policies and procedures shall specify that at no time can a variance approved for one individual be extended to general applicability. These policies and procedures shall assure the ongoing collection of any data relevant to the variance and the presentation of any later report concerning the variance as requested by the commissioner, the State Human Rights Director, the human rights advocate, the LHRC or the SHRC.

H. If an individual is in immediate danger due to a provider's implementation of these regulations, the provider may request a temporary variance pending approval pursuant to the process described in this section. Such a request shall be submitted in writing to the commissioner, chairperson of the SHRC, and state human rights director. The commissioner, chairperson of the SHRC, and state human rights director shall issue a decision within 48 hours of the receipt of such a request.

I. When a variance is approved, the individuals being served by the provider granted the variance should be informed about the details and specifications of the variance.

~~PART VI~~ **PART VII**
REPORTING REQUIREMENTS

12VAC35-115-230. Provider requirements for reporting to the department.

COMMENT: The Board recommends some language clarifications/additions regarding time frames for and content of reporting and recommends that data be made public as is done by a number of other agencies, including the Department of Health and the Department of Health Professions.

A. Providers shall collect, maintain, and report the following information concerning abuse, neglect, and exploitation:

1. The director of a facility operated by the department shall report allegations of abuse and neglect in accordance with all applicable operating instructions issued by the commissioner or his designee, including, where provided for by law, reporting to the protection and advocacy agency as required under §51.5-39.12., Code of Virginia and to the office of the inspector general pursuant to access granted under §37.2-424 (4) and (8).
2. The director of a service licensed or funded by the department shall report each allegation of abuse or neglect to the assigned human rights advocate within 24 hours from the receipt of the allegation (see 12VAC35-115-50). The director shall also inform the human rights advocates as to whether he has reported the allegation to Department of Social Services, Adult Protective Services, or in the case of a minor child, Child Protective Services.
3. The Office of Human Rights shall post on its website all substantiated cases of abuse, neglect, or exploitation for all providers, including facilities, to include for each case: (i) the nature of the abuse, neglect, or exploitation; (ii) the outcomes of the abuse, neglect, or exploitation for the individual, (iii) the number of staff involved; (iv) corrective actions taken by provider; and (v) any sanctions from department or law enforcement actions. This information shall remain available online for no less than two years.
 - a. Whether abuse, neglect, or exploitation occurred;
 - b. ~~Type~~The type of abuse; and
 - c. Whether the act resulted in physical or psychological injury.

B. Providers shall collect, maintain, and report the following information concerning deaths and serious injuries:-:

1. The director of a facility operated by the department shall report to the department deaths and serious injuries in accordance with all applicable operating instructions issued by the commissioner or his designee. This

includes but is not limited to statutory requirements for reporting to the office of the inspector general and the protection and advocacy system.

C. Providers shall collect, maintain, and report the following information concerning seclusion and restraint, including all actions taken, the rationale for employing seclusion or restraint, and documentation of all other interventions utilized and why they were unsuccessful.

1. The director of a facility operated by the department shall report monthly each instance of seclusion or restraint or both in accordance with all applicable operating instructions issued by the commissioner or his designee.
2. The director of a service licensed or funded by the department shall submit a monthly report ~~n annual report~~ of each instance of seclusion or restraint ~~.or both by the 15th of January each year, or more frequently if requested by the department.~~

No changes to 115-230(C-E)

F. The department shall compile all data reported under this section and make this data available to the public and the ~~Inspector General~~ inspector general upon request.

1. The department shall provide the compiled data in writing or by electronic means.
2. The department shall remove all provider-identifying information and all information that could be used to identify a person as an individual receiving services.
3. The department shall post all data by provider on the department's website to include the nature of the allegation, the number of staff involved and the outcome.

No changes to 115-230(G-I)

~~PART VII~~ PART VIII.

ENFORCEMENT AND SANCTIONS.

12VAC35-115-240. Human rights enforcement and sanctions.

COMMENT: The requirement to impose sanctions for human rights violations should be mandatory and the imposition of sanctions made public.

A. The commissioner shall may invoke the sanctions enumerated in ~~'37.1-185.1 § 37.2-419~~ of the Code of Virginia upon receipt of information that a provider licensed or funded by the department is:

1. In violation of (i) the provisions of ~~'37.1-84.1 § 37.2-400~~ and ~~"37.1-179 through 37.1-189.2 §§ 37.2-403 through 37.2-422~~ of the Code of Virginia; , (ii) these regulations ~~;~~ and (iii) provisions of the licensing regulations

promulgated pursuant to ~~"37.1-179.1 and 37.1-182~~ §§ 37.2-404 and 37.2-411 of the Code of Virginia; and

2. ~~Such~~The violation adversely ~~impacts~~affects the human rights of individuals receiving services or poses an imminent and substantial threat to the health, safety, or welfare of individuals receiving services.

The commissioner shall notify the provider in writing of the specific violation or violations found and of his intention to convene an informal conference pursuant to §2.2-4019 of the Code of Virginia at which the presiding officer will be asked to recommend issuance of a special order.

B. The sanctions contained in the special order shall remain in effect ~~during the pendency~~for the duration of any appeal of the special order.

C. Information on sanctions imposed on any provider shall be posted on the department's website, to include but not be limited to the nature of the violation, the date of violation and the sanctions imposed.

~~PART VIII~~PART IX. RESPONSIBILITIES AND DUTIES.

12VAC35-115-250. Offices, composition and duties.

COMMENT: Added new 115-250(A)2 to emphasize the need for alternate forms of communication and reasonable accommodations. Added clarifying language.

A. Providers and their directors shall:

1. Identify a person or persons accountable for helping individuals to exercise their rights and resolve complaints regarding services.
2. Ensure that reasonable accommodations necessary for the individual to understand his rights and responsibilities are provided and that the individual's primary mode of communication is employed.

No changes to 115-250(A) 3-13 or 115-250(A)16 other than renumbering. Minor change to 115-250(A)14 (now 115-250 (A)15)

~~13-14, 15.~~ Post in *prominent* program locations information about the existence and purpose of the human rights program and the protection and advocacy system.

Minor language/clarification change to 115-250(B)

B. Employees of the provider shall, as a condition of employment:

1. Become familiar with these regulations, comply with them in all respects, and help individuals understand and assert their rights.
2. Protect individuals from any form of abuse, neglect ~~and~~, or exploitation (i) by not abusing, neglecting, or exploiting any individual; (ii) by not

permitting or condoning anyone else to abuse, neglect, or exploit ~~abusing, neglecting, or exploiting~~ any individual; and (iii) by reporting all suspected abuse, neglect, and exploitation to the program director. Protecting individuals receiving services from abuse also includes using the minimum force necessary to restrain an individual who is abusing another individual.

No changes to 115-250(C) 1-4 and 6-13. Minor change to 115-250(C)5

C. The human rights advocate shall:

5. Whenever appropriate or when requested by the individual or his authorized representative, file a written complaint with the LHRC for an individual receiving services or, where general conditions or practices interfere with individuals' rights, for ~~the~~ a group of individuals.

COMMENT: In 115-250(D-E), the phrasing of the membership requirements is confusing and difficult to read. We recommend a reorganization of both the LHRC and SHRC section. We also recommend that the visits to facilities by the state human rights director be documented in a public report.

D. The Local Human Rights Committee shall:

1. Consist of five or more members appointed by the SHRC who are broadly representative of professional and consumer interests. ~~a. Membership shall be broadly representative of professional and consumer interests. At least one third of the members on each committee shall be individuals who are receiving services and or family members of similar individuals with at least two individuals who are receiving services or who have received within the five years of their initial appointment public or private mental health, mental retardation, or substance abuse treatment or habilitation services on each committee within five years of their initial appointment. Remaining appointments shall include persons with interest, knowledge, or training in the mental health, mental retardation, or substance abuse field:~~

- a. At least one third of the members on each LHRC shall be individuals who are receiving services or family members of individual who are receiving services. Of this one-third, the committee must include at least two individuals who are receiving or who have received public or private mental health, mental retardation, or substance abuse services within five years of their initial appointment.

- b. At least one member of each LHRC shall be a health care provider.

- c. The remaining members of each LHRC shall include persons with interest, knowledge, or training in the mental health, mental retardation, or substance abuse field:

E. ~~The State Human Rights Committee (SHRC)~~ SHRC shall:

1. Consist of nine members appointed by the board who are broadly representative of professional and consumer interests and come from geographically diverse areas.
 - a. ~~Members shall be broadly representative of professional and consumer interests and of geographic areas in the Commonwealth. At least one third of the members on each LHRC shall be individuals who are receiving services or family members of individual who are receiving services. Of this one-third, the committee must include at least two individuals who are receiving or who have received public or private mental health, mental retardation of substance abuse services within five years of their initial appointment.~~
 - b. At least one member of each SHRC shall be a health care provider.
 - c. The remaining members of each SHRC shall include persons with interest, knowledge, or training in the mental health, mental retardation, or substance abuse field:
 - e. d. No member can be an employee or board member of the department or a CSB.
 - ~~e.~~ All appointments after November 21, 2001, shall be for a term of three years.
 - ~~e.~~ e. If there is a vacancy, interim appointments may be made for the remainder of the unexpired term.
 - e. f. A person may be appointed for no more than two consecutive three year terms. A person appointed to fill a vacancy may serve out that term, and then be eligible for two additional consecutive terms.
2. Elect a ~~chair~~ chairperson from its own members who shall:
 - a. Coordinate the activities of the SHRC;
 - b. Preside at regular meetings, hearings and appeals; and
 - c. Have direct access to the commissioner and the board in carrying out these duties. No changes to 115-250(E)

No changes to 115-250(E)3-16)

- ~~16~~17. ~~Submit a report on its activities to the board and publish each year an annual report of its activities and the status of human rights in the mental health, mental retardation, and substance abuse treatment and services in Virginia and make recommendations for improvement. This report shall be posted on the department's website and available in alternate formats upon request.~~

No changes to 115-250(E)18-22). No changes to 115-250(F) 1-4 or F (6-10). The following change is recommended to 115-250(F)5

- F. The ~~State Human Rights Director~~ state human rights director shall

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5. Periodically visit service settings to monitor the free exercise of ~~those~~ rights enumerated in these regulations and prepare a public annual report on visit findings to be posted on the department's website.

No changes to 115-250(G-H).