

# DHS Responses to Public Comments Regarding Rule 307 - Psychiatric Residential Treatment Facility Services for Under 21

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On behalf of 11:11 Media Impact

Co-Host, iHeart's Trapped in Treatment

**Comment:** Thank you for the opportunity to submit comments on the proposed rulemaking for Psychiatric Residential Treatment Facility (PRTF) services for youth under 21. I write to commend DHS for undertaking this much-needed update to PRTF standards and to offer recommendations to ensure the final rules provide strong protections, consistent oversight, and trauma-informed care for youth in these facilities. Recent national findings have underscored the urgent need for reform – a 2024 U.S. Senate report found “endemic harm within RTFs, including unsafe restraint practices, improper medication use, ... and insufficient oversight,” contributing to tragic outcomes.

In light of such concerns, the proposed Arkansas rules represent a critical step forward. My comments below, organized by topic, draw on best-practice policy recommendations from our organization 11:11 Media Impact report “From Crisis to Care” and are offered to help ensure Arkansas’s PRTF regulations fully align with national best practices and close any remaining gaps.

Use of Restraint and Seclusion

Support for Prohibitions and Reporting:

The proposed rules make significant strides by completely prohibiting mechanical restraints and seclusion in PRTFs. This prohibition is commendable and consistent with trauma-informed care – eliminating practices like strapping down residents or isolating them alone, which are known to risk both physical and psychological harm. Additionally, the requirement that any use of personal (physical) or chemical restraint be strictly limited to true emergencies and be reported monthly to oversight entities (Office of Long-Term Care, the resident’s PASSE, the state Protection & Advocacy system, etc.) is a strong accountability measure. I also support the mandate to notify parents/guardians within 24 hours of each emergency safety intervention, ensuring families are informed and involved in addressing such incidents. Taken together, these provisions will help ensure that restraint is used only as an absolute last resort to protect safety, with transparency to regulators and families.

Recommendations for Strengthening Protections: I urge DHS to consider a few additions to further strengthen these protections, in line with national best practices:

- Ban Dangerous Restraint Techniques: Explicitly prohibit prone restraints and any technique that restricts breathing or blood flow (e.g. choking, chest compressions). We recommend that “no residential facility serving minors shall use or permit prone restraints or any restraint that restricts airflow or blood flow to the brain”. Including a clear ban on prone restraints and neck holds in the Arkansas rules would reinforce the commitment to youth safety and prevent tragic outcomes like asphyxiation.

- Limit and Regulate Chemical Restraints: While mechanical restraints would be disallowed, the rules should also discourage or strictly limit chemical restraints (sedating a child for behavioral control). National policy experts call for prohibiting chemical restraints in all youth facilities, except when medically necessary and prescribed as part of treatment. If Arkansas continues to permit emergency sedative medication, I recommend adding guardrails – for example, require that any “as-needed” sedating medication used for behavioral control be treated and reported as a chemical restraint, not as routine PRN medication. Tightening this definition will prevent facilities from over-relying on drugs to control behavior in lieu of therapeutic interventions. Tracking the ratio of chemical restraints to PRN sedatives, as the rule proposes, is an excellent step to identify any misuse; an outright prohibition on chemical restraints would be an even stronger protection.
- Emphasize Restraint as Last Resort Only: The rule appropriately states that physical restraint may only be used to ensure immediate safety during an emergency and never as a standing order or punishment. I support this and suggest adding language to underscore that restraints are a last resort. For example, the policy report recommends specifying that “physical restraints may only be used when imminent serious bodily harm is present and no other de-escalation is effective, and never for discipline, convenience, or as a substitute for treatment”. Including such language in the Arkansas rule (even if in guidance or training requirements) will reinforce a culture where staff exhaust all de-escalation options before resorting to any physical hold.
- Post-Incident Review and Oversight: I commend the inclusion of post-restraint procedures such as prompt physician evaluation within one hour and detailed documentation in the resident’s record. To build on this, Arkansas could require a formal post-incident debriefing with the resident and staff involved, to learn from the event and adjust the care plan – and involve the parent/guardian in that discussion when appropriate. In addition, I support that all incidents must be reported internally and suggest that DHS consider requiring aggregate public reporting of restraint/seclusion incidence. According to 11:11 Media Impact’s recommendations, facilities or the state should publish facility-level data on restraint and seclusion quarterly (without personal identifiers) to promote transparency. Publicly sharing how often these interventions occur will incentivize reduction in use and allow stakeholders to monitor trends across facilities.

In summary, DHS’s proposed rules on restraint/seclusion mark a progressive policy that prioritizes youth safety. By incorporating the above recommendations – banning high-risk techniques, further curbing chemical restraints, emphasizing “last resort” usage, and enhancing transparency – Arkansas can set a national example in protecting children from the well-documented dangers of restraint and seclusion in treatment facilities.

#### Staff Training and Trauma-Informed Care

Support for Strong Training Standards: The proposed rule establishes robust staff training requirements that are crucial for quality care. Requiring all PRTF staff to be trained upon hire and annually in key areas – including crisis de-escalation, management of aggressive behavior, seclusion/restraint policies, mandatory abuse reporting, and trauma-informed care principles – is very positive. Notably, “trauma-informed care” and understanding of child development and behavioral health are listed as required training topics, which aligns with the best practice of ensuring staff can recognize and respond appropriately to youth who have histories of trauma. The rule also smartly mandates that no staff may initiate or participate in a physical or chemical restraint until properly trained and able to demonstrate

competency in those techniques. This competency-based training approach (including in-person skill demonstration) will help ensure that if staff ever must intervene in a crisis, they do so safely and with minimal force necessary. I strongly support these provisions.

Recommendations for Strengthening Training: To further enhance staff capabilities and promote a therapeutic, trauma-informed environment, I offer a few suggestions:

- Require Ongoing Trauma-Informed and De-escalation Training: The final rules should explicitly maintain that all staff receive annual refreshers in trauma-informed care and de-escalation techniques, consistent with expert recommendations. 11:11 Media Impact suggests that all staff complete a minimum number of hours of such training each year, with records audited during inspections. This could be implemented by specifying a baseline (for example, “at least 8 hours annually of continuing education in de-escalation and trauma-informed approaches”). Regular refreshers will ensure staff stay up-to-date on best practices for calming agitated youth and avoiding re-traumatization.
- Emphasize Mandatory Reporter and Abuse-Prevention Training: While the rule references the Child Maltreatment Mandated Reporter rule, DHS should ensure that comprehensive abuse recognition and reporting training is part of the annual curriculum. Staff must be empowered to recognize signs of abuse/neglect and obligated to report concerns. We recommend annual training for all staff on abuse recognition/reporting, with certification of completion kept on file. Incorporating this will reinforce a culture of vigilance and accountability to protect residents from harm, whether caused by staff or peers.
- Cultural Competence and Family Engagement: It may also strengthen the program to include training in cultural competence and family engagement strategies. Many youths in PRTFs come from diverse backgrounds or are in state custody. Staff should be prepared to work with families (when available) as partners in the treatment process and to provide culturally and linguistically appropriate care. Ensuring family-inclusive, culturally sensitive practices are covered in training aligns with trauma-informed care principles and could be folded into the existing topics (for example, under “appropriate relationships with clients” or “trauma-informed care” modules).

Overall, Arkansas’s training standards as proposed are in line with national best practices that call for well-trained, trauma-informed staff. By mandating annual refreshers in critical areas and highlighting abuse prevention and cultural competency, DHS can further ensure that PRTF personnel have the knowledge, skills, and mindset to create a safe and healing environment for youth. This will help shift facility culture away from punitive approaches and toward supportive, therapeutic care.

#### Licensing and Accreditation Standards

Support for High Standards (Licensure & JCAHO Accreditation): The creation of a dedicated PRTF licensure manual and the requirement that facilities obtain Arkansas DHS licensure as a PRTF and maintain accreditation by The Joint Commission (JCAHO) are excellent provisions. Requiring Joint Commission accreditation (meeting nationally recognized child and adolescent psychiatric care standards) will ensure that any PRTF operating in Arkansas adheres to rigorous quality and safety benchmarks. This aligns with recommendations that all residential facilities meet accreditation standards equal to or exceeding those of the state. I commend DHS for including accreditation as a

baseline – this external oversight will complement state licensing surveys and help drive continuous quality improvement.

In addition, the licensure standards themselves (20 CAR 417) appear appropriately comprehensive – covering administration, staffing, rights, treatment planning, environment, and more – and serve as the “minimum standards” to protect the health and safety of residents. Making these standards clear and enforceable via licensure is a critical step.

Recommendations: A few recommendations to reinforce licensing effectiveness:

- No Exceptions or Loopholes: Ensure that all organizations housing and treating under-21 youth with mental/behavioral needs are required to be licensed as PRTFs (or licensed equivalents). Sometimes facilities attempt to evade licensure by labeling themselves as “boarding schools” or “camps.” Act 636 and these rules should firmly close such loopholes by bringing any such facilities under regulation if they provide similar services. The intent is to prevent unlicensed programs from operating without oversight. DHS should clarify that any residential program for treating youth mental health must meet these standards or cease operation.
- Out-of-State Placements: Many states place youth in facilities across state lines, which raises concern if those facilities are subject to weaker standards. I encourage DHS to apply stringent criteria to any out-of-state PRTFs serving Arkansas youth. Ideally, Arkansas should only contract or allow placement with out-of-state facilities that are licensed and accredited to standards equal to Arkansas’s (as recommended in the policy report). Requiring out-of-state providers to submit annual performance reports and data on incidents, as a condition of use, would further ensure accountability. Since the proposed rules require in-state PRTFs to report on any out-of-state residents they serve, it is logical to also reciprocally demand oversight of any Arkansas youth sent outside. In short, strong licensing/accreditation standards should follow the youth, wherever they receive care.
- Transparency of Ownership and Certification: The rules might include a requirement that facilities disclose any changes in ownership, accreditation status, or key personnel to DHS promptly. Joint Commission accreditation loss or a change in administrators could trigger a review. This will help DHS stay informed and respond quickly if a facility’s situation changes (for example, if financial or leadership issues threaten care quality).

Arkansas’s commitment to high licensing and accreditation standards is laudable and will set a strong foundation for quality. Implementing the above suggestions will ensure no facility falls through the cracks of oversight and that all youth, whether in-state or placed elsewhere, are treated in settings that meet Arkansas’s high bar for safety and care.

#### Discharge and Transition Planning

Support for Comprehensive Discharge Planning: I am very pleased to see the proposed rule requires that discharge planning begin at the time of admission and that clear plans are in place to transition each youth to a less-restrictive setting as soon as safely possible. The explicit requirement that the PRTF develop a formal discharge plan, agreed to by the resident’s parent/guardian, identifying and confirming needed step-down services and supports is a best practice that will facilitate continuity of care. In particular, the rule mandates that the plan include confirmed follow-up mental health services,

educational arrangements, and other supports post-discharge. This is critical – too often children leaving residential care fall through the gaps, so ensuring those connections are made before discharge (with family involvement) greatly improves the chances of a successful reintegration.

The proposal also smartly requires specific steps at discharge, such as providing a post-discharge plan of care summarizing the youth’s treatment, medications, and needed services, and notifying the home school district with adequate lead time so educational placements can resume smoothly. Collecting outcome data at admission, periodically, and at discharge using a standardized tool is another excellent element, as it will help evaluate treatment effectiveness. Taken together, these policies show DHS’s focus on making PRTF stays as brief and effective as possible, with strong planning for what comes next – which is exactly what we want for youth who have to be in residential care.

Recommendations for Strengthening Transitions: To build on this solid framework, I recommend:

- Ensure Aftercare Support and Case Management: The rule could be enhanced by requiring or encouraging PRTFs to facilitate some form of post-discharge follow-up or aftercare coordination. National recommendations emphasize that youth coming out of residential placements should have access to transitional support services (like intensive case management, peer support, or family support services) for at least 6 months after discharge. While the PRTF itself may not provide these services directly, the discharge plan should include warm hand-offs to community providers and possibly a scheduled follow-up meeting or call after 30, 60, and 90 days to check on the youth’s status. Arkansas’s Provider-Led Arkansas Shared Savings Entity (PASSE) care coordinators may play a role here. I suggest the final rule or accompanying guidance state that facilities must coordinate with the youth’s PASSE or community mental health provider prior to discharge to ensure a seamless transition (e.g. scheduling the first outpatient appointment, arranging community support). By formalizing aftercare coordination, DHS can significantly improve outcomes and reduce readmissions.
- Family and Youth Engagement in Planning: The rules rightly require the discharge plan to be agreed upon by the parent or guardian. I encourage facilities to involve the youth and family in every step of transition planning, as developmentally appropriate. This could include family therapy sessions focused on preparing for the youth’s return home, teaching the family strategies to support the youth, and including the youth’s voice in identifying what they need for a successful transition. The 11:11 Media Impact policy recommendations highlight the importance of family inclusion, noting that facilities should work on “engagement and work with the family and natural supports” and ensure “comprehensive family and community supports following the residential stay.” Embedding this philosophy into discharge planning (for example, requiring documentation of how the family was educated or involved in aftercare planning) would strengthen the rule.
- Cross-State Transitions: In cases where an Arkansas youth was placed out-of-state or an out-of-state youth is in an Arkansas PRTF, special care is needed for discharge. The rules already require monthly reporting of discharges of out-of-state residents from Arkansas facilities. I recommend adding that if an Arkansas youth is returning from an out-of-state facility, that facility must coordinate with Arkansas authorities to provide a proper hand-off. Arkansas DHS could mirror the recommendation that “facilities and child welfare agencies develop comprehensive transition plans for youth exiting out-of-state placements, including coordination of education, healthcare, and mental health

services in the youth's home state". This ensures youth coming home to Arkansas are not lost in the shuffle.

In summary, the discharge and transition planning provisions in the proposed rule are very forward-thinking and child-centered. By ensuring early planning, confirmed community services, family involvement, and continued support after release, Arkansas will help youth successfully step down from residential care to home and community. This focus on discharge is vital to fulfilling the rule's purpose of achieving each resident's earliest appropriate return to a less restrictive environment.

#### Enforcement Mechanisms and Oversight

Transparency Support for Strong Enforcement Tools: The proposed rules appropriately equip DHS's Office of Long-Term Care (OLTC) with a robust array of enforcement mechanisms to ensure provider compliance. I support the clear statement that remedies are aimed at prompt compliance, and the flexible authority for OLTC to impose sanctions for any deficiencies found during surveys or investigations. The list of potential remedies is comprehensive and very encouraging: it includes civil monetary penalties, admissions moratoria, mandatory training or corrective action plans, increased state monitoring, appointment of a temporary facility administrator, emergency transfer of residents, license termination, and even exclusion from Medicaid participation. These graduated sanctions give DHS the tools to address problems proportionately – from requiring extra training for minor issues up to shutting down a facility for serious or uncorrected violations. Empowering the regulator in this way is essential to keep children safe, as facilities will face real consequences for non-compliance. I also note the rule allows OLTC to immediately void a license if a facility stops operating, and outlines procedures for orderly closure and record disposition, which are important details for enforcement and continuity.

Support for Transparency Measures: I applaud the inclusion of oversight transparency in the rules. Notably, facilities must "post the Statement of Deficiencies and facility's response, and the outcome of the response from the latest survey, in a public area" for residents, families, and visitors to see. They also must provide the past 12 months of deficiency notices and responses to guardians upon request. This is an excellent requirement that will ensure families are not kept in the dark about a facility's performance. Public postings of survey results create an incentive for facilities to correct problems and maintain high standards, since their reputation with consumers is on the line.

Recommendations for Strengthening Oversight: To further enhance enforcement and transparency, I recommend the following:

- Increase Unannounced Inspection Frequency: The rules allow unannounced complaint investigations and require at least an annual on-site survey. Given the vulnerability of the youth served, DHS should consider conducting unannounced inspections more frequently than once a year. National advocates recommend a minimum of two unannounced inspections per year, with private interviews of a substantial sample of residents. More frequent visits (e.g. every six months) would increase the likelihood of catching problems early and deter facilities from "cutting corners" in between surveys. It is understandable that resources are a factor, but if feasible, increasing inspection frequency (even if one is a narrower review) could greatly strengthen oversight. At minimum, DHS might target additional unannounced visits to facilities with a history of deficiencies or higher-risk profiles.

- Zero Tolerance for Abuse – Immediate Staff Suspension: I urge DHS and PRTF operators to adopt a zero-tolerance policy for abuse or neglect by staff. While the rules enforce reporting of abuse and cooperation with investigators, the regulations could explicitly require facilities to take immediate protective action when abuse allegations arise. For example, the 11:11 Media Impact report recommends that facilities institute policies mandating immediate suspension of any staff member accused of abuse pending investigation. Implementing this as a standard would ensure that children are not left in the care of someone under credible suspicion of harm. It also sends a strong message that abuse will not be tolerated. DHS might incorporate this expectation in the rules (e.g., under personnel or incident reporting requirements) or at least emphasize it during provider trainings and licensing processes. Swift removal of accused staff, coupled with prompt investigations (within 48 hours per the recommendation), will prioritize resident safety and align with best practices for child protection.
- Public Reporting of Aggregate Data: Building on the facility-level transparency already in the rules, DHS should consider publishing aggregate statewide data on PRTF performance and incidents on a regular basis. The public, legislators, and stakeholders would benefit from an annual or quarterly report summarizing key metrics: e.g. number of restraints and seclusions reported by each facility, serious incidents, licensing survey results, and enforcement actions taken. The 11:11 Media policy recommendations suggest requiring facilities to publish quarterly performance and incident reports, which the state licensing office would make publicly available. Arkansas could implement a centralized version of this – for instance, an online dashboard or report listing each PRTF and statistics on critical incidents (with no personal information). This level of transparency can build public trust and help identify systemic issues. It also aligns with the overall push for accountability: shining a light on outcomes pushes facilities to improve and allows informed decision-making by families and policymakers.
- Stakeholder Inclusion and Feedback: As part of oversight, I encourage DHS to maintain open channels for youth, family, and advocate feedback on PRTFs. Consider establishing a youth and family advisory group or listening sessions to hear directly from those with lived experience. The perspective of youth who have been in care, and their families, can be invaluable in identifying blind spots in oversight. This could be an informal practice outside the rule, but it would complement the formal surveys and incident data with qualitative insights. It echoes the report’s emphasis on including “youth and families with lived experience” in developing policies and rights.

In conclusion on oversight, Arkansas’s proposed enforcement scheme is very strong. By adopting a stance of rigorous, transparent oversight and swift corrective action, DHS will help ensure that PRTFs truly provide therapeutic care and do not become, in the words of the Senate report, “warehouses of neglect.” I believe the recommended additions – more frequent unannounced checks, a formal zero-tolerance abuse policy, public data reporting, and stakeholder engagement – will further enhance the accountability and credibility of Arkansas’s PRTF regulatory system.

### Conclusion

In summary, I would like to commend Arkansas DHS for developing these comprehensive PRTF rules. The proposal demonstrates a clear commitment to improving safety, quality, and accountability in psychiatric residential treatment for youth. By addressing critical issues such as restraint/seclusion use, staff training in trauma-informed care, resident rights, discharge planning, and oversight enforcement,

the rule is poised to significantly elevate standards and protect vulnerable youth. The additional recommendations I have provided are intended to bolster these rules even further, ensuring no gaps remain that might allow substandard care or abuse to persist. Implementing these suggestions would help Arkansas fully align its regulations with emerging national reforms aimed at ending abuse and trauma in youth residential programs.

I strongly support the adoption of this rule package with the enhancements noted above. These changes will help to ensure that PRTFs in Arkansas operate as safe, therapeutic, and transparent environments where treatment is truly in the best interest of the child. Arkansas has an opportunity to lead by example, showing how state oversight can transform residential treatment into a model of trauma-informed, evidence-based care rather than a source of further harm.

Thank you for considering my comments and for your dedication to the well-being of youth in psychiatric residential treatment. I am grateful for DHS's work on this issue. Please feel free to contact me for any clarification or further input. I look forward to the finalization and implementation of these important rules, and to the positive impact they will have on children and families in Arkansas. Sincerely,



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Creating Safe and Em

**Response:** Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.

### **Christin Harper**

#### **Arkansas Advocates for Children and Families**

*Public hearing held remotely 08/27/25 @ 10:00 AM CST*

**Comment:** Good morning, Christin Harper, Arkansas Advocates for Children and Families. For the public comment hearing this morning, I really want to reiterate some of the public comments that we submitted during the first public comment period.

Specifically, regarding the on-site inspections of the care. Right now, the rule appears to only require an annual on-site inspection of care and given the number of child abuse hotline reports involving PRTF's and past issues with lack of quality treatment provided in some of these facilities, we would recommend a biannual on-site inspection of care. At one point, when the placement and Residential Licensing Unit oversaw PRTFs, they did actually quarterly visits, so there is precedent for more frequent visits. In addition, while the rule acknowledges the possibility of unannounced visits, it doesn't require them with any prescribed frequency and even traditional foster homes actually have to have at least one annual unannounced visit. Of course, there are differences between foster homes and PRTFs, we recognize that. But, again, requiring annual unannounced visit to each PRTFs just seem prudent, given the mental

and behavioral health needs children place in these facilities, as well as some of the other concerns I already mentioned.

Specific to the quality assurance sections. You know, definitely we're encouraged by the requirement for PRTF facilities to maintain a continuous assurance plan that provides the residents on a quarterly basis. However, the rule only mandates that these plans be available upon request for review by the Office of Long-Term Care and so would as that the rule require PRTFS to submit these quarterly, not just request. That would help OLTC ensure that all PRTF quality assurance plans share basic QA components, which would promote consistency and quality assurance efforts across their facilities and requiring submission of the QA plans would also allow OLTC staff and any contract providers to regularly assess how the PRTFs are addressing any identified issues that are required in those plans.

Finally, even though the rules require the quarterly assurance plans to go to the residents, it also seems it would be helpful if the rules mandated the QA plans also are shared with parents, guardians, or custodians of the residents. Given that most of the individuals placed in PRTFs are still minors, and that information would help improve communication between the facilities and the parents, guardians, custodians, and empower those who are legally responsible for youth to take action when necessary. And so, I'll stop there. Thank you very much for your time.

**Response:** Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.

All visits to a PRTF are unannounced.

### **Reagan Stanford, Abuse and Neglect Managing Attorney**

#### **Disability Rights Arkansas**

**Comment:** Comments submitted on behalf of Disability Rights Arkansas (DRA). DRA is the federally mandated and funded nonprofit organization serving as the Protection and Advocacy System (P&A) for individuals with disabilities in Arkansas. The P&A System is a network of 57 legal advocacy agencies authorized to protect human, civil, and legal rights of all individuals with disabilities, consistent with state and federal laws. DRA's abuse and neglect team provides advocacy services to individuals, monitors facilities, and investigates abuse and neglect. Over the last six years DRA has regularly monitored the Psychiatric Residential Treatment Facilities in the state and conducted numerous abuse investigations.

Facilities should be required to document visual checks, including the location and general activity the child is engaged in, at least every 15 minutes, 24 hours a day. 20 CAR 417-303.

- In the proposed rule the requirement to document visual checks at least every 15 minutes is tied to the times when the 1:8 staff to resident ratio is in effect.

- Under the emergency rule “constant visual on each resident in common areas during waking hours” is required, in addition to 15-minute documentation. The newly proposed rule requires only “supervision and treatment on each child during the 1:4 ratio” with no documentation requirement.

Reporting of physical contact or injuries should not be limited to injuries that require external medical treatment. 20 CAR 417-412 (proposed rule) and 20 CAR 417-411 (Emergency Rule)

- Under the emergency rule one of the events facilities are (or will soon be) required to report is “physical or sexual acts between residents or residents and staff.” In the proposed rule that language has been replaced with “physical injury that requires external medical treatment or sexual acts...”
- These facilities have or should have medical personnel on-site that are not commonly available in other settings, whether they have the ability or choose to treat a resident in-house or send them to an external facility should have no bearing on whether or not the incident is reportable.

The language identifying what must be reported as a serious occurrence should be clarified to clearly include *suspected or reported* abuse and neglect. 20 CAR 417-412

- The proposed rule includes “any incidents of abuse and/or neglect” as a reportable category. Given that serious occurrences must be reported by the close of business the next business day, it is often the case that a determination of whether or not an incident involved abuse or neglect is not able to be made prior to the reporting deadline. Unfortunately, a few PRTFs in Arkansas have in the past opted to read ambiguity into similar language and refused to report incidents unless and until there was a finding of abuse or neglect, which in some cases could be months later.
- Clarifying the language to include “any incidents of suspected or reported abuse and/or neglect” would eliminate this issue.

We are curious what the rationale was for inserting “physical harm or physical injury that caused” into the definition of “serious injury” in a shift from the definition included in the emergency rule.

- The definition in the proposed rule reads - *“Serious injury” means physical harm or a physical injury that caused any significant impairment of the physical condition of the Resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.*
- The significance of this definition is unclear since the only time “serious injury” is referenced outside of the definitions is in the list of events reportable as serious occurrences in 20 CAR 417-412 and that section refers to serious injury as defined in 42 C.F.R. § 483.352 (2001), which as currently written, includes the definition included in the emergency rule.
- If the goal is to attempt to limit or exclude injuries or incidents that are medical in nature, we strongly oppose that goal. Children in these facilities have experienced and been hospitalized for issues that indicate possible lapses in care that do not result from a physical injury including lithium toxicity, fecal compaction, other medication induced conditions, dehydration, and syncope.

Post-Intervention debriefing language should clearly state a requirement for guardians to be offered the opportunity participate.

- 20 CAR 417-504 states that guardians *may* participate in post-intervention debriefings when it is deemed appropriate. This language mirrors 42 CFR 483.370(a) but does not capture the interpretive guidelines that indicate the guardians of minor residents should be given an opportunity to participate in the debriefing. The permissive language in the current rule will maintain the current status quo of guardians being notified of restraints but not offered an opportunity to participate in post-intervention debriefings.

A true finding of child maltreatment should be an automatic bar to employment or cause for termination if already employed. 20 CAR 417-206.

- The proposed rule does not require anything more than “review” by the facility administrator in consultation with OLTC. If the child maltreatment registry is not being used to prevent individuals from working with and having access to some of the most vulnerable children in the state, what is it being used for?
- As an agency that has reviewed hundreds of maltreatment investigations, it is frustratingly rare that allegations against a staff member at a facility result in a true finding. A small portion of reports are almost certainly correctly identified as unfounded allegations, however many more are the result of a lack of evidence or documentation, inability or unwillingness to fully investigate, and inadequate child maltreatment statutes that do not contemplate situations that may be specific to suitability for employment with vulnerable children under psychiatric care. Staff and resident physical altercations, including fist fights, are among the incidents that we have seen not result in a true finding.

The following comments were submitted in reference to the emergency rule but were not incorporated into the currently proposed rule. They remain necessary elements of any attempts to increase and hopefully maintain any baseline of quality care and we hope that their exclusion will be reconsidered.

*Staff Training* – In addition to what is already included in the proposed rules, DHS should:

- Require standardized training on the function of each oversight agency and how to contact each entity for all facility employees annually.
- Set minimum required hours for initial/orientation training and annual staff training. 20 CAR 417-420 includes a requirement for 15 hours of continuing education yearly for certified dietary managers or food service supervisors and 417-205 requires 12 hours annually for Administrators, however 20 CAR 417-402 does not include a minimum number of hours for initial or annual training.

*Definitions Needed* -

- “Chemical restraint” and “Sedating PRN” are not defined in 20 CAR 417-501 or in the 20 CAR 417-102 Definitions. “Drug used as a restraint” is defined in 20 CAR 417-102 and 42 C.F.R. 483, Subpart G using the definition commonly used for “chemical restraint,” however since a distinction is being made between chemical restraints and sedating PRNs, both terms should be clearly defined.

- “Scheduled discharge” as used in 20 CAR 417-407 for purposes of requiring 30 days of medication be provided at discharge.

Additional changes that would improve the safety and quality of services and have previously been proposed by DRA.

- Require resident participation in creation of individualized treatment plan and treatment team reviews. If not present during reviews the reason they were not present should be documented. Based on the prevalence of residents not being included in reviews or being able to articulate their treatment goals we do not believe the language in 20 CAR 417-406 indicating treatment plans should be developed “in consultation with the Resident” is strong enough.
- Require information regarding licensing and oversight agencies, Ombudsman offices, and the state Protection and Advocacy Agency and how to report to them be posted in conspicuous locations visible by staff, residents, and visitors.
- Require providers disclose to DHS all states they accept children from *and* provide all inspection, investigation, and corrective or disciplinary action from all placing states. DHS should maintain a public database of this information.
  - A finding related to a deficient practice has the potential to affect all residents of that facility. States operating independently and not sharing information is inefficient and a disservice to current and future residents and their guardians who deserve to have a full picture of what inspections have revealed.
- The use of prone restraints should be banned. Despite overwhelming evidence of the danger inherent in prone restraints, several facilities in the state continue to utilize the practice.
- Limit therapist caseloads to 10 children or less and limit the ability of the Clinical Director to maintain a caseload.
- Require Clinical Director to have at least three years of clinical experience
- Limit the number of hours direct care staff can work consecutively and within a one-week period.
- Require facilities to check and document resident blood pressure, weight, and BMI at least monthly.
- Require indoor recreational space be provided in addition to outdoor space.
- Set maximum number of residents allowed per unit to 8 or less.
- Allow a maximum of two residents per bedroom and require the ability to accommodate single occupancy rooms as needed.

**Response:** Arkansas Medicaid and our Office of Long-Term Care appreciate the thoughtful feedback. We have committed to relooking at the PRTF licensure standards after the permanent rules are in place for six months and will amend if needed. Your feedback will be considered. Thank you.