

- (i) The pharmacy or drug room shall be under competent supervision.
  - (ii) The pharmacist shall be responsible to the administration of the facility and for developing, supervising and coordinating all activities of the pharmacy.
2. If there is a drug room with no pharmacist, prescription medication shall be dispensed by a qualified pharmacist elsewhere and only storage and distribution shall be done at the facility. A designated person shall have responsibility for the day-to-day operation of the drug room. A consulting pharmacist shall assist in developing policies and procedures for the distribution of drugs, and shall visit the facility as needed.
  3. Special locked storage space shall be maintained at the facility to meet the legal requirements for storage of narcotics and other prescribed drugs.
  4. Written arrangements with outside pharmacies, clinicians or facilities shall be made for emergency pharmaceutical service.
  5. Establishment and maintenance of a satisfactory system of records and bookkeeping in accordance with the policies of the facility.
  6. An automatic stop order on all prescribed drugs not specifically prescribed as to time and number of doses. These stop orders shall be in accordance with federal and State laws. Individual drug plans shall be reviewed by a physician weekly or more frequently as needed.
  7. A drug formulary accepted for use in the facility which is developed and amended at regular intervals by medical staff in cooperation with the pharmacist.
  8. Drugs may be administered only by a licensed nurse, in accordance with the Nurse Practice Act, Ga. Code Ann. § 43-26-12 et seq. relating to the practice of nursing in this State.
  9. Medical orders shall be in writing and signed by the physician. Telephone/verbal orders shall be used sparingly and given only to a licensed nurse or otherwise qualified individual as determined by the medical staff in accordance with State law. The individual receiving the telephone/verbal order shall immediately repeat the order and the prescribing physician shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's clinical record that the order was repeated and verified. Telephone/verbal orders must be signed by the physician within the timeframe designated in the facility's policies and procedures which ensure that it is done as soon as possible. Where telephone/verbal orders are routinely not being signed within the timeframe designated in the policy, the facility will take appropriate corrective action.

10. Intravenous medications and fluids shall be administered in accordance with State law. If administered by licensed nurses, they shall be administered only by those who have been trained and determined competent to perform this duty.

11. Each facility shall provide pharmaceutical services in compliance with State and federal laws and regulations.

**(h) Laboratory and Pathology Services.** Provision shall be made for those services within the facility or with an outside facility to meet the needs of the patient. These services shall be provided by a CLIA certified facility. Laboratory and pathology tests to be performed require an order from a qualified physician and reports from such tests shall be part of the patient's clinical records. Abnormal laboratory and pathology reports shall be followed up appropriately.

**(i) Patients' Rights.** Every effort shall be made to safeguard the legal and civil rights of patients and to make certain that they are kept informed of their rights, including the right to legal counsel and all other requirements of due process when necessary.

1. Treatment. Each patient shall be provided treatment and care in the least restrictive environment as possible; each patient, parent(s), and/or legal guardian shall be encouraged to participate in the development of the patient's individualized treatment plan; and each patient shall be provided treatment and care in a manner that respects the patient's personal privacy and dignity.

2. Visitors. Policies shall allow visitation of patient's family and significant others unless clinically contraindicated. Appropriate places for visits shall be provided.

3. Telephone and Mail. Patients shall be allowed to conduct private telephone conversations with family and friends and to send and receive mail. When restrictions are necessary because of therapeutic or practical reasons, such as expense, these reasons shall be documented, explained to the patient and family and re-evaluated at least monthly.

4. Behavior Management. Behavior management techniques shall be fair and consistent and must be applied based on the individual's needs and treatment plan, and following established and approved behavior management techniques in accordance with the rules described in paragraph 290-4-4-.07 et seq.

5. Restraint and Seclusion. Each patient has the right to be free from restraint or seclusion, in any form, used as a means of coercion, discipline, convenience, or retaliation.

6. Clothing. Individual patients shall have their own appropriate amounts and types of clothing for the particular activities, climate, etc. There shall be an appropriate storage place for their clothing.

7. Grievances. The patients shall have the opportunity to present opinions, recommendations and grievances to appropriate staff members. The facility shall have written policies and carry out appropriate procedures for receiving and responding to such patient communications in a way that will preserve and foster the therapeutic aspects of conflict-resolution and problem solving; e.g., patient-staff government meetings.

**(j) Records.** The form and detail of the clinical records may vary.

1. Content. All clinical records shall contain all pertinent clinical information and each record shall contain at least:

(i) Identification data, consent forms, acknowledgment of patient, parent(s), and/or legal guardian's receipt and explanation of facility's emergency safety intervention procedures and a copy of patients' rights; when these are not obtainable, reason shall be noted;

(ii) Source of referral;

(iii) Reason for referral, e.g. chief complaint, presenting problem;

(iv) Record of the complete assessment;

(v) Initial formulation and diagnosis based upon the assessment;

(vi) Written treatment plan;

(vii) Medication history and record of all medications prescribed;

(viii) Record of all medication administered by facility staff, including type of medication, dosages, frequency of administration, and persons who administered each dose;

(ix) Documentation of course of treatment and all evaluations and examinations, including those from other facilities, example, emergency room or general hospital

(x) Documentation of the use and monitoring of emergency safety interventions;

(xi) Documentation of the use of patient safety observations/interventions;

(xii) Periodic progress report;

(xiii) All consultation reports;

(xiv) All other appropriate information contained from outside sources pertaining to the patient;

(xv) Discharge or termination summary report; and

(xvi) Plans for follow-up and documentation of its implementation.

2. Identification data and consent form shall include the patient's name, address, home telephone number, date of birth, sex, next of kin, school name, grade, date of initial contact and/or admission to the service, legal status and legal document, and other identifying data as indicated.

3. Progress Notes. Progress notes shall include regular notations at least weekly by staff members, consultation reports and signed entries by authorized identified staff. Progress notes by the clinical staff shall:

(i) Document a chronological picture of the patient's clinical course;

(ii) Document all treatment rendered to the patient;

(iii) Document the implementation of the treatment plan;

(iv) Describe each change in each of the patient's conditions;

(v) Describe responses to and outcome of treatment including the use of any emergency safety interventions and medications; and

(vi) Describe the responses of the patient and the family or significant others to significant events.

4. Discharge Summary. The discharge summary shall include the initial formulation and diagnosis, clinical resume, final formulation, and final primary and secondary diagnoses, the psychiatric and physical categories. The final formulation shall reflect the general observations and understanding of the patient's condition initially, during appraisal of the fundamental needs of the patients. All relevant discharge diagnoses should be recorded and coded in the standard nomenclature of the current "Diagnostic and Statistical Manual of Mental Disorders," published by the American Psychiatric Association, and the latest edition of the "International Classification of Diseases," regardless of the use of other additional classification systems. Records of discharged patients shall be completed following discharge within a reasonable length of time, and not to exceed 15 days. In the event of death, a summation statement shall be added to the record either as a final progress note or as a separate resume. This final note shall take the form of a discharge summary and shall include circumstances leading to death. All discharge summaries must be signed by a physician.

5. Recording. Entries in the clinical records shall be made by all staff having pertinent information regarding the patient, consistent with the facility policies, and authors shall fully sign and date each entry. When mental health trainees are involved in, patient

care, documented evidence shall be in the clinical records to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnosis, both psychiatric and physical, shall be recorded in full, and without the use of either symbols or abbreviations.

6. Policies and Procedures. The facility shall have written policies and procedures regarding clinical records which shall provide that:

(i) Clinical records shall be confidential, current and accurate;

(I) The facility shall protect the confidentiality of clinical information and communication between staff members and patients;

(II) All staff shall have training, as part of new staff orientation and with periodic updates, regarding the effective maintenance of confidentiality of clinical records. It shall be emphasized that confidentiality also refers to discussions regarding patients inside and outside the facility. Verbal confidentiality shall be discussed as part of all employee training.

(ii) Clinical records are the property of the facility and shall be maintained for the benefit of the patient, the staff and the facility;

(iii) The facility is responsible for safeguarding the information in the clinical record against loss, defacement, tampering or use by unauthorized persons;

(iv) Except as required by law, the written consent of the patient, or if the patient is a minor, the parent(s), and/or legal guardian, is required for the release of clinical record information;

(v) Records may be removed from the facility's jurisdiction and safekeeping only according to the policies of the facility or as required by law; and

7. Maintenance of Records. Each facility shall provide for a master filing system which shall include a comprehensive record of each patient's involvement in every program aspect.

(i) Appropriate records shall be kept on the unit where the patient is being treated or be directly and readily accessible to the clinical staff caring for the patient;

(ii) The facility shall maintain a system of identification and filing to facilitate the prompt location of the patient's clinical records;

(iii) The facility shall retain patients' records at least until the fifth anniversary of the patients' discharge. If the patient is a minor, the records must be retained for at least five (5) years past the age of majority. Records may be preserved in the facility's

format of choice, including but not limited to paper or electronic format, so long as the records are readable, capable of being reproduced in paper format upon request, and stored and disposed of in a manner that protects the confidentiality of the record;

(iv) The clinical record services required by the facility shall be directed, staffed and equipped to facilitate the accurate processing, checking, indexing, filing, retrieval and review of all clinical records. The clinical records service shall be the responsibility of an individual who has demonstrated competence and training or experience in clinical record administrative work. Other personnel shall be employed as needed, in order to effect the functions assigned to the clinical record services; and

(v) There shall be adequate space, equipment and supplies, compatible with the needs of the clinical record service, to enable the personnel to function effectively and to maintain clinical records so that they are readily accessible.

**(k) Program and Patient Evaluation.** The staff shall work towards enhancing the quality of patient care through specified, documented, implemented and ongoing processes of clinical care evaluation studies and utilization review mechanisms.

#### 1. Individual Case Review.

(i) There shall be regular staff meetings and/or unit meetings to review and monitor the progress of the individual child or adolescent patient. Each patient's case shall be reviewed within a month after admission and at least monthly during residential treatment. Review of the use of emergency safety interventions shall be in accordance with rule 290-4-4-.07(f). The reviews shall be documented and the meeting may also be used for review and revision of treatment plans.

(ii) The facility shall provide for a follow-up review on each discharged patient to determine effectiveness of treatment and disposition.

#### 2. Program Evaluation.

(i) Clinical Care Evaluation Studies. There shall be evidence of ongoing studies to define standards of care consistent with the goals of the facility, effectiveness of the program, the facility's progress in reducing the use of emergency safety interventions, and to identify gaps and inefficiencies in service. Evaluation shall include, but is not limited to, follow-up studies. Studies shall consist of the following elements:

(I) Selection of an appropriate design;

(II) Specification of information to be included;

(III) Collection of data;

(IV) Analysis of data with conclusions and recommendations;

(V) Transmissions of findings; and

(VI) Follow-up on recommendations.

(ii) Utilization Review. Each facility shall have a plan for and carry out utilization review. The review shall cover the appropriateness of admission to services, the provision of certain patterns of services, and duration of services. There shall be documentation of utilization review meetings either in minutes or in individual clinical records.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Services" adopted. F. June 9, 1976; eff. June 29, 1976. **Repealed:** New Rule of same title adopted. F. Nov. 20, 2006; eff. Dec. 10, 2006.

### **290-4-4-.08 Behavior Management and Emergency Safety Interventions.**

#### **(1) Behavior Management.**

(a) The facility shall develop and implement policies and procedures on behavior management. Such policies and procedures shall set forth the types of patients served in accordance with its program purpose, the anticipated behavioral problems of the patients, and acceptable methods of managing such problems.

(b) Such behavior management policies and procedures shall incorporate the following minimum requirements:

1. Behavior management principles and techniques shall be used in accordance with the individual treatment plan, written policies and procedures, treatment goals, safety, security, and these rules and regulations.
2. Behavior management shall be limited to the least restrictive appropriate method, as described in the patient's treatment plan, and in accordance with the prohibitions as specified in these rules and regulations.
3. Behavior management principles and techniques shall be administered by facility staff members and shall be appropriate to the severity of the patient's behavior, chronological and developmental age, size, gender, physical, medical, psychiatric condition, and personal history (including any history of physical or sexual abuse).

(c) The following forms of behavior management shall not be used by staff members with patients receiving services from the facility:

1. Assignment of excessive or unreasonable work tasks;
2. Denial of meals and hydration;
3. Denial of sleep;

4. Denial of shelter, clothing, or essential personal needs;
5. Denial of essential program services;
6. Verbal abuse, ridicule, or humiliation;
7. Restraint, manual holds, and seclusion used as a means of coercion, discipline, convenience, or retaliation;
8. Denial of communication and visits unless restricted in accordance with Rule 290-4-4-.06(i)(2); and
9. Corporal punishment.

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

**(2) Emergency Safety Interventions.**

- (a) Emergency safety interventions shall only be used when a patient exhibits a dangerous behavior reasonably expected to lead to immediate physical harm to the patient or others and less restrictive means of dealing with the injurious behavior have not proven successful or may subject the patient or others to greater risk of injury.
- (b) Any emergency safety intervention involving use of mechanical restraints, manual holds, or seclusion must be ordered by a physician or other licensed professional trained in emergency safety interventions and authorized by State law to order such use.
  1. The order may not be a standing order or on an as-needed basis.
  2. If the order is a verbal order, it must be received by a licensed nurse or otherwise qualified staff as determined by the medical staff in accordance with State law, prior to initiation of the emergency safety intervention, while the intervention is being initiated by staff, or immediately thereafter. The individual issuing the order must verify the verbal order in a signed written form in the patient's record within the timeframe designated by facility policy and procedure which ensures that it is done as soon as possible. The individual ordering the use of the intervention must be available to staff for consultation, at least by a two-way communication device, throughout the course of the emergency safety intervention.
  3. Each order for use of restraint or seclusion must be limited to no longer than the duration of the emergency safety situation.

4. Each order for the use of mechanical restraint, manual hold, or seclusion, must include the name of the physician or other licensed professional, the date and time the order was obtained, the type of intervention ordered, and the length of time for which the use of the intervention was authorized. Restraint and seclusion orders shall not exceed:

(i) Four (4) hours for patients ages 18 to 21;

(ii) Two (2) hours for patients ages 9 to 17;

(iii) One (1) hour for patients under age 9; and

(iv) Fifteen (15) minutes for manual holds with one order renewal for an additional fifteen (15) minutes for a total of thirty (30) minutes.

5. If the emergency safety situation continues beyond the time limit authorized in the order, a registered nurse or other licensed professional must immediately contact the ordering physician or the ordering licensed professional to receive further instruction.

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

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

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

2. Requirements for prohibiting the use of mechanical restraints, manual holds, or seclusion use by any employee not trained in prevention and use of emergency safety interventions, as required by these rules; and

3. Requirements that all actions taken that involve utilizing an emergency safety intervention shall be recorded in the patient's record, including at a minimum the following:

- (i) Date and description of the precipitating incident;
  - (ii) The order for use of any mechanical restraints, manual hold, or seclusion;
  - (iii) Description of the de-escalation techniques used prior to the emergency safety intervention, if applicable;
  - (iv) Environmental considerations;
  - (v) Names of staff participating in the emergency safety intervention;
  - (vi) Any witnesses to the precipitating incident and subsequent intervention;
  - (vii) Exact emergency safety intervention used;
  - (viii) Evidence of the continuous visual monitoring of a patient in mechanical restraint, manual hold, or seclusion, documented minimally at fifteen (15) minute intervals;
  - (ix) The provision of fluids every one (1) hour, food at regular intervals, and bathroom breaks every two (2) hours;
  - (x) Beginning and ending time of the intervention;
  - (xi) Outcome of the intervention;
  - (xii) Detailed description of any injury arising from the incident or intervention; and
  - (xiii) Summary of any medical care provided.
- (e) Emergency safety interventions may be used to prevent runaways only when the patient presents an imminent threat of physical harm to self or others, or as specified in the individual treatment plan.
- (f) Facility staff shall be aware of each patient's known or apparent medical and psychological conditions (e.g. obvious health issues, list of medications, history of physical abuse, etc.), as evidenced by written acknowledgement of such awareness, to ensure that the emergency safety intervention that is utilized does not pose any undue danger to the physical or mental health of the patient.
- (g) Patients shall not be allowed to participate in the emergency safety intervention of another patient.
- (h) Within one hour of the initiation of an emergency safety intervention and immediately following the conclusion of the emergency safety intervention, a physician or other licensed independent practitioner; or a registered nurse or physician assistant;

trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well-being of patients must conduct a face-to-face assessment of the patient. The assessment at a minimum must include:

1. The patient's physical and psychological status;
2. The patient's behavior;
3. The appropriateness of the intervention measures; and
4. Any complications and treatments resulting from the intervention.

**(i) Manual Holds.**

1. Emergency safety interventions utilizing manual holds require at least one trained staff member to carry out the hold. Emergency safety interventions utilizing prone restraints require at least two trained staff members to carry out the hold.
2. When a manual hold is used upon any patient whose primary mode of communication is sign language, the patient shall be permitted to have his or her hands free from restraint for brief periods during the intervention, except when such freedom may result in physical harm to the patient or others.
3. A manual hold requires physician authorization at fifteen (15) minute intervals and may not be used for more than thirty (30) minutes at any one time without the consultation of the ordering physician or other licensed professional authorized to order the use of manual holds. The ordering physician or other licensed professional authorized to order the use of the hold shall be contacted by a two-way communications device or in person to determine that the continuation of the manual hold is appropriate under the circumstances.
4. If the use of a manual hold on a patient reaches a total of one hour within a 24-hour period, the staff shall reconsider alternative treatment strategies, and document same.
5. The patient's breathing, verbal responsiveness, and motor control shall be continuously monitored during any manual hold. Documentation of the monitoring by a trained staff member shall be recorded every 15 minutes during the duration of the restraint.

**(j) Seclusion.**

1. A room used for the purposes of seclusion must meet the following criteria:
  - (i) The room shall be constructed and used in such ways that the risk of harm to the patient is minimized;

- (ii) The room shall be equipped with a viewing window so that staff can monitor the patient;
- (iii) The room shall be lighted and well-ventilated;
- (iv) The room shall be a minimum fifty (50) square feet in area; and
- (v) The room must be free of any item that may be used by the patient to cause physical harm to himself/herself or others.

2. No more than one patient shall be placed in the seclusion room at a time.

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

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

**(k) Training, Evaluation, and Reporting.**

1. All facility staff members who may be involved in the use of emergency safety interventions, shall have evidence of having satisfactorily completed a nationally recognized training program for emergency safety interventions to protect patients and others from injury, which has been approved by the department and taught by an appropriately certified trainer in such program. Emergency safety interventions may only be used by those staff members who have received such training and successfully demonstrated the techniques learned for managing emergency safety situations.

2. At a minimum, the emergency safety intervention program that is utilized shall include the following:

- (i) Techniques for de-escalating problem behavior including patient and staff debriefings;
- (ii) Appropriate use of emergency safety interventions;
- (iii) Recognizing aggressive behavior that may be related to a medical condition;

- (iv) Awareness of physiological impact of a restraint on the patient;
- (v) Recognizing signs and symptoms of positional and compression asphyxia and restraint associated cardiac arrest;
- (vi) Instructions as to how to monitor the breathing, verbal responsiveness, and motor control of a patient who is the subject of an emergency safety intervention;
- (vii) Appropriate self-protection techniques;
- (viii) Policies and procedures relating to using manual holds, including the prohibition of any technique that would potentially impair a patient's ability to breathe;
- (ix) Facility policies and reporting requirements;
- (x) Alternatives to restraint;
- (xi) Avoiding power struggles;
- (xii) Escape and evasion techniques;
- (xiii) Time limits for the use of restraint and seclusion;
- (xiv) Process for obtaining approval for continual restraints and seclusion;
- (xv) Procedures to address problematic restraints;
- (xvi) Documentation;
- (xvii) Investigation of injuries and complaints;
- (xviii) Monitoring physical signs of distress and obtaining medical assistance; and
- (xix). Legal issues.

3. Emergency safety intervention training shall be in addition to the training required in Rule 290-4-4-.04(5)(d) and shall be documented in the staff member's personnel record.

4. The facility shall take and document appropriate corrective action when it becomes aware of or observes the inappropriate use of an emergency safety intervention technique as outlined in these rules and regulations and shall notify each patient's parents and/or legal guardians. Documentation of the incident and the corrective action taken by the facility shall be maintained.

(l) At least monthly, the facility, utilizing a master restraint/seclusion log and the patients' records, shall review the use of all emergency safety interventions for each patient and staff member, including the type of intervention used and the length of time of each use, to determine whether there was a clinical basis for the intervention, whether the use of the emergency safety intervention was warranted, whether any alternatives were considered or employed, the effectiveness of the intervention or alternative, and the need for additional training. Written documentation of all such reviews shall be maintained. Where the facility identifies opportunities for improvement as a result of such reviews or otherwise, the facility shall implement these changes through an effective quality improvement plan designed to reduce the use of emergency safety devices.

(m) Facilities shall submit to the department electronically or by facsimile a report, within 24 hours, whenever the facility becomes aware of an incident which results in any injury of a patient requiring medical treatment beyond first aid that is received by a patient as a result of or in connection with any emergency safety intervention. In addition facilities must report the following:

1. For any 30-day period, where three (3) or more incidents for the same patient occur where the facility has used mechanical restraint or seclusion lasting four (4) or more hours for patients ages 18-21; two (2) or more hours for patients ages 9 to 17; or one (1) or more hours for patients under 9 years of age and/or when three (3) or more incidents for the same patient occur where the facility has used manual holds lasting thirty (30) or more minutes. The reports shall include the type of emergency safety intervention, total amount of time in the intervention, and any actions taken to prevent further use of emergency safety interventions.

2. On a monthly basis, the total number of emergency safety interventions shall be reported by patient unit, including the total amount of time each intervention was used, and the monthly average daily census for each unit. The report shall include a summary of the facility's monthly evaluation of their use of emergency safety interventions, including actions taken.

Authority O.C.G.A. Sec. 31-7-2.1. **History.** Original Rule entitled "Behavior Management and Emergency Safety Interventions" adopted. F. Nov. 20, 2006; eff. Dec. 10, 2006.

#### **290-4-4-.09 Waivers and Variances.**

(1) The department may, in its discretion, grant waivers and variances of specific rules upon application or petition being filed by a facility. The department may establish conditions which must be met by the facility in order to operate under the waiver or variance granted. Waivers and variances may be granted in accordance with the following considerations:

(a) Variance. A variance may be granted by the department upon a showing by the applicant or petitioner that the particular rule or regulation that is the subject of the variance request should not be applied as written because strict application of the rule would cause undue hardship. The applicant or petitioner must also show that adequate

standards affording protection for the health, safety and care of the patients exist and will be met in lieu of the exact requirements of the rule or regulations in question.

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

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

Authority O.C.G.A. Secs. 31-2-6, 49-5-8, 49-5-12.

#### **290-4-4-10 Enforcement and Penalties.**

(1) Enforcement of these rules and regulations shall be done in accordance with Rules and Regulations for Enforcement of Licensing Requirements, Chapter 290-1-6.

(2) The facility shall notify each patient's parents and/or legal guardians of the department's actions to revoke the license or seek an emergency suspension of the facility's license to operate.

(3) The official notice of the revocation or emergency suspension action and any final resolution, together with the department's complaint intake phone number and website address, shall be provided by the facility to each current and prospective patient's parents and/or legal guardians.

(4) The facility shall ensure the posting of the official notice at the facility in an area that is visible to each patient's parents and/or legal guardians.

(5) The facility shall ensure that the official notice continues to be visible to each patient's parents and/or legal guardians throughout the pendency of the revocation and emergency suspension actions, including any appeals.

(6) The facility shall have posted in an area that is readily visible to each patient's parents and/or legal guardians any inspection reports that are prepared by the Department during the pendency of any revocation or emergency suspension action.

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

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

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

(10) Inspections. The facility shall be available at reasonable hours for observation and examination by properly identified representatives of the department.

(a) At least annually, a report providing statistical data and brief program narrative shall be provided to the department, as requested.

(b) The governing body shall notify the department of the anticipated opening date of a newly constructed facility in order that a pre-opening licensure inspection of the treatment facility may be conducted to determine compliance with these rules and regulations.

(c) The administrator or his representative shall accompany the department representative on tours of inspection and shall sign the completed check-list.

(11) Plans of Correction. If violations of these licensing rules are identified, the facility will be given a written report of the violation that identifies the rules violated. The facility shall submit to the department a written plan of correction in response to the report of violation, which states what the facility will do, and when, to correct each of the violations identified. The facility may offer an explanation or dispute the findings or violations in the written plan of correction, so long as an acceptable plan of correction is submitted within ten (10) days of the facility's receipt of the written report of inspection. If the initial plan of correction is unacceptable to the department, the facility will be provided with at least one opportunity to revise the unacceptable plan of correction. Failure to submit an acceptable plan of correction may result in the department commencing enforcement procedures. The facility shall comply with its plan of correction.

Authority O.C.G.A. Sec. 31-2-6.

#### **290-4-4-11 Severability.**

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

Authority O.C.G.A. § 49-6-81 **History:** Code 1981, § 49-6-81, enacted by Ga. L. 2003, p. 298, § 1. O.C.G.A. § 49-6-84. **History:** Code 1981, § 49-6-84, enacted by Ga. L. 2003, p. 298, § 1.

