



SOUTH CAROLINA
DEPARTMENT OF
PUBLIC HEALTH

Regulation 60-93 Standards for Licensing Facilities for Chemically Dependent or Addicted Persons

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SECTION 100 – DEFINITIONS AND LICENSURE.

101. Definitions.

For the purpose of this regulation, the following definitions shall apply:

A. Abuse. Physical abuse or psychological abuse.

1. Physical Abuse. The act of intentionally inflicting or allowing infliction of physical injury on a Patient by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that of a therapeutic procedure prescribed by a licensed physician or other legally authorized healthcare professional. Physical abuse does not include altercations or acts of assault between Patients.

2. Psychological Abuse. The deliberate use of any oral, written, or gestured language or depiction that includes disparaging or derogatory terms to a Patient or within the Patient's hearing distance, regardless of the Patient's age, ability to comprehend, or disability, including threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

B. Administering Medication. The acts of preparing and giving of a single dose of a medication to the body of a Patient by injection, ingestion, or any other means in accordance with the orders of a Physician or other Authorized Healthcare Provider.

C. Administrator. The staff member designated by the Licensee to have the authority and responsibility to manage the Facility and who is in charge of all functions and activities of the Facility.

D. Adult. A person eighteen (18) years of age or older.

E. Aftercare/Continuing Care. Services provided to Patients after discharge from a Facility that facilitates the Patient's integration or reintegration into society. Activities may include self-help groups, supportive work programs, and staff follow-up contacts and interventions.

F. Annual. A time period that requires an activity to be performed at least every twelve (12) months.

G. Assessment. A procedure for determining the nature and extent of the problems and needs of a Patient or potential Patient to ascertain if the Facility can adequately address those problems, meet those needs, and to secure information for use in the development of the Individual Plan of Care.

H. Authorized Healthcare Provider. An individual authorized by law and currently licensed in South Carolina as a Physician, advanced practice registered nurse, or physician assistant to provide specific treatments, care, or services to Patients.

I. Blood Assay for *Mycobacterium tuberculosis* ("BAMT"). A general term to refer to in vitro diagnostic tests that assess for the presence of tuberculosis ("TB") infection with *Mycobacterium tuberculosis*. This term includes, but is not limited to, IFN- γ release assays ("IGRA").

J. Chemical Dependency. A disorder manifested by repeated use of alcohol or another substance to an extent that it interferes with a person's health, social, or economic functioning; some degree of habituation and dependence may be implied. May also be referred to as Substance Use Disorder.

K. Clinical Services Supervisor. The designated individual with responsibility for clinical supervision of treatment Staff and interpretation of program policy and standards.

L. Consultation. A meeting with a licensed Facility and individuals authorized by the Department to provide information to Facilities in order to enable Facilities to better comply with the regulations.

M. Contact Investigation. Procedures that occur when a case of infectious Tuberculosis is identified, including finding persons (contacts) exposed to the case, testing and evaluation of contacts to identify Latent Tuberculosis Infection or Tuberculosis disease, and treatment of these persons, as indicated.

N. Controlled Substance. A medication or other substance included in Schedule I, II, III, IV, and V of the Federal Controlled Substances Act or the South Carolina Controlled Substances Act.

O. Counselor. An individual licensed by the South Carolina Department of Labor, Licensing and Regulation or certified as such by South Carolina Association of Alcoholism and Drug Abuse Counselors.

P. Department. The South Carolina Department of Health and Environmental Control.

Q. Dietitian. An individual currently licensed as a Dietitian by the South Carolina Department of Labor, Licensing and Regulation.

R. Direct Care Staff. Those individuals who provide care and services to the Patient.

S. Discharge. The point at which treatment, care, and services in a Facility are terminated and the Facility no longer maintains active responsibility for the care of the Patient, except for Continuing Care monitoring.

T. Elopement. An instance when a Patient who is physically, mentally, or chemically impaired wanders, walks, runs away, escapes, or otherwise leaves the Facility unsupervised or unnoticed.

U. Exploitation. (1) Causing or requiring a Patient to engage in an activity or labor that is improper, unlawful, or against the reasonable and rational wishes of a Patient. Exploitation does not include requiring a Patient to participate in an activity or labor that is a part of a written individual plan of care or prescribed or authorized by the Patient's attending physician; (2) an improper, unlawful, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a Patient by an individual for the profit or advantage of that individual or another individual; or (3) causing a Patient to purchase goods or services for the profit or advantage of the seller or another individual through undue influence, harassment, duress, force, coercion, or swindling by overreaching, cheating, or defrauding the Patient through cunning arts or devices that delude the Patient and cause him or her to lose money or other property.

V. Facility for Chemically Dependent or Addicted Persons (Facility or Substance Use Disorder Facility). A Facility organized to provide Outpatient or Residential Services to Chemically Dependent or Addicted Persons and their families based on an Individual Plan of Care including diagnostic treatment, individual and group counseling, family therapy, vocational and educational development counseling, and referral services.

W. Follow-up. Intermittent contact with a Patient following discharge from the program, for assessment of Patient status and needs.

X. Health Assessment. An evaluation of the health status of a staff member/volunteer by a Physician, other Authorized Healthcare Provider, or a registered nurse. A registered nurse may complete the Health Assessment pursuant to standing orders approved by a Physician as evidenced by the Physician's signature. The standing orders shall be reviewed annually by the Physician, with a copy of the review maintained at the Facility.

Y. Individual Plan of Care. A written action plan based on assessment data that identifies the Patient's diagnosis and/or needs, the strategy for providing services to meet those needs, treatment goals and objectives, and the criteria for terminating the specified interventions.

Z. In-process Counselor. A counselor accepted by the South Carolina Association of Alcoholism and Drug Abuse Counselors as enrolled for certification.

AA. Inspection. A visit by the Department for the purpose of determining compliance with this regulation.

BB. Intake. The administrative and assessment process for admission to a program.

CC. Interdisciplinary Team. A group designated by the Facility to provide or supervise care, treatment, and services. The group normally includes but is not limited to the following persons: Counselors, social workers, Physicians and other Authorized Healthcare Providers, pharmacists, peer support specialists, etc.

DD. Investigation. A visit by Department representatives to a licensed or unlicensed entity for the purpose of determining the validity of allegations received by the Department relating to statutory and regulatory compliance.

EE. Legend Medications.

1. A Controlled Substance, when under federal law, is required, prior to being dispensed or delivered to be labeled with any of the following statements:

a. "Caution: Federal law prohibits dispensing without prescription."

b. "Rx only"; or

2. A Controlled Substance which is required by any applicable federal or state law to be dispensed pursuant only to a prescription drug order or is restricted to use by practitioners only;

3. Any Controlled Substance considered to be a public health threat, after notice and public hearing as designated by the South Carolina Board of Pharmacy; or

4. Any prescribed compounded prescription Controlled Substance within the meaning of the South Carolina Pharmacy Practice Act.

FF. License. The authorization to operate a Substance Use Disorder Facility as defined in this regulation and as evidenced by a certificate issued by the Department to a Facility.

GG. Licensed Nurse. A person to whom the South Carolina Board of Nursing has issued a license as a registered nurse or licensed practical nurse, or an individual licensed as a registered nurse or licensed practical nurse who resides in another state that has been granted multi-state licensing privileges by the

South Carolina Board of Nursing and may practice nursing in any Facility or activity licensed by the Department subject to the provisions and conditions as indicated in the Nurse Licensure Compact Act.

HH. Licensee. The individual, corporation, organization, or public entity licensed pursuant to this regulation to provide dependency and Substance Use Disorder treatment services.

II. Medical Withdrawal Management Program. A program in a Residential Facility providing for medically-supervised Withdrawal Management, with the capacity to provide screening for medical complications of Substance Use Disorder, a structured program of counseling, if appropriate, and referral for further rehabilitation.

JJ. Medication. A substance that has therapeutic effects, including, but not limited to, Legend, Non-Legend, over-the counter, and nonprescription Medications, herbal products, vitamins, and nutritional supplements.

KK. Medication Unit. A Satellite location established as part of, but geographically separate, from a licensed Opioid Treatment Program to only administer Medications and conduct substance use screening.

LL. Methadone. A synthetic opioid Medication usually administered on a daily basis.

MM. Minor. Any person whose age does not meet the criteria indicated in Section 101.C.

NN. Neglect. The failure or omission of a direct care staff member to provide the care, goods, or services necessary to maintain the health or safety of a Patient including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Failure to provide adequate supervision resulting in harm to Patients, including altercations or acts of assault between Patients, may constitute neglect. Neglect may be repeated conduct or a single incident that has produced or could result in physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect.

OO. Non-Legend Medications. A substance which may be sold without a prescription and which is labeled for use by the consumer in accordance with state and federal law.

PP. Opioid Treatment Program. A program within an Outpatient Facility providing services using Methadone or other opioid treatment Medication, and offering a range of treatment procedures and services for the rehabilitation of persons dependent on opium, morphine, heroin, or any derivative or synthetic Controlled Substance of that group.

QQ. Outpatient Facility. A Facility providing Outpatient Services.

RR. Outpatient Services. Non-Residential services for persons with Substance Use Disorder and/or their families.

SS. Patient. Any individual who receives Outpatient or Residential Services from a licensed Facility.

TT. Physical Examination. An examination of a Patient by a Physician or other Authorized Healthcare Provider which addresses those issues identified in Section 1100 of this regulation.

UU. Primary Counselor. An individual who is assigned by a Facility to develop, implement, and periodically review the Patient's Individual Plan of Care and to monitor a Patient's progress in treatment.

VV. Quality Improvement Program. The process used by a Facility to examine its methods and practices of providing care services, identify the ways to improve its performance, and take actions that result in improved quality of care for the Facility's Patients.

WW. Repeat Violation. The recurrence of a violation cited under the same section of the regulation within a twenty-four (24) month period.

XX. Residential Facility. A twenty-four (24) hour Facility offering Residential Treatment Program, Medical Withdrawal Management, and Social Withdrawal Management services in a Residential setting including services for parents with children.

YY. Residential Treatment Program. A program in a Residential Facility that is designed to improve the Patient's ability to structure and organize the tasks of daily living and foster recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive daily activity, and, as indicated, successful reintegration into family living.

ZZ. Revocation of License. An action by the Department to cancel or annul a Facility License by recalling, withdrawing, or rescinding its authority to operate.

AAA. Satellite Facility. An approved Outpatient Facility at a location other than the main Outpatient Facility that is owned or operated by the same licensee.

BBB. Self-Administration. A procedure by which any Medication is taken orally, injected, inserted, or topically or otherwise administered by a Patient to himself or herself without prompting. The procedure is performed without assistance and includes removing an individual dose from a previously dispensed and labeled container (including a unit dose container), verifying it with the directions on the label, taking it orally, injecting, inserting, or applying topically or otherwise administering the Medication.

CCC. Social Withdrawal Management Program. A program in a Residential Facility providing supervised Withdrawal Management in which neither the Patient's level of intoxication nor physical condition is severe enough to warrant direct medical supervision or the use of Medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling (if appropriate), educational services, and referral for further rehabilitation.

DDD. Staff. Those individuals who are employees (full and part-time) of the Facility, to include those individuals contracted to provide care and services for the Patients.

EEE. Substance Use Disorder. A recurrent use of alcohol or other substance causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

FFF. Suspension of License. An action by the Department requiring a Facility to cease operations for a period of time or to require a Facility to cease admitting Patients, until such time as the Department rescinds that restriction.

GGG. Tuberculosis Risk Assessment. An initial and ongoing evaluation of the risk for transmission of Mycobacterium Tuberculosis in a particular healthcare setting. To perform a risk assessment, the following factors shall be considered: the community rate of Tuberculosis, number of Tuberculosis Patients encountered in the setting, and the speed with which Patients with Tuberculosis disease are suspected,

isolated, and evaluated. The Tuberculosis Risk Assessment determines the types of administrative and environmental controls and respiratory protection needed for a setting.

HHH. Volunteer. An individual who performs tasks that are associated with the operation of the Facility without pay and at the direction of the Administrator or his or her designee.

III. Withdrawal Management. A process of withdrawing a Patient from a specific psychoactive substance in a safe and effective manner.

102. License Requirements.

A. License. No person, private or public organization, political subdivision, or governmental agency shall establish, operate, maintain, represent, advertise, or market itself as a Facility in South Carolina without first obtaining a License from the Department. No Facility shall admit Patients prior to the effective date of the License. When it has been determined by the Department that services for Substance Use Disorder are being provided at a location, and the owner has not been issued a License from the Department, the owner shall cease operation immediately and ensure the safety, health, and well-being of the Patients. Current and/or previous violations of the South Carolina Code or Department regulations may jeopardize the issuance of a License for the Facility or the licensing of any other Facility or addition to an existing Facility that is owned/operated by the licensee. The Facility shall provide only the treatment, services, and care it is licensed to provide pursuant to the definition in Section 101.V. of this regulation. (I)

B. Compliance. An initial License shall not be issued to a proposed Facility until the Licensee has demonstrated to the Department that the proposed Facility is in substantial compliance with the licensing standards. In the event a current Licensee who already has a Facility or activity makes application for another Facility, the currently licensed Facility /activity shall be in substantial compliance with the applicable standards prior to the Department issuing a License to the proposed Facility or amended License to the existing Facility. A paper or electronic copy of the licensing standards shall be maintained at the Facility and accessible to all Staff members and Volunteers. Facilities shall comply with applicable local, state, and federal laws, codes, and regulations.

C. Licensed Services. No Facility shall provide services outside the limits of the type Facility identified on the face of the License and/or which the Facility has been authorized to provide. (I)

D. Satellite Facilities.

1. Outpatient Satellite locations, other than Medication Units, are authorized only in the same county as the main Facility or in contiguous counties to the county in which the main Facility is located.

2. Medication Units. A Licensed Outpatient Facility providing an Opioid Treatment Program may establish a Medication Unit. A Medication Unit shall only administer Medications and conduct substance use screening. Other required services shall be provided at the licensed Facility's primary location. The Medication Unit shall meet the regulatory requirements for Medication administration, staffing, substance use screening, and construction.

a. Medication Units shall be opened no closer than forty-five (45) miles and no further than ninety (90) miles from the primary Opioid Treatment Program.

b. The Facility shall obtain a registration from the Department's Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration for each Medication Unit.

c. The Facility shall not establish, operate, or maintain a Medication Unit without submitting an application to and receiving approval from the Department. The Facility's application for the Medication Unit shall include documentation from the Department evidencing that the applicant received either a Certificate of Need or a determination by the Department that Certificate of Need review is not required.

E. Licensed Bed Capacity. No Residential Facility that has been authorized to provide a set number of licensed beds, as identified on the face of the License, shall exceed the licensed bed capacity. No Facility shall establish new care or services or occupy additional beds or renovated space without first obtaining authorization from the Department. Licensed beds shall not be utilized by any individuals other than Facility Patients. (I)

F. Persons Received in Excess of Licensed Bed Capacity. No Residential Facility shall receive for treatment, care, or services persons in excess of the licensed bed capacity, except in cases of justified emergencies (See Section 1400). (I)

G. Living Quarters for Staff in Residential Facilities. In addition to Patients, only Staff members, Volunteers, or owners of the Facility and members of the owner's immediate family may reside in Facilities licensed under this regulation. Patient rooms shall not be utilized by any individuals other than Facility Patients, nor shall bedrooms of Staff members or family members of the owner or the Licensee be utilized by Patients. Staff members or family members of the owner or Licensee, or Volunteers shall not use Patient living rooms, recreational areas, or dining rooms unless they are on duty.

H. Issuance and Terms of License.

1. The License issued by the Department shall be posted by the Licensee in a conspicuous place in a public area within the Facility.

2. The issuance of a License does not guarantee adequacy of individual care, services, personal safety, fire safety, or the well-being of any Patient or occupant of a Facility.

3. A License is not assignable or transferable and is subject to revocation at any time by the Department for the Licensee's failure to comply with the laws and regulations of this state.

4. A License shall be effective for a specified Facility, at a specific location, for a specified period following the date of issue as determined by the Department. A License shall remain in effect until the Department notifies the Licensee of a change in the status.

5. Facilities owned by the same entity but which are not located on the same adjoining or contiguous property shall be separately licensed. Roads or local streets, except limited access, shall not be considered as dividing otherwise adjoining or contiguous property. For Facilities owned by the same entity, separate Licenses are not required for separate buildings on the same or adjoining grounds where a single type of service is provided.

6. Facilities providing Outpatient and Residential Services on the same premises shall be licensed separately even though owned by the same entity.

I. Facility Name. No proposed Facility shall be named nor shall any existing Facility have its name changed to the same or similar name as any other Facility licensed in South Carolina. The Department shall determine if names are similar. If the Facility is part of a "chain operation" it shall then have the geographic area in which it is located as part of its name.

J. Application. Applicants for a License shall submit to the Department a completed application on a form prescribed, prepared, and furnished by the Department prior to initial licensing. Applicants for a License shall file an application with the Department that includes an oath assuring the contents of the application are accurate and true and in compliance with this regulation.

K. Required Documentation. The application for initial licensure shall include:

1. Completed application;
2. Proof of ownership of real property on which the Facility is located or a rental or lease agreement allowing the Licensee to occupy the real property on which the Facility is located;
3. Verification of emergency evacuation plan (see Section 1401); and
4. Verification of Administrator's qualifications.

L. Licensing Fees. Each applicant shall pay a License fee prior to the issuance of a License.

1. The initial and annual License fee shall be seventy-five dollars (\$75.00) for Outpatient Facilities. The initial and annual License fee for Outpatient Facility satellite locations shall be fifty dollars (\$50.00) per Satellite Facility.

2. For Residential Facilities, the annual License fee shall be ten dollars (\$10.00) per bed or seventy-five dollars (\$75.00), whichever is greater.

M. Licensing Late Fees. Failure to submit a renewal application and fee to the Department by the License expiration date shall result in a late fee of seventy-five dollars (\$75.00) or twenty-five percent (25%) of the licensing fee amount, whichever is greater, in addition to the licensing fee. Failure to submit the licensing fee and licensing late fee to the Department within thirty (30) days of the licensure expiration date shall render the Facility unlicensed. (II)

N. License Renewal. For a License to be renewed, applicants shall file an application with the Department, pay a License fee, and shall not be under consideration for, or undergoing, enforcement actions by the Department. Annual licensing fees shall also include any outstanding Inspection fees. All fees are non-refundable, shall be made payable by check or credit card to the Department or online, and shall be submitted with the application.

O. Amended License. No facility shall establish new care or services or occupy additional beds or renovated space without first obtaining authorization from the Department. A Facility shall request issuance of an amended License by application to the Department prior to any of the following circumstances:

1. Change of licensed bed capacity;
2. Change of Facility location from one geographic site to another;
3. Changes in Facility name or address (as notified by the post office); or
4. Change in Facility service type.

P. Change of Licensee. A Facility shall request issuance of a new License by application to the Department prior to any of the following circumstances:

1. A change in the controlling interest even if, in the case of a corporation or partnership, the legal entity retains its identity and name; or

2. A change in the type of the legal entity, for example, sole proprietorship to or from a corporation, partnership to or from a corporation, even if the controlling interest does not change.

Q. Variance. A variance is an alternative method that ensures the equivalent level of compliance with the standards in this regulation. The Facility may request a variance to this regulation in a format as determined by the Department. Variances shall be considered on a case by case basis by the Department. The Department may revoke issued variances as determined to be appropriate by the Department.

SECTION 200 – ENFORCEMENT OF REGULATIONS

201. General.

The Department shall utilize Inspections, Investigations, Consultations, and other pertinent documentation regarding a proposed or licensed Facility in order to enforce this regulation.

202. Inspections and Investigations.

A. Inspections by the Department shall be conducted prior to initial licensing of a Facility and subsequent Inspections conducted as deemed appropriate by the Department.

B. All Facilities are subject to Inspection and/or Investigation at any time without prior notice by individuals authorized by the South Carolina Code of Laws. When Staff members and /or Patients are absent, the Facility shall post information at the entrance of the Facility to those seeking legitimate access to the Facility, including visitors. The posted information shall include contact information and the expected time of return of the Staff members and Patients. The contact information shall include the name of a designated contact and his or her telephone number. The telephone number for the designated contact shall not be the Facility's telephone number. (I)

C. Individuals authorized by South Carolina law shall be allowed to enter the Facility for the purpose of Inspection and/or Investigation and granted access to all properties and areas, objects, requested records, and documentation at the time of the Inspection or Investigation. The Department shall have the authority to require the Facility to make photocopies of those documents required in the course of Inspections or Investigations. Photocopies shall be used only for purposes of enforcement of regulations and confidentiality shall be maintained except to verify the identity of individuals in enforcement action proceedings. The physical area of Department Inspections and Investigations shall be determined by the Department based on the potential impact or effect upon patients. (I)

D. When there is noncompliance with the licensing standards, the Facility shall submit an acceptable plan of correction in a format determined by the Department. The plan of correction shall be signed by the Administrator and returned by the date specified on the report of Inspection and/or Investigation. The plan of correction shall describe: (II)

1. The actions taken to correct each cited deficiency;

2. The actions taken to prevent recurrences (actual and similar); and

3. The actual or expected completion dates of those actions.

E. In accordance with South Carolina Code Section 44-7-270, the Department may charge a fee for Inspections.

1. Residential Facilities. The fee for initial, relocation, and routine Inspections shall be three hundred fifty dollars (\$350.00), plus twenty-five dollars (\$25.00) per licensed bed. The Inspection fee for a bed increase and/or service modification is two hundred dollars (\$200.00), plus twenty-five dollars (\$25.00) per licensed bed. The fee for all follow-up Inspections shall be two hundred dollars (\$200.00), plus twenty-five dollars (\$25.00) per licensed bed.

2. Outpatient Facilities. The fee for initial, relocation, and routine Inspections shall be four hundred fifty dollars (\$450.00). The Inspection fee for service modification, including the establishment of a Satellite Facility, and follow-up Inspections is two hundred fifty dollars (\$250.00).

F. The Licensee shall pay the following Inspection fees during the construction phase of the project. The plan Inspection fee is based on the total estimated cost of the project whether new construction, an addition, or a renovation. The fees are detailed in the table below.

Construction Inspection Fees	
Plan Inspection	
Total Project Cost	Fee
< \$10,001	\$750
\$10,001 - \$100,000	\$1,500
\$100,001 - \$500,000	\$2,000
> \$500,000	\$2,500 plus \$100 for each additional \$100,000 in project cost
Site Inspection	
50% Inspection	\$500
80% Inspection	\$500
100% Inspection	\$500

203. Consultations.

Consultations shall be provided by the Department as requested by the Facility or as deemed appropriate by the Department.

SECTION 300 – ENFORCEMENT ACTIONS

301. General.

When the Department determines that a Facility is in violation of any statutory provision or regulation relating to the operation or maintenance of such Facility, the Department, upon proper notice to the Licensee, may deny, suspend, or revoke Licenses, or assess a monetary penalty, or both.

302. Violation Classifications.

A. Violations of standards in this regulation are classified as follows:

1. Class I violations are those that present an imminent danger to the health, safety, or well-being of the persons in the Facility or a substantial probability that death or serious physical harm could result therefrom. A physical condition or one or more practices, means, methods, or operations in use in a Facility may constitute such a violation. The condition or practice constituting a Class I violation shall be abated or eliminated immediately unless a fixed period of time, as stipulated by the Department, is required for correction. Each day such violation exists after expiration of the time established by the Department shall be considered a subsequent violation.

2. Class II violations are those, other than Class I violations, that have a negative impact on the health, safety, or well-being of persons in the Facility. The citation of a Class II violation shall specify the time within which the violation is required to be corrected. Each day such violation exists after expiration of this time shall be considered a subsequent violation.

3. Class III violations are those that are not classified as Class I or II in this regulation or those that are against the best practices. The citation of a Class III violation shall specify the time within which the violation is required to be corrected. Each day such violation exists after expiration of this time shall be considered a subsequent violation.

B. The notations, “(I)” or “(II),” placed within sections of this regulation, indicate those standards are considered Class I or II violations if they are not met, respectively. Failure to meet standards not so annotated are considered Class III violations.

C. In determining an enforcement action, the Department shall consider the following factors:

1. Specific conditions and their impact or potential impact on health, safety, or well-being of the Patients including, but not limited to:

a. Deficiencies in Medication management; critical waste water problems; housekeeping, or fire and life safety-related problems that pose a health threat to the Patients;

b. Power, water, gas, or other utility and/or service outages;

c. Patients exposed to air temperature extremes that jeopardize their health;

d. Unsafe condition of the building or structure;

e. Indictment of an Administrator for malfeasance or a felony, which by its nature indicates a threat to the Patients;

f. Direct evidence of Abuse, Neglect, or Exploitation;

g. Lack of food or evidence that the Patients are not being fed properly;

h. No Staff available at the Facility with Patients present;

i. Unsafe procedures and/or treatment being practiced by Staff; (I)

2. Repeated failure of the Licensee or Facility to pay assessed charges for utilities and/or services resulting in repeated or ongoing threats to terminate the contracted utilities and/or services; (II)

3. Efforts by the Facility to correct cited violations;
4. Overall conditions of the Facility;
5. History of compliance; and
6. Any other pertinent conditions that may be applicable to current statutes and regulations.

D. When imposing monetary penalties, the Department may invoke South Carolina Code Section 44-7-320(C) to determine the dollar amount or may utilize the following schedule:

FREQUENCY	CLASS I	CLASS II	CLASS III
1st	\$ 500-1,500	\$ 300-800	\$100-300
2nd	1,000-3,000	500-1,500	300-800
3rd	2,000-5,000	1,000-3,000	500-1,500
4th	5,000	2,000-5,000	1,000-3,000
5th	5,000	5,000	2,000-5,000
6th	5,000	5,000	5,000

SECTION 400 – POLICIES AND PROCEDURES (II)

A. The Facility shall maintain and adhere to written policies and procedures addressing the manner in which the requirements of this regulation shall be met. The Facility shall be in full compliance with the policies and procedures.

B. The written policies and procedures shall include the following:

1. Staffing and training;
2. Reporting incidents, accidents, reportable diseases, closure and zero census;
3. Patient records;
4. Admission and Discharge;
5. Patient care, treatment, and services;
6. Medication management;
7. Maintenance including doors, windows, heating, ventilation, air conditioning, fire alarm, electrical, mechanical, plumbing, and for all equipment;
8. Infection control and housekeeping;
9. Quality Improvement Program; and
10. Fire Prevention;

C. The Facility shall establish a time period for review, not to exceed two (2) years, of all policies and procedures, and such reviews shall be documented and signed by the Administrator. All policies and procedures shall be accessible to Facility staff, printed or electronically, at all times.

SECTION 500 – STAFF AND TRAINING

501. General (II).

A. The Facility shall develop and implement policies and procedures to provide for appropriate Staff and/or Volunteers in numbers and training to suit the needs and condition of the Patients and meet the demands of effective emergency on-site action that might arise. Training requirements/qualifications for the tasks each performs shall be in compliance with all local, state, and federal laws, and current professional organizational standards.

B. The Facility shall maintain accurate information regarding all Staff and/or Volunteers of the Facility. The documentation shall include at least current address, phone number, health and work and/or training background, as well as current information. The Facility shall ensure all employees are assigned certain duties and responsibilities that shall be in writing and in accordance with the individual's capability. (II)

C. When a Facility engages a source other than the Facility to provide services normally provided by the Facility, the Facility shall maintain documentation of the written agreement with the source that describes how and when the services are to be provided, the exact services to be provided, and that these services are to be provided by qualified individuals. The source shall comply with this regulation in regard to Patient care, services, and rights.

D. The Facility shall maintain documentation to ensure the Facility meets staffing requirements in Sections 503, 504, and 505.

502. Administrator (II).

A. Each Facility shall have a full-time Administrator who is responsible for the overall management and operation of the Facility and has at least a bachelor's degree in a related field.

B. A Staff member shall be designated by name or position, in writing, to act in the absence of the Administrator, for example, a listing of the lines of authority by position title, including the names of the individuals filling these positions.

503. Staffing for Residential Facilities (I).

A. All Staff members and/or Volunteers on duty shall be present, awake, and dressed at all times when Patients are present in the Facility. All Staff members and/or Volunteers shall know how to respond to Patient needs and emergencies.

B. Additional Staff shall be provided if it is determined that the minimum Staff requirements are inadequate to provide appropriate services and supervision to the Patients of a Facility.

C. Staffing for Residential Treatment Programs.

1. The number of Staff members that shall be maintained in all Facilities:

a. In each building, there shall be at least one (1) Staff member and/or Volunteer on duty for each ten (10) Patients or fraction thereof present from 7:00 am until 7:00 p.m.

b. In each building, there shall be at least one (1) Staff member and/or Volunteer for each twenty (20) Patients or fraction thereof from 7:00 p.m. until 7:00 a.m.

2. The Facility shall have at least one (1) Physician available during Facility operating hours, either in person or by telephone for consultation and for emergencies.

D. Staffing for Withdrawal Management Programs.

1. In each building, there shall be at least one (1) Direct Care or Counselor Staff member for each ten (10) Patients or fraction thereof on duty at all times.

2. In Residential Facilities providing Medical Withdrawal Management, Staff members and Volunteers shall be under the general supervision of a Physician or registered nurse; a Physician, Licensed Nurse, or other Authorized Healthcare Provider shall be present at all times.

505. Staffing for Opioid Treatment Programs (I).

A. The Opioid Treatment Program Physician shall have authority over all medical aspects of care and make treatment decisions in consultation with treatment Staff consistent with the needs of the Patient, clinical protocols, and research findings. The Facility shall have at least one (1) Physician available during dosing and Facility operating hours, either in person or by telephone for consultation and for emergencies.

B. The Facility shall have a pharmacist or other person licensed to dispense Opioid Treatment Program Medications pursuant to the South Carolina Code of Laws who is responsible for dispensing the amounts of Opioid Treatment Program Medications administered and shall record and countersign all changes in dosing schedules.

C. The Facility shall have one (1) Licensed Nurse present at all times Medications are being administered to Patients.

D. The Opioid Treatment Program shall have at least one (1) full-time counselor on staff for every fifty (50) Patients or fraction thereof. Counselors shall be qualified as specified in Section 508.

506. Inservice Training (II).

A. All Facilities shall provide Staff and Volunteers the necessary training to perform the duties for which they are responsible in an effective manner. The Facility shall require all Staff members and Volunteers to complete the necessary training to perform their duties and responsibilities. The Facility shall document all in-service training. Staff training shall be signed and dated by the individual providing the training and the person receiving the training. The signature for the individual providing the training may be omitted for online training.

B. All Facilities shall provide the following training to all Staff and Volunteers prior to Patient contact and at a frequency as determined by the Facility, but at least annually:

1. The nature of Substance Use Disorder, complications of Chemical Dependency, and withdrawal symptoms.

2. Confidentiality of Patient information and records and the protection of Patient rights.

C. All Residential Facilities shall provide the following training to all Staff and Volunteers prior to Patient contact and at a frequency as determined by the Facility, but at least annually:

1. Cardio-pulmonary resuscitation to ensure that there is at least one (1) certified individual present when Patients are in the Facility;

2. Basic first-aid to include emergency procedures as well as procedures to manage and/or care for minor accidents or injuries;

3. Procedures for checking and recording vital signs;

4. Management/care of persons with contagious and/or communicable disease;

5. Medication management;

6. Use of restraints and seclusion;

7. Seizure response training; and

8. OSHA standards regarding bloodborne pathogens.

D. All Opioid Treatment Programs shall provide opioid Medication treatment training to all Staff and Volunteers prior to Patient contact and at a frequency as determined by the Facility, but at least annually.

E. All Staff members and Volunteers shall have documented orientation to the purpose and environment of the Facility within twenty-four (24) hours of their first day on the job in the Facility.

507. Health Status (I).

A. All Staff and Volunteers who have contact with Patients, including food services Staff and Volunteers, shall have a Health Assessment, as defined in Section 101.X, within twelve (12) months prior to initial Patient contact. The Health Assessment shall include tuberculin skin testing as described in Section 1702.

B. For Staff members and/or Volunteers working at multiple Facilities operated by the same Licensee, the documented Health Assessment shall be accessible at each Facility, provided the information is in compliance with this regulation.

508. Counselors (II).

A. Each Facility shall have at least one (1) Staff Counselor who is fully-certified or licensed. All non-certified and/or licensed Counselors shall be under the direct supervision of an on-site fully-certified or licensed Counselor.

B. Staff and Volunteers providing clinical counseling services shall have one (1) of the following qualifications:

1. Certification:

a. Certification under the system administered by the South Carolina Association of Alcohol and Drug Abuse Counselors Certification Commission, or currently engaged, as verified and documented in the individual's personnel file, in the South Carolina Association of Alcohol and Drug Abuse Counselors certification process that is to be completed within a three (3)-year period from date of hire as a Counselor; or

b. Certification as a Counselor by:

(1) The National Association of Alcohol and Drug Abuse Counselors;

(2) An International Certification Reciprocity Consortium-approved certification board; or

(3) Any other South Carolina Department of Alcohol and Other Drug Abuse Services -approved credentialing or certification association or commission; or

2. Licensure:

a. Licensed as a Psychiatrist by the South Carolina Board of Medical Examiners;

b. Licensed as a Psychologist by the South Carolina Board of Examiners in Psychology;

c. Licensed as a Social worker by the South Carolina Board of Social Work Examiners; or

d. Licensed as a Counselor or therapist by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists, pursuant to Section 40-75-30, of the South Carolina Code of Laws, 1976.; or

3. Licensure as a Licensed Addiction Counselor Associate by the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists, pursuant to Section 40-75-30, of the South Carolina Code of Laws, 1976, under appropriate supervision. Full licensure must be completed within a three (3)-year period from date of hire as a Counselor.

C. Counselors in Opioid Treatment Programs shall have one (1) of the following qualifications:

1. Any of the certifications or licensures in 508.B above; or

2. The American Academy of Health Care Providers in the Addictive Disorders; or

3. The National Board for Certified Counselors; or

4. Any other equivalent, nationally-recognized, and South Carolina Department of Alcohol and Other Drug Abuse Services-approved association or accrediting body that includes similar competency-based testing, supervision, educational, and substantial experience.

D. In Facilities providing prevention services, Counselors shall have one (1) of the following qualifications:

1. Certification by the South Carolina Association of Prevention Professionals and Advocates as a Prevention Professional or Senior Prevention Professional; or

2. In-process of becoming certified as a Prevention Professional. This certification shall be achieved within a thirty-six (36)-month period of time from the date of hire as a prevention Counselor.

E. Any individual employed as a direct Patient Counselor, Opioid Treatment Program Counselor, or prevention services professional, to include contracted Staff, who does not obtain his or her certification or licensing within the above time-periods, shall cease providing counseling services until that certification or licensing status is achieved.

F. The Facility shall verify and maintain documentation of each Counselor's qualifications in the individual's Staff record.

SECTION 600 – REPORTING

601. Accidents and Incidents (II).

A. The Facility shall maintain a record of each accident and/or incident, including usage of mechanical and/or physical restraints, involving Patients, Staff members or Volunteers, occurring in the Facility or on the Facility grounds. The Facility shall retain all documented incidents reported pursuant to this section six (6) years after the Patient stops receiving services at the Facility.

B. The Facility shall report the following types of incidents to the next of kin or responsible party at the earliest practicable hour, not exceeding twenty-four (24) hours of the incident. The Facility shall report the following types of incidents to the Department immediately, not to exceed twenty-four (24) hours, via the Department's electronic reporting system or as otherwise determined by the Department. incidents requiring reporting include, but are not limited to:

1. Confirmed or Suspected Abuse, Neglect or Exploitation against a Patient by Facility Staff;
2. Crimes committed against Patients;
3. Death: For Residential Facilities, any Patient's death in the Facility or on the Facility grounds; for Opioid Treatment Programs, any Patient's death regardless of location;
4. Overdose reversal (naloxone);
5. Elopement (Residential Facility only);
6. Bone fracture or joint fracture;
7. Hospitalization as a result of accident and/or incident;
8. Medication Error;
9. Attempted Suicide; and
10. Severe injury involving use of restraint.

C. The Facility shall submit a separate written investigation report within five (5) days of every incident required to be immediately reported to the Department pursuant to Section 601.B via the Department's electronic reporting system or as otherwise determined by the Department. Reports submitted to the

Department shall contain only: Facility name, License number, type of accident and/or incident, the date of accident and/or incident occurred, number of Patients directly injured or affected, Patient medical record identification number, Patient age and sex, number of Staff directly injured or affected, number of visitors directly injured or affected, witness(es) name(s), identified cause of accident and/or incident, internal investigation results if cause unknown, a brief description of the accident and/or incident including location where occurred, and treatment of injuries.

602. Fire and Disasters (II).

A. The Facility's Administrator or his or her designee shall notify the Department immediately via telephone, e-mail, or fax of any fire in the Facility. The Facility shall submit a complete written report to include fire reports within a time-period determined by the Facility, but not to exceed forty-eight (48) hours from the occurrence of the fire.

B. The Facility's Administrator, or his or her designee, shall notify the Department immediately of any natural disaster or fire that requires displacement of the Patients, or jeopardizes or potentially jeopardizes the safety of the Patients. The Facility shall submit a complete written report that includes the fire report from the local fire department within a time-period as determined by the Facility, but not to exceed forty-eight (48) hours.

603. Communicable Diseases and Animal Bites (I).

The Facility shall report all cases of diseases and animal bites that are required to be reported to the appropriate county health department in accordance with R.61-20, Communicable Diseases.

604. Administrator Change.

The Licensee shall notify the Department via email, or a means as otherwise determined by the Department within seventy-two (72) hours of any change in Administrator status. The Licensee shall provide the Department in writing within ten (10) days the name of the newly-appointed Administrator and the effective date of the appointment.

605. Joint Annual Report.

Residential Facilities providing a Medical Withdrawal Management Program and Outpatient Facilities providing an Opioid Treatment Program, shall complete and return a "Joint Annual Report" to the South Carolina Revenue and Fiscal Affairs Office within the time-period specified by the Department.

606. Accounting of Controlled Substances (I).

Any Facility registered with the Department's Bureau of Drug Control and the federal Drug Enforcement Agency shall report any theft or loss of Controlled Substances to local law enforcement and to the Department's Bureau of Drug Control within seventy-two (72) hours of the discovery of the loss and/or theft. Any Facility permitted by the South Carolina Board of Pharmacy shall report the loss or theft of drugs or devices in accordance with Section 40-43-91 of the South Carolina Code of Laws.

607. Facility Closure.

A. Prior to the permanent closure of a Facility, the Licensee shall notify the Department in writing of the intent to close and the effective closure date. Within ten (10) days of the closure, the Facility shall notify the Department of the provisions for the maintenance of the records, the identification of those Patients

displaced, the relocated site, and the dates. On the date of closure, the License shall be returned to the Department.

B. In instances where a Facility temporarily closes, the Licensee shall notify the Department in writing within fifteen (15) calendar days prior to temporary closure. In the event of temporary closure due to an emergency, the Facility shall notify the Department within twenty-four (24) hours of the closure via telephone, email, or fax. At a minimum this notification shall include, but not be limited to: the reason for the temporary closure, the location where the Patients have been and/or will be transferred, the manner in which the records are being stored, and the anticipated date for re-opening.

C. The Department shall consider, upon appropriate review, the necessity of inspecting and determining the applicability of current construction standards of the Facility prior to its reopening. If the Facility is closed for a period longer than one (1) year, and there is a desire to re-open, the Facility shall re-apply to the Department for licensure and shall be subject to all licensing requirements at the time of that application, including construction-related requirements for a new Facility.

608. Zero Census.

In instances when there have been no Patients in a Facility for any reason for a period of ninety (90) days or more, the Facility shall notify the Department in writing that there have been no admissions, no later than the one hundredth (100th) calendar day following the date of departure of the last active Patient. At the time of that notification, the Department shall consider, upon appropriate review of the situation, the necessity of inspecting the Facility prior to any new and/or readmissions to the Facility. In the event the Facility is at zero census or temporarily closed, the Licensee is still required to apply and pay the licensing fee to keep the License active. If the Facility has no Patients for a period longer than one (1) year and there is a desire to admit a Patient, the Facility shall re-apply to the Department for licensure and shall be subject to all licensing requirements at the time of that application, including construction-related requirements for a new Facility.

SECTION 700 - PATIENT RECORDS

701. Content (II).

A. The Facility shall initiate and maintain a Patient record for every individual screened, assessed and/or treated. The record shall contain sufficient information to identify the Patient and the agency and/or person responsible for each Patient, support the diagnosis, justify the treatment, and describe the response and/or reaction to treatment. The record contents shall also include the provisions for release of information, Patient rights, consent for treatment (approval by parent and/or guardian of Patient), Medications prescribed and administered, and diet (Residential Facilities only), documentation of the course and results, and promote continuity of treatment among treatment providers, consistent with acceptable standards of practice. In Facilities providing services for Parents with children, the name and age of each child shall be maintained in the Facility. All entries shall be written legibly in ink, typed, or electronic media, and signed and dated or documented in the electronic medical record.

B. If the Facility permits any portion of a Patient's record to be generated by electronic or optical means, there shall be policies and procedures to prohibit the use or authentication by unauthorized users.

C. Specific entries and documentation shall include at a minimum:

1. Consultations by Physicians or other Authorized Healthcare Providers;

2. Signed and dated orders and recommendations for all Medication, care, services, and diet (Residential Facilities only) from Physicians or other Authorized Healthcare Providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted; (I)

3. Intake screening and initial physical assessment completed by the nurse or Counselor;

4. A signed and dated original consent for treatment; (I)

5. The report of the mental status examination and other mental health assessments as defined in Section 101.G. as appropriate;

6. Notes of counseling sessions and any other changes in the Patient's mental and physical condition; and

7. Medication management and administration, and treatment records.

8. Discharge summary, completed within a time-period as determined by the Facility, but no later than three (3) business days, and shall include at minimum:

a. Time and circumstances of Discharge or transfer, including condition at Discharge or transfer, or death; and

b. The recommendations and arrangements for further treatments, including Aftercare.

D. Electronic signatures may be used in the Patient record if they are in accordance with applicable laws and regulations, and require a signature. Electronic authorization shall be limited to a unique identifier (confidential code) used only by the individual making the entry to preclude the improper or unauthorized use of any electronic signature

702. Screening (I).

A. The Facility shall have written protocols for screening individuals presenting for admission. The Facility shall maintain documentation of the rationale for the denial of admission and referral of the individual as applicable.

B. All screening shall be documented for each individual presenting to the Facility.

C. For Facilities providing a Medical Withdrawal Management Program, the Intake screening shall be conducted by a Physician or other Authorized Healthcare Provider to determine the need for medical services or referral for serious medical complications.

D. For Facilities providing Social Withdrawal Management, the Intake screening shall be provided by Staff or Volunteers trained to monitor the Patient's physical condition.

E. For Facilities providing an Opioid Treatment Program, screening shall include:

1. Evidence of tolerance to an opioid;

2. History of physiological dependence for at least one (1) year prior to admission. The Opioid Treatment Program Physician may waive the one (1)-year history of dependence when the Patient seeking admission meets one (1) of the following criteria:

- a. The Patient has been recently released from a penal or chronic care Facility with a high risk of relapse;
 - b. The Patient has been previously treated and is at risk of relapse;
 - c. The Patient is pregnant and does not exhibit objective signs of opioid withdrawal or physiological dependence;
3. Evidence of multiple and daily self-administration of an opioid;
4. Reasonable attempts to confirm that the applicant is not enrolled in one (1) or more other Opioid Treatments Programs;
5. Controlled Substance history to determine dependence on opium, morphine, heroin, or any derivative or synthetic controlled substance of that group. The substance history shall include:
- a. Controlled Substance(s) utilized;
 - b. Frequency of use;
 - c. Amount utilized;
 - d. Duration of use;
 - e. Age when first utilized;
 - f. Route of administration;
 - g. Previous treatment(s);
 - h. Unsuccessful efforts to control use; and
 - i. Inappropriate use of prescribed opioids.

703. Assessment for Residential Treatment Programs (II).

A written assessment of the Patient in accordance with Section 101.G shall be conducted by a designated Counselor as evidenced by his or her signature and date within a time-period determined by the Facility, but no later than five (5) business days after admission.

704. Assessment for Withdrawal Management Programs (II).

A written clinical Assessment of the Patient completed by a Licensed Nurse as evidenced by his or her signature and date in accordance with Section 101.G shall be conducted prior to the delivery of treatment. The clinical Assessment shall include a review of the Patient's Controlled Substance misuse/usage and treatment history.

705. Bio-Psycho-Social Assessment for Opioid Treatment Program (II).

A comprehensive Bio-Psycho-Social Assessment shall be completed by the Patient's primary Counselor once the Patient is stabilized but not later than thirty (30) calendar days following admission. The Assessment shall include:

A. A description of the historical course of the Chemical Dependence to include substances of misuse such as alcohol and tobacco, amount, frequency of use, duration, potency, and method of administration, previous withdrawal from Opioid Treatment Program Medication and/or treatment attempts, and any psychological or social complication.

B. A health history regarding chronic or acute medical conditions, such as HIV, STDs, hepatitis (B, C, D), TB, diabetes, anemia, sickle cell trait, pregnancy, chronic pulmonary diseases, and renal diseases.

C. Information related to the family of the Patient.

706. Individual Plan of Care (II).

The Facility shall develop an Individual Plan of Care with participation by the Patient or responsible party and Interdisciplinary Team as evidenced by their signatures and dates. The Individual Plan of Care shall contain specific goal-related objectives based on the needs of the Patient as identified during the Assessment phase, including adjunct support service needs and other special needs. The Individual Plan of Care shall also include the methods and strategies for achieving these objectives and meeting these needs in measurable terms with expected achievement dates. The type and frequency of counseling, as well as Counselor assignment, shall be included. The criteria for terminating specified interventions shall be included in the Individual Plan of Care. Individual Plan of Care shall be reviewed on a periodic basis as determined by the Facility and/or revised as changes in Patient needs occur.

A. In Residential Treatment Programs, an Individual Plan of Care shall be completed no later than seven (7) calendar days after admission.

B. For a Residential Facility offering a Withdrawal Management Program, an Individual Plan of Care shall be completed for supervised withdrawal within a time-period determined by the Facility's policies and procedures, but no later than seven (7) business days after admission.

707. Individual Plan of Care for Opioid Treatment Program (II).

A. The Facility shall develop and document an Individual Plan of Care within thirty (30) calendar days of admission with participation by the Patient and the primary Counselor.

B. The primary Counselor shall review the Patient progress in treatment and accomplishment of Individual Plan of Care goals not less than every ninety (90) calendar days during the first year of treatment and every six (6) months thereafter. The Counselor and Patient or responsible party shall sign and date any changes.

708. Record Maintenance.

A. The Licensee shall provide accommodations, space, supplies, and equipment for the protection, storage, and maintenance of Patient records. Patient records shall be stored in an organized manner.

B. The Patient record is confidential and shall be made available only to individuals authorized by the Facility and in accordance with local, state, and federal laws, codes, and regulations. (II)

C. The Facility shall maintain records generated by organizations or individuals contracted by the Facility for care or services.

D. Upon Discharge of a Patient, the record shall be completed within thirty (30) calendar days and filed in an inactive or closed file maintained by the Licensee.

E. Records of adult Patients may be destroyed after six (6) years following Discharge of the Patient. Records of Minors shall be retained for six (6) years or until majority, whichever period of time is greater. Other regulation-required documents, e.g., Medication destruction, fire drills, etc., shall be retained for at least twelve (12) months or since the last Department routine Inspection, whichever is the longer period.

F. Records of current Patients are the property of the Facility and shall be maintained at the Facility and shall not be removed without court order.

G. In the event of change of ownership, all active Patient records or copies of active Patient records shall be transferred to the new owner(s).

H. When a Patient transfers from one licensed Facility to another within the provider network (same Licensee) the original record may follow the Patient; the sending Facility shall maintain documentation of the Patient's transfer and/or Discharge dates and identification information.

SECTION 800 – ADMISSION (I)

801. General.

Individuals seeking admission shall be identified as appropriate for the level of care or services, treatment, or procedures offered. The Facility shall establish admission criteria that are consistently applied and comply with state and federal laws and regulations. The Facility shall admit only those persons whose needs can be met within the accommodations and services provided by the Facility.

802. Residential Facilities.

A. Residential Facilities shall not admit any person who, because of acute mental illness or intoxication, presents an immediate threat of harm to him or herself and/or others

B. Parental consent shall be obtained for all persons under eighteen (18) years of age prior to admission to a Residential Facility. If any court of competent jurisdiction declares a person under eighteen (18) years of age an emancipated Minor, such person may be admitted to the Facility without parental consent.

C. Residential Treatment Programs shall not admit any person needing Withdrawal Management services, hospitalization, or nursing home care.

D. Withdrawal Management Programs.

1. Appropriate admission to a Facility providing Withdrawal Management shall be determined by a licensed or certified Counselor and subsequently shall be authorized by a Physician or other Authorized Healthcare Provider in accordance with Section 1100.

2. Withdrawal Management Programs shall not admit any person needing hospitalization, Residential Treatment Program, or nursing home care.

3. Parental consent shall be obtained for all persons under eighteen (18) years of age prior to admission to a Residential Treatment Program. If any court of competent jurisdiction declares a person under eighteen (18) years of age an emancipated Minor, then such person may be admitted to the program without parental consent.

803. Opioid Treatment Programs.

A. Persons shall not be admitted to the Opioid Treatment Program to receive opioids for pain management only. Appropriate referrals by the Opioid Treatment Program Physician shall be made as necessary, e.g., pain management specialist.

B. No person under eighteen (18) years of age shall be admitted to an Opioid Treatment Program unless a parent, legal guardian, or responsible adult consents in writing to such treatment.

SECTION 900 – PATIENT CARE, TREATMENT, AND SERVICES

901. General.

A. The Facility shall provide Patient care and services , including routine and emergency medical care , as identified in the Patient record and as ordered by a Physician or other Authorized Health Care Provider. Care and services shall be provided and coordinated among those responsible during the treatment process and modified as warranted based on any changing needs of the Patient, and detailed in the Individual Plan of Care. (I)

B. Care, treatment, and services shall be rendered effectively and safely in accordance with orders from Physicians, other Authorized Healthcare Providers, and certified and/or licensed Counselors, and precautions taken for Patients with special conditions, e.g., pacemakers, wheelchairs, etc. (I)

C. The Facility shall document that Patients were offered the opportunity to participate in Aftercare and/or Continuing Care programs offered by the Facility or through referral. (II)

D. In the event of closure of a Facility for any reason, the Facility shall ensure continuity of treatment and/or care by promptly notifying the Patient’s attending Physician or other Authorized Healthcare Provider or Counselor and arranging for referral to other Facilities at the direction of the Physician or other Authorized Healthcare Provider or Counselor. The facility shall document the notification and referral in the Patient’s medical record.

902. Residential Facilities. (II)

A. Patients shall receive assistance in activities of daily living as documented in the Individual Plan of Care.

B. Patients shall be provided necessary items and assistance to maintain their personal hygiene.

C. Opportunities shall be provided for participation in religious services. Assistance in obtaining pastoral counseling shall be provided upon request by the Patient.

D. Precautions shall be taken for the protection of the personal possessions of the Patients, including their personal funds. The Facility may secure the personal funds of the Patient provided the Patient authorizes the Facility to do so. The Facility shall maintain an accurate accounting of the funds, including evidence of purchases by Facility on behalf of the Patients. No personal monies shall be given to anyone, including family members, without written consent of the Patient. If money is given to anyone by the Facility, a receipt shall be obtained.

E. Residential Treatment Programs shall document in the Patient's medical record that the Facility has provided or made available the following:

1. Specialized professional consultation, supervision, and direct affiliation with other levels of treatment;
2. Arrangements for appropriate laboratory and toxicology tests as needed;
3. Counselors to assess and treat Patients for Substance Use Disorders and obtain and interpret information regarding the needs of the Patients;
4. Counselors to provide a planned regimen of twenty-four (24) hour professionally-directed evaluation, care, and treatment services for persons with Substance Use Disorders and their families to include individual, group, and/or family counseling directed toward specific Patient goals indicated in his or her Individual Plan of Care;
5. Educational guidance and educational program referral when indicated; and
6. Vocational counseling for any Patient when indicated. For those not employed, Staff and/or Volunteers shall facilitate the Patient's pursuit of employment search;

F. Withdrawal Management Programs.

1. Facilities Offering a Medical Withdrawal Management Program shall document in the Patient's medical record that the facility has provided the following:

- a. Continuing observation and monitoring of each Patient's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action. Each Patient's general condition, including vital signs, shall be documented at a frequency as determined by the Facility, but not less than three (3) times during the first seventy-two (72) hours of admission to the Facility;
- b. A plan for supervised withdrawal, to be implemented upon admission;
- c. Counseling designed to motivate Patients to continue in the treatment process and referral to the appropriate treatment modality.

2. Facilities offering a Social Withdrawal Management Program shall document in the Patient's medical record that the Facility has provided the following:

- a. Development of an Individual Plan of Care for supervised withdrawal;
- b. Continuing observation of each Patient's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action; and

c. Counseling designed to motivate Patients to continue in the treatment process.

3. Facilities providing a Withdrawal Management Program shall provide room, dietary service, care, and supervision necessary for the maintenance of the Patient.

903. Facilities Providing an Opioid Treatment Program.

A. Services (II).

1. Services shall be directed toward reducing or eliminating the use of illicit Controlled Substances, criminal activity, or the spread of infectious disease while improving the quality of life and functioning of the Patient. Opioid Treatment Programs shall follow rehabilitation stages in sufficient duration to meet the needs of the Patient. These stages include initial treatment, early stabilization, long-term treatment, medical maintenance, and immediate emergency treatment when needed.

2. The Opioid Treatment Program shall directly provide, contract, or make referrals, for services based upon the needs of the Patient.

3. As part of Substance Use Disorder rehabilitative services provided by the Opioid Treatment Program, each Patient shall be provided with individual, group, and family counseling as based on needs identified during the assessment. The frequency and duration of counseling provided to Patients shall be determined by the needs of the Patient and be consistent with the Individual Plan of Care. Counseling shall address, as a minimum:

a. Treatment and recovery objectives included in the Individual Plan of Care, as well as education regarding HIV, Hepatitis, and other infectious diseases. HIV testing shall be made available as appropriate, while maintaining Patient confidentiality;

b. Concurrent substance misuse;

c. Involvement of family and significant others with the informed consent of the Patient;

d. Providing treatment groups; and

e. Guidance in seeking alternative therapies, if applicable.

B. Support Services.

1. The Opioid Treatment Program shall ensure that a comprehensive range of support services, including, but not limited to, vocational, educational, employment, legal, mental health and family problems, medical, Substance Use Disorder, HIV or other communicable diseases, pregnancy and prenatal care, and social services are made available to Patients who demonstrate a need for such services. Support services may be provided either directly or by appropriate referral. Support services recommended and utilized shall be documented in the Patient record.

2. When appropriate, the Opioid Treatment Program shall link the Patient with an educational program, and vocational employment services. Deviations from compliance with these outcomes shall be documented in the Patient's record.

3. The Opioid Treatment Program shall establish and utilize formal linkages with community-based treatment services, through an established set of procedures for coordinating care with Physicians or other health or behavioral care providers when appropriate.

4. The Opioid Treatment Program shall establish linkages with the criminal justice system to encourage continuous treatment of individuals incarcerated or on probation and parole.

C. Services to Pregnant Patients in an Opioid Treatment Program (II).

1. The Facility shall make reasonable effort to ensure that pregnant Patients receive prenatal care by a Physician and that the Physician is notified of the Patient's participation in the Opioid Treatment Program when the Facility becomes aware of the pregnancy.

2. The Opioid Treatment Program shall provide, through in-house services or referral, and document in the Individual Plan of Care, appropriate services and interventions for the pregnant Patient to include:

- a. Physician consultation at least monthly;
- b. Nutrition counseling; and
- c. Parenting training to include newborn care, health and safety, parent/infant interaction, and bonding.

3. The Facility shall maintain signed documentation of a Patient's acknowledgement of refusal of prenatal care.

4. Opioid Treatment Program FDA-approved Medication for opioid treatment dosage levels shall be maintained at an appropriate level for pregnant Patients as determined by the Opioid Treatment Program Physician and documented in the Patient's record. (I)

5. When a pregnant Patient chooses to discontinue participation in the Opioid Treatment Program, the program Physician, in coordination with the attending obstetrician, shall supervise the termination process.

904. Substance Use Testing for Opioid Treatment Programs (II).

A. Substance use testing shall be used as a clinical tool for the purposes of diagnosis and in the development of Individual Plans of Care.

B. Substance use testing for the presence of Opioid Treatment Program Medication, benzodiazepines, cocaine, opiates, marijuana, amphetamines, and barbiturates, as well as other substances, when clinically indicated by the Opioid Treatment Program Physician, shall be conducted at a frequency as determined by the Opioid Treatment Program.

C. Results of substance use testing shall be addressed by the primary Counselor with the Patient, in order to intervene in Controlled Substance use behavior.

D. The Opioid Treatment Program shall establish and implement written testing procedures, including random collection of substance testing samples, to effectively minimize the possibility of falsification of the sample, to include security measures for prevention of tampering.

E. Patients granted take home dosages shall undergo random substance use testing on a monthly basis. For Patients whose substance use testing reports indicate positive results for any illicit substances, non prescription Medications, or a negative result of Opioid Treatment Program Medication, the frequency for substance use testing shall be determined by the Opioid Treatment Program Physician or other Authorized Healthcare Provider. Documentation of the rationale for the frequency shall be documented in the Patient's medical record.

F. Only those laboratories certified in accordance with the federal Clinical Laboratories Improvement Amendments shall be utilized by the Opioid Treatment Program for urinalysis.

905. Orientation for Patients Admitted to an Opioid Treatment Program.

Patient orientation shall be accomplished within seven (7) calendar days of admission and documented in the Patient record. The orientation shall include:

- A. Opioid Treatment Program guidelines, rules, and regulations;
- B. Confidentiality;
- C. Substance use testing procedure;
- D. Administering Opioid Treatment Program Medication;
- E. Signs and symptoms of an overdose and when to seek emergency assistance;
- F. Discharge procedures;
- G. Treatment phases;
- H. HIV/AIDS information and education;
- I. Patient rights (See Section 1000);
- J. The nature of Substance Use Disorders and recovery including misunderstandings regarding methadone or other opioid treatment Medication; and
- K. For pregnant Patients, risk to the unborn child.

906. Transportation.

Residential Facilities shall provide or assist in securing local transportation for Patients for emergent or non-emergent health reasons to health care providers such as, but not limited to, Physicians, dentists, physical therapists, or for treatment at renal dialysis clinics.

907. Safety Precautions and Restraints (I).

A. Periodic or continuous mechanical, physical, or chemical restraints during routine care of a Patient shall not be used, nor shall Patients be restrained for Staff convenience or as a substitute for care or services. However, in cases of extreme emergencies when a Patient is a danger to him or herself or others, mechanical and/or physical restraints may be used as ordered by a Physician or other Authorized Healthcare Provider,

and until appropriate medical care can be secured. Only those devices specifically designed as restraints may be used.

B. Emergency restraint orders shall specify the reason for the use of the restraint, the type of restraint to be used, the maximum time the restraint may be used, and instructions for observing the Patient while restrained, if different from the Facility's written procedures. Patients certified by a Physician or other Authorized Healthcare Provider as requiring restraint for more than twenty-four (24) hours shall be transferred to an appropriate Facility.

C. During emergency restraint, Patients shall be monitored at least every fifteen (15) minutes and provided with an opportunity for motion and exercise at least every thirty (30) minutes. Prescribed Medications and treatments shall be administered as ordered, and Patients shall be offered nourishment and fluids and given bathroom privileges.

D. The use of mechanical restraints shall be documented in the Patient's record, and shall include the date and time implemented, the length of time restrained, observations while Patient is restrained.

908. Services for Minors (II).

A. In Residential Facilities, Minors shall be housed separately from adults except in Facilities providing services for Parents with children.

B. In those instances where Minors are served, the Facility shall ensure that the special needs of these Patients are addressed, including, but not limited to, education-related considerations.

C. The Facility shall ensure treatment and counseling are conducted to meet the physical, mental, and emotional developmental needs of the Minor.

D. The Facility shall refer Minors who require special medical needs to a Physician who has clinical experience with Minors and dependency. The Facility shall monitor Minors for treatment reactions that may be developmentally detrimental. A plan shall be in place in the event that special medical care is required.

909. Referral Services.

A. Referrals for care and/or services shall not be made to unlicensed Facilities if such Facilities are required to be licensed. (II)

B. The Facility shall provide information regarding appropriate self-help groups to Patients and encourage their participation in such activities, and document the information was provided in the Patient's record.

C. The facility shall maintain documentation of the rationale for the denial of admission and referral for services offered to the Patient as applicable.

D. A community resource file shall be developed, maintained, and used for proper Patient referral and placement. The file shall include a listing of services, fees, hours of operation, and contact person as well as material to be provided to the Patient. The Facility shall provide the Patient with information and offer referral for community resources such as transportation, hospital emergency services, and ambulance services.

SECTION 1000 – PATIENT RIGHTS AND ASSURANCES

1001. Informed Consent (II).

A. Upon admission, there shall be a written, signed, and dated informed consent between the Patient and the Facility. The informed consent shall include at least the following:

1. An explanation of the specific care, services, and/or equipment provided by the Facility, such as, administration of Medication, provision of special diet as necessary, assistance with bathing, toileting, feeding, dressing, and mobility;

2. Discharge and transfer provisions to include the conditions under which the Patient may be Discharged, and the agreement terminated, and the disposition of personal belongings; and

3. Documentation of the explanation of the Patient's rights (see Section 1002) and the grievance procedure.

4. Each person enrolling in an Opioid Treatment Program shall be notified of the autopsy provision in South Carolina Code Section 44-53-750 as a part of such person's informed consent.

B. The provision of care and services to Patients shall be guided by the recognition of and respect for cultural differences to ensure reasonable accommodations shall be made for Patients with regard to differences, such as, but not limited to, religious practice and dietary preferences.

1002. Patient Rights (II).

A. Patient rights shall be guaranteed and prominently displayed in a public area. Documentation of the explanation of the Patient's Bill of Rights shall be maintained in the Patient's medical record. The Patient rights shall include:

1. The opportunity to participate in the Individual Plan of Care;

2. Informed consent for treatment;

3. Grievance and/or complaint procedures, including the address and phone number of the Department, and a provision prohibiting retaliation should the grievance right be exercised;

4. Confidentiality of Patient records;

5. Respect for the Patient's property (Residential Facilities Only);

6. Freedom from Abuse, Neglect, and Exploitation; (I)

7. Privacy in visits unless contraindicated in the recovery and treatment process or as ordered by a Physician or other Authorized Healthcare Provider;

8. Privacy during treatment and while receiving personal care; and

9. Respect and dignity in receiving care, treatment, and services.

B. For Facilities providing Residential Services, the Patients shall be assured freedom of movement. Patients shall not be locked in or out of their rooms or any common usage areas, , in the Facility, or in or out of the Facility building. (I)

C. Care and services and items provided by the Facility, the charge, and those services that are the responsibility of the Patient shall be delineated in writing and the Patient shall be made aware of such charges and services as verified by his or her signature.

D. The Facility shall comply with all current federal, state, and local laws and regulations related to discrimination, e.g., Title VII, Section 601 of the Civil Rights Act of 1964, ADA, and ensure that there is no discrimination with regard to source of payment in the recruitment, location of Patient, acceptance or provision of goods and services to Patients or potential Patients, provided that payment offered is not less than the cost of providing services.

E. In Residential Facilities, no care and/or treatment and/or services shall be provided to individuals who are not Patients of the Facility, except those services provided to family members as part of the Patient's recovery plan.

1003. Discharge and Transfer.

A. Unless a Patient is under court order or detained subject to a pending judicial process, a Patient may be transferred or Discharged only for medical reasons, the welfare of the Patient, the welfare of other Patients of the Facility, lack of progress or participation in treatment, or successful completion of the program. He or she shall be given written notice of Discharge except when the health, safety, or well-being of other Patients of the Facility would be endangered.

B. When a Patient is transferred from one Facility to another, a transfer summary, to include copies of relevant documents, shall be forwarded to the receiving Facility within a time-period as determined by the Facility but not to exceed seventy-two (72) hours from transfer. The Facility shall ensure that Medication, personal possessions and funds of the Patient are forwarded to the receiving Facility and/or site in a manner that ensures continuity of care and/or treatment and/or services and maximum convenience to the Patient.

C. A Patient transferring from another Opioid Treatment Program shall have a Physical Examination upon admission and have his or her dose determined by a Physician prior to receiving the first dosage.

SECTION 1100 – PATIENT PHYSICAL EXAMINATION

A. Residential Facilities. A Physical Examination shall be completed by a Physician or other Authorized Healthcare Provider for Patients within thirty (30) calendar days prior to admission or two (2) business days of admission for Patients . Physical Examinations conducted by Physicians or other Authorized Healthcare Providers licensed in other states are permitted for new admissions under the condition that the Patient undergoes a second Physical Examination by a South Carolina licensed Physician or other Authorized Healthcare Provider within thirty (30) calendar days of admission to the Facility. The Physical Examination shall address:

1. The appropriateness of level of services;
2. Identification of special conditions and/or care required;
3. A tuberculin skin test, as described in Section 1702, unless there is a previously documented positive reaction;

4. If a Patient or potential Patient has a communicable disease, the Facility shall follow the recommendations made by a Physician or other Authorized Healthcare Provider in order to:

a. Ensure that the Facility has the capability of providing adequate care and preventing the spread of that condition, and that Staff and Volunteers are adequately trained; or

b. Transfer the Patient to an appropriate Facility, if necessary; and

5. A substance use test. Following the test, the Physician or Authorized Healthcare Provider shall determine the frequency of subsequent testing based on the Patient's clinical presentation.

B. In Facilities providing services for parents with children, there shall be a report of an examination for each child by a Physician or other Authorized Healthcare Provider attesting to the health status and special care needs that may impact the child, his/ or her parent, and/or others within the Facility. The examination shall be conducted not earlier than thirty (30) calendar days prior to the parent's admission or no later than forty-eight (48) hours after admission.

C. Opioid Treatment Program.

1. Physical Examination. A Physical Examination conducted by the Opioid Treatment Program Physician or other Authorized Healthcare Provider shall be completed within seventy-two (72) hours prior to the first dose of Opioid Treatment Program Medication and shall address the following at a minimum: (I)

a. Evidence of communicable or Infectious disease;

b. Pulmonary, liver, renal, and cardiac abnormalities;

c. Neurological issues;

d. Vital signs;

e. Evidence of clinical signs of dependency; and

f. Examination of head, ears, eyes, nose, throat, thyroid, chest (including heart, lungs and breast), abdomen, extremities, and skin.

2. Medical Laboratory Analysis. A medical laboratory analysis shall be conducted within seven (7) calendar days of admission and shall include:

a. Serological test for Infectious disease;

b. Initial substance use testing for Controlled Substance profile;

c. Liver profile; and

d. If indicated, an electrocardiogram, chest x-ray, and/or a biological pregnancy test.

3. In the event the medical staff are unable to obtain an adequate blood draw for the medical laboratory analysis on the first attempt, the Facility shall reattempt within the seven (7) days of admission. After three (3) documented attempts within the seven (7) days of admission, the Opioid Treatment Program Physician or other Authorized Healthcare Provider may waive the blood testing requirements. The Physician's

decision shall be documented in the Patient's medical record. The Facility shall follow its policies and procedures related to infection control if the Physician waives the blood testing requirement.

D. In the event that a Patient transfers from one Residential Facility to another, an additional admission Physical Examination and/or tuberculin skin test shall not be necessary, provided the Physical was conducted not earlier than twelve (12) months prior to the admission of the Patient, and the Physical meets all other requirements specified in Section 1100.A.1, unless the receiving Facility has an indication that the health status of the Patient has changed significantly. In such instances of transfer, issues of appropriateness of level of treatment placement shall be addressed in the Patient record.

SECTION 1200 – MEDICATION MANAGEMENT

1201. General (I).

A. Medications, including Controlled Substances, medical supplies, and those items necessary for the rendering of first aid shall be properly managed in accordance with local, state, and federal law and regulations, which includes the securing, storing, and administering, dispensing, and delivering of medications, medical supplies, and biologicals, their disposal when discontinued or outdated, and their disposition at Discharge, death, or transfer of a Patient. All Facilities that manage Medication of Patients shall comply with this section.

B. Applicable reference materials published within the previous three (3) years shall be available at the Facility in order to provide Staff and/or Volunteers with adequate information concerning Medications.

1202. Medication Orders (I).

A. Medication, including oxygen, shall be administered and delivered to Patients only upon orders of a Physician or other Authorized Healthcare Provider. Medications accompanying Patients at admission may be administered and/or delivered to Patients, provided the Medication is in the original container and the order/authorization is subsequently obtained as a part of the admission Physical Examination. If there are concerns regarding whether or not such Medications should be administered and/or delivered due to the condition or state of the Medication, e.g., old, expired, makeshift labels, or the condition or state of health of the newly-admitted individual, Staff and Volunteers shall consult with or make arrangements to have the Patient examined by a Physician or other Authorized Healthcare Provider, or at the local hospital emergency room prior to administering or delivering any Medications.

B. All orders (including verbal orders) shall be signed and dated by a Physician or other Authorized Healthcare Provider within a time-period as designated by the Facility, but no later than seventy-two (72) hours after the order is given.

C. In an Opioid Treatment Program, all orders shall be documented, signed, and dated by the Opioid Treatment Program Physician. The Opioid Treatment Program Physician shall determine the initial and subsequent dosage and schedule, and prescribe such dose and schedule to include changes by verbal or written order to the pharmacist and Licensed Nurse. However, the verbal order shall be documented, signed, and dated by the Opioid Treatment Program Physician within seventy-two (72) hours.

D. Orders for Controlled Substances shall be authenticated by the prescribing Physician or designee.

E. Medications and medical supplies ordered for a specific Patient shall not be administered and/or delivered to any other Patient.

1203. Administering Medication (I).

A. Doses of Medication shall be administered by the same Licensed Nurse who prepared them for administration. Preparation shall occur no earlier than one (1) hour prior to administering. Preparation of doses for more than one (1) scheduled administration shall not be permitted. Each Medication dose administered shall be recorded on the Patient's Medication administration record ("MAR") as it is administered. Should an ordered dose of Medication not be administered, an explanation as to the reason shall be recorded on the MAR. The recording of Medication administration shall include: the medication name, dosage, mode of administration, date, time, and the signature of the individual administering or supervising the taking of the Medication. Initials in lieu of signatures are acceptable provided such initials can be readily identified on the MAR. If the ordered dosage is to be given on a varying schedule, for example, "take two tablets the first day and one tablet every other day by mouth with noon meal," the number of tablets shall also be recorded.

B. When a Physician or other Authorized Healthcare Provider changes the dosage of a Medication, a new entry reflecting the change shall be documented in the Medication administration record ("MAR"). No dose shall be administered until the Patient's identity has been verified and the dosage compared with the currently ordered and documented dosage level. Ingestion shall be observed and verified by the person authorized to administer the Medication.

C. Opioid Treatment Program Only:

1. The Facility shall not administer a Patient's initial dose of Opioid Treatment Program Medication until the program Physician or other Authorized Healthcare Provider has determined that all admission criteria have been met, to include a completed Physical Examination by the program Physician or other Authorized Healthcare Provider and confirmation of current Medication regimen being taken by the applicant.

2. The initial dose of methadone shall not exceed thirty (30) milligrams and the initial total daily dose for the first day shall not exceed forty (40) milligrams unless the Opioid Treatment Program Physician or other Authorized Healthcare Provider justifies in the Patient record that forty (40) milligrams did not suppress the abstinence symptoms after three (3) hours of observation following the initial dose. There shall be written justification in the Patient record, signed and dated by the Opioid Treatment Program Physician or other Authorized Healthcare Provider, for doses in excess of one hundred (100) milligrams of methadone per day after the first day.

3. A Patient's scheduled dose may be temporarily delayed if necessary, e.g., to obtain a urine sample or for Counselor consultation. The dose shall not be withheld, however, for failure to comply with the Opioid Treatment Program rules or procedures unless the decision is made to terminate the Patient's participation in the Opioid Treatment Program. A dose may be withheld only when the Opioid Treatment Program Physician or other Authorized Healthcare Provider determines that such action is medically indicated.

4. When the Opioid Treatment Program Physician prescribes Controlled Substances other than Opioid Treatment Program Medications, such prescriptions shall not be administered to any Patient unless the Opioid Treatment Program Physician or other Authorized Healthcare Provider first examines the Patient and assesses his or her potential for misuse of such Medications.

D. Self-administration of Medications shall be allowed only on the specific written orders of a Physician or other Authorized Healthcare Provider. An appropriate Staff member delivering the Medication shall

document the delivery. Such documentation shall include the date, time, and the signature of the individual delivering the Medication.

E. When Patients who cannot Self-Administer Medications leave the Facility for an extended time, the proper amount of Medications, placed into a prescription vial or bottle, along with dosage, mode, date, and time of administration, shall be given to a responsible person who will be in charge of the Patient during his or her absence from the Facility and properly documented in the Medication administration record. If there is no designated responsible party for the Patient, then the attending Physician or other Authorized Healthcare Provider shall be contacted for proper instructions.

F. The Medications prescribed for a Patient shall be protected from use by other Patients, visitors, and Staff and Volunteers. For those Patients who have been authorized by a Physician or other Authorized Healthcare Provider to Self-Administer Medications, such Medications (nitroglycerin, rescue inhalers, epinephrine auto-injectors) may be kept on the Patient's person, i.e., a pocketbook, pocket, or any other method that would enable the Patient to control the items.

1204. Pharmacy Services (I).

A. Any pharmacy within the Facility shall be provided by or under the direction of a licensed pharmacist in accordance with accepted professional principles and appropriate federal, state, and local laws and regulations.

B. Facilities that maintain stocks of Medications and biologicals for Patient use within the Facility shall obtain and maintain from the South Carolina Board of Pharmacy a valid, current, non-dispensing drug outlet permit that is displayed in a conspicuous location in the Facility.

C. Labeling of Medications dispensed to Patients shall be in compliance with local, state, and federal laws and regulations applicable to retail pharmacies.

1205. Medication Containers (I).

A. Medications for Patients shall be obtained from a permitted pharmacy or Authorized Healthcare Provider as allowed by law on an individual prescription basis. These Medications shall bear a label affixed to the container that reflects at least the following: name of pharmacy, name of Patient, name of the prescribing Physician or other Authorized Healthcare Provider, date and prescription number, directions for use, and the name and dosage unit of the Medication. The label shall be brought into accord with the directions of the Physician or other Authorized Healthcare Provider each time the prescription is refilled. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the pharmacy for re-labeling or disposal.

B. Medications for each Patient shall be kept in the original container(s) including unit dose systems; there shall be no transferring between containers or opening blister packs to remove Medications for destruction or adding new Medications for administration, except under the direction of a pharmacist. In addition, for those Facilities that utilize the unit dose system or multi-dose system, an on-site review of the Medication program by a pharmacist shall be conducted on at least a quarterly basis to ensure the program has been properly implemented and maintained. For changes in dosage, the new packaging shall be available in the Facility no later than the next administration time subsequent to the order. This shall be documented and signed by the pharmacist.

C. Medications for Patients shall be obtained from a permitted pharmacy or prescriber on an individual prescription basis. These Medications shall bear a label affixed to the container that reflects at least the

following: name of pharmacy, name of Patient, name of the prescribing Physician or dentist, date and prescription number, directions for use, and the name and dosage unit of the Medication.

D. When a Physician or other legally Authorized Healthcare Provider changes the dosage of a Medication, such information shall be documented in the Medication administration record and a label that does not obscure the original label shall be attached to the container that states, “Directions changed; refer to MAR and Physician or other Authorized Healthcare Provider orders for current administration instructions.”

1206. Medication Storage (I).

A. Medications may be stored in a separate locked box within a refrigerator at or near the Medication storage area, either behind a locked door or the refrigerator shall be locked.

B. Controlled Substances and ethyl alcohol shall be stored in accordance with applicable state and federal laws. A record of the stock and distribution of all Controlled Substances shall be maintained in such a manner that the disposition of any particular item may be readily traced.

C. Medications shall be stored:

1. Separately from poisonous Controlled Substances or body fluids;
2. In a manner which provides for separation between topical and oral Medications, and which provides for separation of each individual Patient’s Medication.

D. Stock Medications

1. Unless the Facility has a permitted pharmacy, stocks of Legend Medications shall not be stored except those specifically prescribed for individual Patients.

2. Non-legend Medications may be retained and labeled as stock in the Facility for administration as ordered by a Physician or other Authorized Healthcare Provider.

3. Stocks of naloxone may be stored for emergency overdose crises, with or without specific prescription for individual Patients.

4. If stock non-Patient specific Controlled Substances are to be used, a Controlled Substances registration from the Department’s Bureau of Drug Control and a Controlled Substances registration from the federal Drug Enforcement Administration shall be obtained. The registrations shall be displayed in a conspicuous location within the Facility.

E. No Medications may be left in a Patient’s room unless the Facility provides an individual cabinet/compartments that is kept locked in the room of each Patient who has been authorized to Self-Administer in writing by a Physician, or other Authorized Healthcare Provider. In lieu of a locked cabinet or compartment, a room that can be locked and is licensed for a capacity of one (1) Patient is acceptable provided the Medications are not accessible by unauthorized persons, the room is kept locked when the Patient is not in the room, the Medications are not Controlled Substances, and all other requirements of this section are met.

F. The Medications prescribed for a Patient shall be protected from use by other Patients, visitors and Staff and Volunteers. For those Patients who have been authorized by a Physician or other Authorized

Healthcare Provider to self-administer Medications, such Medications may be kept on the Patient's person, i.e., a pocketbook, pocket, or any other method that would enable the Patient to control the items.

G. During nighttime hours in semi-private rooms, only Medications that a Physician or other Authorized Healthcare Provider has ordered in writing for emergency/immediate use, e.g., nitroglycerin, rescue inhalers, or epinephrine auto-injectors may be kept unlocked in or upon a cabinet or bedside table, and only when the Patient to whom that Medication belongs is present in the Patient room.

1207. Disposition of Medications (I).

A. The Facility shall release Medications to the Patient upon Discharge, unless specifically prohibited by the ordering Physician or Authorized Healthcare Provider.

B. Patient's Medications shall be destroyed by the Facility Administrator or his or her designee or returned to dispensing pharmacy when:

1. Medication has deteriorated or exceeded its safe shelf-life; and
2. Unused portions remain due to death, Discharge, or discontinuance of the Medications. Medications that have been discontinued by order may be stored for a period not to exceed thirty (30) calendar days provided they are stored separately from current Medications.

C. The destruction of Medication shall occur within five (5) days of the above-mentioned circumstances, be witnessed by the Administrator or his or her designee, and the mode of destruction indicated.

D. The destruction of controlled substances Medications shall be accomplished only by the Administrator or his or her designee on-site and witnessed by a Licensed Nurse or pharmacist, or by returning them to the dispensing pharmacy and obtaining a receipt from the pharmacy.

1208. Opioid Treatment Program Take-home Medication (II).

A. Opioid Treatment Program Medication, including guest and take-home doses, shall be administered to Patients in single doses. Take-home bottles shall be labeled in accordance with federal and state law and regulations and shall contain necessary cautionary statements; caps shall be childproof.

B. Take-home Opioid Treatment Program Medication may be given to Patients who demonstrate a need for a more flexible schedule in order to enhance and continue the rehabilitative process. However, since Opioid Treatment Program Medication is an opioid subject to misuse if not managed properly, precautions shall be taken to prevent its potential misuse. The Opioid Treatment Program Physician shall ensure that take-home Medication is given to those Patients who meet the following criteria for eligibility:

1. Adherence to Opioid Treatment Program rules, regulations, and policies;
2. Length of time in the Opioid Treatment Program and level of maintenance treatment;
3. Presence of Opioid Treatment Program Medication in substance use testing;
4. Potential complications from concurrent health problems;
5. Lengthy travel distance to the Facility; and

6. Progress in maintaining a stable lifestyle as evidenced by:

- a. Absence of misuse of opioids and non-opioids;
- b. Absence of alcohol misuse, or determination that the using alcohol and is in treatment for the alcohol misuse problem;
- c. Regularity of attendance at the Opioid Treatment Program, to include required counseling sessions;
- d. Absence of serious behavior problems, including loitering at the Opioid Treatment Program;
- e. Absence of known recent criminal activity;
- f. Employment, school attendance, or other appropriate activity; and
- g. Assurance that take-home Medication can be securely transported and stored by the Patient for his or her use only.

C. The decision to provide take-home Medication to Opioid Treatment Program Patients and the amount provided shall be based upon and determined by the reasonable clinical judgment of the Opioid Treatment Program Physician and appropriately documented and recorded in the Patient's file prior to the initiation of the take-home dose. The Opioid Treatment Program Physician shall document compliance by the Patient with all of the aforementioned requirements prior to providing the first take-home dose. (I)

D. The Patient's take-home status shall be reviewed and documented at least on a quarterly basis by the primary Counselor.

E. If a Patient, due to special circumstances, such as illness, personal or family crisis, travel, or other hardship, is unable to conform to the applicable treatment schedule, he or she may be permitted to receive up to a two (2)-week supply of Opioid Treatment Program Medication, based on the clinical judgment of the Opioid Treatment Program Physician. The justification for permitting the adjusted schedule shall be recorded in the Patient's record by the Opioid Treatment Program Physician.

F. One-time or temporary (usually not to exceed three (3) days) take-home Medication shall be approved by the Facility for family or medical emergencies or other exceptional circumstances.

G. A Patient transferring from another Opioid Treatment Program or readmitted after having left the Opioid Treatment Program voluntarily and who has complied with Facility rules and program policies and procedures may be granted an initial take-home schedule that is no greater than that allowed at the time of transfer or voluntary Discharge provided all criteria other than length of treatment are met.

H. A Patient discharged from another Opioid Treatment Program shall only be initially granted take-home privileges from the new admitting Opioid Treatment Program provided the requirements of Section 1209 are met.

I. Take-home Medication shall be labeled with the name of the Opioid Treatment Program, address, telephone number, and packaged in conformance with state and federal regulations.

J. A diversion control plan shall be established to assure quality care while preventing the diversion of Opioid Treatment Program Medication from treatment to illicit use. The plan shall include:

1. Clinical and administrative continuous monitoring;
2. Problem identification, correction and prevention;
3. Accountability to the Patient and community; and
4. Opioid Treatment Program Medication usage and amount accountability.

1209. Opioid Treatment Program Guest-Dosing (II).

A. When a Patient is separated from his or her Opioid Treatment Program for an extended period, and the Patient is in the vicinity of another Licensed Opioid Treatment Program, guest-dosing may occur provided there is: (I)

1. Authorization in writing from the sending Opioid Treatment Program Physician or other Authorized Healthcare Provider; and

2. Information from the sending Opioid Treatment Program to include at least the following: Patient name, identifying information, means of identity verification, dates of guest-dosing, amount of each day's dose, number of take-home doses (if any), urinalysis history, and any other information requested by the authorizing treatment Opioid Treatment Program.

B. Records of guest-dosing shall be maintained at the Opioid Treatment Program providing the guest-dosing.

C. Guest-dose status for a Patient shall not exceed twenty-eight (28) days unless there are special circumstances, and an extension of time is agreed upon by the two (2) Opioid Treatment Programs involved.

D. A Facility desiring to administer guest dosing for Patients from neighboring states in the event of a natural disaster or emergency shall:

1. Request that the Department concur that an emergency situation exists by contacting the Department;

2. Administer the guest-dosing only upon written orders from the Facility's Opioid Treatment Program physician; and

3. Maintain documentation of the physician's rationale for the dosing protocol and information utilized to make the decision.

1210. Security of Medications (I).

A. The areas where Opioid Treatment Program stock Medications are maintained or administered shall be secured. Access to Controlled Substances, which include Opioid Treatment Program Medications, shall be limited to persons licensed or registered to order, administer, or dispense those Medications.

B. Immediately after administering, the remaining contents of the containers shall be purged to prevent the accumulation of residual Opioid Treatment Program Medications. The Opioid Treatment Program shall ensure that take-home Medications bottles are returned to the Opioid Treatment Program. All used

containers, as well as take-home bottles given to Patients, shall be made inaccessible to unauthorized individuals. Used containers shall be disposed of by the Opioid Treatment Program.

SECTION 1300 – MEAL SERVICE

1301. General (II).

A. All Facilities that prepare food on-site shall be approved by the Department, and shall be regulated, inspected, and graded pursuant to R.61-25, Retail Food Establishments. Facilities preparing food on-site, licensed for sixteen (16) beds or more subsequent to the promulgation of this regulation shall have commercial kitchens. Existing Facilities with sixteen (16) licensed beds or more may continue to operate with equipment currently in use; however, only commercial kitchen equipment shall be used when replacements are necessary. Those Facilities with fifteen (15) beds or less shall be regulated pursuant to R.61-25 with certain exceptions in regard to equipment (may utilize domestic kitchen equipment).

B. When meals are catered to a Facility, such meals shall be obtained from a food service establishment permitted by the Department, pursuant to R.61-25 and there shall be a written executed contract with the food service establishment on file in the Facility.

C. All food to be served to Patients shall be transported, received, stored, and handled in accordance with R.61-25. Washing and sanitation of all food contact and non-food contact surfaces, equipment, and utensils shall meet the standards required by R.61-25. A handwash lavatory shall be provided in the food service area equipped with liquid soap and a hand drying provision. Hand sanitizers shall not be used in lieu of liquid soap.

D. If food is prepared at a central kitchen and delivered to separate Facilities or separate buildings and/or floors of the same Facility, provisions shall be made and approved by the Department for proper maintenance of food temperatures and a sanitary mode of transportation.

E. Food shall be prepared by methods that conserve the nutritive value, flavor, and appearance. The food shall be palatable, properly prepared, and sufficient in quantity and quality to meet the daily nutritional needs of the Patients in accordance with written dietary policies and procedures. Efforts shall be made to accommodate the religious, cultural, and ethnic preferences of each individual Patient and consider variations of eating habits, unless the orders of a Physician or other Authorized Healthcare Provider contraindicate.

1302. Food and Food Storage (II).

Residential Facilities shall maintain at least a one (1)-week supply of staple foods and a two (2)-day supply of perishable foods on the premises. Supplies shall be appropriate to meet the requirements of the menu and special diets.

1303. Meals and Services.

A. Residential Facilities shall serve a minimum of three (3) nutritionally-adequate meals in each twenty-four (24)-hour period unless otherwise directed by the Patient's Physician or other Authorized Healthcare Provider. Not more than fourteen (14) hours shall elapse between the serving of the evening meal and breakfast the following day. (II)

B. Specific times for serving meals shall be established, documented on a posted menu, and followed.

C. Suitable food and snacks shall be available and offered between meals at no additional cost to the Patients. (II)

1304. Meal Service Personnel for Residential Facilities (II).

A. The health, disease control, and cleanliness of all those engaged in food preparation and serving shall be in accordance with R.61-25.

B. Dietary services shall be organized with established lines of accountability and clearly defined job assignments for those engaged in food preparation and serving. There shall be trained Staff and/or Volunteers to supervise the preparation and serving of the proper diet to the Patients . Patients may engage in food preparation in accordance with Facility guidelines; however, trained Staff and/or Volunteers shall supervise.

1305. Menus.

A. Menus shall be planned and written at a minimum of one (1) week in advance and dated as served. The current week's menu, including routine and special diets and any substitutions or changes made, shall be readily available or posted in one (1) or more conspicuous places in a public area. All substitutions made on the master menu shall be recorded in writing.

B. If the Facility accepts Patients in need of medically-prescribed special diets, the menus for such diets shall be planned by a professionally qualified Dietitian, or shall be reviewed and approved by a Physician or other Authorized Healthcare Provider. The Facility shall maintain documentation that each of these menus has been planned by a Dietitian, a Physician, or other Authorized Healthcare Provider. At a minimum, documentation for each Patient's special diet menu shall include the signature of the Dietitian, the Physician, or other Authorized Healthcare Provider, his or her title, and the date he or she signed the menu.

C. Records of menus as served shall be maintained for at least thirty (30) days.

SECTION 1400 – EMERGENCY PROCEDURES AND DISASTER PREPAREDNESS

1401. Disaster Preparedness (II).

A. All Residential Facilities shall develop, by contact and consultation with their county emergency preparedness agency, a written plan for actions to be taken in the event of a disaster and implement the written plan for actions at the time of need. Prior to initial licensing of a Facility by the Department, the completed plan shall be submitted to the Department for review. At the time of each License renewal, a completed form prescribed and furnished by the Department addressing specific components of the plan shall be included with each application submitted to the Department. All Staff and Volunteers shall be made familiar with this plan and instructed as to any required actions. A copy of the plan shall be available for Inspection by the Patient and/or responsible party and the Department upon request. The plan shall be reviewed and updated Annually, and as appropriate. The Facility shall conduct and document a rehearsal of the emergency and disaster evacuation plan at least Annually and shall not require Patient participation.

B. The disaster plan for Residential Facilities shall include, but not be limited to:

1. A sheltering plan to include:

a. The licensed bed capacity and average occupancy rate;

b. Name, address, and phone number of the sheltering facility(ies) to which the Patients will be relocated during a disaster; and

c. A letter of agreement signed by an authorized representative of each sheltering facility that shall include: the number of relocated Patients that can be accommodated; sleeping, feeding, and medication plans for the relocated Patients; and provisions for accommodating relocated staff. The letter shall be updated annually with the sheltering facility and whenever significant changes occur. For those facilities located in Beaufort, Berkeley, Charleston, Colleton, Dorchester, Horry, Jasper, and Georgetown counties, at least one (1) sheltering facility must be located in a county other than these counties.

2. A transportation plan to include agreements with entities for relocating Patients that addresses:

- a. The number and type of vehicles required;
- b. How and when the vehicles are to be obtained;
- c. Who (by name or organization) will provide drivers;
- d. Procedures for providing appropriate medical support during relocation;
- e. The estimated time to accomplish the relocation; and
- f. The primary and secondary routes to be taken to the sheltering facility.

3. A staffing plan for the relocated Patients to include:

- a. How care will be provided to the relocated Patients including the number and type of Staff;
- b. Plans for relocating Staff or assuring transportation to the sheltering facility; and
- c. Co-signed statement by an authorized representative of the sheltering facility if staffing will be provided by the sheltering facility.

4. A written, signed, and dated statement from the county emergency preparedness agency verifying the Facility's plan was developed and reviewed through contact and consultation with the county emergency preparedness agency.

C. During any emergent event, the Facility shall provide data, Facility and evacuation status, and other requested information as determined by the Department, and at a frequency as determined by the Department.

D. Evacuation is a temporary measure in order to evacuate Patients from potentially hazardous and/or harmful circumstances and shall not exceed seven (7) calendar days. In the event evacuated Patients are unable to return to the Facility within seven (7) days due to damage to the Facility or its components, the lack of electricity and/or water, or other similar reasons, the Facility shall endeavor to assess each Patient's current condition and identify each Patient's current needs and preferences. Based on the resources available, the Facility shall implement each Patient's Discharge plan. For Patients needing assistance or support following Discharge, the Facility shall coordinate the transfer of the Patients to their responsible parties or to appropriately licensed Facilities capable of meeting the Patients' needs. Prior to the seventh

(7th) day, if the Facility determines an extension of time is needed, the Facility may request approval from the Department.

1402. Licensed Capacity During an Emergency (II).

A. In the event that the Facility temporarily provides shelter for evacuees who have been displaced due to a disaster, then for the duration of that emergency, provided the health, safety, and well-being of any Patient is not compromised, it is permissible to temporarily exceed the licensed capacity for the Facility in order to accommodate these individuals.

B. A Facility desiring to temporarily admit Patients in excess of its licensed bed capacity due to an emergency shall:

1. Request that the Department concur that an emergency situation exists by contacting the Department;
2. Determine the maximum number of Patients to be temporarily admitted;
3. Establish an anticipated date for Discharge of the temporary Patients;
4. Outline how and where the temporary Patients will be housed; and
5. Contact the county emergency preparedness agency to advise them of additional Patients.

C. The Facility shall not require the Patients temporarily admitted during the emergency situation to undergo tuberculin screening or submit to an admission history and physical examination.

D. The Facility shall notify the Department when the Patient census has returned to, or moves below, normal bed capacity by Discharge or transfer to licensed beds.

E. If the event occurs after normal business hours, the Facility shall contact the Department promptly during the next business day.

F. The Facility shall resolve in advance all other issues related to the temporary Patients (for example, Staff, Physician orders, additional food, and handling of Medications) by memorandum of agreements, internal policies and procedures, and emergency planning documents

1403. Emergency Call Numbers (II).

Emergency call data shall be posted in a conspicuous place and shall include at least the telephone numbers of fire and police departments, an ambulance service, and the poison control center. Other emergency call information shall be available, to include the names, addresses, and telephone numbers of the Staff to be notified in case of emergency, and the Physician or other Authorized Healthcare Provider on-call.

1404. Continuity of Essential Services (II).

There shall be a written plan to be implemented to assure the continuation of essential Patient supportive services for such reasons as power outage, water shortage, or in the event of the absence from work of any portion of the work force resulting from inclement weather or other causes.

SECTION 1500 – FIRE PREVENTION

1501. Arrangements for Fire Department Response (I).

A. Each Facility shall develop, in coordination with its supporting fire department and/or disaster preparedness agency, suitable written plans for actions to be taken in the event of fire.

B. Facilities located outside of a service area or range of a public fire department shall arrange for the nearest fire department to respond in case of fire by written agreement with that fire department. A copy of the agreement shall be kept on file in the Facility and a copy shall be forwarded to the Department. If the agreement is changed, a copy shall be forwarded to the Department.

1502. Fire Response Training (I).

A. Each Staff member and Volunteer shall receive training within twenty-four (24) hours of his or her first day of employment in the Facility, and at least Annually thereafter, addressing at a minimum, the following:

1. The Facility fire plan including evacuation routes and procedures;
2. Reporting a fire;
3. Use of the fire alarm system, if applicable;
4. Location and use of fire-fighting equipment;
5. Methods of fire containment; and
6. Specific responsibilities, tasks, or duties of each individual.

B. Documentation of the fire response training shall be signed and dated by both the individual providing the training and the individual receiving the training, and maintained in the individual's Staff record.

1503. Fire Drills (I).

A. A plan for the evacuation of Patients, Staff members, and visitors, to include evacuation routes and procedures, in case of fire or other emergencies, shall be established and posted in conspicuous public areas throughout the Facility.

B. Patients shall be made familiar with the fire plan and evacuation plan upon admission. The Facility shall maintain documentation of the review of the fire plan and evacuation plan with the Patient in the Patient's record.

C. All Patients capable of assisting in their own evacuation shall be trained in the proper actions to take in the event of a fire.

D. For Residential Facilities only:

1. Unless otherwise mandated by statute or regulation, an unannounced fire drill shall be conducted at least quarterly for all shifts. Each Staff member and Volunteer shall participate in a fire drill at least once each year. Records of drills shall be maintained at the Facility, indicating the date, time, shift, description,

and evaluation of the drill, and the names of Staff and Volunteers and number of Patients directly involved in responding to the drill.

2. All Patients at the time of the fire drill shall participate in the drill. In instances when a Patient refuses to participate in a drill, efforts shall be made to encourage participation, e.g., counseling, implementation of incentives rewarding patients for participation, specific Staff-to-Patient and Volunteer-to-Patient assignments to promote Patient participation. Continued refusal may necessitate implementation of the Discharge planning process to place the Patient in a setting more appropriate to their needs and abilities.

SECTION 1600 – MAINTENANCE

1601. General (II).

A. The Facility shall keep all equipment and building components (for example, doors, windows, lighting fixtures, plumbing fixtures) in good repair and operating condition. The Facility shall document preventive maintenance. The Facility shall comply with the provisions of the codes officially adopted by the South Carolina Building Codes Council and the South Carolina State Fire Marshal applicable to the Facility. (II)

B. If applicable, a documented and implemented procedure shall be developed for calibrating Medication-dispensing instruments consistent with manufacturer’s recommendations to ensure accurate dosing and tracking.

1602. Preventive Maintenance of Emergency Equipment and Supplies (II).

Each Facility shall develop and implement a written preventive maintenance program for all fire alarm, electrical, mechanical, plumbing, fire protection systems and for all equipment and supplies including, but not limited to, all Patient monitoring equipment, isolated electrical systems, conductive flooring, Patient grounding systems, and medical gas systems. Facilities shall check and/or test this equipment at intervals ensuring proper operation and state of good repair. After repairs and/or alterations to any equipment or system, the Facility shall thoroughly test the equipment or system for proper operation before returning it to service. The Facility shall maintain records for each piece of emergency equipment to indicate its history of testing and maintenance.

SECTION 1700 – INFECTION CONTROL AND ENVIRONMENT

1701. Staff Practices.

Staff practices shall promote conditions that prevent the spread of infectious, contagious, or communicable diseases and provide for proper disposal of toxic and hazardous substances. These preventive measures and/or practices shall be in compliance with applicable guidelines of Bloodborne Pathogens Standard of the Occupational Safety and Health Act of 1970; the Centers for Disease Control and Prevention and R.61-105, Infectious Waste Management; and other applicable federal, state, and local laws and regulations.

1702. Tuberculosis Risk Assessment and Screening (I).

A. Tuberculosis Testing. The Facility may utilize either Tuberculin skin testing or Blood Assay for Mycobacterium tuberculosis (“BAMT”) for detecting Mycobacterium tuberculosis infection:

1. Tuberculin skin testing. A small dose (0.1 mil) of purified protein derivative (PPD) tuberculin is injected just beneath the surface of the skin (by the intradermal Mantoux method), and the area is examined

for induration (hard, dense, raised area at the site of the TST administration) forty-eight to seventy-two (48 to 72) hours after the injection (but positive reactions can still be measurable up to a week after administering the TST). The size of the indurated area is measured with a millimeter ruler and the reading is recorded in millimeters, including zero (0) millimeters to represent no induration. Redness and/or erythema is insignificant and is not measured or recorded. Authorized Healthcare Providers are permitted to perform tuberculin skin testing and symptom screening.

2. Blood Assay for Mycobacterium tuberculosis (“BAMT”). A general term to refer to in vitro diagnostic tests that assess for the presence of tuberculosis (“TB”) infection with Mycobacterium tuberculosis. This term includes, but is not limited to, IFN- γ release assays (“IGRA”).

B. The Facility shall conduct an annual tuberculosis risk assessment in accordance with the Centers for Disease Control guidelines to guide the Facility’s infection control policies and procedures related to the appropriateness and frequency of tuberculosis screening and other tuberculosis related measures to be taken.

C. Baseline Status.

1. The Facility shall determine the baseline status of all staff according to current Centers for Disease Control and Departmental Tuberculosis guidelines.

2. Tuberculosis Screening. All staff within three (3) months prior to Patient contact shall have a baseline two-step Tuberculin Skin Test (“TST”) or a single Blood Assay for Mycobacterium tuberculosis (“BAMT”). If a newly employed staff or volunteer has had a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT) can be administered and read to serve as the baseline prior to Patient contact.

D. Post Exposure. After known exposure to a person with potentially infectious tuberculosis disease without use of adequate personal protection, the tuberculosis status of all staff shall be determined in a manner prescribed in the Centers for Disease Control and Department’s most current tuberculosis guidelines.

E. Annual Tuberculosis Training. All staff shall receive annual training regarding tuberculosis to include risk factors and signs and symptoms of tuberculosis disease. The annual tuberculosis training shall be documented in a staff record and maintained at the Facility.

F. Serial Screening. The Facility shall follow the Centers for Disease Control and Department’s most current tuberculosis guidelines related to serial screening.

1703. Tuberculosis Screening for Patients (I).

A. At baseline, Patients in Residential Facilities shall have evidence of a two-step tuberculin skin test or single Blood Assay for Mycobacterium tuberculosis. If the Patient in a Residential Facility has a documented negative tuberculin skin test (at least single-step) within the previous twelve (12) months, the Patient shall have only one (1) tuberculin skin test or single Blood Assay for Mycobacterium tuberculosis to establish a baseline status.

B. Patients in Residential Facilities shall have at least the first step within thirty (30) days prior to admission and no later than forty-eight (48) hours after admission.

C. Patients in the Opioid Treatment Program shall receive the first step of the two-step tuberculin test within seventy-two (72) hours of admission to the Facility. The second step of the two-step tuberculin skin test must be administered within the next seven to fourteen (7 to 14) days.

D. Patients with Positive Tuberculosis Results.

1. Patients with a baseline positive or newly positive test result for *Mycobacterium tuberculosis* infection (i.e., tuberculosis skin test or Blood Assay for *Mycobacterium Tuberculosis*) or documentation of treatment for latent tuberculosis infection, tuberculosis disease or signs or symptoms of tuberculosis, e.g., cough, weight loss, night sweats, fever, shall have a chest radiograph performed immediately to exclude tuberculosis disease (or evaluate an interpretable copy taken within the previous three (3) months). Routine repeat chest radiographs are not required unless symptoms or signs of TB tuberculosis disease develop or unless recommended by a Physician. These Patients will be evaluated for the need for treatment of TB tuberculosis disease or latent tuberculosis infection and will be encouraged to follow the recommendations made by a Physician with tuberculosis expertise (i.e., the Department's Tuberculosis Control program).

2. Patients who are known or suspected to have tuberculosis disease shall be transferred from the Facility if the Facility does not have an Airborne Infection Isolation room, required to undergo evaluation by a Physician, and permitted to return to the Facility only with approval by the Department's Tuberculosis Control program.

1704. Housekeeping (II).

A. The Facility and its grounds shall be neat, clean, free of vermin, and free of offensive odors.

B. Interior housekeeping shall at a minimum include:

1. Cleaning each specific area of the Facility;
2. Cleaning and disinfection, as needed, of equipment used and/or maintained in each area, appropriate to the area and the equipment's purpose or use;
3. Chemicals indicated as harmful on the product label, cleaning materials and supplies shall be in locked storage areas and inaccessible to Patients; and
4. During use of chemicals indicated as harmful on the product label, cleaning materials and supplies shall be in direct possession of the Staff member and monitored at all times.

C. Exterior housekeeping shall at a minimum include:

1. Cleaning of all exterior areas, such as porches and ramps, and removal of safety impediments such as water, snow, and ice; and
2. Keeping Facility grounds free of weeds, rubbish, overgrown landscaping, and other potential breeding sources for vermin.

1705. Infectious Waste (I).

Accumulated waste, including all contaminated sharps, dressings, pathological, and/or similar infectious waste, shall be disposed of in a manner compliant with R.61-105, Infectious Waste Management, and the OSHA Bloodborne Pathogens Standard.

1706. Pets (II).

A. Healthy animals that are free of fleas, ticks, and intestinal parasites, and have been examined by a veterinarian prior to entering the Facility, have received required inoculations, if applicable, and that present no apparent threat to the health, safety, and well-being of the Patients, shall be permitted in the Facility, provided they are sufficiently fed, and cared for, and that the pets and their housing and food containers are kept clean.

B. Pets shall not be allowed near Patients who have allergic sensitivities to pets, or for other reasons, such as Patients who do not wish to have pets near them.

C. Pets shall not be allowed in the kitchen area. Pets shall be permitted in Patient dining and activities areas only during times when food is not being served. If the dining and activities area is adjacent to a food preparation or storage area, those areas shall be effectively separated by walls and closed doors while pets are present.

1707. Clean and Soiled Linen and Clothing for Residential Facilities (II).

A. Clean Linen and Clothing.

1. A supply of clean, sanitary linen and clothing shall be available at all times;
2. In order to prevent the contamination of clean linen and clothing by dust or other airborne particles or organisms, clean linen and clothing shall be stored and transported in a sanitary manner, for example, enclosed and covered; and
3. Clean linen and clothing shall be separated from storage for other purposes.

B. Soiled Linen and Clothing.

1. Soiled linen and clothing shall not be sorted, rinsed, or washed outside of the laundry service area;
2. Provisions shall be made for collecting, transporting, and storing soiled linen and clothing;
3. Soiled linen and clothing shall be kept in enclosed, covered, and leak proof containers; and
4. Laundry operations shall not be conducted in Patient rooms, dining rooms, or in locations where food is prepared, served, or stored. Patients may sort, rinse, and handwash their own soiled, delicate, personal items, e.g., pantyhose, underwear, socks, handkerchiefs, clothing, accessories, heirloom linens, needlepoint, crocheted, or knitted pillows or pillowcases, or other similar items personally owned and cared for by, in a private bathroom or sink, provided the practice does not create a safety hazard, e.g. water on the floor.

SECTION 1800 – QUALITY IMPROVEMENT PROGRAM (II)

A. Facilities shall maintain a written, implemented Quality Improvement Program that provides effective self-assessment and implementation of changes designed to improve the treatment/care/services provided by the Facility.

B. The Quality Improvement Program, at a minimum, shall:

1. Establish desired outcomes and the criteria by which policy and procedure effectiveness is regularly, systematically, and objectively accomplished;
2. Identify, evaluate, and determine the causes of any deviation from the desired outcomes;
3. Identify the action taken to correct deviations and prevent future deviation, and the person(s) responsible for implementation of these actions;
4. Establish ways to measure the quality of Patient care and Staff performance, as well as the degree to which the policies and procedures are followed;
5. Analyze the appropriateness of Individual Plans of Care and the necessity of treatment/care/services rendered;
6. Analyze the effectiveness of the fire plan;
7. Analyze all incidents and accidents to include Patient deaths;
8. Analyze any infection, epidemic outbreaks, or other unusual occurrences which threaten the health, safety, or well-being of the Patients; and
9. Establish a systematic method of obtaining feedback from Patients and other interested persons, e.g., family members and peer organizations, as expressed by the level of satisfaction with treatment/care/services received.

SECTION 1900 – DESIGN AND CONSTRUCTION

1901. Codes and Standards.

All Facilities shall be planned, designed, and equipped to provide and promote the health, safety, and well-being of each Patient. Facility design shall be such that all Patients have access to required services.

1902. Local and State Codes and Standards (II).

A. Facilities shall comply with provisions of the codes officially adopted by the South Carolina Building Codes Council and the South Carolina State Fire Marshal applicable to the type of Facility. No Facility shall be licensed unless the Department has assurance that responsible local zoning and building officials have approved the Facility for code compliance.

B. All Facilities shall meet the construction codes and regulations for the building and its essential equipment and systems in effect at the time the License was issued unless specifically required otherwise in writing by the Department.

C. Facilities shall ensure all additions, alterations, or renovations meet the codes, regulations, and requirements in effect at the time of the plan's approval.

D. Any Facility that closes or has its License revoked and for which application for licensure is made at the same site shall be considered a new building and shall meet the current codes, regulations, and requirements for the building and its essential equipment and systems in effect at the time of application for licensing.

1903. Submission of Plans and Specifications (II).

A. Prior to construction for new buildings, additions, major alterations or replacement to existing buildings, when a building is licensed for the first time, when a building changes License type, or a Facility increases occupant load/licensed capacity, plans and specifications shall be submitted to the Department for review, unless otherwise agreed to with the Department. Final plans and specifications shall be prepared by an architect and/or engineer registered in South Carolina and shall bear their seals and signatures. Architectural plans shall also bear the seal of a South Carolina registered architectural corporation. These submissions shall be made in at least three (3) stages: schematic, design development, and final. All plans shall be drawn to scale with the title, stage of submission, and date shown thereon. Any construction changes from the approved documents shall be approved by the Department. Construction work shall not commence until a construction plan approval has been received from the Department. During construction the owner and/or Licensee shall employ a registered architect and/or engineer for supervision and Inspections.

B. The Facility shall submit plans and specifications to the Department for review and approval for projects that have an effect on:

1. The function of a space;
2. The accessibility to or of an area;
3. The structural integrity of the Facility;
4. The active and/or passive fire safety systems;
5. Doors;
6. Walls;
7. Ceiling system assemblies;
8. Exit corridors;
9. Life safety systems; or
10. That increase the occupant load or capacity of the Facility.

C. Cosmetic changes utilizing paint, wall covering, floor covering, etc., that are required to have a flame-spread rating or other safety criteria shall be documented with copies of the documentation and certifications, kept on file at the Facility, and made available to the Department.

D. All subsequent addenda, change orders, field orders, and documents altering the Department review must be submitted. Any substantial deviation from the accepted documents shall require written notification, review, and re-approval from the Department.

1904. Construction Inspections.

Construction work that violates applicable codes or standards shall be brought into compliance. All projects shall obtain all required permits from the locality having jurisdiction. Construction without a proper permit shall not be inspected by the Department.

SECTION 2000 – FIRE PROTECTION, PREVENTION, AND LIFE SAFETY (I)

A. Facilities with six (6) or more licensed Residential beds shall have a partial, manual, automatic, supervised fire alarm system. The Facility shall arrange the system to transmit an alarm automatically to a third party. The alarm system shall notify by audible and visual alarm all areas and floors of the building. The alarm system shall shut down central recirculation systems and outside air units that serve the area(s) of alarm origination as a minimum.

B. For Residential Facilities only, all fire, smoke, heat, sprinkler flow, and manual fire alarming devices shall be connected to and activate the main fire alarm system when activated.

C. The fire-resistive ratings for the various structural components shall comply with the applicable code(s) in Section 1900. Fire-resistive ratings of various materials and assemblies not specifically listed in the codes can be found in publications of recognized testing agencies such as Underwriters Laboratories - Building Materials List and Underwriters Laboratories - Fire Resistance Directory.

D. The Facility shall not have single and multi-station smoke alarms.

SECTION 2100 – [RESERVED]

SECTION 2200 – [RESERVED]

SECTION 2300 – [RESERVED]

SECTION 2400 – ELECTRICAL

2401. Receptacles (II).

A. Patient Room. Each Patient room shall have duplex grounding type receptacles located to include one (1) at the head of each bed.

B. Corridors. Duplex receptacles for general use shall be installed approximately fifty (50) feet apart in all corridors and within twenty-five (25) feet of the ends of corridors.

2402. Ground Fault Protection (I).

A. Ground fault circuit-interrupter protection shall be provided for all outside receptacles and bathrooms.

B. The Facility shall provide ground fault circuit-interrupter protection for any receptacles within six (6) feet of a sink or any other wet location. If the sink is an integral part of the metal splashboard grounded by the sink, the entire metal area is considered part of the wet location.

2403. Exit Signs (I).

A. In Facilities licensed for six (6) or more beds, required exits and ways to access thereto shall be identified by electrically-illuminated exit signs.

B. Changes in egress direction shall be marked with exit signs with directional arrows.

C. Exit signs in corridors shall be provided to indicate two (2) directions of exit.

2404. Emergency Electric Service (I).

Emergency electric services shall be provided as follows:

- A. Exit lights, if required;
- B. Exit access corridor lighting;
- C. Illumination of means of egress; and
- D. Fire detection and alarm system, if required.

2405. Emergency Generator Service.

A. Residential Facilities shall have an emergency generator and shall provide certification that construction and installation of emergency generator service complies with requirements of all adopted state, federal, or local codes, ordinances, and regulations.

B. Residential Facilities shall have an emergency generator that provides emergency electrical service during interruption of the normal electrical service and shall be provided to the distribution system as follows:

- 1. Exit lights and exit directional signs;
- 2. Exit access corridor lighting;
- 3. Lighting of means of egress and Staff work areas;
- 4. Fire detection and alarm systems;
- 5. In Patient care areas;
- 6. Signal system;
- 7. Equipment necessary for maintaining telephone service;
- 8. Elevator service that will reach every Patient floor when rooms are located on other than the ground floor;
- 9. Fire pump (if applicable);
- 10. Equipment for heating and cooling Patient rooms;
- 11. Public restrooms;
- 12. Essential mechanical equipment rooms;
- 13. Battery-operated lighting and a receptacle in the vicinity of the emergency generator;
- 14. Alarm systems, water flow alarm devices, and alarms required for medical gas systems; and

15. Patient records when solely electronically based.

SECTION 2500 – [RESERVED]

SECTION 2600 – PHYSICAL PLANT

2601. Facility Accommodations and Floor Area (II).

A. Residential Facilities shall provide sufficient living arrangements for all Patients, including quiet reading, study, relaxation, entertainment, or recreation.

B. Residential Facilities shall meet minimum square footage requirements as follows: (II)

1. Twenty (20) square feet per licensed bed of living and recreational areas combined, excluding bedrooms, halls, kitchens, dining rooms, bathrooms, and rooms not available to the Patients. In Facilities for parents with children, there shall be at least twenty (20) square feet per licensed bed and ten (10) square feet per child of living and recreational areas together.

2. Fifteen (15) square feet of floor space in the dining area per licensed bed. In Facilities for parents with children, dining space shall accommodate fifteen (15) square feet per licensed bed and seven and a half (7.5) square feet per child.

C. Residential Facilities shall not require Patients to ambulate from one site to another outside the building and shall not impede Patients from ambulating from one site to another due to the presence of physical barriers.

D. Residential Facilities shall make accommodations available to meet group needs of Patients and their visitors.

E. Residential Facilities shall ensure visual and auditory privacy between Patients and Staff and Volunteers.

2602. Design (I).

Facilities shall be planned, designed, and equipped to provide and promote the health, safety, and well-being of each Patient. Facility design shall be such that all Patients have access to required services. There shall be two hundred (200) gross square feet per licensed bed in Residential Facilities ten (10) beds or less, and an additional one hundred (100) gross square feet per licensed bed for each licensed bed over ten (10).

2603. Furnishings and Equipment (I).

A. Facilities shall ensure the physical plant is free of fire hazards and impediments to fire prevention.

B. Facilities shall not have any portable electric or unvented fuel heaters.

C. Facilities shall ensure that fireplaces and fossil-fuel stoves have partitions, screens, or other means to prevent burns. Facilities shall ensure that fireplaces are vented to the outside and shall prohibit “unvented” type gas logs. Facilities shall ensure that gas fireplaces have a remote gas shutoff within the room but not inside the fireplace.

2604. Exits (I).

A. If exit doors and cross-corridor doors are locked, the requirements under Special Locking Arrangements shall be met as applicable to the code listed in Section 1900.

B. Facilities shall maintain halls, corridors, and all other means of egress from the building free of obstructions.

C. Facilities shall not assign Patients needing physical or verbal assistance to exit the building to rooms located above or below the floor of exit discharge.

D. Facilities shall ensure that each Patient room opens directly to an approved exit access corridor without passage through another occupied space or has an approved exit directly to the outside at grade level and accessible to a public space free of encumbrances. When two (2) Patient rooms share a common “sitting” area, the “sitting” area shall open onto the exit access corridor.

2605. Water Supply and Hygiene (II).

Facilities shall ensure that Patient and Staff handwashing lavatories, and Patient showers and tubs are supplied with hot and cold water at all times.

2606. Temperature Control (I).

A. Facilities shall ensure that plumbing fixtures accessible to Patients and requiring hot water to have a water supply that is thermostatically controlled to a temperature of at least one hundred (100) degrees Fahrenheit and not to exceed one hundred and twenty (120) degrees Fahrenheit at the fixture.

B. Residential Facilities shall ensure that water heaters provide at least six (6) gallons of water per hour per bed at the above temperature range. (II)

C. Hot water supplied to the kitchen equipment/utensil washing sink shall be supplied at one hundred and twenty (120) degrees Fahrenheit provided all kitchen equipment/utensils are chemically sanitized. For those Facilities sanitizing with hot water, the sanitizing compartment of the kitchen equipment and utensil washing sink shall be capable of maintaining the water at a temperature of at least one hundred and seventy one (171) degrees Fahrenheit.

D. Hot water provided for washing linen and clothing shall not be less than one hundred and sixty (160) degrees Fahrenheit. Should chlorine additives or other chemicals which contribute to the margin of safety in disinfecting linen/clothing be a part of the washing cycle, the minimum hot water temperature shall not be less than one hundred and ten (110) degrees Fahrenheit, provided hot air drying is used. (II)

2607. Cross-connections (I).

Facilities shall ensure that there are no cross-connections in plumbing between safe and potentially unsafe water supplies. Facilities shall ensure water is delivered at least two (2) delivery pipe diameters above the rim or points of overflow to each fixture, equipment, and service unless protected against back-siphonage by approved vacuum breakers or other approved back-flow preventers. Facilities shall ensure that all faucets and fixtures which may be attached to a hose have an approved vacuum breaker or other approved back-flow preventer.

2608. Wastewater Systems (I).

A. Residential Facilities shall ensure the wastewater system for commercial kitchens is in accordance with R.61-25, Retail Food Establishments.

B. Facilities shall dispose of liquid waste in a wastewater system approved by the local authority.

2609. Electric Wiring (I).

Facilities shall ensure that a licensed electrician, registered engineer, or certified building inspector inspects the electric wiring at least annually.

2610. Panelboards (II).

Facilities shall label the panelboard directory to conform to the actual room numbers or designations and shall maintain clear access to the panelboard.

2611. Lighting.

A. Facilities shall maintain lighting in spaces occupied by persons, machinery, and equipment within buildings, approaches to buildings, and parking lots. (II)

B. Facilities shall provide artificial light with sufficient illumination for reading, observation, and activities.

C. Residential Facilities shall maintain general lighting in all parts of Patients' rooms, and shall provide at least one (1) light fixture for night lighting in each Patient room. Residential Facilities shall provide a reading light to each Patient.

D. Facilities shall maintain lighted hallways, stairs, and all other means of egress at all times.

2612. Heating, Ventilation, and Air Conditioning (II).

A. Facilities shall ensure that a certified or licensed technician inspects the heating, ventilation, and air conditioning system at least annually.

B. Facilities shall maintain a temperature between seventy-two (72) and seventy-eight (78) degrees Fahrenheit in Patient areas.

C. Facilities shall ensure that heating, ventilation, and air conditioning supplies and return grills are installed at least three (3) feet away from a smoke detector. (I)

D. Facilities shall ensure that heating, ventilation, and air conditioning grills are not installed in the floors.

E. Facilities shall ensure that intake air ducts are filtered and maintained to prevent the entrance of dust, dirt, and other contaminating materials. Facilities shall ensure discharge from the heating, ventilation, and air conditioning system does not irritate Patients, Staff, and Volunteers.

F. Facilities shall have operable windows or approved mechanical ventilation in every bathroom and restroom.

G. Facilities shall ensure all kitchen areas are ventilated to prevent excessive heat, steam, condensation, vapors, smoke, and fumes.

2613. Patient Rooms.

A. Residential Facilities shall provide the following equipment in each Patient room for each Patient:

1. A comfortable single bed having a mattress with moisture-proof cover, sheets, blankets, pillow and pillowcases. Roll-away type beds, cots, bunkbeds, and folding beds are not permitted. Facilities are permitted to remove a Patient bed and place the mattress on a platform or pallet, or utilize a recliner, upon approval by the Physician or other Authorized Healthcare Provider and documentation is provided in the Individual Plan of Care. (II)

2. A closet or wardrobe, a bureau consisting of at least three (3) drawers, and a compartmentalized bedside table or nightstand to adequately accommodate each Patient's personal clothing, belongings, and toilet articles. Facilities are permitted to utilize built-in storage.

3. A comfortable chair for each Patient occupying the room. If the available square footage of the Patient room will not accommodate a chair for each Patient or if the provision of multiple chairs impedes Patient ability to freely and safely move about within their room, Facilities shall provide at least one (1) chair and make additional chairs available for temporary use in the Patient's room for visitors.

B. Facilities that use hospital-type beds shall maintain at least two (2) lockable casters on each bed, located either diagonally or on the same side of the bed.

C. Facilities shall not place beds in corridors, solaria, or other locations not designated as Patient room areas. (I)

D. Facilities shall ensure Patient rooms have a maximum of three (3) beds. Facilities with mothers with children shall ensure Patient rooms have a maximum of one (1) licensed bed and two (2) cribs or beds. (II)

E. Facilities shall not have any Patient rooms in a basement.

F. Facilities shall not provide access to a Patient room through another Patient room, toilet, bathroom or kitchen.

G. Facilities shall provide bed pans, urinals, hot water bottles, and any other equipment necessary to meet Patient needs. Facilities are permitted to have portable toilets in Patient rooms only at night or in case of temporary illness, and shall keep them stored at all other times. Facilities are permitted to permanently position a portable toilet at a Patient's bedside if the toilet is sanitary and the Patient room is private and of a sufficient size. (II)

H. Facilities are permitted to utilize side rails when required for safety and when ordered by a Physician or other Authorized Healthcare Provider. (II)

I. Facilities shall ensure privacy when personal care is being given to a Patient in a semi-private room.

J. Facilities shall consider Patient compatibility in the assignment of rooms for which there is multiple occupancy.

K. Facilities shall have at least one (1) private room available in the Facility in order to provide assistance in addressing Patient compatibility issues, Patient preferences, and accommodations for Patients with communicable disease.

2614. Patient Room Floor Area.

A. Except for Residential Facilities of five (5) beds or less, each Patient room is considered a tenant space and shall be enclosed by one (1)-hour fire-resistive construction with a twenty (20)-minute fire-rated door, opening onto an exit access corridor. (I)

B. Each Patient room shall be an outside room with an outside window or door for exit in case of emergency. This window or door may not open onto a common screened porch. (I)

C. The Patient room floor area is a usable or net area and does not include wardrobes (built-in or freestanding), closets, or the entry alcove to the room. The following allowance of floor space shall be as a minimum: (II)

1. Rooms for only one (1) Patient: one hundred (100) square feet;

2. Rooms for more than one (1) Patient: eighty (80) square feet per Patient.

3. In Facilities for mothers with children, rooms for Patient and child: eighty (80) square feet per licensed bed and forty (40) square feet per child with a maximum of two (2) children per Patient. When a bed is required in lieu of a crib for a child, the square footage shall be fifty (50) square feet per child.

D. Facilities shall maintain at least three (3) feet between beds. (II)

2615. Bathrooms and Restrooms (II).

A. Privacy shall be provided at toilets, urinals, bathtubs, and showers.

B. An adequate supply of toilet tissue shall be maintained in each bathroom.

C. There shall be at least one (1) handwash lavatory adjacent to each toilet. Liquid soap shall be provided in public restrooms and bathrooms used by more than one (1) Patient. Communal use of bar soap is prohibited. A sanitary individualized method of drying hands shall be available at each lavatory.

D. Easily cleanable receptacles shall be provided for waste materials. Such receptacles in toilet rooms for women shall be covered. The Facility shall ensure receptacles are non-combustible or fire resistant as required by building codes reference in Section 1900.

E. All bathroom floors shall be entirely covered with an approved nonabsorbent covering. Walls shall be nonabsorbent, washable surfaces to the highest level of splash.

F. There shall be a mirror above each bathroom lavatory for Patients' grooming.

G. In Residential Facilities:

1. Facilities shall provide an ample number of toilets to serve the needs of the Patients Staff members, Volunteers, and the public. Facilities shall provide Patients with a minimum of one (1) toilet for each six (6) licensed beds or fraction thereof.

2. All bathtubs, toilets, and showers used by Patients shall have approved grab bars securely fastened in a usable fashion.

3. There shall be one (1) bathtub or shower for each eight (8) beds or fraction thereof.

4. Separate bathrooms shall be provided for Staff members, Volunteers, and the public.

5. Toilet facilities shall be at or adjacent to the kitchen for kitchen employees.

6. Soap, bath towels, and washcloths shall be provided to each Patient as needed. Bath linens assigned to specific Patients may not be stored in centrally-located bathrooms. Provisions shall be made for each Patient to properly keep their bath linens in their room, such as, on a towel hook or bar designated for each Patient occupying that room, or bath linens to meet Patient needs shall be distributed as needed, and collected after use and stored properly, per Section 1707.

H. Facilities shall have bathrooms and restrooms equipped for handicapped persons as required by building codes referenced in Section 1900.

2617. Patient Care Unit and Station for Medical Withdrawal Management Programs (II).

A. Each Patient care unit shall have a Patient care station.

B. A Patient care unit shall contain not more than forty-four (44) licensed beds; and the Patient care station shall not be more than one hundred fifty (150) feet from a Patient room, and shall be located and arranged to permit visual observation of the unit corridor(s).

C. Each Patient care station shall contain separate spaces for the storage of wheelchairs and general supplies/equipment for that station.

D. There shall be at, or near each Patient care station, a separate medicine preparation room with a cabinet with one or more locked sections for Controlled Substances, work space for preparation of medicine, and a sink. As an alternative, a medicine preparation area with counter, cabinet space, and a sink shall be required on those units where there is:

1. A unit dose system in which final Medication preparation is not performed on the Patient care station; or

2. A twenty-four (24) hour pharmacy on the premises; or

3. Procedures that preclude Medication preparation at the Patient care station.

2618. Doors (II).

A. All Patient rooms and bathrooms and restrooms shall have opaque doors for the purpose of privacy.

B. All glass doors, including sliding or patio type doors shall have a contrasting or other indicator that causes the glass to be observable.

C. Bathroom and restroom door widths shall be not less than thirty-six (36) inches.

D. Doors to Patient occupied rooms shall be at least thirty-six (36) inches wide.

E. Doors that have locks shall be unlockable and openable with one action.

F. If Patient room doors are lockable, there shall be provisions for emergency entry. There shall not be locks that cannot be unlocked and operated from inside the room.

G. All Patient room doors shall be solid-core.

2619. Elevators (II).

Facilities shall ensure that a certified elevator inspector inspects and tests elevators upon installation prior to first use and annually thereafter.

2620. Screens (II).

Facilities shall equip windows, doors, and openings intended for ventilation with insect screens.

2621. Janitor's Closet (II).

Residential Facilities shall maintain a lockable janitor's closet equipped with a mop sink or receptor and space for the storage of supplies and equipment.

2622. Storage Areas.

A. Facilities shall provide adequate general storage areas for Patient and Staff and Volunteer belongings, equipment, and supplies.

B. Facilities shall ensure that areas used for storage of combustible materials and storage areas exceeding one hundred (100) square feet in area are equipped with a National Fire Protection Association-approved automatic sprinkler system. (I)

C. In storage areas provided with a sprinkler system, a minimum vertical distance of eighteen (18) inches shall be maintained between the top of stored items and the sprinkler heads. The tops of storage cabinets and shelves attached to or built into the perimeter walls may be closer than eighteen (18) inches below the sprinkler heads. In non-sprinklered storage areas, there shall be at least twenty-four (24) inches of space from the ceiling. (I)

D. All ceilings, floor assemblies, and walls enclosing storage areas of one hundred (100) square feet or greater shall be of not less than one (1) hour fire-resistive construction with three-fourths (3/4) hour fire-rated door(s) and closer(s). (I)

E. Facilities shall ensure that storage buildings on the premises meet the applicable code listed in Section 1900 regarding distance from the licensed building. An appropriate controlled environment shall be provided if necessary for storage of items requiring such an environment.

F. Facilities shall ensure that items stored in mechanical rooms are located away from mechanical equipment and are not a type of storage that might create a fire or other hazard. (I)

G. Facilities shall not store supplies and equipment directly on the floor. Facilities shall not store supplies and equipment susceptible to water damage and contamination under sinks or other areas with a propensity for water leakage.

H. Facilities licensed for more than fifteen (15) beds shall maintain a soiled linen storage room designed, enclosed, and used solely for that purpose and equipped with mechanical exhaust directly to the outside.

2623. Telephone Service.

A. Facilities shall provide at least one (1) telephone on each floor of the Facility with at least one (1) active main or fixed-line telephone service available.

B. Facilities shall provide at least one (1) telephone on each floor for Staff members and Volunteers to conduct routine business of the Facility and to summon assistance in the event of an emergency. The Facility shall ensure Patients have privacy when using the telephone.

2624. Location.

A. Facilities shall ensure that roads serving the Facility are passable at all times.

B. Facilities shall provide parking space to meet the needs of Patients, Staff, Volunteers, and visitors.

C. Facilities shall maintain adequate access to and around the building for firefighting equipment. (I)

D. Facilities providing an Opioid Treatment Program shall not operate within five hundred (500) feet of:

1. The property line of a church;
2. The property line of a public or private elementary or secondary school;
3. A boundary of any Residential district;
4. A public park adjacent to any Residential district; or
5. The property line of a lot devoted to Residential use.

2625. Outdoor Area.

A. Facilities shall ensure outdoor areas where unsafe , unprotected physical hazards exist are enclosed by a fence or a natural barrier of a size, shape, and density that effectively impedes travel to the hazardous area. (I)

B. Facilities shall protect mechanical and equipment rooms that open to the outside of the Facility from unauthorized individuals.

SECTION 2700 – SEVERABILITY

In the event that any portion of this regulation is construed by a court of competent jurisdiction to be invalid, or otherwise unenforceable, such determination shall in no manner affect the remaining portions of this regulation, and they shall remain in effect, as if such invalid portions were not originally a part of this regulation.

SECTION 2800 - GENERAL

Conditions that have not been addressed in this regulation shall be managed in accordance with the best practices as interpreted by the Department.