Licensing Division Texas Department of Family and Protective Services

Minimum Standards For Emergency Shelters

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Minimum Standards

For

Emergency Shelters

Texas Department of Family and Protective Services
Licensing Division

In This Publication

Through the enactment of House Bill 2292, 78th Legislature, 2003, effective February 1, 2004, the name of the Texas Department of Protective and Regulatory Services (PRS) has been changed to the Texas Department of Family and Protective Services (DFPS). This legislation states that a reference in law to PRS means DFPS.

Most of the minimum standard rules currently cite PRS. Until existing rules have gone through the rule making process for the purpose of changing agency names, the new names will be shown in brackets to indicate that the language in this publication differs from the language in the rule.

Emergency Shelter – An operation that provides short-term care (less than 30 days), for 13 or more children up to the age of 18 years.

DFPS Rule, TAC 40 §720.923, effective 8/1/2001

Department refers to the Texas Department of Family and Protective Services (DFPS).

Licensing refers to the Licensing Division of DFPS.

Facility (or Facilities) refers to child-care operations regulated under these standards.

DFPS Rules, 40 TAC refers to the Texas Administrative Code, Title 40, Part XIX, where minimum standards for all regulated facilities are published. Most of the minimum standards for 24-hour child-care facilities are in Chapter 720, Subchapter H, and Chapter 745. These rules are generally quoted word-for-word, though minor edits have been made to fit the style of this publication. Some cross-references to standards are shown in brackets to indicate that we have changed the original rule number reference to the standard number used in this publication.

Standards Clarification Memoranda are letters from Licensing that provide clarification of the minimum standards in this publication. Copies of memos that still are useful have been provided at the back of this publication in order of issuance. Each memo has a unique number based on the year and sequence of issuance (for example, RCCL 98-2 would be the second memo issued in calendar year 1998). In a cross-reference the number will follow either “A&I” (Action and Information) or “RCCL” (Residential Child Care Licensing).

See the Glossary for additional definitions.

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Introduction

Minimum Standards

These minimum standards are developed by the Texas Department of Family and Protective Services (DFPS) with the assistance of child-care providers, parents, lawyers, doctors, child-care professionals, and experts in fire, sanitation, and safety. The child-care licensing law sets guidelines for what must be included in the standards and requires that minimum standards be reviewed and commented on by the State Advisory Committee on Child-Care Facilities. The licensing law requires that proposed standards be distributed to child-care providers for a 60-day review and comment period before adopting the proposed standards as rules. The Administrative Procedure and Texas Register Act requires that proposed standards be published for public comment before they are adopted as rules. The department considers recommendations from providers, other interested groups, and individuals in formulating the final draft, which is filed as rules with the Secretary of State. Standards are a product of contributions from many people and groups and thus reflect what the citizens of Texas consider reasonable and minimum.

Maintaining Compliance

It is essential that operation employees and caregivers recognize four critical aspects of Licensing's efforts to protect the children in care and to help operation employees and caregivers comply with the law, rules, and standards. The four aspects are:

- Inspection
- Technical assistance
- Investigations of complaints
- Caregiver's rights and entitlements

The Inspection

Various aspects of regulated operations are evaluated for compliance with the minimum standards during regular inspections. The emphasis on these inspections is to prevent risk to children in care. All operations are designated a monitoring plan based on their compliance history:

Plan 1

Inspections are made every three to five months. Plan 1 is used for operations that are too new to have established a compliance record, have made inadequate attempts to correct deficiencies, or have repeated deficiencies that do not place children at immediate risk.

Plan 2

Inspections are made every six to nine months. Plan 2 is used for operations that have a few deficiencies that do not place children at immediate risk and deficiencies are corrected on time.

Plan 3

Inspections are made every 10 to 12 months. Plan 3 is used for operations that consistently comply with the minimum standards or whose deficiencies are few and are promptly corrected.

Deficiency

A deficiency is any failure to comply with a standard, rule, law, specific term of the permit or condition of evaluation, probation, or suspension. During any inspection, if licensing staff find that the facility does not meet minimum standards in specific areas, these areas are discussed with appropriate operation employees and caregivers. Technical assistance and consultation on the problem area are provided. Operation employees and caregivers can discuss disagreements and concerns with licensing staff. If the concerns are not resolved, the provider may request an administrative review.

Technical Assistance

Part of the licensing program's job is to offer consultation to potential applicants and permit holders about meeting and maintaining standards.

Investigation of Complaints

When a complaint alleges abuse or neglect, standards deficiency, or a violation of the law, licensing staff must investigate, notify the operation of the investigation, and provide a written report of the results of that investigation within prescribed time frames.

Your Rights and Entitlements

Waivers and Variances

If an operation is unable to comply with a standard for economic reasons, or is able to meet the intent of the standard in a different way, a waiver or variance of the standard may be requested. Licensing staff can explain the process.

Administrative Review

If a provider disagrees with a Licensing decision or action, the provider may request an administrative review. The provider is given an opportunity to show compliance with applicable law, minimum standards, restrictions and/or conditions imposed.

Appeals

A provider may request an appeal hearing on a Licensing decision to deny an application or revoke or suspend a permit or a condition placed on the permit after initial issuance.

Appeal hearings are conducted by the State Office of Administrative Hearings (SOAH).

For Further Information

It is important that operation employees and caregivers clearly understand the purpose of minimum standards and the reasons for Licensing's inspections. Do not hesitate to ask questions of licensing staff that will help you understand any actions and options. You may obtain information about licensing standards or procedures by calling the Texas Department of Family and Protective Services toll-free telephone number, 1-800-252-5400, or go to the DFPS web site at www.dfps.state.tx.us.

1000 Organization and Administration

1100 Legal Basis for Operation

DFPS Rules, 40 TAC §720.901, effective 12/21/84

1. Emergency shelters (other than those owned by a sole proprietor) must make available to the Licensing division of the Texas Department of [Family and Protective Services] documentation of their legal basis for operation. The emergency shelter must notify Licensing of any changes in the legal basis for operation. The emergency shelter must document the legal basis for operation in **one** of the following ways:
   a. An incorporated emergency shelter must state its purposes in the Articles of Incorporation. A corporation must make available to the department a copy of the Articles of Incorporation and Certificate of Incorporation.
   b. Emergency shelters operated by state agencies or other governmental entities must make available to the department documentation of enabling legislation and a copy of a constitution or bylaws, if they exist.
   c. Emergency shelters operated by a partnership or association must make available to the department partnership agreements or documents reflecting the existence or creation of an association.
2. Churches and corporations must make available to the department a copy of the resolution authorizing the operation of the facility.

1200 Governing Body Responsibilities

DFPS Rules, 40 TAC §720.902, effective 12/21/84

1. All emergency shelters must have a governing body that is responsible for and has authority over the policies and activities of the emergency shelter. If an emergency shelter is owned by a partnership, the department considers the partners as the governing body for fulfilling the responsibilities specified in this [standard]. If an emergency shelter is owned by a sole proprietor, the sole proprietor must fulfill the responsibilities of a governing body as specified in this [standard].

   Corporately owned emergency shelters must provide the department with a list of names, addresses, and titles of the governing body, the officers, and/or executive committee.

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Emergency shelters that are owned jointly or individually must provide the department with a list of names and addresses of the partners or owners. The governing body of the emergency shelter must notify the Licensing division of any changes.

2. The governing body is responsible for policies and programs, for ensuring adequate financing, and for ensuring compliance with minimum standards.
3. The emergency shelter must operate according to its written policies. The governing body is responsible for ensuring that copies of policies required by the minimum standards are available to facility staff. *[See RCCL 89-35.]*
4. The governing body must [meet the requirements in Appendix V, Criminal History and Central Registry Background Checks for administrators. The rules in Appendix V supersede what were previously Standard 1200.4 and its sub-items.]

1210 Required Behavior Intervention Policies and Procedures

Appendix VI: DFPS Rules, 40 TAC §§720.1003(a)-(h) and (j), 720.1007(a)(4), effective 3/1/2006

1. All child-care facilities and child-placing agencies must have policies and procedures consistent with [Appendix VI].
2. These policies and procedures must include a complete description of permitted behavior interventions.
3. The child-care facility and/or child-placing agency must set, in its behavior intervention policies, the specific intervention techniques that will be used within the parameters set by minimum standards.
4. The facility's behavior intervention procedures must include all child-care facility and/or child-placing agency requirements for and restrictions on the use of permitted interventions.
5. The facility must notify the Department of Family and Protective Services of any changes to these policies and procedures before implementation of the changes.
6. The child-care facility and/or child-placing agency must follow its written behavior intervention policies and procedures.
7. The child-care facility must post the behavior interventions allowed in the child-care facility in a place where the children/clients can view them, or at admission, must provide each child and the child's parent or managing conservator with a personal copy of the facility's behavior interventions policies.

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8. Prior to or at admission, a caregiver must explain to children, based on their level of functioning and comprehension, the child-care facility's policies and practices on the use of restraint. The explanation must include who can use a restraint, the actions caregivers must first attempt to defuse the situation and avoid the use of restraint, the kinds of situations in which restraint may be used, the types of restraints authorized by the agency under which the home operates, when the use of a restraint must cease, what action the child must exhibit to be released from the restraint, and the way to report an inappropriate restraint. This explanation must be documented in the child's record.
9. A child-care facility [and/or child-placing agency] may not discharge or otherwise retaliate against:
   a. An employee, client, resident, or other person because the employee, client, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility; or
   b. A client or resident of the facility because someone on behalf of the client or resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility.
10. A facility must have procedures for addressing the administration of more than three personal restraints of the same child within a seven-day period. Procedures for addressing the frequency of the interventions must include either individualized, written orders allowing for more frequent restraints, recommendations from the child's treatment team which allow for more frequent restraints, or a retroactive review of the frequent restraints and the child's behavior that necessitated the restraints.
    a. Written orders for personal restraint must meet the requirements outlined in [Standard 4222 and Appendix VI, §720.1007(b)], and must include clinical justification and a plan for reducing the need for personal restraint.
    b. Recommendations from a treatment team allowing for more frequent restraints must meet the requirements outlined in [Standard 4222 and Appendix VI, §720.1007(b)], and must include clinical justification and a plan for reducing the need for personal restraint.
    c. A retroactive review of frequent restraints must include a review of the records of the personal restraints, an examination of alternatives for managing the child's behavior, and the establishment of a plan for reducing the need for personal restraint.
       1. The review must be conducted as soon as possible and no later than 30 days after the fourth personal restraint by the persons responsible for the child's plan of service and/or treatment. The review must meet the requirements of a service plan or treatment team review.
       2. The review must include consideration of potential medical (including psychiatric) contraindications, including a child's history of physical or sexual abuse. This consideration must be documented.

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3. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the fourth restraint.
4. The review must be documented.
5. If there are more than three such reviews within a 90-day period, the child must be examined by a licensed psychiatrist, a licensed psychologist, a licensed master social worker with advanced clinical practice, or a licensed professional counselor. The professional conducting the examination must make treatment plan or plan of service recommendations regarding the use of personal restraint.

1220 Less Restrictive Behavior Interventions

Appendix VI: DFPS Rules, 40 TAC §720.1004(a), (b), effective 9/1/2000

1. A child-care facility and/or child-placing agency's policies and procedures must address the use of less restrictive and intrusive behavior interventions as preventive measures and de-escalating interventions to avoid the need for the use of restraint or seclusion.
2. A child-care facility and/or child-placing agency's policies and procedures must require that caregivers attempt and prove ineffective preventive, de-escalative, and less restrictive techniques before the emergency use of restraint or seclusion.

1230 Behavior Intervention Training Policies

Appendix VI: DFPS Rules, 40 TAC §720.1012(a), (b)(1), (b)(9)-(10), (d)(2), (d)(4)-(5), effective 9/1/2000

1. All child-care facilities and child-placing agencies must have a training policy for behavior intervention. The policy must include the amount and type of training required for different levels of caregivers (if applicable), training content, and how the training will be delivered. Child-care facilities and child-placing agencies must require training in the use of restraints or seclusion allowed by the child-care facility and/or child-placing agency's behavior intervention policies.
2. All new caregivers who will have contact with children must complete a pre-service training curriculum of behavior intervention that meets the requirements in [Standard 2511 and Appendix VI, §720.1012(b)(3)-(b)(7)] prior to being responsible for the care of children.
3. The pre-service training curriculum must include drawings, photographs, or videos of each personal restraint intervention permitted by the child-care facility and/or child-placing agency policy.

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4. The pre-service training curriculum must include drawings or photographs of each mechanical restraint device permitted by the child-care facility policy and complete specifications from the manufacturer. Any modifications to the specifications from the manufacturer on the use of a mechanical restraint device must be shown along with the required approval from a licensed psychiatrist.
5 The child-care facility and/or child-placing agency must have policies that specify the qualifications for assuming the responsibility for restraint and/or seclusion implementation, including required experience and training requirements.
6. All child-care facility and/or child-placing agency's policies must be compliant with the types of interventions the child-care facility and/or child-placing agency is permitted to use under minimum standards and the needs of the specific population for whom the child-care facility and/or child-placing agency provides care.
7. The policy on caregivers qualified in behavior intervention must also include an evaluation component for determining when a specific caregiver meets the requirements of a caregiver qualified in behavior intervention, and an on-going program to evaluate caregivers qualified in behavior intervention and the use of restraint and seclusion. In regards to agency homes, the child-placing agency, not its agency homes, is responsible for these evaluations.

1240 Evaluation of Behavior Intervention Policies

Appendix VI: DFPS Rules, 40 TAC §720.1013(b), effective 9/1/2000

1. The child-care facility and/or child-placing agency must develop an overall evaluation program with the following objectives:
   a. development and maintenance of an environment or milieu that supports positive and constructive behaviors on the part of children in care;
   b. safe, appropriate, and effective use of any form of restraint or seclusion; and
   c. elimination or reduction of physical injuries and any other negative impact of necessary restraints or seclusions on the child's behaviors or emotional development.
2. The child-care facility and/or child-placing agency evaluation must include an evaluation of the facility's policies and procedures, including the facility's training policy and curriculum.
3. The results of the regular evaluation must be made available to the Texas Department of [Family and Protective Services]. In regards to agency homes, the child-placing agency, not its agency homes, is responsible for these evaluations.

1300 Fiscal Accountability

DFPS Rules, 40 TAC §720.903, effective 10/1/1999

1. When the signed application is submitted, new emergency shelters must submit a 12-month budget to the licensing division. *[See RCCL 92-4.]*
2. New emergency shelters must have funds sufficient for the first year of operation. They must have reserve funds or documentation of available credit equal to the operating costs for the first three months.

1400 Placement in Foster or Adoptive Homes

DFPS Rules, 40 TAC §720.904, effective 12/21/1984

An emergency shelter must be licensed for child-placing activity before it places children in care into foster or adoptive homes or another institution. *[See the Texas Human Resources Code, Chapter 42.]*

1500 Reports and Records

DFPS Rules, 40 TAC §720.905, effective 12/1/2005

1. The emergency shelter must report immediately any serious occurrence involving a child to the managing conservator or parents, if the emergency shelter knows the managing conservator's or parents' identity and how to contact them. The emergency shelter must document in the child's record notification of the parents or managing conservator. If the managing conservator or parents cannot be contacted, the emergency shelter must document this in the child's record. *[See RCCL 86-4.]*
2. The emergency shelter must complete written reports concerning serious occurrences involving staff members or children. The emergency shelter must ensure that each report includes the date and time of occurrence, the staff members or children involved, the nature of the incident, and the circumstances. The emergency shelter must file a copy of the report at the shelter and make it available for review by Licensing staff.

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3. The emergency shelter must report the following types of serious occurrences to the Licensing Division within 24 hours:
   a. Suicide attempts;
   b. Incidents of cruel or abusive treatment;
   c. Incidents which critically injure or permanently disable a child;
   d. Death of a child *[see RCCL 97-2];* and
   e. An allegation that a person who directly cares for or has access to a child in care has abused drugs within the past seven days.

   *[**Note:** for reports regarding restraints or seclusion, see*
   - *Standard 4211.4 or Appendix M, §720.1005(d)*
   - *Standard 4221.2 or Appendix M, §720.1007(a)(2)]*
4. The emergency shelter must have written policies and procedures to be followed when a child is absent without permission, including the following:
   a. Specific actions staff members must take to locate the child
   b. Procedures staff members must follow to notify parents or managing conservators and the appropriate law enforcement agency
5. If a child is absent without permission, the shelter must report his absence to the appropriate law enforcement agency and managing conservator or parents, if the emergency shelter knows the managing conservator's or parents' identity and how to reach them. *[See RCCL 87-3.]*
   a. The shelter must consider the absence of a child under 10 years old (chronological or developmental age, whichever is less) as absence without permission as soon as staff members responsible for the child's care do not know where he is. The shelter must consider the absence of a child 10 years old or older as absence without permission when staff members responsible for the child's care do not know his whereabouts for three hours.
   b. Within four hours after a child is determined to be absent without permission, the shelter must report the child's absence to:
      (1) parents or managing conservator if the shelter knows the parents' or managing conservator's identity and how to reach them;
      (2) appropriate law enforcement agency.
6. The emergency shelter must report to the appropriate law enforcement agency and managing conservator or parents the removal of a child by an unauthorized person, if the emergency shelter knows the managing conservator's or the parents' identity and how to contact them. The emergency shelter must document in the child's record notification of the child's parents or managing conservator and the appropriate law enforcement agency. If the parents or managing conservator cannot be contacted, the emergency shelter must document this in the child's record.

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7. The emergency shelter must report to the Licensing Division within 24 hours disasters or emergency situations, such as fires or severe weather, requiring closure of a living unit in the emergency shelter.
8. The administrator of the emergency shelter must submit reports to the Licensing Division regarding any:
    a. change in administrator;
    b. impending change that would necessitate a change in the conditions of the license (capacity, age range, sex, location, or name).
9. The emergency shelter must allow Licensing staff to inspect the emergency shelter at reasonable times. *[See the Texas Human Resources Code §42.044.]*
10. The emergency shelter must make records available for review at the facility by Licensing staff.
11. The emergency shelter must display the license at the facility. *[See Texas Human Resources Code §42.048(d). For information on handling children who turn 18 while in care, see RCCL 89-9.]*

2000 Personnel

2100 Policies

DFPS Rules, 40 TAC §720.906, effective 12/21/1984

1. Emergency shelters must have written job descriptions that specify the duties staff are expected to perform. The emergency shelter must make a copy of the job descriptions available to staff and to Licensing.
2. If volunteers or sponsoring families are used, emergency shelters must have written policies stating the qualifications for volunteers or sponsoring families and the procedures for selecting them. The emergency shelter must maintain a copy of these policies and procedures for review by Licensing.

2200 Administrator Qualifications and Responsibilities

DFPS Rules, 40 TAC §720.907, effective 12/21/1984

1. The administrator must be licensed as provided by the Texas Human Resources Code, Chapter 43. *[See RCCL 97-1, RCCL 96-3.]*
2. The administrator is responsible for implementing the policies adopted by the governing body, the ongoing operation of the emergency shelter, and compliance with [these] *Minimum Standards for Emergency Shelters*.
3. If the administrator is involved in activities that cause frequent or extended absences from the emergency shelter, an assistant administrator must be retained. The assistant administrator must take responsibility for the program and [administer] the general affairs of the emergency shelter. This requirement must be included in the job descriptions and written plans for staffing.

   If responsibility for the administration of the shelter is delegated to an assistant administrator, he [or she] must be licensed.
4. The administrator must make available to staff organizational charts and written plans for staffing.
5. The administrator must [meet the requirements in Appendix IV, Criminal History and Central Registry Background Checks for administrators. The rules in Appendix IV supersede what were previously Standard 2200.5 and its sub-items.]

2300 Staffing

DFPS Rules, 40 TAC §720.908, effective 12/21/1984

1. The administrator must designate a person or persons to be responsible for the emergency shelter in his absence.
2. The emergency shelter must employ and supervise staff necessary to ensure the health and safety of the children in care. *[See RCCL 96-3.]*
3. The emergency shelter must have staff coverage throughout the 24-hour period. *[See RCCL 92-5.]*
   a. At least one child-care staff [member] must be on duty during waking hours for every four children under five years old. The emergency shelter must have at least one child-care staff [member] for every eight children five years old or older.
   b. The staff-child ratio applies to the total emergency shelter and includes children of staff who live in child-care units. Staff must be readily available to children. The emergency shelter must count only child-care staff or volunteers meeting the same qualifications in the staff-child ratio.
   c. During sleeping hours, one child-care worker must be in the living unit for every 16 children. If night staff is awake, the department requires one child-care worker in the living unit for every 24 children. Besides required staff, at least one staff member must be on call in case of an emergency.
4. The emergency shelter must ensure that tasks that conflict or interfere with child-care responsibilities are not assigned to child-care staff. The emergency shelter must ensure that job descriptions and staff assignments show no conflicts in assignments.

2400 Qualifications and Responsibilities

DFPS Rules, 40 TAC §720.909, effective 5/1/2000

1. Facility staff must meet the requirements in [Appendix V], Criminal History and Central Registry Background Checks. [The rules in Appendix V supersede what were previously Standards 2400.2 and .3.]
4. The emergency shelter must verify the personal qualifications of employees. Each staff must submit a statement to the facility concerning any felony and/or misdemeanor convictions within the preceding ten years and of any pending criminal charges.
5. The emergency shelter must not allow in the shelter persons whose behavior or health status endangers the children.

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6. Staff must have an examination for tuberculosis within 12 months before employment. The emergency shelter must ensure that reexamination is according to recommendations of local public health authorities or the regional office of the Texas Department of [State] Health [Services]. Children of staff who have contact with other children at the shelter must meet the same requirements as those for children in care.
7. Child-care staff must be at least 18 years old and be able to read and write.

2500 Training

DFPS Rules, 40 TAC §720.910, effective 12/21/1984

[See RCCL 89-10, RCCL 89-29.]

1. The emergency shelter must provide orientation for all new staff. *[See RCCL 93-1.]*
2. All staff working with children must receive annually 15 hours of in-service training (exclusive of orientation and first-aid training) related to children's services. *[See RCCL 93-1.]*
   a. The emergency shelter must document in-service training for staff working with children. The emergency shelter must include in the documentation the date, the subject, and the name of the person who conducted the training.
   b. Child-care and supervisory staff must be trained in admission and referral procedures and in helping children to cope with separation from parents and family. *[See RCCL 93-1.]*
3. Child-care staff who are not licensed/certified health professionals must have first-aid training.
   a. The emergency shelter must document first-aid training received or scheduled for child-care staff.
   b. A Red Cross instructor or a licensed/certified health professional must conduct the training.
   c. The emergency shelter must update first-aid training for child-care staff at least every three years. The emergency shelter must maintain certificates or statements of training to document that training has been updated.

[For behavior intervention training policy requirements, see Standard 1230 or Appendix VI, §720.1012(a), (b)(1), (b)(9)-(10), and (d)(2), (4), (5).]

2510 Behavior Intervention Training

2511 Pre-Service Behavior Intervention Training

Appendix VI: DFPS Rules, 40 TAC §720.1012(b)(3)-(8), effective 3/1/2006

1. The training must be direct delivery training provided by a qualified instructor. The use of video instruction as part of a training curriculum is considered direct delivery training as long as the instructor is available for questions during the training. Training on the implementation of restraints or seclusion must be delivered directly by the instructor and cannot be delivered by a video.
2. A qualified instructor is an instructor certified in a recognized method of therapeutic behavior intervention or is an instructor who is able to document knowledge of the subject material, training delivery methods and techniques, and training evaluation or assessment methods and techniques.
3. The training must be competency-based and the trainer must require participants to demonstrate skill competency at the end of the training.
4. Facilities whose policies do not allow for the use of any type of restraint or seclusion, including personal restraint, must require a pre-service training that meets the curriculum requirements in [items a through h, below]. Facilities whose policies allow for the use of any one type of restraint or seclusion must require pre-service training that meets all of the curriculum requirements listed in this paragraph and require that at least three quarters of the pre-service training focus on early identification of potential problem behaviors and strategies and techniques of less restrictive interventions.

   [**Staff**] **training components** [**include**]**:**

   a. developing and maintaining an environment or milieu that supports positive constructive behaviors;
   b. [assessing] causes of behaviors potentially harmful to self or others in children and adolescents including aspects of the environment or milieu;
   c. [determining] early signs of behaviors that may become dangerous to [a child] or others;
   d. [understanding] strategies and techniques the child can use to avoid harmful behaviors;
   e. teaching children to use the strategies and techniques to avoid harmful behavior and supporting the children's efforts;
   f. [learning] less-restrictive [intervention] strategies [for preventing] potentially harmful behaviors;
   g. [learning] less-restrictive [intervention] strategies [for use] with oppositional children;

(continued)

h. [understanding] the risks associated with the use of prone and supine restraints, including positional, compression, or restraint asphyxia; and

i. [determining] strategies for [the] re-integration of children into the milieu after restraint or seclusion.

5. The remainder of the pre-service behavior intervention training for caregivers who are providing care in a home or facility whose policies allow for the use of any one type of restraint or seclusion must focus on the:

   a. different roles and responsibilities of caregivers qualified in behavior intervention and caregivers who are not qualified in behavior intervention; and

   b. safe implementation of the restraints and/or seclusion permitted by the rules in this chapter and by the child-care facility and/or child-placing agency's policies and procedures.

6. If a child-care facility and/or child-placing agency's behavior intervention policies do not allow for a certain type of restraint, the child-care facility and/or child-placing agency does not have to offer training in the use of that restraint or seclusion.

2512 Exceptions to Pre-Service Behavior Intervention Training

Appendix VI: DFPS Rules, 40 TAC §720.1012(b)(2), effective 9/1/2000

New caregivers who already meet both of the requirements set out in [items a and b, below] are **not** required to complete the required pre-service training. These qualifications must be documented in the caregiver's record.

The new caregiver [who is exempt from pre-service training requirements] has:

a. been employed in a residential child-care setting within the previous year; and

b. received training within the previous year in the types of behavior intervention used at the child-care facility and/or child-placing agency where the caregiver will be employed, and the new caregiver can demonstrate his or her knowledge and understanding of the training.

2513 Annual Behavior Intervention Training Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1012(c), (d)(1), effective 9/1/2000

1. All caregivers having contact with children must complete at least four clock hours annually of behavior intervention training specific to the behavior interventions allowed by the facility's policies.
2. Annual training must focus on reinforcing basic principles covered in the initial training and developing and refining caregivers' skills. The facility may determine the content of the annual training based on the facility's evaluation of behavior intervention needs in the facility or homes. Training in any of the areas specified in [Standard 2511.4 and Appendix VI, §720.1012(b)(6),] and training in the proper use and implementation of restraints and/or seclusion is acceptable.
3. The four clock hours will be considered part of the overall annual training requirements.
4. All annual training must be direct delivery training provided by a qualified instructor, as described in [Standard 2511.2 and Appendix VI, §720.1012(b)(4)].
5. Only caregivers designated as caregivers qualified in behavior intervention may implement any form of restraint or seclusion.

2600 Staff Records

DFPS Rules, 40 TAC §720.911, effective 10/1/1999

[See RCCL 89-10.]

1. The emergency shelter must maintain personnel records for each employee. The emergency shelter must include in these records information on:
   a. qualifications for the position;
   b. tuberculosis test reports for all staff as required by Standard 2400.6;
   c. conviction record statement;
   d. date of employment;
   e. date and reason for separation from employment;
   f. forwarding address of staff no longer employed;

3000 Admission

3100 Admission Policies

DFPS Rules, 40 TAC §720.912, effective 1/1/2004

(a) An emergency shelter may provide shelter services only during an emergency constituting an immediate danger to the physical health or safety of the child or the child's offspring. The information constituting the immediate danger must be documented in the child's record.

(b) An emergency shelter may admit only those children for whom it has an operational program and who meet the admission policies.

(1) The emergency shelter must have written admission policies that specify the age, gender, and type of children served. The emergency shelter must submit a copy of the admission policies to the licensing division when the signed application is submitted.

(2) If the emergency shelter adopts a change in the admission policies that requires changes in the conditions of the license, the shelter must apply to the department for a new license.

(3) An emergency shelter must not offer, at the same time and in the same facility, two types of care that conflict with the best interests of the children, the use of staff, or the use of the facility. The shelter must document that there is no conflict.

(4) An emergency shelter must not accept more children than the maximum number specified on the license or children whose age and gender violate the conditions of the license.

(c) An emergency shelter may not deny a child admission to the shelter because of race.

(d) An emergency shelter must not knowingly accept for care a child who has exhibited suicidal behavior or behavior dangerous to others within 30 days before admission or retain a child in care who exhibits such behavior unless:

(1) the physical plant or setting is such that staff can provide direct, continuous observation if necessary; and

(2) the emergency shelter has ensured that medical treatment and psychiatric consultation are available 24 hours a day from a licensed physician. The shelter must obtain written documentation to substantiate that medical treatment and psychiatric care are available. This does not require the licensed physician or psychiatrist to be on staff at the emergency shelter.

(continued)

(e) A child of any age may stay in an emergency shelter for a maximum of 15 days. However, an emergency shelter may continue the placement of a child less than five years old for more than 15 days for up to a total of 30 days in care if he has a sibling or a parent under 18 years old in the emergency shelter or there is an appropriate reason for the continuation of care that is documented in the child's record. An emergency shelter may continue placement of a child five years of age or older for up to a total of 90 days in care if there is an appropriate reason for the continuation of care that is documented in the child's record. The appropriate reasons for continuation of care are:

(1) The person or agency responsible for the child has identified for the emergency shelter verbally or in writing that the person or agency has arranged a placement for the child, but requirements to place the child cannot be completed timely because of circumstances beyond the control of the placing party or the emergency shelter. The shelter must place written documentation received from the person or agency responsible for the child in the child's record or document the verbal information in the child's record. The documentation must include:

(A) the name, address, and telephone number of the facility where the child will be placed;

(B) the specifics of what is needed to complete the placement;

(C) the reason(s) why the requirements for placement could not be completed timely; and

(D) the date the placement will be completed;

(2) The person or agency responsible for the child has identified for the emergency shelter verbally or in writing that the person or agency has arranged a placement for the child, but the placement cannot be completed and another placement must be found because of circumstances beyond the control of the placing party or the emergency shelter. The shelter must place written documentation received from the person or agency responsible for the child in the child's record or document the verbal information in the child's record. The documentation must include:

(A) the name, address, and telephone number of the facility where the child was to be placed;

(B) the reason(s) why the placement could not be completed;

(C) the date placement plans were interrupted; and

(D) the specifics, including dates, of all efforts to locate another placement;

(continued)

(3) The child has special needs and the person or agency responsible for the child has identified for the emergency shelter verbally or in writing that the person or agency cannot make a timely and appropriate placement for the child because of circumstances beyond the control of the placing party or the emergency shelter. The shelter must place written documentation received from the person or agency responsible for the child in the child's record or document the verbal information in the child's record. The documentation must include:

(A) a description of the child's special needs from an expert in the area of the child's disabling or limiting condition and the type of placement appropriate to meet those needs; and

(B) names, addresses, and telephone numbers of placements explored, the date of contact, and the reason why each placement was unavailable and/or inappropriate;

(4) The child has qualified for financial assistance under Chapter 31, Human Resources Code, and is on the waiting list for housing assistance; or

(5) The child meets the requirements to consent to emergency care found at §720.913(b)(1) and consents to the continuation of services to the child or the child's offspring.

(f) The documentation of the appropriate reason for the continuation of care must be in the child's record by the 16th day that the child is in care, and documentation of additional continuations must be included in the child's record every 30 days thereafter. The emergency shelter must make this documentation available for review by licensing staff.

(g) If the child is in emergency care for more than 15 days, the emergency shelter must have a written plan for the discharge of the child from the person or agency responsible for the child, if any.

(1) The emergency shelter must obtain written documentation from the person or agency responsible for the child that the initial plan is reviewed and updated at least weekly.

(2) The emergency shelter must make the initial plan and weekly reviews available for review by staff of the licensing branch.

(h) Each child in an emergency shelter must receive a health screening examination within 48 hours or on the first workday after admission.

(1) A licensed physician, physician's assistant, registered nurse, licensed vocational nurse, or paramedic must provide the screening examination.

(2) The results of the screening examination, signed and dated by the person doing the examination, must be documented in the child's record.

(3) If the child is coming from a medical setting, the emergency shelter may accept a statement from a licensed physician in place of the examination.

(continued)

(i) If a child in an emergency shelter shows symptoms of illness or abuse, a licensed physician must immediately examine the child.

(j) If a child shows symptoms of abuse or neglect, the emergency shelter must immediately report this to child protective services staff.

3110 Individual Behavior Intervention Case Evaluations

Appendix VI: DFPS Rules, 40 TAC §720.1013(a), effective 9/1/2000

For each child in care, the child-care facility and/or child-placing agency must evaluate the use and effectiveness of behavior intervention techniques as part of each child's plan of service or treatment plan. The evaluation must take place at each review of the child's plan of service or treatment plan. The evaluation must focus on:

1. the frequency, patterns, and effectiveness of specific behavior interventions;
2. strategies to reduce the need for behavior interventions overall; and
3. specific strategies to reduce the need for use of personal, emergency medication, and/or mechanical restraint or seclusion, where applicable.

3200 Intake Information

DFPS Rules, 40 TAC §§720.913, effective 1/1/2004; 720.1003(i), effective 9/1/2000

1. At admission, shelter staff must complete a record that identifies the child and her immediate needs. During admission, shelter staff must obtain, if possible, the following information:
    a. Child's immediate needs
    b. Name of the referral source: placing agency or individual
    c. Date and time of placement
    d. Reason for emergency placement
    e. Description of the child's conditions as observed by the intake worker
    f. Child's understanding of emergency shelter care
    g. Child's feelings about the crisis situation and shelter care

(continued)

2. At admission or as soon as possible after admission, the emergency shelter must obtain the following information:
   a. The child's identity, date of birth, and any additional information needed to determine the child's ability to consent to emergency shelter services for the child or the child's offspring. To consent to services, the child must be:
      (1) 16-years-old or older; and
         A. residing separate and apart from the child's parent, regardless of whether the parent consents to the residence and regardless of the duration of the residence; and
         B. managing the child's own financial affairs, regardless of the source of income; or
      (2) single and is pregnant or is the parent of a child;
   b. Name, address, and telephone number of the child's parents or managing conservator, if available. This information is not required if the child meets the requirements to consent to emergency shelter services.
   c. Medication the child is taking
   d. Allergy to medication or food

   If the information is not available at admission, the emergency shelter must document in the child's record efforts made to obtain the information.
3. The emergency shelter must identify in its policies and procedures which staff reviews admission information and makes admissions.
4. When a child is admitted and does not meet the requirements to consent to emergency shelter services, the emergency shelter must try to contact the child's managing conservator or parents within 24 hours, if the emergency shelter knows the managing conservator's or the parents' identity and how to contact them. If the parents or managing conservator cannot be contacted, shelter staff must notify a public agency ([such as DFPS Child Protective Services], juvenile probation, or [the] police department) of the child's presence. The emergency shelter must document in the child's record efforts to contact the parents or managing conservator and contacts with public agencies. *[See RCCL 86-4.]*
5. The emergency shelter must provide orientation for newly admitted children.
6. Prior to or at admission, children must be notified, based on their level of functioning and comprehension, of their right to voluntarily provide comments on any restraint or seclusion, including the incident that led to the restraint/seclusion and the manner in which staff intervened, in which they are the subject or to which they are a witness. This notification must include an explanation of the process for submitting such comments, which must be easily understood and accessible. This notification need not be made after every restraint and seclusion that occurs at the facility as long as the process for submitting such comments has been made clear and accessible. For example, a facility could create a standardized form that is easily accessible or give children the permission to submit such comments on regular paper to any staff person. *[For documentation requirements, see Standard 1210.8 and Appendix VI, §720.1003(h).]*

3300 Children's Records

DFPS Rules, 40 TAC §720.914, effective 12/21/1984

1. The emergency shelter must maintain accurate and current records for each child in care. Besides other required documentation, the emergency shelter must include in each child's record the following information, if available:
   a. Name
   b. Date of birth
   c. Place of birth
   d. Sex
   e. Religion
   f. Race
   g. Names, addresses, and telephone numbers of parents, brothers, and sisters
   h. Names, addresses, and telephone numbers of other persons who have a significant relationship with the child
   i. Date of admission
   j. Date of discharge
2. The emergency shelter must ensure that a child's records are kept confidential and inaccessible to unauthorized persons.
   a. The emergency shelter may disclose information from a child's records only to individuals involved in direct and authorized services to the child or in the administration of the emergency shelter.
   b. The emergency shelter must keep these records at the shelter and make them available for review by Licensing staff.

4000 Child Care And Training

4100 Daily Care

DFPS Rules, 40 TAC §720.915, effective 12/21/1984

1. The emergency shelter must develop the daily schedule to meet the children's needs.
2. Child-care staff must keep a record of significant occurrences for each child. The emergency shelter must make this record available for review by Licensing.
3. The emergency shelter must provide for the immediate needs of the children.
4. The emergency shelter must obtain professional consultation and treatment for children with urgent special needs. When the services are obtained, the emergency shelter must document in the child's record that he received them.
5. The emergency shelter must ensure that each child is supplied with personal clothing suitable to the child's age and size. The emergency shelter must ensure that the clothing is comparable to the clothing of other children in the community. Children must have some choice in selecting their clothing.
6. The emergency shelter must give children training in personal care, hygiene, and grooming. The emergency shelter must supply each child with personal care, hygiene, and grooming equipment.
7. The emergency shelter must provide supervised indoor and outdoor recreation and equipment so that every child may participate.
8. The emergency shelter must account for a child's personal money separately from the emergency shelter's funds.
9. The emergency shelter must distinguish between tasks which children are expected to perform as a part of living together and jobs to earn spending money.

4110 Less Restrictive Behavior Intervention Procedures

DFPS Rule, TAC 40 §720.1004(c), (d), effective 9/1/2000

1. Less restrictive measures may include, but are not limited to, quiet time and time out.
2. If a caregiver uses physical force or a physical barrier to restrain a child or prevent a child from leaving a quiet time or time out, the intervention becomes a personal restraint regulated under [Standard 4220 and Appendix VI, §720.1007] or seclusion regulated under [Standard 4230 and Appendix VI, §720.1011].

4200 Children's Rights

DFPS Rules, 40 TAC §720.916, effective 8/1/2001

1. The staff of the emergency shelter must allow privacy for each child. *[See RCCL 98-1.]*

   Children's mail (including electronic mail), incoming and outgoing, must not be opened or read and children's telephone calls, incoming and outgoing, must not be monitored by facility staff unless the need for such restriction is documented in the child's record. If restrictions continue longer than one month, the restrictions must be re-evaluated at least monthly. Reasons for the continued restriction must be explained to the child and documented in the child's record. The need for restrictions must be determined and any re-evaluation must be conducted by the licensed child-care administrator.
2. Each child must have access to a quiet, private area where he can withdraw from the group when appropriate.
3. The emergency shelter must allow contacts between the child and her family while the child is in care unless the rights of the parents have been terminated by court order or family contact is not in the child's best interest. The emergency shelter must base the frequency of contact on the needs of the child. The frequency of contact is determined with the participation of the child's family or managing or possessory conservator and shelter staff. The emergency shelter must file any limitations on contacts in the child's record.
   a. The emergency shelter must allow children to send and receive mail and conduct telephone conversations with family members or their managing conservator. The best interests of the child or a court order may necessitate restrictions on this communication.
   b. If the child or her family requests contact but the emergency shelter determines it is not appropriate, a psychiatrist, licensed psychologist, social worker, or licensed administrator must determine the restrictions from communication. The emergency shelter must document in the child's record the reasons for the restrictions. *[See RCCL 96-3.]*
   c. If limits on communications or visits are necessary for practical reasons (such as expense), the emergency shelter must determine the limits with the child and her family. The emergency shelter must document these limits in the child's record.
4. The emergency shelter must have written policies regarding visits, gifts, mail, and telephone calls between the child and her family or managing conservator. The emergency shelter must make these policies available for review by Licensing staff. *[See RCCL 89-13.]*
5. The emergency shelter must allow a child to bring personal possessions to the emergency shelter and to acquire personal possessions. If limits are necessary on the kinds of possessions a child may or may not receive, the shelter staff must discuss these with the child and his parents or managing conservator.

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6. The emergency shelter must not require a child to acknowledge his dependence, destitution, or neglect. The emergency shelter must not require the child to make statements regarding his background or dependence on the shelter for care.
7. The emergency shelter must not require a child to make public statements to acknowledge gratitude to the emergency shelter.
8. The emergency shelter must not require children in care to perform at public gatherings.
9. The emergency shelter must not make public pictures, reports, or identification that humiliate, exploit, or invade the privacy of a child or his family or managing conservator. The emergency shelter must not use reports or pictures from which children may be identified without the written consent of the child and the parents of managing conservator.
10. The emergency shelter must not discriminate on the basis of race.
11. The emergency shelter must consider children's opinions and recommendations in the development and evaluation of the emergency shelter's program and activities. The emergency shelter must document this procedure. The emergency shelter must make a copy of the procedure available for review by Licensing staff.
12. The emergency shelter must have written policies for the discipline of children in care. The emergency shelter must provide copies of the policies to shelter staff. The emergency shelter must submit copies of the discipline policy with each application for a license. *[See RCCL 98-1.]*
    a. Only adult staff may discipline children.
    b. The emergency shelter must not subject children to cruel, harsh, unusual, or unnecessary punishment.
    c. The emergency shelter must ensure that the reasons for any punishment or imposition of restrictions are made clear to children. *[See RCCL 89-12.]*
    d. The emergency shelter must keep a record of each time children are restricted to the emergency shelter for longer than 24 hours.
    e. The emergency shelter must not belittle or ridicule children or their families.
    f. The emergency shelter must not deny children food, mail, or visits with their families as punishment. *[See RCCL 95-02.]*
    g. The emergency shelter must not threaten children with the loss of shelter placement as punishment.
    h. The emergency shelter must ensure that discipline fits the needs of the individual child. *[See RCCL 95-02, RCCL 96-2, RCCL 98-1.]*
    i. The emergency shelter must not punish children by shaking, striking, or spanking.
13. The emergency shelter must not allow children in care to act as or be employed as staff.

4210 Restraint and Seclusion

4211 Restraint and Seclusion: General Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1005, effective 9/1/2000

1. Before the use of restraint or seclusion, a caregiver qualified in behavior intervention must make the determination that the situation is an emergency situation. The basis for this decision must be documented.
2. Any form of restraint or seclusion may only be administered by a caregiver qualified in behavior intervention.
3. No type of restraint or seclusion may be used as:
   a. punishment;
   b. a convenience for caregivers; or
   c. a substitute for program treatment.
4. All reports to Licensing of child death, suicide attempts, and incidents in which a child experiences substantial bodily harm must include the complete documentation of any emergency medications, restraints, and/or seclusions which were implemented within 48 hours prior to the incident.

4212 Mechanical Restraint: General Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1008(a), effective 9/1/2000

The use of mechanical restraints is prohibited in all child-care facilities except residential treatment centers and institutions serving mentally retarded children.

4220 Personal Restraint

4221 Personal Restraint: General Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1007(a)(1)-(3), effective 9/1/2000

1. Personal restraint may only be used in emergency situations as defined in [the Glossary], or to administer intra-muscular medication or other medical treatments prescribed by a physician. In situations where a child is significantly damaging property, but is not posing a risk of harm to himself or others, a short personal restraint may be used to intervene only to immediately prevent the damage and only if less restrictive techniques have been attempted and have failed. The child must be released from this restraint as soon as the damaging behavior has been de-escalated. A personal restraint used to intervene in significant property damage is regulated as a personal restraint under [the 24-Hour Child-Care Licensing rules].

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2. Any serious incident report of an injury resulting from a short personal restraint that is made to Licensing must include documentation of the restraint and the precipitating circumstances and specific behaviors which led to the restraint.

   *[**Note:** The interventions listed below are **not** subject to the requirements in Standard 1210.9 and Appendix VI, §§720.1007(a)(4), which address more than three personal restraints of the same child within a seven-day period.]*

   [Examples of these interventions include:]

   a. Short personal restraints that last no longer than one minute.
   b. A short personal restraint used to intervene in a situation of imminent significant risk when a child's behavior is being restrained because of an external hazard and caregivers must protect the child, particularly a young child, from immediate danger — for example, preventing a toddler from running into the street or coming in contact with a hot stove. The restraint must end immediately after the danger is averted.
   c. A short personal restraint used as a physical response to intervene when a child under the age of five (chronological or developmental age) demonstrates disruptive behavior, such as a tantrum in a public place. The physical response must be an appropriate response to the disruptive behavior and efforts to de-escalate the behavior must have failed. The restraint must end as soon as the disruptive behavior has been de-escalated.
3. Before the use of personal restraint, other preventive, de-escalative, less restrictive techniques must be attempted and proven ineffective at defusing the situation.

4222 Recommendations or Written Orders for Personal Restraint

Appendix VI: DFPS Rules, TAC 40 §720.1007(b), effective 9/1/2000

1. A licensed psychiatrist or licensed psychologist may write orders for the use of personal restraint for a specific child. A child's treatment team may write recommendations for the use of personal restraint for a specific child. Orders and treatment team recommendations must state that personal restraint may only be used in emergency situations.
2. The psychiatrist or psychologist ordering personal restraint or the treatment team recommending personal restraint must first take into consideration any potential medical (including psychiatric) contraindications, including a child's history of physical or sexual abuse. This consideration must be documented in the child's records.
3. The psychiatrist or psychologist ordering personal restraint may use PRN *[see Glossary]* orders. PRN orders for personal restraint must be reviewed by the psychiatrist or psychologist at least every three months. The review must be documented in the child's record.

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4. Orders and treatment team recommendations for personal restraint must designate the specific procedure authorized, including any specific measures for ensuring the child's health, safety, and well-being, and the protected, private nature of the setting.
5. Orders and treatment team recommendations must include the circumstances under which the intervention may be used, instructions for observation of the child while in restraint, the behaviors that indicate the child is ready to be released from restraint, the number of times a child may be restrained in a seven-day period, and the amount of time the child may be restrained regardless of behaviors exhibited.

4223 Implementation of Personal Restraint

Appendix VI: DFPS Rules, TAC 40 §720.1007(c), effective 3/1/2006

1. When personal restraint is appropriate, it must be discontinued as soon as the child's behavior no longer constitutes an emergency situation.
2. Personal restraint must be initiated in a way that minimizes the risk of physical discomfort, harm, or pain to the child. Only the minimal amount of reasonable and necessary physical force may be used to implement personal restraint. During any personal restraint, a caregiver qualified in behavior intervention must monitor the child's breathing and other signs of physical distress and take appropriate action to ensure adequate respiration, circulation, and overall well-being. The caregiver monitoring the child should not be the same caregiver that is restraining the child. Appropriate action includes responding prudently to a potentially life-threatening situation when a child indicates he cannot breathe. Any personal restraint that employs a technique listed below is prohibited:
   a. restraints that impair the child's breathing by putting pressure on the child's torso;
   b. restraints that obstruct the child's airway, including a procedure that places anything in, on, or over the child's mouth, nose, or neck;
   c. restraints that obstruct the caregiver's view of the child's face; or
   d. restraints that interfere with the child's ability to communicate.

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3. A person qualified in behavior intervention:
   a. May use a prone or supine hold on a child in care only:
      i. As a transitional hold that lasts no longer than one minute;
      ii. As a last resort when other less restrictive interventions have proven to be ineffective; and
      iii. When an observer who is not continuously involved in the restraint ensures the child's breathing is not impaired. The observer must be trained in the risks associated with the use of prone and supine restraints, including positional, compression, or restraint asphyxia. Child-care facilities[, including foster and foster group homes,] with a capacity of 50 or fewer children are exempt from meeting this observation requirement.
   b. May use other types of personal restraint techniques permitted by facility policy:
      i. For a maximum time of one hour for children and adolescents ages 9 to 17 years.
      ii. For a maximum time of 30 minutes for children under age nine years.
4. Continuation of personal restraint(s) beyond the stated maximum is permitted only if an order from a licensed psychiatrist allowing for the continuation exists. Such an order must meet all of the criteria in [Standard 4222 and Appendix VI, §720.1007(b)] and must include a clinical justification for the amount of time it permits the child to be restrained.
5. Only a caregiver qualified in behavior intervention may apply personal restraint.
6. When a child must be personally restrained, the caregiver must consider the characteristics of the immediate physical environment and the permitted forms of personal restraint and act to protect the child's safety. Caregivers must make every effort to act to protect the child's privacy, including shielding the child from onlookers. Caregivers must make every effort to act to protect the child's personal dignity and well-being, including ensuring that the child's body is appropriately covered.
7. If an emergency health situation occurs during personal restraint, the child must be released immediately and treatment obtained.
8. As soon as possible after personal restraint is started, appropriate caregiver(s) must explain to the child in restraint the behaviors the child must exhibit to be released from the restraint or have the restraint reduced, and permit the child to make suggestions about what actions the caregiver(s) can take to help the child de-escalate.

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9. If the child does not appear to understand what action he must take to be released from the restraint, the caregiver(s) must attempt to re-explain it every 15 minutes until understanding is reached or the child is released from restraint.
10. Personal restraint may be simultaneously implemented in combination with emergency medication only if specifically allowed by written orders and only if the specified restraint(s) is allowed in the facility by the rules in this section. These orders must include clinical justification for the combination. The clinical justification for the combination of emergency medication and personal restraint must be provided by the physician ordering the emergency medication.

4224 Personal Restraint Follow-Up

Appendix VI: DFPS Rules, TAC 40 §720.1007(d), effective 9/1/2000

1. When a child is released from personal restraint, the caregiver(s) must take appropriate actions to help the child return to normal activities. A child does not have to return to the activities he was engaged in prior to the restraint or the activities in which the group is participating at the time the child is released from restraint. The actions of the caregiver(s) must include:
    a. providing the child with an appropriate transition and offering the child an opportunity to return to regular activities;
    b. observing the child for at least 15 minutes; and
    c. providing the child with an opportunity to discuss the situation which led to the need for personal restraint and the caregiver’s reaction to that situation privately as soon as possible and no later than 48 hours after the release from restraint. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child’s reaction to those strategies; and the restraint itself and the child’s reaction to the restraint.
2. Staff involved in the personal restraint must make every attempt to debrief concerning the incident.

4225 Documentation of Personal Restraint

Appendix VI: DFPS Rules, TAC 40 §720.1007(e), effective 3/1/2006

The use of personal restraint must be documented as soon as possible and no later than 24 hours after the initiation of the restraint. Documentation must include:

1. the child's name;
2. a description and assessment of the precipitating circumstances and the specific behaviors which constituted the emergency situation, and if applicable, the specific behaviors which continued to constitute an emergency situation;
3. the use of alternative strategies attempted before the use of personal restraint and the child's reaction to those strategies;
4. the time the restraint began;
5. the name of the caregiver(s) participating in the restraint;
6. the specific restraint techniques used, including a prone or supine restraint used as a transitional hold;
7. the de-escalating strategies employed during the restraint;
8. the total length of time the child was restrained;
9. all attempts to explain to the child what behaviors were necessary for release from the restraint;
10. any injury the child sustained as a result of the incident or the use of restraint, and the care or treatment provided;
11. the actions the caregiver(s) took to facilitate the child's return to normal activities following release from restraint; and
12. the child's reaction to the opportunity [to discuss the situation leading up to the need for personal restraint] offered in [Standard 4224.1.c and Appendix VI, §720.1007(d)(1)(C)], the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself (if applicable).

4230 Seclusion

4231 Seclusion: General Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1011(a), effective 9/1/2000

1. The use of seclusion is prohibited in all child-care facilities except residential treatment centers, child-care facilities serving children with autistic-like behavior, and emergency shelters.
2. Seclusion may only be used in emergency situations. Emergency shelters may only use seclusion in an emergency situation and only until the child is no longer a danger to himself or others or until immediate medical attention can be obtained.
3. Before the emergency use of seclusion, other preventive, de-escalative, less restrictive techniques must be attempted and proven ineffective at defusing the situation.

4232 Seclusion Orders

Appendix VI: DFPS Rules, TAC 40 §720.1011(b), effective 9/1/2000

1. No form of seclusion may be used with a child without appropriate orders in the child's record. Only a licensed psychiatrist or licensed psychologist may write orders for the use of seclusion for a specific child. The professional ordering seclusion must first take into consideration any potential medical and or psychiatric contraindications, including a child's history of physical or sexual abuse. This consideration must be documented in the child's records. Orders for seclusion are not required in an emergency shelter.
2. A licensed psychiatrist ordering seclusion may use PRN orders. PRN orders are not permitted to extend the maximum amount of time allowed in seclusion as outlined in [Standard 4232.5 and Appendix VI, §720.1011(b)(5)]. PRN orders for seclusion must be reviewed by the psychiatrist at least every three months. PRN orders from a licensed psychologist are not permitted.
3. Orders for seclusion must include any specific measures for ensuring the child's health, safety, and well being.
4. Orders must include the circumstances under which the seclusion may be used, any instructions for heightened observation of the child while in seclusion, the behaviors that indicate the child is ready to be released from seclusion, and the maximum amount of time the child may be secluded regardless of behaviors exhibited.
5. For children and adolescents ages 9 to 17 years, maximum time in seclusion must not exceed two hours. For children under age nine years, this must not exceed one hour. If a child is released from seclusion and then secluded again within the same 12-hour period, the time spent in seclusion is cumulative and may not exceed the stated maximums.
6. Continuation beyond the maximum amount of time permitted by the original order requires authorization from the prescribing psychiatrist or psychologist and is allowed only subsequent to a face-to-face evaluation with the child by a caregiver qualified in behavior intervention. Authorization to extend must be obtained before the end of the time period or seclusion must be discontinued. If authorization for continuation is obtained over the telephone, continuation orders must be documented and the psychiatrist or psychologist must personally sign, date, and indicate the time of the telephone order within 24 hours of the time the order was issued. For additional regulations required when the seclusion is continued beyond the maximum amount of time, see [Standard 4233.12 and Appendix VI, §720.1011(c)(12)].

(continued)

7. If a child has been secluded for more than 12 hours or has been secluded more than twice within a seven-day period, the ordering psychiatrist or psychologist, along with the treatment team, must review the child's placement, treatment plan, and the orders for seclusion as soon as possible and no later than 30 days after the seclusion that lasted more than 12 hours or the third seclusion. The review must include an examination of alternatives for managing the child's behavior and the establishment of a plan for reducing the need for seclusion. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the seclusion that lasted more than 12 hours or the third seclusion. The review must be documented in the child's record.

4233 Implementation of Seclusion

Appendix VI: DFPS Rules, TAC 40 §720.1011(c), effective 9/1/2000

1. When seclusion is the appropriate intervention, it must be discontinued as soon as the child is no longer a danger to himself or others.
2. Seclusion must be initiated in a way that minimizes the risk of physical discomfort, harm, or pain to the child. Only the minimal amount of reasonable and necessary physical force may be used to implement seclusion.
3. Only a caregiver qualified in behavior intervention may place a child in seclusion.
4. Seclusion must not be implemented without the required orders, except for the emergency use of seclusion in an emergency shelter. If orders do not exist for a child in residential treatment centers or child-care facilities serving children with autistic-like behavior and seclusion is necessary to protect the child from endangering himself or others, a caregiver qualified in behavior intervention may place a child in seclusion, but must obtain and document a licensed psychiatrist's or psychologist's verbal order by telephone no later than one hour following initiation of the seclusion. The psychiatrist or psychologist must personally sign, time, and date the telephone order within 24 hours of the time the order was issued.
5. The child-care facility and/or child-placing agency must provide a protected, private, observable environment for a child placed in seclusion. The environment must safeguard the child's personal dignity and well being.
6. A room used for seclusion must have at least 40 square feet of floor space, be free of safety hazards, be adequately ventilated during warm weather, be adequately heated during cold weather, and be appropriately lighted.
7. The seclusion room must have at least a mat and bedding, except when the psychiatrist writes orders to the contrary specific to a child.
8. If an emergency health situation occurs during seclusion, the child must be released immediately and treatment obtained.

(continued)

9. As soon as possible after seclusion is started, the caregiver(s) must explain to the child in seclusion the behaviors the child must exhibit to be released from seclusion, and permit the child to make suggestions about what actions the caregiver(s) can take to help the child de-escalate the situation.
10. If the child does not appear to understand what actions he must take to be released from seclusion, a caregiver must re- explain it every 15 minutes until understanding is reached or the child is released from seclusion.
11. Caregivers must continuously observe a child placed in seclusion. This observation can take place through such means as a window or a one-way mirror.
12. If a seclusion continues, with the appropriate orders specified in [Standard 4232.6 and Appendix VI, §720.1011(b)(6)], beyond the maximum two hours, a child must be allowed:
    a. bathroom privileges at least once every two hours;
    b. an opportunity to drink water or other appropriate liquids at least once every two hours;
    c. regularly prescribed medications unless otherwise ordered by the physician; and
    d. regularly scheduled meals and snacks served in a safe and appropriate manner.
13. Seclusion may be simultaneously implemented in combination with emergency medication only if specifically allowed by the written orders and only if the specified restraint(s) or seclusion are allowed in the facility by the rules in this section. These orders must include clinical justification for the combination. The clinical justification for the combination of emergency medication with seclusion must be coordinated and provided by both the psychiatrist or psychologist ordering the seclusion and the physician ordering the emergency medication, if they are different persons. Seclusion may not be simultaneously implemented in combination with mechanical restraint.

4234 Release From Seclusion

Appendix VI: DFPS Rules, TAC 40 §720.1011(d), effective 9/1/2000

1. When a child exhibits release behaviors described in the written order, a caregiver qualified in behavior intervention must release the child from seclusion. The child must be released no later than five minutes after the child begins exhibiting the required behaviors. Children in emergency shelters must be released as soon as they are no longer a danger to themselves or others, or until immediate medical attention can be obtained.
2. If a child falls asleep in seclusion, the door must be unlocked. The child must remain under continuous observation until he awakens and is evaluated.

4235 Seclusion Follow Up

Appendix VI: DFPS Rules, TAC 40 §720.1011(e), effective 9/1/2000

1. When a child is released from seclusion, the caregiver(s) must take appropriate actions to help the child return to normal activities. This must include:
   a. providing the child with an appropriate transition and offering the child an opportunity to return to regular activities;
   b. observing the child for at least 15 minutes; and
   c. providing the child with an opportunity to discuss the situation which led to the need for seclusion and the caregiver's reaction to that situation privately as soon as possible and no later than 48 hours after the release from seclusion. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child's reaction to those strategies; and the restraint itself and the child's reaction to the restraint.
2. This subsection does not apply to emergency shelters.
3. Staff involved in the seclusion must make every attempt to debrief concerning the incident.

4236 Documentation of Seclusion

Appendix VI: DFPS Rules, TAC 40 §720.1011(f), effective 9/1/2000

The use of seclusion must be documented as soon as possible and no later than 24 hours after initiating the seclusion. Documentation must include:

1. the child's name;
2. a description of the precipitating circumstances and the specific behaviors which constituted an emergency situation;
3. the use of alternative strategies attempted before the use of seclusion and the child's reaction to those strategies;
4. the time seclusion began;
5. the name of the caregiver(s) participating in the seclusion;
6. the de-escalating strategies employed during seclusion;
7. the total length of time the child was secluded;
8. all attempts to explain to the child what behaviors were necessary for release from the seclusion;
9. any injury the child sustained as a result of the incident or the use of seclusion.
10. the actions that the caregiver(s) took to facilitate the child's return to normal activities following release from seclusion; and
11. the child's reaction to the opportunity [to discuss the situation leading to the need for seclusion] offered in [Appendix VI, §720.1011(e)(1)(C)] the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself (if applicable).

4240 Emergency Medication

4241 Emergency Medication: General Requirements

Appendix VI: DFPS Rules, 40 TAC §720.1006(a), effective 9/1/2000

1. The use of emergency medication is only permitted in emergency situations and only when ordered by a licensed physician.
2. The use of chemical restraint is prohibited.
3. The use of chemical sprays, drops, ointments, or any form of topically-administered substance, including tear gas and pepper sprays, for emergency medication is prohibited.
4. Medications that have a secondary effect of immobilizing or sedating a child or modifying the behavior of a child, but are administered solely for medical reasons other than immobilizing or sedating a child or modifying the behavior of the child (e.g. Benadryl for an allergic reaction or medication to control seizures) are not emergency medications or chemical restraints and are not regulated as such under [the 24-Hour Child-Care Licensing Rules.]

4242 Orders for Emergency Medication

Appendix VI: DFPS Rules, TAC 40 §720.1006(b), effective 9/1/2000

1. A licensed physician's order allowing emergency medication must include information on administering the medication and a complete description of the behaviors (e.g. hitting, biting, kicking) and circumstances under which medication may be administered to restrain the child.
2. The physician ordering emergency medication must first take into consideration any potential medical contraindications, including psychiatric contraindications such as sexual abuse, and behavioral contraindications such as substance abuse.
3. The physician ordering emergency medication may use PRN orders as long as all of the information in [items 1 and 2, above,] is included in the order. PRN orders for emergency medication must be reviewed by the physician at least every three months.

(continued)

4. If a child has been restrained with emergency medication more than twice within a 30-day period, the physician, along with the treatment team and a licensed psychiatrist, must review the child's placement, treatment plan, and the orders for emergency medication within 30 calendar days of the third emergency medication. The review must include an examination of alternatives for managing the child's behavior and the establishment of a plan for reducing the need for emergency medication. In the instances when a child does not have a treatment team or a treatment plan, the orders for emergency medication must be reviewed by the physician, a licensed psychiatrist, and the person responsible for developing the child's plan of service. In emergency shelters, the orders for emergency medication must be reviewed by the administrator of the emergency shelter, the physician, and a licensed psychiatrist. This review must take place as soon as possible and no later than 30 days after the third emergency medication. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the third emergency medication. This review must be documented in the child's record.

4243 Implementation of Emergency Medication

Appendix VI: DFPS Rules, TAC 40 §720.1006(c), effective 9/1/2000

1. A caregiver qualified in behavior intervention must administer the medication only after conducting an assessment of the precipitating behaviors and circumstances and determining that an emergency situation exists.
2. Emergency medication may be simultaneously implemented in combination with personal restraint, seclusion, or mechanical restraint only if specifically allowed by the written orders and only if the specified restraint(s) or seclusion are allowed in the facility by the rules in this section. These orders must include clinical justification for the combination.
   a. Clinical justification for the combination of emergency medication and personal restraint must be provided by the physician ordering the emergency medication.
   b. Clinical justification for the combination of emergency medication with mechanical restraint must be coordinated and provided by both the psychiatrist ordering the mechanical restraint and the physician ordering the emergency medication, if they are different persons.
   c. Clinical justification for the combination of emergency medication with seclusion must be coordinated and provided by both the psychiatrist or psychologist ordering the seclusion and the physician ordering the emergency medication, if they are different persons.

(continued)

3. A child must be provided with an opportunity to discuss the situation which led to the need for emergency medication and the caregiver's reaction to that situation privately as soon as possible and no later than 48 hours after the cessation of the emergency medication. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child's reaction to those strategies; and the restraint itself and the child's reaction to the restraint.
4. Caregivers involved in the emergency medication must make every attempt to debrief concerning the incident.

4244 Documentation of Emergency Medication

Appendix VI: DFPS Rules, TAC 40 §720.1006(d), effective 9/1/2000

1. The use of emergency medication must be documented in the child's record as soon as possible and no later than 24 hours after the initiation of the restraint.
2. Documentation must include:
   a. the child's name;
   b. a description and assessment of the precipitating circumstances and the specific behaviors which constituted the emergency situation;
   c. the use of alternative strategies attempted before the use of emergency medication and the child's reaction to those strategies;
   d. the time the emergency medication was administered;
   e. the name of the caregiver(s) participating in the intervention that led to the need for emergency medication and the name of the caregiver(s) who administered the emergency medication;
   f. the specific medication used;
   g. any injury the child sustained as a result of the incident or any adverse effects caused by the use of medication;
   h. the actions the caregiver took to facilitate the child's return to normal activities following the end of the emergency medication; and
   i. the child's reaction to the opportunity [to discuss the situation leading up to the need for emergency medication] offered in [Standard 4243.3 and Appendix VI, §720.1006(c)(d)], the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself (if applicable).

4300 Medical and Dental Care

DFPS Rules, 40 TAC §720.917, effective 12/21/1984

1. The emergency shelter must have written policies and procedures for obtaining diagnosis and treatment of medical and dental problems demanding immediate attention.
   a. The emergency shelter must make copies of the policies and procedures available for review by Licensing staff.
   b. The emergency shelter must inform all staff of the policies and procedures to be followed in an emergency.
2. At admission or as soon as possible after admission, the emergency shelter must obtain medical information about each child. The emergency shelter must include in the child's medical record the following information:
   a. Any medications the child is taking
   b. Any chronic health problems, such as severe allergies, seizures, diabetes, hearing or sight loss, or a heart condition
3. The emergency shelter must make provisions for emergency medical and dental care and for routine treatment of known chronic health problems.
4. The emergency shelter must ensure that an ill child can be separated from the other children.
5. The emergency shelter must comply with laws, rules, and regulations regarding immunizations of children. *[See the Texas Human Resources Code §42.043.]* The emergency shelter must follow requirements of the Texas Department of [State] Health [Services] regarding immunizations of children in shelters. (Contact the local health department for immunization requirements.) *[See A&I 82-14.]*

   Based on an interpretation by the Texas Department of [State] Health [Services], children in emergency shelters less than 30 days may start immunizations when placed in a more permanent care facility.
6. The emergency shelter must comply with laws, rules, and regulations regarding acquisition, storage, and administration of medications. *[See Appendix II, Procedural Guide for Pharmaceutical Services in the Child-Caring Institution; and Appendix VII, Schedule II of Controlled Substances to identify drugs that must be stored as required by Appendix II.C.5. See also A&I 82-14, RCCL 89-1, RCCL 89-4, RCCL 92-10.]*
7. The emergency shelter must ensure that medication records include the medication given, the time, the dosage, and the name of the person administering the medication. *[See RCCL 89-3, RCCL 89-23.]*
8. Unless a child is participating in a medically approved self-medication program, adult staff must give all medications. Adult staff must give medication according to the instructions on the label. *[See RCCL 89-23.]*

(continued)

9. The emergency shelter must maintain medical records for each child. The emergency shelter must include in the record [the following]:
   a. A medical consent form signed by a person authorized by the Texas Family Code to give consent. If the shelter is unable to obtain written consent, the shelter must make a notation in the record. The emergency shelter must obtain written consent as soon as possible after verbal consent. If the emergency shelter is unable to get consent, the shelter must document in the medical record the attempts made and the reasons why it was not obtained. *[See Appendix III, Statutory References.]*
   b. A record of the screening exam.

[For behavior intervention emergency medication, see

- *Standard 4240, Emergency Medications*
- *Appendix VI, §720.1006*
- *Appendix II, Procedural Guide for Pharmaceutical Services in the Child-Caring Institution]*

4310 Protective Devices

Appendix VI: DFPS Rules, 40 TAC §720.1009, effective 9/1/2000

1. Protective devices may be used only if permitted by a physician's orders. The orders must indicate the circumstances under which the protective device is permitted. Orders may be obtained at the child's initial visit to the physician after placement.
2. Protective devices may not be used to restrain a child for any other reason than to prevent involuntary injury, permit wounds to heal, or administer intra-muscular medication or other medical treatments prescribed by a physician.
3. The use of protective devices must be documented in a child's record and must be part of the child's plan of service when it is developed and reviewed. The plan of service and its review must include discussion of ways to reduce the need for protective devices.
4. Devices intended to encourage mobility and/or restrain a child for safety purposes, such as wheelchairs, car seats, high-chairs, strollers, and child leashes manufactured and sold specifically to harness young children for safety purposes, are not regulated as protective devices if used appropriately.
5. Protective devices and the devices listed in [item 4, above,] and [Appendix VI, §720.1009(d)] may not be used as:
   a. punishment;
   b. a convenience for caregivers; or
   c. a substitute for program treatment.

4320 Supportive Devices

Appendix VI: DFPS Rules, 40 TAC §720.1010, effective 9/1/2000

1. Supportive devices may be used to posturally support an individual or assist in obtaining and maintaining normal bodily functioning (for example, use of posey vests for individuals who are not able to posturally support themselves). The facility and/or agency must have written policies and procedures that address the proper implementation and monitoring of supportive devices.
2. The use of a supportive device is considered an adjunct to proper care of an individual, and may not be used as a substitute for appropriate nursing care.
3. The use of a supportive device must be prescribed by a physician whose written order indicates the circumstances under which the supportive device is permitted.
4. The use of supportive devices must be documented in a child's record and must be part of the child's plan of service when it is developed and reviewed. The plan of service and its review must include discussion of ways to reduce the need for supportive devices.
5. If the prescribed device is not specifically for assisting with sleep or safety during sleep, it must be removed during the night and other rest periods.
6. Supportive devices may not be used:
   a. as punishment;
   b. for the purpose of convenience of staff or other individuals; or
   c. as a substitute for effective treatment or habilitation.

4400 Nutrition

DFPS Rules, 40 TAC §720.918, effective 12/21/1984

[See RCCL 89-20.]

The emergency shelter must provide children food of adequate quality and in sufficient quantity to supply the nutrients needed for growth and development.

a. The emergency shelter must use "Food for Fitness — A Daily Food Guide," developed by the United States Department of Agriculture, as a basis for meeting these Standards. *[See Appendix IV, Daily Food Guide.]*
b. The emergency shelter must provide children a minimum of three meals daily and snacks.
c. The emergency shelter must keep menus on file for one month after use.
d. The emergency shelter must ensure that all milk and milk products are Grade A pasteurized or from sources approved by the Texas Department of [State] Health [Services].
e. The emergency shelter must ensure that there are no more than 14 hours between the last meal or snack of one day and the serving of the first meal of the following day.

4500 Discharge

DFPS Rules, 40 TAC §720.919, effective 1/1/2004

1. The emergency shelter must ensure that the following persons, as appropriate, *[see A&I 82-13, RCCL 86-4]* are involved in planning the discharge of a child from the emergency shelter:
   a. The child
   b. The child's managing conservator or parents, if the emergency shelter knows the managing conservator's or parents' identity and how to contact them
   c. The shelter staff
2. The emergency shelter must document in the child's record the date and circumstances of the child's discharge. The emergency shelter must record the name, address, and relationship of the person to whom the child is discharged.
3. The emergency shelter must not discharge a child *[see RCCL 86-4]* except on written authorization from the parent or managing conservator, to anyone other than:
   a. the parent(s);
   b. the managing conservator;
   c. Texas Department of [Family and Protective Services], Child Protective Services, staff; or
   d. the law enforcement agency staff.
4. If the emergency shelter is unable to plan the discharge with the persons as provided in Standard 4500.1, above, the shelter must document the circumstances in the child's record if:
   a. an emergency discharge is necessary;
   b. a child leaves without consent; or
   c. a child meets the requirements to consent for emergency shelter services and decides not to include the managing conservator or the parents in planning for the child's discharge.

5000 Buildings, Grounds and Equipment

5100 Health and Safety

DFPS Rules, 40 TAC §720.920, effective 12/21/1984

1. The emergency shelter must file documentation of current and approved fire, health, and safety inspections at the shelter. When the signed application for a license is submitted, the emergency shelter must submit copies of the inspection reports to Licensing. The required annual inspections are the following:
   a. Fire inspections which meet requirements set by the local fire marshal. In areas where there is no certified fire inspector, the state fire marshal must make the inspection.
   b. Health inspections that meet or exceed regulations set by local health ordinances and the Texas Department of [State] Health [Services].
   c. Gas pipe inspections. The local gas company or a licensed plumber must pressure-test gas pipes and document that there are no leaks.
   d. Liquefied Petroleum Gas (LPG) inspection. Liquefied petroleum gas systems must be inspected by the Liquefied Petroleum Gas Division of the Texas Railroad Commission.
2. The emergency shelter must maintain written plans and procedures for disasters and emergencies [such as fires or severe weather]. Shelter staff must know the procedures to follow.
3. The emergency shelter must ensure that outdoor swimming pools are fenced. When pools are not in use, the emergency shelter must close and lock all entrances and exits to outdoor and indoor pools. The emergency shelter must lock machinery rooms to prevent children from entering them.
4. A certified lifeguard must be on duty when the emergency shelter’s swimming area is in use. The emergency shelter must document certification in the personnel records.

5200 Environment

DFPS Rules, 40 TAC §720.921, effective 12/21/1984

1. The emergency shelter must maintain, repair, and clean buildings and grounds so that they are not hazardous to health and safety. The emergency shelter must:
   a. ensure that outdoor areas are well drained;
   b. ensure that windows and doors used for ventilation are screened;
   c. ensure that equipment and furniture are safe and sturdy *[see RCCL 92-8];*
   d. ensure that children in care are provided adequate protection from flammable and poisonous substances;
   e. store explosive materials, firearms, and projectiles, such as darts, arrows, and BBs, out of children's reach *[see RCCL 89-33, RCCL 99-1]*.
2. The emergency shelter must ensure that animals on the premises are vaccinated and treated as recommended by a licensed veterinarian. The emergency shelter must file at the shelter documentation of vaccinations and treatment.
3. The emergency shelter must take measures to keep the shelter free of rodents, insects, and stray animals.
4. The emergency shelter must have indoor areas where children can gather. There must be a minimum of 40 square feet per child. Bedrooms, halls, kitchens, and any rooms not available to children are not included in the minimum space requirement.
5. The emergency shelter must ensure that each sleeping room contains at least 50 square feet per occupant. The emergency shelter must ensure that bedrooms for single occupants have at least 80 square feet.
6. When the signed application is submitted, the emergency shelter must submit to Licensing sketches of floor plans showing dimensions and purposes of all rooms.
7. The emergency shelter must ensure that furniture does not block exit ways.
8. Children must have their own bedsteads and mattresses. The emergency shelter must ensure that beds are kept clean and comfortable. The emergency shelter must ensure that mattresses have covers or protectors. *[See A&I 82-5.]*
9. The emergency shelter must ensure that there is accessible storage space available for each child's clothing and personal possessions.
10. A child six years old or older must not share the same bedroom with a person of the opposite sex.
11. The emergency shelter must ensure that there is one lavatory, one tub or shower with hot and cold running water, and one toilet for every eight children.
   a. The emergency shelter must ensure that separate toilet and bath facilities are provided for boys and girls six years old and older.
   b. The emergency shelter must ensure that bathrooms are near the sleeping area.
   c. The emergency shelter must ensure that bathrooms are thoroughly cleaned daily.

5300 Food Preparation, Storage, and Equipment

DFPS Rules, 40 TAC §720.922, effective 12/21/1984

The emergency shelter must ensure that all food and drink are of safe quality and prepared and served in a sanitary manner. The emergency shelter must:

a. Ensure that food preparation, dining and storage areas, equipment, and furniture are clean and in good repair.

b. Store all food items off the floor. The emergency shelter must store all food items, except those which are to be washed or peeled, in covered containers that are insect- and rodent-proof unless the food items are refrigerated.

c. Not permit animals in food storage, preparation, and dining areas.

d. Not reuse one-time-use paper and plastic dishes, utensils, and containers.

Glossary

Note: *The following words and terms, when used in this publication, shall have the following meanings, unless the context clearly indicates otherwise. All definitions, unless otherwise indicated, are taken from DFPS Rules 40 TAC §§720.570, 720.923, 720.1001, 745.21, and 745.8553 - 745.8559.*

Abuse

Abuse is any intentional, knowing, or reckless act or omission by someone working under the auspices of an operation that causes or may cause emotional harm or physical injury to, or the death of, a child that the operation serves. Intentional, knowing, or reckless acts and omissions include:

(1) Any act such as striking, shoving, shaking, or hitting a child, whether intended as discipline or not;

(2) Failure to make a reasonable effort to prevent abuse by another person;

(3) Causing, expressly permitting, or encouraging a child to use alcohol or a controlled substance as defined by Health and Safety Code, Chapter 481 (other than a prescription drug that is prescribed to the child and used as prescribed);

(4) Using alcohol or a controlled substance in a manner or to the extent that the use results in physical injury or emotional harm;

(5) Sexual conduct that constitutes the offense of indecency with a child as defined under Penal Code, §21.11, sexual assault as defined under Penal Code, §22.011, or aggravated sexual assault as defined under Penal Code, §22.021;

(6) Compelling or encouraging the child to engage in sexual conduct;

(7) Failure to make reasonable effort to prevent sexual conduct to a child;

(8) Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knows or should know that the resulting photograph, film, or depiction of the child is obscene as defined by Penal Code, §43.21, or pornographic; and

(9) Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child as defined by Penal Code, §43.25.

Adaptive Behavior

The effectiveness or degree with which a person meets the standards of personal independence and social responsibility expected of his age and cultural group.

Affinity

Related by marriage as set forth in the [Texas] Government Code, §573.024 (relating to Determination of Affinity).

(a) Two individuals are related to each other by affinity if:
  (1) they are married to each other; or
  (2) the spouse of one of the individuals is related by consanguinity to the other individual.

(b) The ending of a marriage by divorce or the death of a spouse ends relationships by affinity created by that marriage unless a child of that marriage is living, in which case the marriage is considered to continue as long as a child of that marriage lives.

(c) Subsection (b) applies to a member of the board of trustees of or an officer of a school district only until the youngest child of the marriage reaches the age of 21 years.

Ambulatory

The ability to walk independently and without assistance.

Auspices

See *Person who works under the auspices of an operation.*

Caregiver

A person whose duties include the supervision, guidance, and protection of a child or children.

DFPS Rules, 40 TAC §745.21(4).

Caregiver Qualified in Behavior Intervention

A caregiver who meets minimum standard qualifications and is further qualified by training and experience in crisis management and the proper use of de-escalation techniques, restraints, and/or seclusion allowed in the child-care facility.

Chemical Restraint

The use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means, solely for the purpose of immobilizing a child or sedating a child as a mechanism of control.

Child

A person under 18 years old.

Child-Care Administrator

A child-care administrator is a person who:

(1) Supervises and exercises direct control over a residential child-care operation that has a permit to serve seven or more children; and

(2) Is responsible for the operation's program and personnel, regardless of whether he has an ownership interest in the operation or shares his duties with anyone.

DFPS Rules, 40 TAC §745.8901

Child-Care Facility

An establishment subject to regulation by Licensing which provides assessment, care, training, education, custody, treatment, or supervision for a child who is not related by blood, marriage, or adoption to the owner or operator of the facility, for all or part of the 24-hour day, whether or not the establishment operates for profit or charges for its services. A child-care facility includes the people, administration, governing body, activities on or off the premises, operations, buildings, grounds, equipment, furnishings, and materials. A child-care facility does not include child-placing agencies, listed family homes, or maternity homes.

Child-Placing Agency

A person, including an organization, other than the parents of a child who plans for the placement of or places a child in a child-care operation or adoptive home.

Children's or Family Services

Services designed to:

a. support or reinforce the ability of parents to meet children's needs,
b. supplement the care children receive from parents or to compensate for certain inadequacies in parental care, and
c. substitute for parental care either in whole or in part.

Consanguinity

Two individuals are related to each other by consanguinity if one is a descendant of the other; or they share a common ancestor. An adopted child is considered to be related by consanguinity for this purpose.

Texas Government Code, §573.022

Contiguous Operations

Two or more operations that touch at a point on a common border or located in the same building.

Deficiency

Any failure to comply with a standard, rule, law, specific term of your permit, or condition of your evaluation, probation, or suspension.

Department

The Texas Department of [Family and Protective Services (DFPS)].

Designated Perpetrator

A designated perpetrator is a person on the [DFPS] central registry found by [DFPS] to have abused or neglected a child, but who has not exhausted his right to an administrative review or due process hearing. See Subchapter M of [DFPS Rules, Chapter 745], relating to Administrative Reviews and Due Process Hearings.

DFPS Rules, 40 TAC §745.731(a) (Brackets added.)

Division

The Licensing Division within the Texas Department of [Family and Protective Services].

Emergency Admission

An emergency exists if:

a. a child is in danger,

b. a child is a danger to others, or

c. a child is abandoned and does not have a place to stay.

Emergency Medication

The use of any chemical, including pharmaceuticals, through topical application, oral administration, injection, or other means, in an emergency situation solely for the purpose of modifying a child's behavior.

Emergency Order

An order given in an emergency situation for the immediate use of restraint, emergency medication, or seclusion. An emergency order is limited to the specific emergency situation and is not valid on a standing or PRN order basis.

Emergency Placement

An emergency exists if a child is in danger; a child is a danger to others; or a child is abandoned and does not have a place to stay.

Emergency Shelter

An operation that provides short-term care (less than 30 days), for 13 or more children up to the age of 18 years.

Emergency Situation

A situation in which it is immediately necessary to restrain, seclude, or administer emergency medication to a child to prevent imminent:

a. probable death or substantial bodily harm to the child because the child overtly or continually is threatening or attempting to commit suicide or serious bodily harm; or

b. physical harm to others because of threats, attempts, or other acts the child overtly or continually makes or commits, and preventative, de-escalative, or verbal techniques have proven ineffective in defusing the potential for injury. These situations may include aggressive acts by the child, including serious incidences of shoving or grabbing others over their objections. These situations do not include verbal threats or verbal attacks.

Emotional Harm

An observable impairment in a child's psychological growth, development, or functioning. Emotional harm is any significant change in a child's physical health or social behavior, including changes in sleeping and eating patterns. Emotional harm also includes any "substantial emotional harm." A mental health professional does not have to determine that there is emotional harm.

DFPS Rules, 40 TAC §745.8555(a)

Employee

Any person employed by or that contracts with the permit holder, including but not limited to caregivers, drivers, kitchen personnel, maintenance and administrative personnel, and the center/program director.

Endanger

To expose a child to a situation where physical or mental injury to a child is likely to occur.

Escorting

Use of physical force by a caregiver to move or direct a child to another location. Escorting is a type of personal restraint. Escorting does not include the re-direction or guidance of a child that does not physically resist moving with the caregiver and the situation does not escalate into a need to physically force the child to move.

Exploitation

The illegal or improper use of a child or of the resources of a child for monetary or personal benefit, profit, or gain by an employee, volunteer, or other individual working under the auspices of a facility as further described by rule or policy.

Texas Family Code, §261.401(a)(2)

External Drug

A drug that, if administered orally or by injection, may harm or kill the patient.

Finding

The conclusion of an investigation or inspection indicating compliance or deficiency with one or more minimum standards or laws.

First-Aid Supplies

Required supplies include multi-size adhesive bandages, gauze pads, tweezers, cotton balls, hydrogen peroxide, syrup of ipecac, and a thermometer.

Full-Time

At least 30 hours per week.

Governing Body

The entity with ultimate authority and responsibility for the operation.

Governing Body Designee

The person named on the application as the designated representative of a governing body who is officially authorized by the governing body to speak for and act on its behalf in a specified capacity.

Hospital

Refers only to a licensed or accredited facility.

Imminent Significant Risk

Risk that is immediate. Given the situation, a prudent person must be able to conclude that bodily harm will occur to either the child or to another person if there is no immediate intervention. Imminent significant risk does include the probability of imminent harm resulting from a child running away. Imminent significant risk does not include:

a. harm that might occur over time or at a later time; or
b. verbal threats or verbal attacks.

Intentional, Knowing, or Reckless Act or Omission

An act or omission is intentional, knowing, or reckless if the person committing it:

(1) Deliberately causes or might cause physical injury or emotional harm to the child;

(2) Knows or should know that physical injury or emotional harm to the child is a likely result of the act or omission; or

(3) Consciously disregards an unjustifiable risk of physical injury or emotional harm to the child.

DFPS Rules, 40 TAC §745.8555(b)

Involuntary Self-Injury

Involuntary movements that are potentially self-injurious (requiring, for example, helmets for individuals with seizures, use of bedrails to prevent individuals from falling out of bed, seat belts to prevent individuals from falling out of wheelchairs).

Legend Drug

A drug that bears the following caution on its label: "Federal law prohibits dispensing without a prescription." A prescription from a licensed physician is required for purchase.

Living Unit

A building or part of a building where a group of children live.

Mechanical Restraint

The application of a device for the purpose of restricting the free movement of the whole or a portion of a child's body in order to control physical activity.

Mental Health Field

A major field of study focusing on normal and abnormal human development and personal and interpersonal relationship skills. A degree in a mental health field must be from an accredited college or university and include a clinical internship or field placement.

Minimum Standards

The rules contained in [Title 40 of the Texas Administrative Code,] Chapters 715, 720, and 727 (relating to Day Care Licensing, Standards for 24-Hour Care Facilities, and Licensing of Maternity Facilities) and Subchapters G, H, and I of [Chapter 745] (relating to Child Day-Care, Residential Child-Care, and Maternity Homes Minimum Standards) which are minimum requirements for permit holders and which are enforced by [DFPS] to protect the health, safety and well-being of children.

Mobile Nonambulatory

The inability to walk without assistance, but ability to move from place to place using devices such as walkers, crutches, wheel chairs, wheeled platforms, and so on.

Neglect

Neglect is an act or omission that is a breach of a duty by a person working under the auspices of an operation that causes or may cause substantial emotional harm or substantial physical injury to a child. The breach of a duty includes:

(1) Failure to take an action that a reasonable member of that profession, reasonable caregiver, or reasonable person should take in the same situation;

(2) Taking an action that a reasonable member of that profession, reasonable caregiver, or reasonable person should not take in the same situation;

(3) Placing a child in or failing to remove him from a situation that a reasonable member of that profession, reasonable caregiver, or reasonable person should realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities;

(4) Leaving a child in a situation where a reasonable member of that profession, reasonable caregiver, or reasonable person would expect the child to be exposed to substantial physical injury or substantial emotional harm without arranging for necessary care for the child;

(5) Failure to seek, to obtain, or to follow through with medical care for a child;

(6) Failure to provide a child with food, clothing, and shelter necessary to sustain the life or health of the child;

(7) Placing a child in or failing to remove the child from a situation in which a reasonable member of that profession, reasonable caregiver, or reasonable person should know exposes the child to the risk of sexual conduct;

(8) A violation of any law, rule, or minimum standard that causes substantial emotional harm or substantial physical injury to a child;

(9) Repeated (two or more) violations of any law, rule, or minimum standard, after notice and an opportunity to correct the violation, that may cause substantial emotional harm or substantial physical injury to a child;

(10) Failure to comply with an individual treatment plan, plan of service, or individualized service plan that causes substantial emotional harm or substantial physical injury to a child; and

(11) Repeated failures (two or more) to comply with an individual treatment plan, plan of service, or individualized service plan, after notice and an opportunity to correct the failure, that may cause substantial emotional harm or substantial physical injury to a child.

DFPS Rules, 40 TAC §745.8559

New Operation

A child-care operation that is not yet in operation.

Nonambulatory

The inability to walk independently and without assistance; applies to both mobile nonambulatory and nonmobile individuals.

Nonmobile

The inability to move from place to place.

Non-Legend Drug

A drug that does not require a prescription from a licensed practitioner for purchase. May also be called an over-the-counter (OTC) drug. A written prescription for a non-legend drug does not make the drug legend.

Normalization Principle

The principle of helping [people who are] developmentally disabled to live as normally as possible; making available to them patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society. Specifically, the use of means that are as culturally normative as possible to elicit and maintain behavior that is as culturally normative as possible.

Omission

A failure to act.

DFPS Rules, 40 TAC §745.8555(c)

Operation

A person or entity offering a program that may be subject to Licensing regulation. An operation includes the building and grounds where the program is offered, any person involved in providing the program, and any equipment used in providing the program. An operation includes a child-care facility, child-placing agency, listed family home, or maternity home.

Parent

A person that has legal responsibility for or legal custody of a child, including the managing conservator or legal guardian.

Permit

A license, certification, registration, listing, or any other written authorization granted by Licensing to operate a child-care facility, child-placing agency, listed family home, or maternity home. This also includes a child-care administrator's license.

Permit Holder

The person or entity granted the permit.

Personal Restraint

The application of physical force, including escorting, without the use of any device for the purpose of restricting the free movement of the whole or a portion of a child's body in order to control physical activity.

Person Who Works Under the Auspices of an Operation

The following persons work under the auspices of an operation:

(1) Any employee or volunteer of the operation;

(2) Any person under contract with the operation;

(3) A director, owner, operator, or administrator of an operation;

(4) Anyone who has responsibility for the children in care;

(5) Anyone who has unsupervised access to the children in care;

(6) Anyone who regularly or routinely lives at the operation; and

(7) Any other person permitted by act or omission to have access to children in care.

DFPS Rules, 40 TAC §745.8553

Physical Force

Pressure applied to a child's body that reduces or eliminates the child's ability to move freely.

Physical Injury

Any bodily harm, including minor scrapes, cuts, and bruises. This includes any bodily harm resulting from the discipline of a child and any "substantial physical injury."

DFPS Rules, 40 TAC §745.8555(d)

Physician

A person registered and licensed under the Medical Practice Act or practicing on a U.S. military installation.

PRN Order

Pro re nata or "as needed according to circumstances" order.

Professional Staff

People include

a. **Psychiatrist:** A licensed physician with advanced training in the diagnosis and treatment of mental and emotional disorders.

b. **Psychologist:** A person licensed as set forth in the Texas Occupations Code, Chapter 501.

d. **Social Worker:** A person licensed by the Texas State Social Work Board of Examiners as a social worker.

e. **Person Qualified to Provide Social Work Services:** A person with a master's degree in social work from an accredited college or university.

(continued)

f. **Professional Counselors Licensed by the Texas State Board of Examiners of Professional Counselors:** Other professional staff in fields such as nursing, special education, vocational counseling, and so on, may be included in the professional staffing plan for residential treatment centers if their responsibilities are appropriate to the scope of the facility's program description. These professionals must have the minimum qualifications generally recognized in their area of specialization.

Program

Activities and services provided by an operation.

Protective Devices

Mechanical restraints used to prevent involuntary self-injury, to permit wounds to heal, or to administer medication prescribed by a physician.

Psychologist

A person licensed as set forth in the Texas Occupations Code, Chapter 501.

Quiet Time

A procedure in which a child voluntarily enters and remains in a designated area for a period of time.

Regulation

The enforcement of statutes and the development and enforcement of rules, including minimum standards. Regulation includes the licensing, certifying, registering, and listing of an operation or child-care administrator.

Report

An expression of dissatisfaction or concern about an operation, made known to [DFPS] staff, that alleges a possible violation of minimum standards or the law and involves risk to a child or children in care.

Residential Child Care

Residential child care means the care, custody, supervision, assessment, training, education, or treatment of an unrelated child or children up to the age of 18 years for 24 hours a day that occurs in a place other than the child's own home. Residential child care also includes maternity homes and child-placing agencies.

DFPS Rules, 40 TAC §745.35

Restraint

The use of physical force alone, the use of a device, or the use of emergency medication in order to assist a child in regaining control. This includes personal restraint, mechanical restraint, and emergency medication as defined in this section.

Sample Drug

A drug given without charge to a licensed practitioner that may be prescribed in the treatment regimen.

Schedule II Drug

A drug classified under the Dangerous Drugs and Controlled Substances Act of 1970 that has a high potential for abuse with severe psychic or physical dependence possible. See Appendix VII, Schedule II of Controlled Substances.

Seclusion

The placement of a child, for any period of time, in a room or other area where the child is alone and is physically prevented from leaving by a locked or barricaded entryway. An intervention that restricts a child to a room which involves a caregiver placing his or her body between the child and the exit from that area (e.g. standing in the doorway of a room) is not a seclusion because the child is not alone. If a caregiver uses physical force or a physical barrier to restrain a child or prevent a child from leaving, the intervention becomes a personal restraint regulated under §720.1007 of [Appendix V] (relating to Personal Restraint) or seclusion regulated under §720.1011 of [Appendix V] (relating to Seclusion).

Serious Incident

Any nonroutine occurrence that has an impact on the care, supervision, and/or treatment of a child or children. This includes, but is not limited to, suicide attempts, injuries requiring medical treatment, runaways, commission of a crime, [and] allegations of abuse and/or neglect or abusive treatment.

Sexual Conduct

Includes any of the following:

(1) Any touching of the anus, breast, or any part of the genitals of a child with intent to arouse or gratify the sexual desire of any person;

(2) Exposing the anus, breast, or any part of the genitals, knowing the child is present, with the intent to arouse or gratify the sexual desire of any person;

(3) Engaging a child in any activity that is obscene as defined in the Penal Code, §43.21;

(4) Requesting, soliciting, or compelling a child to engage in any activity that is obscene as defined in the Penal Code, §43.21;

(continued)

(5) In the presence of a child, engaging in or displaying any activity that is obscene as defined in the Penal Code, §43.21;

(6) In the presence of a child, requesting, soliciting, or compelling another person to engage in any activity that is obscene as defined in the Penal Code, §43.21; or

(7) The illegal or improper use of a child, which may or may not include sexual contact or touching, with intent to arouse or gratify the sexual desire of any person.

DFPS Rules, 40 TAC §745.8555(e)

Significantly Below Average Intellectual Functioning

Performance that is two or more standard deviations from the mean or average of the tests (usually 68 on Stanford-Binet or Cattell and 70 on the Wechsler).

Staff/Child Ratio

The ratio applies to the total [operation] and includes children of [employees] who live in child-care units. Persons counted in the child/caregiver ratio must

a. be engaged in child-care activity, and

b. meet at least the qualifications for child-care staff.

Standing Orders

An order or prescription in force permanently or until specifically changed or canceled.

Substantial Emotional Harm

An observable impairment in a child's psychological growth, development, or functioning that is significant enough to require treatment by a medical or mental health professional. Evidence that the emotional harm is substantial includes the nature of the act or omission, the age of the child, and/or the persistence of the symptoms. Substantial emotional harm is presumed when the act or omission is of a sexual nature, the child acts out sexually, or the child attempts suicide. A mental health professional does not have to determine that there is substantial emotional harm.

DFPS Rule, TAC 40 §745.8555(f)

Substantial Physical Injury

Bodily harm that warrants treatment by a medical professional, including dislocated, fractured, or broken bones; concussions; lacerations requiring stitches; second and third degree burns; and damage to internal organs. Evidence that physical injury is substantial includes the location and/or severity of the bodily harm and/or the age of the child.

DFPS Rule, TAC 40 §745.8555(g)

Suicide Attempts

Child's attempt to take his own life using means or methods capable of causing serious injury or means or method that the child believes capable of causing serious injury.

Supervise (Children)

Awareness of and responsibility for a child's on-going activity. Supervision requires caregivers to have knowledge of program and children's needs and to be accountable for service delivery. The operation is responsible for providing the degree of supervision indicated by a child's age; developmental level; and physical, emotional, and social needs.

Supportive Devices

Mechanical restraints used to posturally support an individual or to assist individuals who cannot obtain and/or maintain normal bodily functioning as outlined in §720.1010 of [Appendix V] (relating to Supportive Devices).

Time Out

A procedure in which a child is restricted to a designated area, including his room, for a period of time for purposes of behavior modification, but is not physically prevented from leaving by a locked or barricaded entryway. A caregiver may close a door or stand in an entryway to enforce the time out, as long as the door is not locked.

Volunteer

A person who provides services to an operation without monetary compensation. Includes "sponsoring families." When a child in care is invited by another child in the community to participate in family, community, church, school, or other activities, this is not considered "volunteer services" and the family is not considered a "sponsoring family."

Volunteer — Short-Term Services through an Organization or Agency

Volunteer services provided [to an operation] through a church, civic, fraternal, or other organization or agency where individuals providing services have only occasional short-term contact with children in care. The operation must be aware of and approve the organization or agency's policies on volunteers who have contact with children.

Volunteer — Used as Child-Care Staff

A volunteer who provides child-care services to a group of children without direct supervision by operation employees and/or whose presence must be counted for the operation to meet the child/caregiver ratio.

Appendix I: Certain Criminal Offenses in the Texas Penal Code and the Health and Safety Code

Note: An offense term in the Texas Penal code or under the Texas Controlled Substance Act may change during a legislative session. Some offenses in the Titles listed in this appendix have changed over the past few years. This appendix focuses specifically on the offenses listed under DFPS Rules, 40 TAC §745.651 (a) and (b). Not included are offenses under §745.651 (c) or any like offense under the law of another state or federal law that a person committed within the past ten years.

Offenses under the Texas Penal Code

Title 4. Inchoate Offenses

Chapter 15 Preparatory Offenses

- §15.031. Criminal Solicitation of a Minor

Title 5. Offenses Against the Person

Chapter 19. Criminal Homicide

- §19.02. Murder
- §19.03. Capital Murder
- §19.04. Manslaughter
- §19.05. Criminally Negligent Homicide

Chapter 20. Kidnapping and Unlawful Restraint

- §20.02. Unlawful Restraint
- §20.03. Kidnapping
- §20.04. Aggravated Kidnapping
- §20.05. Unlawful Transport

Chapter 21. Sexual Offenses

- §21.06. Homosexual Conduct
- §21.07. Public Lewdness
- §21.08. Indecent Exposure
- §21.11. Indecency With a Child
- §21.15. Improper Photography or Visual Recording

(continued)

Chapter 22. Assaultive Offenses

§22.01. Assault

§22.011. Sexual Assault

§22.015. Coercing, Soliciting, or Inducing Gang Membership

§22.02. Aggravated Assault

§22.021. Aggravated Sexual Assault

§22.04. Injury to a Child, Elderly Individual, or Disabled Individual

§22.041. Abandoning or Endangering a Child

§22.05. Deadly Conduct

§22.07. Terroristic Threat

§22.08. Aiding Suicide

§22.09. Tampering With Consumer Product

§22.10. Leaving a Child in a Vehicle

§22.11. Harassment by Persons in Certain Correctional Facilities

Title 6, Chapter 25. Offenses Against the Family

§25.01. Bigamy

§25.02. Prohibited Sexual Conduct

§25.03. Interference With Child Custody

§25.031. Agreement to Abduct From Custody

§25.04. Enticing a Child

§25.05. Criminal Nonsupport

§25.06. Harboring a Runaway Child

§25.07. Violation of Protective Order or Magistrate's Order

§25.071. Violation of Protective Order Preventing Offense Caused by Bias or Prejudice.

§25.08. Sale or Purchase of Child

§25.09. Advertising for Placement of Child

Title 7. Chapter 29 Offenses Against Property

§29.02. Robbery

§29.03 Aggravated Robbery

Title 8. Offenses Against Public Administration

Chapter 38 Obstructing Governmental Operation

§38.17. Failure to Stop or Report Aggravated Sexual Assault of a Child

(continued)

Title 9. Offenses Against Public Order and Decency

Chapter 42. Disorderly Conduct and Related Offenses

§42.072 Stalking

Chapter 43. Public Indecency

Subchapter A. Prostitution

§43.02. Prostitution

§43.03. Promotion of Prostitution

§43.04. Aggravated Promotion of Prostitution

§43.05. Compelling Prostitution

Subchapter B. Obscenity

§43.22. Obscene Display or Distribution

§43.23. Obscenity

§43.24. Sale, Distribution, or Display of Harmful Material to Minor

§43.25. Sexual Performance by a Child

§43.251. Employment Harmful to Children

§43.26. Possession or Promotion of Child Pornography

Title 10. Offenses Against Public Health, Safety, and Morals

Chapter 46. Weapons

§46.13. Making a Firearm Accessible to a Child

Chapter 49. Intoxication and Alcoholic Beverage Offenses

§49.02. Public Intoxication

§49.031. Possession of Alcoholic Beverage in Motor Vehicle

§49.04. Driving While Intoxicated

§49.05. Flying While Intoxicated

§49.06. Boating While Intoxicated

§49.065. Assembling or Operating an Amusement Ride While Intoxicated

§49.07. Intoxication Assault

§49.08. Intoxication Manslaughter

§49.09. Enhanced Offenses and Penalties

(continued)

Offenses Under the Health and Safety Code

Chapter 481. Texas Controlled Substance Act

Subchapter D. Offenses and Penalties

§481.112. Manufacture or Delivery of Substance in Penalty Group 1 (Penalty Groups are defined in previous sections of this subchapter)

§481.1121. Manufacture or Delivery of Substance in Penalty Group 1-A

§481.113. Manufacture or Delivery of Substance in Penalty Group 2

§481.114. Manufacture or Delivery of Substance in Penalty Group 3 or 4

§481.115. Possession of Substance in Penalty Group 1

§481.1151. Possession of Substance in Penalty Group 1-A

§481.116. Possession of Substance in Penalty Group 2

§481.117. Possession of Substance in Penalty Group 3

§481.118. Possession of Substance in Penalty Group 4

§481.119. Manufacture, Delivery, or Possession of Miscellaneous Substances

§481.120. Delivery of Marihuana

§481.121. Possession of Marihuana

§481.122. Delivery of Controlled Substance or Marihuana to Child

§481.123. Delivery, Manufacture, or Possession of Controlled Substance Analogue

§481.124. Possession or Transport of Certain Chemicals with Intent to Manufacture Controlled Substance

§481.125. Possession or Delivery of Drug Paraphernalia

§481.126. Illegal Expenditure or Investment

§481.127. Unauthorized Disclosure of Information

§481.128. Commercial Matters

§481.129. Fraud

§481.131. Diversion of Controlled Substance Property or Plant

§481.132. Multiple Prosecutions

§481.133. Falsification of Drug Test Results

§481.134. Drug-Free Zones

§481.136. Unlawful Transfer or Receipt of Chemical Precursor

§481.137. Transfer of Precursor Substance for Unlawful Manufacture

§481.138. Unlawful Transfer or Receipt of Chemical Laboratory Apparatus

§481.139. Transfer of Chemical Laboratory Apparatus for Unlawful Manufacture

§481.140. Use of Child in Commission of Offense

Appendix II: Procedural Guide for Pharmaceutical Services in the Child-Caring Institution

DFPS Rules, 40 TAC §720.1101, effective 9/11/1992

A. A pharmacist consultant is recommended for a child-caring institution to assist in the development of pharmacy services.

B. **Definitions**

1. **Non-legend** — A drug which does not require a prescription from a prescribing practitioner for purchase. A non-legend drug may also be referred to as an OTC (Over the Counter) drug. Although a prescription may be written for a non-legend drug, it does not make the drug legend.
2. **Legend** — A drug which bears the following inscription on the label of its container: “Federal law prohibits dispensing without a prescription.” A prescription from a licensed practitioner is required for a purchase of a legend drug.

C. **Physical Facilities**

1. It is necessary that the door leading to the medication room or cabinet medication storage area be equipped with a locking device.
2. The medication room or cabinet medication storage must have a separate cabinet, box, or drawer to store poisons and drugs “for external use only.”
3. The facility must have a method of storing medications requiring refrigeration.
4. Any suitable location within the medication room or cabinet medication storage area may be used for storage of non-legend drugs.
5. A medication cabinet containing a locking device and located within the locked drug room may contain separate boxes, drawers, or sections for poisons, medications for “external use only,” and medications covered by Section II of the *Controlled Substances Act*. In this case it is not necessary for each of the boxes, drawers, or sections to have a separate locking device.
6. The facility should have emergency drugs and equipment developed by the professional medical staff (first aid).
7. The facility should have a medication station which contains forms suitable for maintaining adequate records of all medications administered to patients by the authorized individuals.
8. The medication area must be clean and orderly.

(continued)

D. **Medication Labels:**

1. Must be legible, unsoiled, and complete.
2. Must contain the following information:
   a. Patient's full name
   b. Prescribing physician's name
   c. Pharmacy prescription file number
   d. Name and strength of the drug
   e. Date of issue (date the prescription was filled or refilled)
   f. Expiration date of all time-dated drugs
   g. Name, address, and telephone number of pharmacy issuing the drug
   h. Warning labels as applicable (Examples: "refrigerate, external use only, not for I.V. use")
3. Labeling errors must be reported to the issuing pharmacist immediately by the nurse or authorized individual.

E. **Storage of Medication**

1. Medication must be stored in the original containers as received from the pharmacy.
2. Preparation for the administration of a single dose of medication must be done immediately prior to the administration of the medication, i.e., preparing individual doses of medication for the next day's use is not allowed.
3. Storage of drugs must be in their required place, i.e., drugs requiring refrigeration must be stored within the refrigerator.
4. Transferring between containers of medication is illegal, i.e., pouring medication from a large container to a small one. Transferring medication from one patient's container to another patient's container (borrowing) is also illegal.
5. Discontinued medications are to be turned in to the administrator's office within 90 days of the date of discontinuance to be disposed of in accordance with federal and state laws. Proper records of disposition of these medications must be kept.
6. Medications which have passed an expiration date are to be turned in to the administrator's office immediately to be disposed of in accordance with federal and state laws. Proper records of the disposition of these medications must be kept.
7. Medications of deceased patients are to be turned in to the administrator's office immediately to be disposed of in accordance with federal and state laws. Proper records of the disposition of these medications are to be kept. Should there be a delay because of charge personnel (director of nurses and/or medication nurse) not being available for immediate removal of medication, documentation of the interim period should be made.

(continued)

8. The administrator is responsible for inventory and storage of discontinued medications, medications which have passed an expiration date, and medications of deceased patients. When the home has an accumulation of such medications, these medications shall be disposed of in accordance with federal and state laws.

F. **Order Procedure for Medications**

1. If a specific amount of medication or the time for discontinuance is not specified, the medication will not be renewed except on the orders of the treating physician. A "prn" refill order or an indefinite order must be reviewed regularly every six months.
2. The nurse or the authorized individual and the patient's physician will review each patient's medication as part of the treatment plan. This review will take place as deemed appropriate by the nurse or authorized individual approximately every 30 days.

G. **Administration of Medication**

1. The nursing station must have readily available items necessary for the proper administration of the medication.
2. In the interest of patient care, all medications should be administered by authorized personnel only. It shall be the duty of the person responsible for administering the medication to ascertain that the medication is, in fact, taken by the patient.
3. Each dose administered should be properly recorded and initialed in the clinical record by the individual administering the dose.
4. Medications prescribed for one patient must not be administered to any other patient. (Borrowing is prohibited.)
5. **Medication Errors and Drug Reactions**
   a. Such errors and reactions must be immediately reported to the patient's physician and to the consultant or issuing pharmacist.
   b. Any entry of the incident and the subsequent reporting thereof should be made in the patient's record.

H. All legend pharmaceuticals are to be prescribed by a treating physician.

I. Sample medications are not allowed unless properly labeled and administered. *[See RCCL 92-10.]*

J. An "external use only" drug is any drug that, if administered to a patient either by mouth or by injection, may cause harm or death to the patient. Ear drops, nose drops, ointments, ophthalmic preparations, lotions, suppositories, etc., are all classified as "external use only" drugs.

Appendix III: Statutory References

Consent to Medical Treatment

Texas Family Code

§32.001. Consent by Non-Parent

(a) The following persons may consent to medical, dental, psychological, and surgical treatment of a child when the person having the right to consent as otherwise provided by law cannot be contacted and that person has not given actual notice to the contrary:

(1) a grandparent of the child;

(2) an adult brother or sister of the child;

(3) an adult aunt or uncle of the child;

(4) an educational institution in which the child is enrolled that has received written authorization to consent from a person having the right to consent;

(5) an adult who has actual care, control, and possession of the child and has written authorization to consent from a person having the right to consent;

(6) a court having jurisdiction over a suit affecting the parent-child relationship of which the child is the subject;

(7) an adult responsible for the actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by a juvenile court to the care of an agency of the state or county; or

(8) a peace officer who has lawfully taken custody of a minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.

(b) The Texas Youth Commission may consent to the medical, dental, psychological, and surgical treatment of a child committed to it under Title 3 when the person having the right to consent has been contacted and that person has not given actual notice to the contrary.

(c) This section does not apply to consent for the immunization of a child.

(d) A person who consents to the medical treatment of a minor under Subsection (a)(7) or (8) is immune from liability for damages resulting from the examination or treatment of the minor, except to the extent of the person’s own acts of negligence. A physician or dentist licensed to practice in this state, or a hospital or medical facility at which a minor is treated is immune from liability for damages resulting from the examination or treatment of a minor under this section, except to the extent of the person’s own acts of negligence.

§32.003. Consent to Treatment by Child

(a) A child may consent to medical, dental, psychological, and surgical treatment for the child by a licensed physician or dentist if the child:
  (1) is on active duty with the armed services of the United States of America;
  (2) is:
    (A) 16 years of age or older and resides separate and apart from the child's parents, managing conservator, or guardian, with or without the consent of the parents, managing conservator, or guardian and regardless of the duration of the residence; and
    (B) managing the child's own financial affairs, regardless of the source of the income;
  (3) consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the licensed physician or dentist to a local health officer or the Texas Department of [State] Health [Services], including all diseases within the scope of Section 81.041, Health and Safety Code;
  (4) is unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to the pregnancy;
  (5) consents to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use; or
  (6) is unmarried and has actual custody of the child's biological child and consents to medical, dental, psychological, or surgical treatment for the child.

(b) Consent by a child to medical, dental, psychological, and surgical treatment under this section is not subject to disaffirmance because of minority.

(c) Consent of the parents, managing conservator, or guardian of a child is not necessary in order to authorize hospital, medical, surgical, or dental care under this section.

(d) A licensed physician, dentist, or psychologist may, with or without the consent of a child who is a patient, advise the parents, managing conservator, or guardian of the child of the treatment given to or needed by the child.

(e) A physician, dentist, psychologist, hospital, or medical facility is not liable for the examination and treatment of a child under this section except for the provider's or the facility's own acts of negligence.

(f) A physician, dentist, psychologist, hospital, or medical facility may rely on the written statement of the child containing the grounds on which the child has capacity to consent to the child's medical treatment.

§32.005. Examination Without Consent of Abuse or Neglect of Child

(a) Except as provided by Subsection (c), a physician, dentist, or psychologist having reasonable grounds to believe that a child's physical or mental condition has been adversely affected by abuse or neglect may examine the child without the consent of the child, the child's parents, or other person authorized to consent to treatment under this subchapter.

(b) An examination under this section may include X-rays, blood tests, photographs, and penetration of tissue necessary to accomplish those tests.

(c) Unless consent is obtained as otherwise allowed by law, a physician, dentist, or psychologist may not examine a child:

(1) 16 years of age or older who refuses to consent; or

(2) for whom consent is prohibited by a court order.

(d) A physician, dentist, or psychologist examining a child under this section is not liable for damages except for damages resulting from the physician's or dentist's negligence.

Health Regulations

Swimming Pool Construction and Maintenance

The following publications are available from the Texas Department of [State] Health [Services], Literature and Forms Unit, 1100 West 49th Street, Austin, TX 78756:

Minimum Standards of Sanitation and Health Protection Measures
(Texas Health and Safety Code, Chapter 341)

Design Standards for Swimming Pool Construction

A Training Course in Swimming Pool Operation

Water Safety

The following publication is available from the Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, TX 78744.

A Digest of the Texas Water Safety Act

Appendix IV:
Daily Food Guide

Based on the U.S. Dept. of Agriculture's
Food for Fitness—A Daily Food Guide

Kinds and Amounts of Foods to Be Served to Meet Half of the Daily Nutritional Needs of Children

Food Group	**Ages/Size per Serving**		
	1 to 3 Years	4 to 6 Years	7 and Older
Milk and Milk Alternatives			
Milk	1-½ cups	1-½ cups	1-½ cups
Cheese	1-¼ cups	1-½ cups	2 cups
Dried milk	4 tablespoons	4 tablespoons	4 tablespoons
Other servings that equal ½ cup of milk are a ½ cup of yogurt or 1 cup of cottage cheese.			
Meats and Meat Alternatives			
Meat, fish, poultry (cooked)	1 ounce	1-½ ounces	2 ounces
Eggs	½ egg	1 egg	1 egg
Peanut butter	1 tablespoon	1-½ tablespoons	2 table-spoons
Cooked dried beans or peas	¼ cup	3/8 cup	1 cup
Cheese	1 ounce	2 ounces	3 ounces
Vegetables			
See vitamin source tables, Appendix V	¼ cup	½ cup	¾ cup
Fruits			
See vitamin source tables, Appendix V	¼ cup or ½ cup 100% juice	½ cup or 1 cup 100% juice	¾ cup or 1-½ cups 100% juice
Breads and Bread Alternatives (whole grain or enriched)			
Sliced Breads	2 slices	2 slices	2 slices
Dry cereal	¾ cup	1 cup	1-¼ cups
Cooked cereal	¾ cup	1 cup	1-¼ cups
Rice or noodles	1 cup	1-¼ cups	1-¼ cups

Examples of Kinds of Foods to Be Served to Meet the Daily Nutritional Needs of Children

Milk and Milk Alternatives

Milk and milk alternatives food group supplies these key nutrients: Calcium, riboflavin (vitamin B2) and protein for strong bones and teeth, healthy skin, and good vision. It is best to serve fluid milk, lowfat and regular cheeses, and lowfat and regular yogurt to meet the milk requirement. Children over two years of age may be offered lowfat milk products. Children from birth through 11 months should be encouraged to consume breast milk supplied by the mother.

Milk and Milk Alternatives		
Milk	**Cheese*** (low-fat and regular)	**Yogurt**
Low-fat	American	Commercial
Whole (regular)	Cottage **	Low-fat
Skim (fat-free)	Monterey Jack	Regular
Non-fat dry	Swiss	Plain
Buttermilk	Mozzarella	Flavored
Cheddar	Ricotta **	
** Do not count the same slice of cheese as both milk and meat.* *** Double serving is required.*		

Meats and Meat Alternatives

Meats and meat alternatives food group supplies these key nutrients: protein, niacin, iron, and thiamin (vitamin B1) for muscle, bone, and blood cells and healthy skin and nerves.

Meats and Meat Alternatives		
Meats: canned, dried, fresh, and frozen		
Beef	Lamb	Pork
Chicken	Luncheon meats	Turkey
Fish/shellfish	Liver and other organ meats	Veal
Meat Alternatives		
Cheese*	Vegetable protein (when mixed with meat, poultry, fish)	
Dry beans		
Dry peas	Nuts/*Seeds* (peanuts, almonds, pecans, cashews, sunflower, and pumpkin *Seeds*)	
Eggs		
Lentils		
** Do not count the same slice of cheese as both milk and meat.*		

Vegetables and Fruits

Vegetables and fruits food groups supply these key nutrients: Vitamins A and C to sustain night vision, help resist infections, and heal wounds.

Vitamin A Sources in Vegetables and Fruits		
The vegetables and fruits listed below supply at least 750 international units of vitamin A per 1/4- or 1/2-cup serving. When these vegetables and fruits are served at least three times a week in recommended amounts along with a variety of additional vegetables and fruits used to meet the vegetables and fruits requirement, the vitamin A content generally meets half of the recommended dietary allowance for each age group.		
¼ **cup serving** (about 1,500 or more international units of vitamin A)		
Beet greens	Dandelion greens	Peppers, sweet, red
Carrots	Kale	Pumpkin
Chard, Swiss	Mangos	Sweet potatoes
Chili peppers, red	Mixed vegetables	Spinach
Collards	Mustard greens	Squash, winter (acorn, butternut, Hubbard)
Cress, garden	Peas and carrots (canned, frozen)	Turnip greens
¼ **cup serving** (about 750 to 1,500 international units of vitamin A)		
Apricots	Cantaloupe	Papayas
Broccoli	Chicory greens	Purple plums (canned)
½ **cup serving** (about 750 to 1,500 international units of vitamin A)		
Asparagus, green	Endive, curly	Prunes
Cherries, red sour	Escarole	Peaches (except canned)
Chili peppers, green (fresh)	Nectarines	Tomatoes, tomato juice, reconstituted paste, puree)

Vitamin C (ascorbic acid) Sources in Vegetables and Fruits		
The vegetables and fruits listed below supply about eight milligrams or more vitamin C per ¼-cup serving. When these vegetables and fruits are served daily in recommended amounts along with a variety of additional vegetables and fruits to meet the vegetables and fruits requirement, the vitamin C content generally meets half of the recommended dietary allowance for each age group.		
¼ **cup serving** (about 25 milligrams or more of vitamin C)		
Acerola	Chili peppers, red, green	Oranges
Broccoli	Guavas	Papayas
Brussels sprouts	Orange juice	Peppers, sweet, red, green

(continued)

Vitamin C (ascorbic acid) Sources in Vegetables and Fruits *(continued)*		
¼ cup serving (about 15 to 25 milligrams of vitamin C)		
Cauliflower	Grapefruit-orange juice	Mustard greens
Collards	Kale	Strawberries
Cress, garden	Kohlrabi	Tangerine juice
Grapefruit	Kumquats	Tangerines
Grapefruit juice	Mangos	Pineapple juice (vitamin C restored—canned)
¼ cup serving (about 8 to 15 milligrams of vitamin C)		
Asparagus	Okra	Tangelos
Cabbage	Raspberries, red	Turnip greens
Cantaloupe	Rutabagas	Turnips
Dandelion greens	Sauerkraut	Tomatoes
Honeydew melon	Spinach	Tomato juice (reconstituted paste, puree)
Potatoes (baked, boiled, steamed)	Potatoes (reconstituted, instant, mashed, vitamin C restored)	Sweet potatoes (except those canned in syrup)

Other Vegetables and Fruits		
Apples, applesauce	Dates	Peaches (canned)
Avocados	Eggplant	Pears
Bananas	Figs	Pimentos
Bean sprouts	Fruit cocktail	Pineapple
Beans, green, wax	Fruits for salads	Plums
Beets	Grapes	Radishes
Berries (black, blue)	Lettuce	Raisins
Celery	Mushrooms	Rhubarb
Chinese cabbage	Olives	Squash, summer
Corn	Onions	Watercress
Cranberries	Parsley	Peas and carrots (canned)
Cranberry sauce	Parsnips	Cowpeas, immature Seeds
Cucumbers	Watermelon	Potatoes (mashed, fried)
100% fruit juices (apple, grape, pineapple)		

Breads and Bread Alternatives

Breads and bread alternatives food group supplies these key nutrients: carbohydrate, thiamin (vitamin B1), iron and niacin for energy and a healthy nervous system.

Breads and Bread Alternatives *All of the following must be whole grain or enriched:*		
Sliced breads: French, raisin, rye, soy, white, whole wheat		
Crackers: graham, saltines, soda, melba toast, zwieback		
Bagels	English muffins	Rice
Barley	Farina	Rolled wheat or oats
Biscuits	Fruit breads	Rolls and buns
Boston brown bread	Grits	Soft pretzels
Bread sticks	Hush puppies	Sopapillas
Bulgur	Macaroni	Spaghetti
Chow mien noodles	Muffins	Spoon bread
Cornbread	Noodles	Sweet rolls
Croissants	Pancakes	Syrian bread (pita)
Dumplings	Pizza crust	Tortillas
Breakfast cereal (dry or cooked)	Ravioli pasta	Waffles

Iron

Serve several good sources of iron each day. The following table lists iron-rich food sources.

Meats and Meat Alternatives		
Dry beans and peas	Peanut butter	Turkey
Eggs	Shellfish	
Meats in general, especially liver and other organ meats		
Vegetables and Fruits		
Vegetables—dark green, leafy: beet greens, chard, collards, kale, mustard greens, spinach, turnip greens		
Fruits—dried: apples, apricots, dates, figs, peaches, prunes, raisins		
Apricots (canned)	Brussels sprouts	Potatoes (canned)
Asparagus (canned)	Cherries (canned)	Sauerkraut (canned)
Beets (canned)	Grapes (canned)	Squash (winter)
Broccoli	Parsnips	Sweet potatoes
Bean sprouts	Peas, green	Tomatoes (canned)
Beans — green, wax, lima (canned)	Vegetable juice (canned)	Tomato juice, paste, puree, sauce
Breads and Bread Alternatives		
All whole grain or enriched breads and bread alternatives		

Foods to Avoid

The following foods should be limited or omitted:		
Sugar-coated cereals	Sausage	Coffee
Potato chips	Candy	Tea
Snack chips	Doughnuts	Soft drinks
Bacon	Fruit-flavored drinks (use only 100% juice)	Brownies and cookies with icing
Rich pastries and other food high in sugar, fat, and salt		

Sample Meal Pattern

The following sample meal pattern is an aid to menu planning. The specific food items mentioned are used as an example.

Possible Food-Group Choices		
Breakfast or A.M. Snack	Milk and milk alternatives	½ cup
	Breads and bread alternatives	1 slice or 1 ounce
Lunch	Milk and milk alternatives	¾ cup
	Meats and meat alternatives	1-½ ounces
	Two servings of vegetables	¼ cup per serving
	Breads and bread alternatives	1 slice or 1 ounce
P.M. Snack	Fruits (or 100% fruit juice)	¼ cup

Example Menu Following the Meal Pattern		
Breakfast or A.M. Snack	Milk	½ cup
	Cereal	1 ounce
Lunch	Milk	¾ cup
	Roast beef	1-½ ounces
	New potatoes	¼ cup
	Spinach	¼ cup
	Whole wheat bread	1 slice
P.M. Snack	100% orange juice	¼ cup
[See RCCL 89-20.]		

Appendix V: Criminal History and Central Registry Background Checks

§745.11. What words must I know to understand [Chapter 745, Licensing]?

DFPS Rules, 40 TAC, effective 3/1/2002

The following words have the following meanings when used in this chapter:

(1) I, my, you, and your - An applicant or permit holder, unless otherwise stated.

(2) We, us, our, and Licensing - The Licensing Division of the Texas Department of [Family and Protective Services (DFPS)].

Subchapter F, Background Checks

Division 1, Definitions

§745.601. What words must I know to understand [Subchapter F, Background Checks]?

DFPS Rules, 40 TAC, effective 3/1/2002

These words have the following meanings:

(1) Frequently — More than two times in a 30-day period.

(2) Regularly — On a scheduled basis.

Division 2, Requesting Background Checks

§745.611. What are background checks?

DFPS Rules, 40 TAC, effective 3/1/2002

Background checks are searches of different databases. There are three types of background checks:

(1) Criminal history checks conducted by the Department of Public Safety for crimes committed in the state of Texas;

(2) Criminal history checks conducted by the Federal Bureau of Investigation for crimes committed anywhere in the United States; and

(3) Central registry checks conducted by [DFPS]. The Central Registry is a database of people who have been found by Child Protective Services, Adult Protective Services, or Licensing to have abused or neglected a child.

§745.613. What is the purpose of background checks?

DFPS Rules, 40 TAC, effective 3/1/2002

These checks are completed to determine whether:

(1) A person has any criminal or abuse and neglect history; and

(2) His presence is a risk to the health or safety of children in care.

§745.615. On whom must I request background checks?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) You must request background checks for each person 14 years or older, other than clients of the operation, who will regularly or frequently be present at your operation while children are in care, including:

(1) Employees, including those you intend to hire;

(2) Any person(s), including volunteers, who are counted in the child/caregiver ratio;

(3) Person(s) applying to adopt or foster children through any licensed child-placing agency; and

(4) Any person under contract with your operation who has unsupervised contact with children in care on a regular or frequent basis.

(b) You must also request background checks for the following:

(1) The directors, owners, operators, or administrators of the operation;

(2) Non-client residents of the operation that are 14 years or older; and

(3) Applicants for a child-care administrator's license.

(c) You do not have to request a background check on professionals who have cleared a background check through another governmental regulatory entity, and you do not employ or contract with the professional.

§745.617. If my operation is located in a large building that includes other businesses or services, must I request a background check on people working in the building who are not involved in my operation?

DFPS Rules, 40 TAC, effective 3/1/2002

You do not have to request a background check unless the individual is regularly or frequently present in the area of the building where the operation is located.

§745.619. For a registered family home that is also a foster home, must I request background checks on foster children who are over 14 years old?

DFPS Rules, 40 TAC, effective 9/16/2003

No. Foster children are considered clients.

§745.621. Must I request background checks on board members of corporations or associations who own or govern the operation?

DFPS Rules, 40 TAC, effective 3/1/2002

No, we do not require a background check unless the individual board member is also an employee or a volunteer who is counted in the child/caregiver ratio and will regularly or frequently be present at your operation while children are in care.

§745.623. How do I request a background check?

DFPS Rules, 40 TAC, effective 3/1/2002

You must verify and send us the following identifying information for every person required to be checked in §745.615 of this title (relating to On whom must I request background checks?), on a signed Licensing form provided by your local Licensing staff:

(1) Name (last, first, middle), including any maiden or married names or alias;

(2) Date of birth;

(3) Sex;

(4) Social security number;

(5) Current and previous address; and

(6) Race (this information does not have to be verified).

§745.625. When do I submit a request for a background check?

DFPS Rules, 40 TAC, effective 3/1/2002

You must submit a request for a background check:

(1) When you submit your application for a permit to us;

(2) When you hire a new person, but no later than two business days after the new person is hired or is present in your operation;

(3) When a non-client resident 14 years old or older lives or moves into your home or operation, or a non-client resident becomes 14 years old;

(4) When you apply to be a foster or adoptive parent; and

(5) Every 24 months after each person's name was first submitted.

§745.627. When should I request an FBI criminal history check?

DFPS Rules, 40 TAC, effective 3/1/2002

You should request FBI criminal history checks on persons who live outside of Texas or about whom there is reason to believe other criminal history exists. In these situations you must submit FBI fingerprints cards.

§745.629. How do I submit an FBI fingerprint card for a background check?

DFPS Rules, 40 TAC, effective 3/1/2002

We will provide you with a fingerprint card. The person who will be the subject of the FBI check must then go to his local law enforcement office or DPS office and have his fingerprints taken. Then you send the completed card to your local Licensing office.

§745.631. Must Licensing complete the background check(s) before issuing my permit?

DFPS Rules, 40 TAC, effective 9/16/2003

For registered or listed family homes and independent foster homes and foster group homes, we must receive the results from the background checks before the issuance of a permit. For all other permits, we may issue a permit to an applicant before we receive the results of the background checks.

§745.633. Can a child-placing agency (CPA) verify a foster home, foster group home, or adoptive home prior to receiving the results of the background checks?

DFPS Rules, 40 TAC, effective 3/1/2002

No, a CPA must receive a cleared background check from us before verifying the home.

§745.635. Can I do my own criminal history background checks?

DFPS Rules, 40 TAC, effective 3/1/2002

Yes, but your background checks will not replace those we must conduct. You must still send us all the information required in §745.623 of this title (relating to How do I request a background check?).

Division 3, Criminal Convictions and Central Registry Findings of Child Abuse or Neglect

§745.651. What types of criminal convictions may preclude a person from being present in an operation?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) A misdemeanor or felony under Title 5 (Offenses Against the Person), Title 6 (Offenses Against the Family), Chapter 29 (Robbery) of Title 7, Chapter 43 (Public Indecency) or §42.072 (Stalking) of Title 9, §15.031 (Criminal Solicitation of a Minor) of Title 4, §38.17 (Failure to Stop or Report Aggravated Sexual Assault of Child) of Title 8 of the Texas Penal Code (TPC), or any like offense under the law of another state or federal law;

(b) A misdemeanor or felony under the Texas Controlled Substances Act, §46.13 (Making a Firearm Accessible to a Child) or Chapter 49 (Intoxication and Alcoholic Beverage Offenses) of Title 10 of the Texas Penal Code, or any like offense under the law of another state or federal law that the person committed within the past ten years;

(c) Any other felony under the Texas Penal Code or any like offense under the law of another state or federal law that the person committed within the past ten years; and

(d) Deferred adjudications covering an offense listed in subsections (a)-(c) of this section, if the person has not completed the probation successfully.

§745.653. If a criminal history check reveals a criminal conviction other than those listed in §745.651 of this title (relating to What types of criminal convictions may preclude a person from being present in an operation?), will Licensing notify me of the results?

DFPS Rules, 40 TAC, effective 3/1/2002

Yes, we will notify you, but you will not be required to take any action.

§745.655. What types of central registry findings may preclude a person from being present in an operation?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) Any sustained finding of child abuse or neglect, including sexual abuse, physical abuse, emotional abuse, physical neglect, neglectful supervision, or medical neglect. For more information on sustained perpetrators, see Division 5 of this subchapter (relating to Designated and Sustained Perpetrators of Child Abuse or Neglect); and

(b) Any central registry finding of child abuse or neglect (whether sustained or not), where we have determined the presence of the person in a child-care operation poses an immediate threat or danger to the health and safety of children. For more information on immediate threat, see Division 6 of this subchapter (relating to Immediate Threat or Danger to the Health or Safety of Children).

§745.657. What is the consequence of having one of these types of criminal convictions or central registry findings?

DFPS Rules, 40 TAC, effective 3/1/2002

There are three possible consequences of having either a conviction listed in §745.651 of this title (relating to What types of criminal convictions may preclude a person from being present in an operation?), or a central registry finding listed in §745.655 of this title (relating to What types of central registry findings may preclude a person from being present in an operation?):

(1) A person is permanently barred and must not be present at an operation while children are in care;

(2) A person is temporarily barred and may not be present at an operation while children are in care pending the outcome of the administrative review and due process hearing;

(3) A person must not be present at a child-care operation while children are in care, unless a risk evaluation is approved. See Division 4 of this subchapter (relating to Evaluation of Risk Because of a Criminal Conviction or a Central Registry Finding of Child Abuse or Neglect).

§745.659. What will happen if a person at my child-care operation has a criminal conviction or a central registry finding?

DFPS Rules, 40 TAC, effective 3/1/2002

We will notify the child-care operation in writing:

(1) Of any criminal conviction listed under §745.651 of this title (relating to What types of criminal convictions may preclude a person from being present in an operation?), and any central registry finding listed in §745.655(a) of this title (relating to What types of central registry findings may preclude a person from being present in an operation?), including whether:

(A) This conviction or finding permanently bars this person from being present at an operation while children are in care, or whether you may request a risk evaluation for this person; and

(B) If this person is eligible for a risk evaluation, whether this person may be present at your child-care operation while children are in care pending the outcome of the risk evaluation.

(2) Of any central registry finding listed in §745.655(b) of this title. The notification letter will inform you that this person has not at this time had any due process regarding this matter. However, if we determine that he is an immediate threat or danger to the health or safety of children, you must immediately remove him from contact with children. We will subsequently notify your operation of any future decisions regarding this matter, including whether the person may have contact with children.

§745.661. What must I do after Licensing notifies me that a person at my operation has one of these types of criminal convictions or central registry findings?

DFPS Rules, 40 TAC, effective 3/1/2002

You must take appropriate action, which may include immediately removing this person from your child-care operation while the children are in care, and/or requesting a risk evaluation for this person. Your decision in this matter should be based upon the information provided to you, as specified in §745.659 of this title (relating to What will happen if a person at my child-care operation has a criminal conviction or a central registry finding?).

§745.663. What if the person with the criminal conviction or central registry finding believes the information obtained is incorrect?

DFPS Rules, 40 TAC, effective 3/1/2002

Your responsibilities are the same as noted in §745.661 of this title (relating to What must I do after Licensing notifies me that a person at my operation has one of these types of criminal convictions or central registry findings?). However, you may contact the local Licensing staff who sent the notice letter to discuss the accuracy of the information. For criminal convictions, you may conduct an FBI fingerprint check to determine the accuracy of the conviction.

Division 4, Evaluation of Risk Because of a Criminal Conviction or a Central Registry Finding of Child Abuse or Neglect

§745.681. When may I request a risk evaluation?

DFPS Rules, 40 TAC, effective 3/1/2002

You may request a risk evaluation when:

(1) We have informed you that the person with the criminal conviction or central registry finding of child abuse or neglect is eligible for a risk evaluation; and

(2) You believe the person with the criminal conviction or central registry finding (this may be yourself in some situations) does not pose a risk to the health or safety of children.

§745.683. Who is responsible for submitting a request for a risk evaluation?

DFPS Rules, 40 TAC, effective 9/16/2003

(a) If the person with the criminal conviction or central registry finding is an independent foster home parent or a family home caregiver, then he must request the risk evaluation for himself;

(b) If the person with the criminal conviction or central registry finding is a child-placing agency foster parent or adoptive parent, then the child-placing agency must request the risk evaluation; and

(c) For everyone else, the governing body, director, designee, foster home parent, or family home caregiver, as appropriate, must request the risk evaluation.

§745.685. How do I submit a request for a risk evaluation?

DFPS Rules, 40 TAC, effective 3/1/2002

You must obtain a risk evaluation form from your local Licensing office, complete the form, attach the appropriate documentation, and send the form back to your local Licensing office.

§745.687. What must I include in my request for a risk evaluation based on criminal history?

DFPS Rules, 40 TAC, effective 3/1/2002

You must include the following:

(1) A completed Request for Risk Evaluation Based on Past Criminal History or Central Registry Findings form;

(2) A valid rationale of why the person does not pose a risk to the health or safety of children;

(3) A copy of the record of judicial finding or conviction;

(4) If the individual was incarcerated:

(A) A copy of local, state, or federal release order;

(B) The date the individual was released from incarceration; and

(C) If applicable, the terms and conditions of parole;

(5) If the person was given a probated sentence, information related to the terms and conditions of the probation;

(6) The nature and seriousness of the crime for which he was convicted;

(7) The extent and nature of the person's past criminal history;

(8) Age of the person when the crime was committed;

(9) The time that has elapsed since the person's last criminal activity;

(10) Evidence of rehabilitative effort;

(11) The conduct and work activities of the person;

(12) Other evidence of the person's present fitness, including letters of recommendation from the prosecuting attorney, law enforcement, and correctional officers who were involved in the case;

(13) Documentation showing that the person has maintained a record of steady employment, has supported his children, has maintained a record of good conduct, and has paid any outstanding court costs, fees, fines, and restitution related to the conviction or deferred adjudication; and

(14) If the person is an employee or volunteer or potential employee or volunteer, information about his anticipated job responsibilities, plans for supervision, and hours and days of service.

§745.689. What must I include in my request for a risk evaluation based on a central registry finding?

DFPS Rules, 40 TAC, effective 3/1/2002

You must include the following:

(1) A completed Request for Risk Evaluation Based on Past Criminal History or Central Registry Findings form;

(2) A valid rationale that the person who has a central registry finding does not pose a risk to the health or safety of children;

(3) The final child abuse or neglect investigation report (Note: If the requester does not have a copy of the record, then the local Licensing staff should include this information in the request.);

(4) Nature and seriousness of the abuse or neglect finding(s);

(5) The extent and nature of the person's past abuse or neglect history;

(6) Age of the person at the time of the abuse or neglect;

(7) The time that has elapsed since the person's last abuse or neglect activity;

(8) Evidence that factors which impact the risk of future abuse or neglect have changed;

(9) Other evidence of the person's present fitness, including letters of recommendation from employers, caseworker, or others who have or have had contact with the person;

(10) The conduct and work activity of the person;

(11) Documentation showing that the person has maintained a record of steady employment, has supported his dependents, and has maintained a record of good conduct; and

(12) If the person is an employee or volunteer or potential employee or volunteer, information related to job responsibilities that would be performed, plans for supervision, and hours and days of service.

§745.691. Will Licensing accept incomplete requests for risk evaluation?

DFPS Rules, 40 TAC, effective 3/1/2002

No. We will return your request if it does not include all of the information listed in §745.687 and §745.689 of this title (relating to What must I include in my request for a risk evaluation based on criminal history? and What must I include in my request for a risk evaluation based on a central registry finding?).

§745.693. In what circumstances can someone with a criminal history be present in a child-care operation?

DFPS Rules, 40 TAC, effective 9/16/2003

(a) The following chart lists the types of criminal convictions that we monitor, whether the person with the conviction is eligible for a risk evaluation, and whether he may be present in a child-care operation while children are in care pending the outcome of the risk evaluation:

Type of Criminal Conviction	Is This Person Eligible for a Risk Evaluation?	If This Person Is Eligible for a Risk Evaluation, May the Person be Present at a Child-Care Operation While Children are in Care Pending the Outcome of the Risk Evaluation?
(1) A felony conviction of an offense under Title 5, Title 6, Chapter 29 of Title 7, Chapter 43 or §42.072 of Title 9, §15.031 of Title 4, or §38.17 of Title 8 of the Texas Penal Code (TPC), or any like offense under the law of another state or federal law.	No, this person is permanently barred from being present at a child-care operation while children are in care.	Not applicable, because this person is not eligible for a risk evaluation.
(2) A misdemeanor conviction of an offense under Title 5, Title 6, Chapter 29 of Title 7, Chapter 43 or §42.072 of Title 9, §15.031 of Title 4, or §38.17 of Title 8 of the TPC, or any like offense under the law of another state or federal law.	No, for listed and registered family homes this person is permanently barred from being present in the family home while children are in care. Yes, for all other types of child-care operations this person is eligible for a risk evaluation.	Not applicable for listed and registered family homes, because this person is not eligible for a risk evaluation. Yes, for all other types of child-care operations, if we previously gave written approval for the person to remain at the operation with the same conviction in question.
(3) A felony or misdemeanor conviction of an offense under the Texas Controlled Substances Act or §46.13 or Chapter 49 of Title 10 of the TPC, or any like offense under the law of another state or federal law that the person committed within the past ten years.	Yes	Yes, if we previously gave written approval for the person to remain in the operation with the same conviction in question.
(4) A felony conviction of an offense under any other title of the TPC, or any like offense under the law of another state or federal law that the person committed within the past ten years.	Yes	Yes, if we previously gave written approval for the person to remain in the operation with the same conviction in question.

(b) We will treat a deferred adjudication the same as a conviction until the probation is successfully completed.

§745.695. In what circumstances can someone with a central registry finding be present in a child-care operation?

DFPS Rules, 40 TAC, effective 3/1/2002

The following chart lists the general types of central registry findings that we can release to you, whether the person with the finding is eligible for a risk evaluation, and whether he may be present in a child-care operation while children are in care pending the outcome of the risk evaluation:

Types of Findings for Child Abuse or Neglect	Is This Person Eligible for a Risk Evaluation?	If This Person Is Eligible for a Risk Evaluation, May the Person be Present at a Child-Care Operation While Children are in Care Pending the Outcome of the Risk Evaluation?
(1) A Sustained Finding of Physical Abuse.	No, this person is permanently barred from being present at a child-care operation while children are in care.	Not applicable, because this person is not eligible for a risk evaluation. This person must not be present at an operation while children are in care.
(2) A Sustained Finding of Sexual Abuse.	No, this person is permanently barred from being present at a child-care operation while children are in care.	Not applicable, because this person is not eligible for a risk evaluation. This person must not be present at an operation while children are in care.
(3) A Sustained Finding of Emotional Abuse.	Yes	Yes, if we previously approved a risk evaluation for the same finding, the more recent check does not reveal new information about the finding, and the circumstances of the person's contact with children at the operation are the same as when we approved the risk evaluation.
(4) A Sustained Finding of Neglect (including neglectful supervision and medical neglect).	Yes	Yes, if we previously approved a risk evaluation for the same finding, the more recent check does not reveal new information about the finding, and the circumstances of the person's contact with children at the operation are the same as when we approved the risk evaluation.
(5) A Finding, Not Already Sustained, of Any Child Abuse or Neglect Previously Mentioned In This Chart, Where We Have Determined the Presence of the Person In a Child-Care Operation Is an Immediate Threat or Danger to the Health or Safety of Children.	No, this person is temporarily barred from being present at a child-care operation while children are in care.	Not applicable, because this person is not eligible for a risk evaluation. This person must not be present at an operation while children are in care. Note: The removal from contact with children is not permanent until the finding is sustained. If the State Office of Administrative Hearings overturns the finding, then there will no longer be a central registry finding, and the person may be present at an operation.

§745.697. Is an approved risk evaluation permanent?

DFPS Rules, 40 TAC, effective 3/1/2002

An operation does not have to request a risk evaluation for the same criminal conviction or central registry finding that a previous background check revealed if:

(1) We previously approved a risk evaluation for the same finding or criminal conviction;

(2) The more recent check does not reveal a new finding or criminal conviction; and

(3) The circumstances of the person's contact with children at the operation are the same as when we approved the risk evaluation.

§745.699. What should I do if a person in my child-care operation is currently the subject of a criminal investigation?

DFPS Rules, 40 TAC, effective 3/1/2002

You must report the investigation to us once there is a criminal indictment for a felony or a criminal information for a misdemeanor.

§745.701. May a person charged with a crime be present in an operation while children are in care?

DFPS Rules, 40 TAC, effective 3/1/2002

We determine on a case-by-case basis whether someone charged with a crime may be present in an operation while children are in care. The person may not be present if a conviction for the charged offense would prohibit him from being at the operation pending the outcome of a risk evaluation, or if we determine that he poses an immediate threat to the health or safety of children.

§745.703. If I have knowledge that a person has a criminal conviction or central-registry finding, can he be present in my operation while children are in care?

DFPS Rules, 40 TAC, effective 3/1/2002

This person may be present in your operation while children are in care if you have requested a background check under §745.613 of this title (relating to What is the purpose of background checks?), and:

(1) The results do not indicate that he has a criminal conviction or a central-registry finding that may preclude him from being present in an operation while children are in care under §745.651 and §745.655 of this title (relating to What types of criminal convictions may preclude a person from being present in an operation? and What types of central registry findings may preclude a person from being present in an operation?); or

(2) We have approved a risk evaluation on him.

§745.705. What must I do if a person in my child-care operation is the subject of an abuse or neglect investigation?

DFPS Rules, 40 TAC, effective 3/1/2002

If you have knowledge that Child Protective Services is conducting an investigation, you must report this to us immediately. The person under investigation by us or CPS may have contact with children unless we determine that he poses an immediate threat or danger to the health or safety of children.

§745.707. Who makes the final decision on a risk evaluation?

DFPS Rules, 40 TAC, effective 7/1/2004

The Director of Licensing or his designee reviews the risk evaluation request and determines whether or not a person with a criminal conviction or central registry finding poses a risk to children in a particular operation. If a child day-care operation requests the evaluation, the designee will be a regional director. If a residential operation requests the evaluation, the designee will be a division administrator.

§745.709. What is the basis of the risk evaluation decision?

DFPS Rules, 40 TAC, effective 3/1/2002

We base the risk evaluation decision upon all of the information submitted under §745.687 or §745.689 of this title (relating to What must I include in my request for a risk evaluation based on criminal history? and What must I include in my request for a risk evaluation based on a central registry finding?), the compliance history and regulatory status of the operation, the role and responsibility of the person in his current position, and any federal requirements for adoptive and foster parents regarding criminal convictions.

§745.711. What can I do if I disagree with the risk evaluation decision?

DFPS Rules, 40 TAC, effective 3/1/2002

You have no rights to have a risk evaluation decision reviewed or appealed.

Division 5, Designated and Sustained Perpetrators of Child Abuse or Neglect

§745.731. What are designated perpetrators and sustained perpetrators of child abuse or neglect?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) A designated perpetrator is a person on the [DFPS] central registry found by [DFPS] to have abused or neglected a child, but who has not exhausted his right to an administrative review or due process hearing. See Subchapter M of this chapter (relating to Administrative Reviews and Due Process Hearings).

(b) A sustained perpetrator is also a person on the [DFPS] central registry found by [DFPS] to have abused or neglected a child, but who has already been offered his rights to an administrative review and due process hearing, and the:

(1) Designated perpetrator's rights to the administrative review and due process hearing have expired; or

(2) Finding was upheld in the due process hearing.

§745.733. Will Licensing release a central registry finding on a designated perpetrator or sustained perpetrator to my operation?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) In most situations, we will not release the central registry finding for a designated perpetrator until the designated perpetrator's rights to dispute the finding have been completed. However, there are some instances where we may release the central registry finding on a designated perpetrator before his rights to dispute the finding have been completed. We may release the central registry finding to:

(1) Your operation if we determine the presence of the designated perpetrator is an immediate threat or danger to the health or safety of children. In this situation we will also instruct you that this person must be immediately removed from contact with children;

(2) Individuals who have control over the designated perpetrator's access to children, if we determine the presence of the designated perpetrator is an immediate threat or danger to the health or safety of children;

(3) A court for the purpose of justifying a request for appropriate judicial relief; or

(4) Parents of children in care when we determine the information is necessary to meet a child's needs.

(b) We may release the central registry finding for a sustained perpetrator without any further notification from [DFPS] to:

(1) Operations with licensing permits or an application for a permit; and

(2) Individuals who have control over the sustained perpetrator's access to children.

§745.735. What notice will Licensing send a designated perpetrator or a sustained perpetrator working at an operation?

DFPS Rules, 40 TAC, effective 3/1/2002

(a) We will notify the designated perpetrator:

(1) Of the abuse or neglect finding;

(2) Whether we will release the finding to his employer prior to or after the administrative and/or due process hearing is completed; and

(3) Of his rights to an administrative review and due process hearing with instructions on how to request them.

(b) We will not notify a sustained perpetrator of the central registry finding or of any subsequent release of the finding. We notified him of his rights when we designated him as a perpetrator.

Division 6, Immediate Threat or Danger to the Health or Safety of Children

§745.751. What factors does Licensing consider when determining if a person or an operation is an immediate threat to the health or safety of children?

DFPS Rules, 40 TAC, effective 3/1/2002

We consider the following:

(1) The severity of the deficiency, including abuse or neglect;

(2) The circumstances surrounding the deficiency, including abuse or neglect:

(3) The seriousness of any injuries to children;

(4) The length of time since the deficiency, including abuse or neglect, occurred;

(5) Whether the deficiency has been repeated;

(6) The compliance history of the operation;

(7) The current regulatory status of the operation;

(8) How quickly corrections to the deficiency can be made;

(9) If any corrections have already been made:

(10) The role of the person in the abuse or neglect;

(11) The current position, role, and responsibilities of the person; and

(12) The degree and/or immediacy of the threat or danger.

§745.753. How will I know whether Licensing has determined that a person or my operation poses an immediate threat or danger to the health or safety of children?

DFPS Rules, 40 TAC, effective 3/1/2002

We will notify the person and/or the operation in the original notice of the decision or action that we are taking. The notice will indicate that we have determined the person or the operation poses an immediate threat or danger to the health or safety of children and whether the person may continue to work in their present position or the operation may continue to operate pending the outcome of the administrative review and due process hearing.

Appendix VI: Behavior Intervention Rules

Behavior Intervention Precedence

DFPS Rules, 40 TAC §720.1002, effective 9/1/2000

Sections 720.1001 [(see Glossary) through] 720.1013 of this [Appendix] (relating to Definitions, Behavior Intervention Precedence, Required Behavior Intervention Policies and Procedures, Less Restrictive Behavior Interventions, Restraint and Seclusion: General Requirements, Emergency Medication, Personal Restraint, Mechanical Restraint, Protective Devices, Supportive Devices, Seclusion, Behavior Intervention Training, and Evaluation of Behavior Interventions) take precedence over all other rules in [these standards], in the event of a conflict.

Required Behavior Intervention Policies and Procedures

DFPS Rules, 40 TAC §720.1003, effective 3/1/2006

(a) All child-care facilities and child-placing agencies must have policies and procedures consistent with §§720.1001 through 720.1013 of this [Appendix] (relating to Definitions [see Glossary], Behavior Intervention Precedence, Required Behavior Intervention Policies and Procedures, Less Restrictive Behavior Interventions, Restraint and Seclusion: General Requirements, Emergency Medication, Personal Restraint, Mechanical Restraint, Protective Devices, Supportive Devices, Seclusion, Behavior Intervention Training, and Evaluation of Behavior Interventions) addressing behavior interventions.

(b) These policies and procedures must include a complete description of permitted behavior interventions.

(c) The child-care facility and/or child-placing agency must set, in its behavior intervention policies, the specific intervention techniques that will be used within the parameters set by minimum standards.

(d) The facility's behavior intervention procedures must include all child-care facility and/or child-placing agency requirements for and restrictions on the use of permitted interventions.

(e) The facility must notify the Department of Family and Protective Services of any changes to these policies and procedures before implementation of the changes.

(f) The child-care facility and/or child-placing agency must follow its written behavior intervention policies and procedures.

(continued)

(g) The child-care facility must post the behavior interventions allowed in the child-care facility in a place where the children/clients can view them, or at admission, must provide each child and the child's parent or managing conservator with a personal copy of the facility's behavior intervention policies.

(h) Prior to or at admission, a caregiver must explain to children, based on their level of functioning and comprehension, the child-care facility's policies and practices on the use of restraint. The explanation must include who can use a restraint, the actions caregivers must first attempt to defuse the situation and avoid the use of restraint, the kinds of situations in which restraint may be used, the types of restraints authorized by the agency under which the home operates, when the use of a restraint must cease, what action the child must exhibit to be released from the restraint, and the way to report an inappropriate restraint. This explanation must be documented in the child's record.

(i) Prior to or at admission, children must be notified, based on their level of functioning and comprehension, of their right to voluntarily provide comments on any restraint or seclusion, including the incident that led to the restraint/seclusion and the manner in which staff intervened, in which they are the subject or to which they are a witness. This notification must include an explanation of the process for submitting such comments, which must be easily understood and accessible. This notification need not be made after every restraint and seclusion that occurs at the facility as long as the process for submitting such comments has been made clear and accessible. For example, a facility could create a standardized form that is easily accessible or give children the permission to submit such comments on regular paper to any staff person.

(j) A child-care facility and/or child-placing agency may not discharge or otherwise retaliate against:

   (1) An employee, client, resident, or other person because the employee, client, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility; or

   (2) A client or resident of the facility because someone on behalf of the client or resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility.

Less Restrictive Behavior Interventions

DFPS Rules, 40 TAC §720.1004, effective 9/1/2000

(a) A child-care facility and/or child-placing agency's policies and procedures must address the use of less restrictive and intrusive behavior interventions as preventive measures and de-escalating interventions to avoid the need for the use of restraint or seclusion.

(b) A child-care facility and/or child-placing agency's policies and procedures must require that caregivers attempt and prove ineffective preventive, de-escalative, and less restrictive techniques before the emergency use of restraint or seclusion.

(c) Less restrictive measures may include, but are not limited to, quiet time and time out.

(d) If a caregiver uses physical force or a physical barrier to restrain a child or prevent a child from leaving a quiet time or time out, the intervention becomes a personal restraint regulated under §720.1007 of this [Appendix] (relating to Personal Restraint) or seclusion regulated under §720.1011 of this [Appendix] (relating to Seclusion).

Restraint and Seclusion: General Requirements

DFPS Rules, 40 TAC §720.1005, effective 9/1/2000

(a) Before the use of restraint or seclusion, a caregiver qualified in behavior intervention must make the determination that the situation is an emergency situation. The basis for this decision must be documented.

(b) Any form of restraint or seclusion may only be administered by a caregiver qualified in behavior intervention.

(c) No type of restraint or seclusion may be used as:

(1) punishment;

(2) a convenience for caregivers; or

(3) a substitute for program treatment.

(d) All reports to Licensing of child death, suicide attempts, and incidents in which a child experiences substantial bodily harm must include the complete documentation of any emergency medications, restraints, and/or seclusions which were implemented within 48 hours prior to the incident.

Emergency Medication

DFPS Rules, 40 TAC §720.1006, effective 9/1/2000

(a) General.

(1) The use of emergency medication is only permitted in emergency situations and only when ordered by a licensed physician.

(2) The use of chemical restraint is prohibited.

(3) The use of chemical sprays, drops, ointments, or any form of topically-administered substance, including tear gas and pepper sprays, for emergency medication is prohibited.

(4) Medications that have a secondary effect of immobilizing or sedating a child or modifying the behavior of a child, but are administered solely for medical reasons other than immobilizing or sedating a child or modifying the behavior of the child (e.g. Benadryl for an allergic reaction or medication to control seizures) are not emergency medications or chemical restraints and are not regulated as such under this chapter [DFPS Rules, 40 TAC Chapter 720.]

(b) Orders for emergency medication.

(1) A licensed physician's order allowing emergency medication must include information on administering the medication and a complete description of the behaviors (e.g. hitting, biting, kicking) and circumstances under which medication may be administered to restrain the child.

(2) The physician ordering emergency medication must first take into consideration any potential medical contraindications, including psychiatric contraindications such as sexual abuse, and behavioral contraindications such as substance abuse.

(3) The physician ordering emergency medication may use PRN orders as long as all of the information in paragraphs (1) and (2) of this subsection is included in the order. PRN orders for emergency medication must be reviewed by the physician at least every three months.

(continued)

(4) If a child has been restrained with emergency medication more than twice within a 30-day period, the physician, along with the treatment team and a licensed psychiatrist, must review the child's placement, treatment plan, and the orders for emergency medication within 30 calendar days of the third emergency medication. The review must include an examination of alternatives for managing the child's behavior and the establishment of a plan for reducing the need for emergency medication. In the instances when a child does not have a treatment team or a treatment plan, the orders for emergency medication must be reviewed by the physician, a licensed psychiatrist, and the person responsible for developing the child's plan of service. In emergency shelters, the orders for emergency medication must be reviewed by the administrator of the emergency shelter, the physician, and a licensed psychiatrist. This review must take place as soon as possible and no later than 30 days after the third emergency medication. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the third emergency medication. This review must be documented in the child's record.

(c) Implementation of emergency medication.

(1) A caregiver qualified in behavior intervention must administer the medication only after conducting an assessment of the precipitating behaviors and circumstances and determining that an emergency situation exists.

(2) Emergency medication may be simultaneously implemented in combination with personal restraint, seclusion, or mechanical restraint only if specifically allowed by the written orders and only if the specified restraint(s) or seclusion are allowed in the facility by the rules in this section. These orders must include clinical justification for the combination.

(A) Clinical justification for the combination of emergency medication and personal restraint must be provided by the physician ordering the emergency medication.

(B) Clinical justification for the combination of emergency medication with mechanical restraint must be coordinated and provided by both the psychiatrist ordering the mechanical restraint and the physician ordering the emergency medication, if they are different persons.

(C) Clinical justification for the combination of emergency medication with seclusion must be coordinated and provided by both the psychiatrist or psychologist ordering the seclusion and the physician ordering the emergency medication, if they are different persons.

(continued)

(3) A child must be provided with an opportunity to discuss the situation which led to the need for emergency medication and the caregiver's reaction to that situation privately as soon as possible and no later than 48 hours after the cessation of the emergency medication. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child's reaction to those strategies; and the restraint itself and the child's reaction to the restraint.

(4) Caregivers involved in the emergency medication must make every attempt to debrief concerning the incident.

(d) Documentation of emergency medication.

(1) The use of emergency medication must be documented in the child's record as soon as possible and no later than 24 hours after the initiation of the restraint.

(2) Documentation must include:

(A) the child's name;

(B) a description and assessment of the precipitating circumstances and the specific behaviors which constituted the emergency situation;

(C) the use of alternative strategies attempted before the use of emergency medication and the child's reaction to those strategies;

(D) the time the emergency medication was administered;

(E) the name of the caregiver(s) participating in the intervention that led to the need for emergency medication and the name of the caregiver(s) who administered the emergency medication;

(F) the specific medication used;

(G) any injury the child sustained as a result of the incident or any adverse effects caused by the use of medication;

(H) the actions the caregiver took to facilitate the child's return to normal activities following the end of the emergency medication; and

(I) the child's reaction to the opportunity offered in subsection (c)(3) of this section, the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself, (if applicable).

Personal Restraint

DFPS Rules, 40 TAC §720.1007, effective 3/1/2006

(a) General.

(1) Personal restraint may only be used in emergency situations as defined in [the Glossary] (relating to Definitions), or to administer intra-muscular medication or other medical treatments prescribed by a physician. In situations where a child is significantly damaging property, but is not posing a risk of harm to himself or others, a short personal restraint may be used to intervene only to immediately prevent the damage and only if less restrictive techniques have been attempted and have failed. The child must be released from this restraint as soon as the damaging behavior has been de- escalated. A personal restraint used to intervene in significant property damage is regulated as a personal restraint under this chapter.

(2) The interventions listed in [the following] subparagraphs (A) - (C) … are not subject to the requirements of paragraph [(a)(4), below] … or subsections (b), (d), and (e) of this [rule, §720.1007]. Any serious incident report of an injury resulting from a short personal restraint that is made to Licensing must include documentation of the restraint and the precipitating circumstances and specific behaviors which led to the restraint.

(A) Short personal restraints that last no longer than one minute.

(B) A short personal restraint used to intervene in a situation of imminent significant risk when a child's behavior is being restrained because of an external hazard and caregivers must protect the child, particularly a young child, from immediate danger — for example, preventing a toddler from running into the street or coming in contact with a hot stove. The restraint must end immediately after the danger is averted.

(C) A short personal restraint used as a physical response to intervene when a child under the age of five (chronological or developmental age) demonstrates disruptive behavior, such as a tantrum in a public place. The physical response must be an appropriate response to the disruptive behavior and efforts to de-escalate the behavior must have failed. The restraint must end as soon as the disruptive behavior has been de-escalated.

(3) Before the use of personal restraint, other preventive, de-escalative, less restrictive techniques must be attempted and proven ineffective at defusing the situation.

(continued)

(4) A facility must have procedures for addressing the administration of more than three personal restraints of the same child within a seven-day period. Procedures for addressing the frequency of the interventions must include either individualized, written orders allowing for more frequent restraints, recommendations from the child's treatment team which allow for more frequent restraints, or a retroactive review of the frequent restraints and the child's behavior that necessitated the restraints.

(A) Written orders for personal restraint must meet the requirements outlined in subsection (b) of this [rule, §720.1007,] and must include clinical justification and a plan for reducing the need for personal restraint.

(B) Recommendations from a treatment team allowing for more frequent restraints must meet the requirements outlined in subsection (b) of this [rule, §720.1007,] and must include clinical justification and a plan for reducing the need for personal restraint.

(C) A retroactive review of frequent restraints must include a review of the records of the personal restraints, an examination of alternatives for managing the child's behavior, and the establishment of a plan for reducing the need for personal restraint.

(i) The review must be conducted as soon as possible and no later than 30 days after the fourth personal restraint by the persons responsible for the child's plan of service and/or treatment. The review must meet the requirements of a service plan or treatment team review.

(ii) The review must include consideration of potential medical (including psychiatric) contraindications, including a child's history of physical or sexual abuse. This consideration must be documented.

(iii) The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the fourth restraint.

(iv) The review must be documented.

(v) If there are more than three such reviews within a 90-day period, the child must be examined by a licensed psychiatrist, a licensed psychologist, a licensed master social worker with advanced clinical practice, or a licensed professional counselor. The professional conducting the examination must make treatment plan or plan of service recommendations regarding the use of personal restraint.

(continued)

(b) Recommendations or written orders for personal restraint.

(1) A licensed psychiatrist or licensed psychologist may write orders for the use of personal restraint for a specific child. A child's treatment team may write recommendations for the use of personal restraint for a specific child. Orders and treatment team recommendations must state that personal restraint may only be used in emergency situations.

(2) The psychiatrist or psychologist ordering personal restraint or the treatment team recommending personal restraint must first take into consideration any potential medical (including psychiatric) contraindications, including a child's history of physical or sexual abuse. This consideration must be documented in the child's records.

(3) The psychiatrist or psychologist ordering personal restraint may use PRN orders. PRN orders for personal restraint must be reviewed by the psychiatrist or psychologist at least every three months. The review must be documented in the child's record.

(4) Orders and treatment team recommendations for personal restraint must designate the specific procedure authorized, including any specific measures for ensuring the child's health, safety, and well-being, and the protected, private nature of the setting.

(5) Orders and treatment team recommendations must include the circumstances under which the intervention may be used, instructions for observation of the child while in restraint, the behaviors that indicate the child is ready to be released from restraint, the number of times a child may be restrained in a seven-day period, and the amount of time the child may be restrained regardless of behaviors exhibited.

(c) Implementation of personal restraint.

(1) When personal restraint is appropriate, it must be discontinued as soon as the child's behavior no longer constitutes an emergency situation.

(continued)

(2) Personal restraint must be initiated in a way that minimizes the risk of physical discomfort, harm, or pain to the child. Only the minimal amount of reasonable and necessary physical force may be used to implement personal restraint. During any personal restraint, a caregiver qualified in behavior intervention must monitor the child's breathing and other signs of physical distress and take appropriate action to ensure adequate respiration, circulation, and overall well-being. The caregiver monitoring the child should not be the same caregiver that is restraining the child. Appropriate action includes responding prudently to a potentially life-threatening situation when a child indicates he cannot breathe. Any personal restraint that employs a technique listed in [the following] subparagraphs (A) - (D) … is prohibited:

(A) restraints that impair the child's breathing by putting pressure on the child's torso;

(B) restraints that obstruct the child's airway, including a procedure that places anything in, on, or over the child's mouth, nose, or neck;

(C) restraints that obstruct the caregiver's view of the child's face; or

(D) restraints that interfere with the child's ability to communicate.

(3) A person qualified in behavior intervention:

(A) May use a prone or supine hold on a child in care only:

(i) As a transitional hold that lasts no longer than one minute;

(ii) As a last resort when other less restrictive interventions have proven to be ineffective; and

(iii) When an observer who is not continuously involved in the restraint ensures the child's breathing is not impaired. The observer must be trained in the risks associated with the use of prone and supine restraints, including positional, compression, or restraint asphyxia. Child-care facilities with a capacity of 50 or fewer children, including foster and foster group homes, are exempt from meeting this observation requirement.

(B) May use other types of personal restraint techniques permitted by facility policy:

(i) For a maximum time of one hour for children and adolescents ages 9 to 17 years.

(ii) For a maximum time of 30 minutes for children under age nine years.

(continued)

(4) Continuation of personal restraint(s) beyond the stated maximum is permitted only if an order from a licensed psychiatrist allowing for the continuation exists. Such an order must meet all of the criteria in subsection (b) of this [rule, §720.1007,] and must include a clinical justification for the amount of time it permits the child to be restrained.

(5) Only a caregiver qualified in behavior intervention may apply personal restraint.

(6) When a child must be personally restrained, the caregiver must consider the characteristics of the immediate physical environment and the permitted forms of personal restraint and act to protect the child's safety. Caregivers must make every effort to act to protect the child's privacy, including shielding the child from onlookers. Caregivers must make every effort to act to protect the child's personal dignity and well-being, including ensuring that the child's body is appropriately covered.

(7) If an emergency health situation occurs during personal restraint, the child must be released immediately and treatment obtained.

(8) As soon as possible after personal restraint is started, appropriate caregiver(s) must explain to the child in restraint the behaviors the child must exhibit to be released from the restraint or have the restraint reduced, and permit the child to make suggestions about what actions the caregiver(s) can take to help the child de-escalate.

(9) If the child does not appear to understand what action he must take to be released from the restraint, the caregiver(s) must attempt to re-explain it every 15 minutes until understanding is reached or the child is released from restraint.

(10) Personal restraint may be simultaneously implemented in combination with emergency medication only if specifically allowed by written orders and only if the specified restraint(s) is allowed in the facility by the rules in this section. These orders must include clinical justification for the combination. The clinical justification for the combination of emergency medication and personal restraint must be provided by the physician ordering the emergency medication.

(continued)

(d) Personal restraint follow-up.

(1) When a child is released from personal restraint, the caregiver(s) must take appropriate actions to help the child return to normal activities. A child does not have to return to the activities he was engaged in prior to the restraint or the activities in which the group is participating at the time the child is released from restraint. The actions of the caregiver(s) must include:

(A) providing the child with an appropriate transition and offering the child an opportunity to return to regular activities;

(B) observing the child for at least 15 minutes; and

(C) providing the child with an opportunity to discuss the situation which led to the need for personal restraint and the caregiver’s reaction to that situation privately as soon as possible and no later than 48 hours after the release from restraint. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child’s reaction to those strategies; and the restraint itself and the child’s reaction to the restraint.

(2) Staff involved in the personal restraint must make every attempt to debrief concerning the incident.

(e) Documentation of personal restraint. The use of personal restraint must be documented as soon as possible and no later than 24 hours after the initiation of the restraint. Documentation must include:

(1) the child’s name;

(2) a description and assessment of the precipitating circumstances and the specific behaviors which constituted the emergency situation, and if applicable, the specific behaviors which continued to constitute an emergency situation;

(3) the use of alternative strategies attempted before the use of personal restraint and the child’s reaction to those strategies;

(4) the time the restraint began;

(5) the name of the caregiver(s) participating in the restraint;

(6) the specific restraint techniques used, including a prone or supine restraint used as a transitional hold;

(7) the de-escalating strategies employed during the restraint;

(continued)

(8) the total length of time the child was restrained;

(9) all attempts to explain to the child what behaviors were necessary for release from the restraint;

(10) any injury the child sustained as a result of the incident or the use of restraint, and the care or treatment provided;

(11) the actions the caregiver(s) took to facilitate the child's return to normal activities following release from restraint; and

(12) the child's reaction to the opportunity offered in subsection (d)(1)(C) of this [rule, §720.1007], the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself, (if applicable).

Mechanical Restraint

DFPS Rules, 40 TAC §720.1008, effective 9/1/2000

(a) General.

(1) The use of mechanical restraints is prohibited in all child-care facilities except residential treatment centers and institutions serving mentally retarded children.

(2) Mechanical restraints may only be used in emergency situations and only under orders that meet the requirements of subsection (b) of this [rule, §720.1008].

(3) Before the emergency use of a mechanical restraint, other preventive, de-escalative, less restrictive techniques must be attempted and proven ineffective at defusing the situation.

(4) Only commercially available devices specifically designed for the safe and comfortable restraint of humans may be used as mechanical restraints. Any alteration of commercially available devices must be reviewed and approved by a licensed psychiatrist who must:

(A) base the approval on the individual child's special physical needs; and

(B) take into consideration any potential medical contraindications, including psychiatric contraindications, for example history of sexual abuse.

(5) Mechanical restraint devices must be inspected after each use to ensure that they are in good repair and are free from tears or protrusions that may cause injury. Damaged devices may not be used to restrain a child.

(continued)

(6) The following types of devices must not be used to restrain children:

(A) those with metal wrist or ankle cuffs;

(B) those with rubber bands, rope, cord, or padlocks or key locks as fastening devices;

(C) long ties, such as leashes; or

(D) bed sheets or blankets.

(b) Mechanical restraint orders.

(1) No form of mechanical restraint may be used with a child without emergency orders from a licensed psychiatrist.

(2) The psychiatrist ordering mechanical restraint must first take into consideration any potential medical and or psychiatric contraindications, including a child's history of physical or sexual abuse. This consideration must be documented in the child's records.

(3) PRN orders for mechanical restraints are not permitted.

(4) Orders for mechanical restraint must designate the specific device or devices authorized, including any specific measures required to ensure the child's health, safety, and well being.

(5) Orders must include the circumstances under which the intervention may be used, instructions for observation of the child while in restraint, the behaviors that indicate the child is ready to be released from restraint, and the maximum amount of time the child may be restrained regardless of behaviors exhibited.

(6) For children and adolescents ages 9 to 17 years, maximum time in mechanical restraint must not exceed one hour. For children under age nine years, this must not exceed 30 minutes. If a child is released from mechanical restraint and then restrained again within the same 12-hour period, the time spent in restraint is cumulative and may not exceed the stated maximums.

(7) Continuation beyond the maximum amount of time permitted by the original order requires authorization from the prescribing psychiatrist and must not exceed 12 hours total. Authorization to extend must be obtained before the end of the time period or the restraint must be discontinued. If authorization for continuation is obtained over the telephone, continuation orders must be documented and the psychiatrist must personally sign, date, and indicate the time on the telephone order within 72 hours of the time the order was issued. For additional regulations required when the restraint is continued beyond the maximum amount of time, see subsection (c)(10) of this [rule, §720.1008].

(continued)

(8) If a child has been mechanically restrained for more than three hours or has been mechanically restrained more than twice within a seven-day period, the ordering psychiatrist, along with the treatment team, must review the child's placement, treatment plan, and the orders for mechanical restraints as soon as possible and no later than 30 days after the mechanical restraint that lasted more than three hours or the third mechanical restraint. The review must include an examination of alternatives for managing the child's behavior and the establishment of a plan for reducing the need for mechanical restraint. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the mechanical restraint that lasted more than three hours or the third mechanical restraint. The review must be documented in the child's record.

(c) Implementation of mechanical restraint.

(1) Mechanical restraint must not be implemented without the required orders.

(2) When mechanical restraint is the appropriate intervention, it must be discontinued as soon as the child is no longer a danger to himself or others.

(3) Mechanical restraint must be initiated in a way that minimizes the risk of physical discomfort, harm, or pain to the child. Only the minimal amount of reasonable and necessary physical force may be used to implement mechanical restraint.

(4) Only a caregiver qualified in behavior intervention may apply mechanical restraint.

(5) The child-care facility and/or child-placing agency must provide a protected, private, observable environment for a child placed in restraint. The environment must safeguard the child's personal dignity and well being.

(6) If an emergency health situation occurs during mechanical restraint, the child must be released immediately and treatment obtained.

(7) As soon as possible after mechanical restraint is started, the appropriate caregiver(s) must explain to the child in restraint the behaviors the child must exhibit to be released from the restraint or have the restraint reduced and permit the child to make suggestions about what actions the caregiver(s) can take to help the child de-escalate.

(continued)

(8) If the child does not appear to understand what actions he must take to be released from the restraint, a caregiver must attempt to re-explain it every 15 minutes until understanding is reached or the child is released from restraint.

(9) A caregiver qualified in behavior intervention must provide continuous face-to-face observation of a child in mechanical restraint. In addition to the continuous observation, a caregiver qualified in behavior intervention must ensure that the child has adequate respiration and circulation at all times. Checks for circulation, skin color, and respiration must be conducted at least every 15 minutes by a caregiver qualified in behavior intervention, in addition to continual observation.

(10) If a mechanical restraint continues, with the appropriate orders specified in subsection (b)(7) of this [rule, §720.1008], beyond the maximum one hour, a child must be allowed:

(A) bathroom privileges at least once every two hours;

(B) an opportunity to drink water or other appropriate liquids at least once every two hours;

(C) regularly prescribed medications unless otherwise ordered by the physician;

(D) regularly scheduled meals and snacks served in a safe and appropriate manner;

(E) an environment that is free of safety hazards, adequately ventilated during warm weather, adequately heated during cold weather, and appropriately lighted; and

(F) an opportunity for range of motion or exercise for at least five minutes of each hour a child is in restraint.

(11) Mechanical restraint may be simultaneously implemented in combination with emergency medication only if specifically allowed by the written orders and only if the specified restraint(s) or seclusion are allowed in the facility by the rules in this section. These orders must include clinical justification for the combination. The clinical justification must indicate what behaviors continued to be exhibited that constituted an emergency despite the mechanical restraint. The clinical justification for the combination of emergency medication with mechanical restraint must be coordinated and provided by both the psychiatrist ordering the mechanical restraint and the physician ordering the emergency medication, if they are different persons. Mechanical restraint may not be simultaneously implemented in combination with seclusion.

(continued)

(d) Release from mechanical restraint.

(1) When a child exhibits release behaviors described in the written order, a caregiver qualified in behavior intervention must release the child from restraint. The child must be released no later than five minutes after the child begins exhibiting the required behaviors.

(2) If a child falls asleep in mechanical restraint, he must be released from the restraint. The child must then remain under continuous observation until he awakens and is evaluated.

(e) Mechanical restraint follow up.

(1) When a child is released from mechanical restraint, the caregiver(s) must take appropriate actions to help the child return to normal activities. This must include:

(A) providing the child with an appropriate transition and offering the child an opportunity to return to regular activities;

(B) observing the child for at least 15 minutes; and

(C) providing the child with an opportunity to discuss the situation which led to the need for mechanical restraint and the caregiver's reaction to that situation privately as soon as possible and no later than 48 hours after the release from restraint. If the child refuses the opportunity to discuss the restraint, he shall be allowed to discuss the matter at any subsequent time. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child's reaction to those strategies; and the restraint itself and the child's reaction to the restraint.

(2) Staff involved in the mechanical restraint must make every attempt to debrief concerning the incident.

(f) Documentation of mechanical restraint. The use of mechanical restraint must be documented as soon as possible and no later than 24 hours after the initiation of the restraint. Documentation must include:

(1) the child's name;

(2) a description and assessment of the precipitating circumstances and the specific behaviors which constituted the initial emergency situation, and if applicable, the specific behaviors which continued to constitute an emergency situation;

(continued)

(3) the use of alternative strategies attempted before the use of mechanical restraint and the child's reaction to those strategies;

(4) the time restraint began;

(5) the name of caregiver(s) participating in the restraint;

(6) the specific restraint device used;

(7) the de-escalating strategies employed during the restraint;

(8) the total length of time the child was restrained;

(9) continuous observation and regular respiration and circulation checks;

(10) all attempts to explain to the child what behaviors were necessary for release from the restraint;

(11) any injury the child sustained as a result of the incident or the use of restraint;

(12) the actions that the caregiver(s) took to facilitate the child's return to normal activities following release from restraint; and

(13) the child's reaction to the opportunity offered in subsection (e)(1)(C) of this [rule, §720.1008], the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself, (if applicable).

Protective Devices

DFPS Rules, 40 TAC §720.1009, effective 9/1/2000

(a) Protective devices may be used only if permitted by a physician's orders. The orders must indicate the circumstances under which the protective device is permitted. Orders may be obtained at the child's initial visit to the physician after placement.

(b) Protective devices may not be used to restrain a child for any other reason than to prevent involuntary injury, permit wounds to heal, or administer intra-muscular medication or other medical treatments prescribed by a physician.

(c) The use of protective devices must be documented in a child's record and must be part of the child's plan of service when it is developed and reviewed. The plan of service and its review must include discussion of ways to reduce the need for protective devices.

(continued)

(d) Devices intended to encourage mobility and/or restrain a child for safety purposes, such as wheelchairs, car seats, high-chairs, strollers, and child leashes manufactured and sold specifically to harness young children for safety purposes, are not regulated as protective devices if used appropriately.

(e) Protective devices and the devices listed in subsection (d) of this [rule, §720.1009,] may not be used as:

(1) punishment;

(2) a convenience for caregivers; or

(3) a substitute for program treatment.

Supportive Devices

DFPS Rules, 40 TAC §720.1010, effective 9/1/2000

(a) Supportive devices may be used to posturally support an individual or assist in obtaining and maintaining normal bodily functioning (for example, use of posey vests for individuals who are not able to posturally support themselves). The facility and/or agency must have written policies and procedures that address the proper implementation and monitoring of supportive devices.

(b) The use of a supportive device is considered an adjunct to proper care of an individual, and may not be used as a substitute for appropriate nursing care.

(c) The use of a supportive device must be prescribed by a physician whose written order indicates the circumstances under which the supportive device is permitted.

(d) The use of supportive devices must be documented in a child's record and must be part of the child's plan of service when it is developed and reviewed. The plan of service and its review must include discussion of ways to reduce the need for supportive devices.

(e) If the prescribed device is not specifically for assisting with sleep or safety during sleep, it must be removed during the night and other rest periods.

(f) Supportive devices may not be used:

(1) as punishment;

(2) for the purpose of convenience of staff or other individuals; or

(3) as a substitute for effective treatment or habilitation.

Seclusion

DFPS Rules, 40 TAC §720.1011, effective 9/1/2000

(a) General.

(1) The use of seclusion is prohibited in all child-care facilities except residential treatment centers, child-care facilities serving children with autistic-like behavior, and emergency shelters.

(2) Seclusion may only be used in emergency situations. Emergency shelters may only use seclusion in an emergency situation and only until the child is no longer a danger to himself or others or until immediate medical attention can be obtained.

(3) Before the emergency use of seclusion, other preventive, de-escalative, less restrictive techniques must be attempted and proven ineffective at defusing the situation.

(b) Seclusion orders.

(1) No form of seclusion may be used with a child without appropriate orders in the child's record. Only a licensed psychiatrist or licensed psychologist may write orders for the use of seclusion for a specific child. The professional ordering seclusion must first take into consideration any potential medical and or psychiatric contraindications, including a child's history of physical or sexual abuse. This consideration must be documented in the child's records. Orders for seclusion are not required in an emergency shelter.

(2) A licensed psychiatrist ordering seclusion may use PRN orders. PRN orders are not permitted to extend the maximum amount of time allowed in seclusion as outlined in paragraph [(b)](5) of this [rule, §720.1011]. PRN orders for seclusion must be reviewed by the psychiatrist at least every three months. PRN orders from a licensed psychologist are not permitted.

(3) Orders for seclusion must include any specific measures for ensuring the child's health, safety, and well being.

(4) Orders must include the circumstances under which the seclusion may be used, any instructions for heightened observation of the child while in seclusion, the behaviors that indicate the child is ready to be released from seclusion, and the maximum amount of time the child may be secluded regardless of behaviors exhibited.

(continued)

(5) For children and adolescents ages 9 to 17 years, maximum time in seclusion must not exceed two hours. For children under age nine years, this must not exceed one hour. If a child is released from seclusion and then secluded again within the same 12-hour period, the time spent in seclusion is cumulative and may not exceed the stated maximums.

(6) Continuation beyond the maximum amount of time permitted by the original order requires authorization from the prescribing psychiatrist or psychologist and is allowed only subsequent to a face-to-face evaluation with the child by a caregiver qualified in behavior intervention. Authorization to extend must be obtained before the end of the time period or seclusion must be discontinued. If authorization for continuation is obtained over the telephone, continuation orders must be documented and the psychiatrist or psychologist must personally sign, date, and indicate the time of the telephone order within 24 hours of the time the order was issued. For additional regulations required when the seclusion is continued beyond the maximum amount of time, see subsection (c)(12) of this [rule, §720.1011].

(7) If a child has been secluded for more than 12 hours or has been secluded more than twice within a seven-day period, the ordering psychiatrist or psychologist, along with the treatment team, must review the child's placement, treatment plan, and the orders for seclusion as soon as possible and no later than 30 days after the seclusion that lasted more than 12 hours or the third seclusion. The review must include an examination of alternatives for managing the child's behavior and the establishment of a plan for reducing the need for seclusion. The regularly scheduled review of the child's plan of service or treatment plan can serve as this review as long as it meets the requirements of this subsection and takes place no later than 30 days after the seclusion that lasted more than 12 hours or the third seclusion. The review must be documented in the child's record.

(c) Implementation of seclusion.

(1) When seclusion is the appropriate intervention, it must be discontinued as soon as the child is no longer a danger to himself or others.

(2) Seclusion must be initiated in a way that minimizes the risk of physical discomfort, harm, or pain to the child. Only the minimal amount of reasonable and necessary physical force may be used to implement seclusion.

(continued)

(3) Only a caregiver qualified in behavior intervention may place a child in seclusion.

(4) Seclusion must not be implemented without the required orders, except for the emergency use of seclusion in an emergency shelter. If orders do not exist for a child in residential treatment centers or child-care facilities serving children with autistic-like behavior and seclusion is necessary to protect the child from endangering himself or others, a caregiver qualified in behavior intervention may place a child in seclusion, but must obtain and document a licensed psychiatrist's or psychologist's verbal order by telephone no later than one hour following initiation of the seclusion. The psychiatrist or psychologist must personally sign, time, and date the telephone order within 24 hours of the time the order was issued.

(5) The child-care facility and/or child-placing agency must provide a protected, private, observable environment for a child placed in seclusion. The environment must safeguard the child's personal dignity and well being.

(6) A room used for seclusion must have at least 40 square feet of floor space, be free of safety hazards, be adequately ventilated during warm weather, be adequately heated during cold weather, and be appropriately lighted.

(7) The seclusion room must have at least a mat and bedding, except when the psychiatrist writes orders to the contrary specific to a child.

(8) If an emergency health situation occurs during seclusion, the child must be released immediately and treatment obtained.

(9) As soon as possible after seclusion is started, the caregiver(s) must explain to the child in seclusion the behaviors the child must exhibit to be released from seclusion, and permit the child to make suggestions about what actions the caregiver(s) can take to help the child de-escalate the situation.

(10) If the child does not appear to understand what actions he must take to be released from seclusion, a caregiver must re- explain it every 15 minutes until understanding is reached or the child is released from seclusion.

(11) Caregivers must continuously observe a child placed in seclusion. This observation can take place through such means as a window or a one-way mirror.

(continued)

(12) If a seclusion continues, with the appropriate orders specified in subsection (b)(6) of this [rule, §720.1011], beyond the maximum two hours, a child must be allowed:

(A) bathroom privileges at least once every two hours;

(B) an opportunity to drink water or other appropriate liquids at least once every two hours;

(C) regularly prescribed medications unless otherwise ordered by the physician; and

(D) regularly scheduled meals and snacks served in a safe and appropriate manner.

(13) Seclusion may be simultaneously implemented in combination with emergency medication only if specifically allowed by the written orders and only if the specified restraint(s) or seclusion are allowed in the facility by the rules in this section. These orders must include clinical justification for the combination. The clinical justification for the combination of emergency medication with seclusion must be coordinated and provided by both the psychiatrist or psychologist ordering the seclusion and the physician ordering the emergency medication, if they are different persons. Seclusion may not be simultaneously implemented in combination with mechanical restraint.

(d) Release from seclusion.

(1) When a child exhibits release behaviors described in the written order, a caregiver qualified in behavior intervention must release the child from seclusion. The child must be released no later than five minutes after the child begins exhibiting the required behaviors. Children in emergency shelters must be released as soon as they are no longer a danger to themselves or others, or until immediate medical attention can be obtained.

(2) If a child falls asleep in seclusion, the door must be unlocked. The child must remain under continuous observation until he awakens and is evaluated.

(e) Seclusion follow up.

(1) When a child is released from seclusion, the caregiver(s) must take appropriate actions to help the child return to normal activities. This must include:

(A) providing the child with an appropriate transition and offering the child an opportunity to return to regular activities;

(B) observing the child for at least 15 minutes; and

(continued)

(C) providing the child with an opportunity to discuss the situation which led to the need for seclusion and the caregiver's reaction to that situation privately as soon as possible and no later than 48 hours after the release from seclusion. The goal of the discussion is to allow the child to discuss his behavior and the precipitating circumstances that constituted the emergency situation; the strategies attempted before the use of the restraint and the child's reaction to those strategies; and the restraint itself and the child's reaction to the restraint.

(2) This subsection does not apply to emergency shelters.

(3) Staff involved in the seclusion must make every attempt to debrief concerning the incident.

(f) Documentation of seclusion. The use of seclusion must be documented as soon as possible and no later than 24 hours after initiating the seclusion. Documentation must include:

(1) the child's name;

(2) a description of the precipitating circumstances and the specific behaviors which constituted an emergency situation;

(3) the use of alternative strategies attempted before the use of seclusion and the child's reaction to those strategies;

(4) the time seclusion began;

(5) the name of the caregiver(s) participating in the seclusion;

(6) the de-escalating strategies employed during seclusion;

(7) the total length of time the child was secluded;

(8) all attempts to explain to the child what behaviors were necessary for release from the seclusion;

(9) any injury the child sustained as a result of the incident or the use of seclusion;

(10) the actions that the caregiver(s) took to facilitate the child's return to normal activities following release from seclusion; and

(11) the child's reaction to the opportunity offered in subsection (e)(1)(C) of this [rule, §720.1011], the date and time the discussion was offered, the date and time the discussion took place (if applicable), and the actual discussion itself, (if applicable).

Behavior Intervention Training

DFPS Rules, 40 TAC §720.1012, effective 9/1/2000

(a) Training policies and procedures. All child-care facilities and child-placing agencies must have a training policy for behavior intervention. The policy must include the amount and type of training required for different levels of caregivers (if applicable), training content, and how the training will be delivered. Child-care facilities and child-placing agencies must require training in the use of restraints or seclusion allowed by the child-care facility and/or child-placing agency's behavior intervention policies.

(b) Pre-service training.

(1) All new caregivers who will have contact with children must complete a pre-service training curriculum of behavior intervention that meets the requirements in paragraphs [(b)(3) - (b)(7), below,] of this [rule, §720.1012] prior to being responsible for the care of children.

(2) New caregivers who already meet both of the requirements set out in subparagraphs (A) and (B) [below] are not required to complete the required pre-service training. These qualifications must be documented in the caregiver's record. The new caregiver has:

(A) been employed in a residential child care setting within the previous year; and

(B) received training within the previous year in the types of behavior intervention used at the child-care facility and/or child- placing agency where the caregiver will be employed, and the new caregiver can demonstrate his or her knowledge and understanding of the training.

(3) The training must be direct delivery training provided by a qualified instructor. The use of video instruction as part of a training curriculum is considered direct delivery training as long as the instructor is available for questions during the training. Training on the implementation of restraints or seclusion must be delivered directly by the instructor and cannot be delivered by a video.

(4) A qualified instructor is an instructor certified in a recognized method of therapeutic behavior intervention or is an instructor who is able to document knowledge of the subject material, training delivery methods and techniques, and training evaluation or assessment methods and techniques.

(continued)

(5) The training must be competency-based and the trainer must require participants to demonstrate skill competency at the end of the training.

(6) Facilities whose policies do not allow for the use of any type of restraint or seclusion, including personal restraint, must require a pre-service training that meets the curriculum requirements in subparagraphs (A) - (H) [below]. Facilities whose policies allow for the use of any one type of restraint or seclusion must require pre-service training that meets all of the curriculum requirements listed in this paragraph and require that at least three quarters of the pre-service training focus on early identification of potential problem behaviors and strategies and techniques of less restrictive interventions. The training components are:

(A) developing and maintaining an environment or milieu that supports positive constructive behaviors;

(B) causes of behaviors potentially harmful to self or others in children and adolescents including aspects of the environment or milieu;

(C) early signs of behaviors that may become dangerous to self or others;

(D) strategies and techniques the child can use to avoid harmful behaviors;

(E) teaching children to use the strategies and techniques to avoid harmful behavior and supporting the children's efforts;

(F) less restrictive strategies caregivers can use to intervene in potentially harmful behaviors;

(G) less restrictive strategies caregivers can use to work with oppositional children;

(H) the risks associated with the use of prone and supine restraints, including positional, compression, or restraint asphyxia; and

(I) strategies for re-integration of children into the milieu after restraint or seclusion.

(7) The remainder of the pre-service behavior intervention training for caregivers who are providing care in a home or facility whose policies allow for the use of any one type of restraint or seclusion must focus on the:

(A) different roles and responsibilities of caregivers qualified in behavior intervention and caregivers who are not qualified in behavior intervention; and

(B) safe implementation of the restraints and/or seclusion permitted by the rules in this chapter and by the child-care facility and/or child-placing agency's policies and procedures.

(8) If a child-care facility and/or child-placing agency's behavior intervention policies do not allow for a certain type of restraint, the child-care facility and/or child-placing agency does not have to offer training in the use of that restraint or seclusion.

(9) The pre-service training curriculum must include drawings, photographs, or videos of each personal restraint intervention permitted by the child-care facility and/or child-placing agency policy.

(10) The pre-service training curriculum must include drawings or photographs of each mechanical restraint device permitted by the child-care facility policy and complete specifications from the manufacturer. Any modifications to the specifications from the manufacturer on the use of a mechanical restraint device must be shown along with the required approval from a licensed psychiatrist.

(c) Annual training.

(1) All caregivers having contact with children must complete at least four clock hours annually of behavior intervention training specific to the behavior interventions allowed by the facility's policies.

(2) Annual training must focus on reinforcing basic principles covered in the initial training and developing and refining caregivers' skills. The facility may determine the content of the annual training based on the facility's evaluation of behavior intervention needs in the facility or homes. Training in any of the areas specified in subsection (b)(6) of this [rule, §720.1012,] and training in the proper use and implementation of restraints and/or seclusion is acceptable.

(3) The four clock hours will be considered part of the overall annual training requirements.

(4) All annual training must be direct delivery training provided by a qualified instructor, as described in subsection (b)(4) of this [rule, §720.1012].

(d) Caregiver qualified in behavior intervention.

(1) Only caregivers designated as caregivers qualified in behavior intervention may implement any form of restraint or seclusion.

(2) The child-care facility and/or child-placing agency must have policies that specify the qualifications for assuming the responsibility for restraint and/or seclusion implementation, including required experience and training requirements.

(continued)

(3) If a residential treatment center or institution serving mentally retarded children allows the use of mechanical restraint, the facility must address the caregivers qualified to implement mechanical restraint separately. These caregivers must be registered nurses, at a minimum.

(4) All child-care facility and/or child-placing agency's policies must be compliant with the types of interventions the child-care facility and/or child-placing agency is permitted to use under minimum standards and the needs of the specific population for whom the child-care facility and/or child-placing agency provides care.

(5) The policy on caregivers qualified in behavior intervention must also include an evaluation component for determining when a specific caregiver meets the requirements of a caregiver qualified in behavior intervention, and an on-going program to evaluate caregivers qualified in behavior intervention and the use of restraint and seclusion. In regards to agency homes, the child-placing agency, not its agency homes, is responsible for these evaluations.

Evaluation of Behavior Interventions

DFPS Rules, 40 TAC §720.1013, effective 9/1/2000

(a) Individual case evaluations. For each child in care, the child-care facility and/or child-placing agency must evaluate the use and effectiveness of behavior intervention techniques as part of each child's plan of service or treatment plan. The evaluation must take place at each review of the child's plan of service or treatment plan. The evaluation must focus on:

(1) the frequency, patterns, and effectiveness of specific behavior interventions;

(2) strategies to reduce the need for behavior interventions overall; and

(3) specific strategies to reduce the need for use of personal, emergency medication, and/or mechanical restraint or seclusion, where applicable.

(b) Child-care facility and/or child-placing agency policy evaluation.

(1) The child-care facility and/or child-placing agency must develop an overall evaluation program with the following objectives:

(A) development and maintenance of an environment or milieu that supports positive and constructive behaviors on the part of children in care;

(B) safe, appropriate, and effective use of any form of restraint or seclusion; and

(C) elimination or reduction of physical injuries and any other negative impact of necessary restraints or seclusions on the child's behaviors or emotional development.

(continued)

(2) The child-care facility and/or child-placing agency evaluation must include an evaluation of the facility's policies and procedures, including the facility's training policy and curriculum.

(3) The results of the regular evaluation must be made available to the Texas Department of [Family and Protective Services]. In regards to agency homes, the child-placing agency, not its agency homes, is responsible for these evaluations.

Appendix VII: Schedule II of Controlled Substances

Pursuant to the Texas Controlled Substances Act, Health and Safety Code, Chapter 481, these schedules, established January 1, 2002, supercede previous schedules and contain the most current version of the schedules of all controlled substances from the previous schedules and modifications.

> ***Note:*** *January 1, 2002 — Changes to the schedules are designated by an asterisk (*). Additional information can be obtained by contacting the Texas Department of [State] Health [Services], Bureau of Food and Drug Safety, 1100 West 49th Street, Austin, Texas 78756. The telephone number is (512) 719-0237 and the website address is http://www.tdh.state.tx.us/bfds/dmd*

Schedule II Substances, Vegetable Origin or Chemical Synthesis

The following substances, however produced, except those narcotic drugs listed in other schedules:

(1) Opium and opiate, and a salt, compound, derivative, or preparation of opium or opiate, other than thebaine-derived butorphanol, naloxone and its salts, naltrexone and its salts, and nalmefene and its salts, but including:

- (1-1) Codeine;
- (1-2) Dihydroetorphine * ;
- (1-3) Ethylmorphine;
- (1-4) Etorphine hydrochloride;
- (1-5) Granulated opium;
- (1-6) Hydrocodone;
- (1-7) Hydromorphone;
- (1-8) Metopon;
- (1-9) Morphine;
- (1-10) Opium extracts;
- (1-11) Opium fluid extracts;
- (1-12) Oxycodone;
- (1-13) Oxymorphone;
- (1-14) Powdered opium;
- (1-15) Raw opium;
- (1-16) Thebaine; and,
- (1-17) Tincture of opium;

(continued)

(2) a salt, compound, isomer, derivative, or preparation of a substance that is chemically equivalent or identical to a substance described by Paragraph (1) of Schedule II substances, vegetable origin or chemical synthesis, other than the isoquinoline alkaloids of opium;

(3) Opium poppy and poppy straw;

(4) Cocaine, including:

(4-1) its salts, its optical, position, and geometric isomers, and the salts of those isomers; and,

(4-2) coca leaves and a salt, compound, derivative, or preparation of coca leaves that is chemically equivalent or identical to a substance described by this paragraph, other than decocainized coca leaves or extractions of coca leaves that do not contain cocaine or ecgonine; and,

(5) Concentrate of poppy straw, meaning the crude extract of poppy straw in liquid, solid, or powder form that contains the phenanthrene alkaloids of the opium poppy;

Opiates

The following opiates, including their isomers, esters, ethers, salts, and salts of isomers, if the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Alfentanil;

(2) Alphaprodine;

(3) Anileridine;

(4) Bezitramide;

(5) Carfentanil;

(6) Dextropropoxyphene, bulk (nondosage form);

(7) Dihydrocodeine;

(8) Diphenoxylate;

(9) Fentanyl;

(10) Isomethadone;

(11) Levo-alphacetylmethadol (some trade or other names: levo-alpha-acetylmethadol, levomethadyl acetate, LAAM);

(12) Levomethorphan;

(13) Levorphanol;

(14) Metazocine;

(15) Methadone;

(16) Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane;

(continued)

(17) Moramide-Intermediate, 2-methyl-3-morpholino-1,1-diphenyl-propane-carboxylic acid;

(18) Pethidine (meperidine);

(19) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine;

(20) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

(21) Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(22) Phenazocine;

(23) Piminodine;

(24) Racemethorphan;

(25) Racemorphan;

(26) Remifentanil; and

(27) Sufentanil;

Schedule II Stimulants

Unless listed in another schedule and except as provided by the Texas Controlled Substances Act, Health and Safety Code, Section 481.033, a material, compound, mixture, or preparation that contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) Methamphetamine, including its salts, optical isomers, and salts of optical isomers;

(3) Methylphenidate and its salts; and,

(4) Phenmetrazine and its salts;

Schedule II Depressants

Unless listed in another schedule, a material, compound, mixture or preparation that contains any quantity of the following substances having a depressant effect on the central nervous system, including the substance's salts, isomers, and salts of isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Amobarbital;

(2) Glutethimide;

(3) Pentobarbital; and,

(4) Secobarbital;

(continued)

Schedule II Hallucinogenic Substances

(1) Nabilone (Another name for nabilone: (±)-trans-3-(1,1-dimethylheptyl)-6,6a,7,8, 10,10a-hexahydro-1-hydroxy-6,6-dimethyl-9H-dibenzo[b,d]pyran-9-one);

Schedule II Precursors

Unless specifically excepted or listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances:

(1) Immediate precursor to methamphetamine:

(2) Phenylacetone and methylamine if possessed together with intent to manufacture methamphetamine;

(3) Immediate precursor to amphetamine and methamphetamine:

(4) Phenylacetone (some trade or other names: phenyl-2-propanone; P2P; benzyl methyl ketone; methyl benzyl ketone); and

(5) Immediate precursors to phencyclidine (PCP):

(6) 1-phenylcyclohexylamine; and,

(7) 1-piperidinocyclohexanecarbonitrile (PCC).

Appendix VIII: DFPS Model Drug Testing Policy

DFPS Rules, 40 TAC, Chapter 745, Licensing
Subchapter H, Residential Child-Care Minimum Standards
Division 6, Drug Testing
effective 12/1/2005

§745.4151. What drug testing policy must my residential child-care operation have?

(a) The Department of Family and Protective Services is required to adopt a model drug testing policy for residential child-care operations under the Human Resources Code, §42.057. Your residential child-care operation must either adopt the model drug testing policy or have a written drug testing policy that meets or exceeds the criteria in the model policy. Although this policy only covers drugs, coverage of alcohol may be included. The department recommends that an operation obtain legal advice before adopting and implementing any drug testing policy.

(b) Residential child-care operations must pay for any required drug tests, except as provided in subsection (c)(7) of this section.

(c) The mandatory criteria for the Model Drug Testing Policy For Residential Child-Care Operations include:

(1) Purpose. (Name of residential child-care operation) has a vital interest in ensuring the safety of resident children through the appropriate drug testing of employees, while also protecting the rights of the employees.

(2) Scope. This policy applies to all employees of residential child-care operations, including child-placing agencies, that have direct contact with children in care. It also applies to all contract employees that have direct contact with children in care and volunteers that frequently and regularly have direct contact with children. This policy does not apply to foster parents that are verified by child-placing agencies.

(3) Definitions. The following definitions apply to this section.

(A) Abusing drugs - The use of any:

(i) Drug or substance defined by the Texas Controlled Substances Act, Texas Health and Safety Code, Chapter 481; or

(ii) Prescription or non-prescription drug that is not being used for the purpose for which it was prescribed or manufactured.

(B) Drug testing - The scientific analysis of urine, blood, breath, saliva, hair, tissue, and other specimens for detecting a drug.

(continued)

(C) Random drug testing - A testing cycle that varies the frequency and intervals that specimens are collected for testing and selects employees in a random manner that does not eliminate already tested employees from future testing. The testing should ensure all employees are subject to random testing on a continuing basis.

(D) Good cause to believe the employee may be abusing drugs - A reasonable belief based on facts sufficient to lead a prudent person to conclude that the employee may be abusing drugs. Sufficient facts may include direct observations of the employee using or possessing drugs, or exhibiting physical symptoms, including but not limited to slurred speech or difficulty in maintaining balance; erratic or marked changes in behavior, including a decrease in the quality or quantity of the employee's productivity, judgment, reasoning, and concentration and psychomotor control, accidents, and deviations from safe working practices; or any other reliable information.

(4) Mandatory drug testing.

(A) All applicants that are intended to be hired for employment are subject to pre-employment testing, and may not provide direct care or have access to a child in care until the drug test results are available;

(B) All employees are subject to random, unannounced drug testing;

(C) Any employee that is the subject of a child abuse or neglect investigation, when DFPS determines there is "good cause to believe the employee may be abusing drugs", must be drug tested within 24 hours of notification by DFPS to the residential child-care operation; and

(D) Any employee who is alleged to be abusing drugs must be tested within 24 hours, if there is "good cause to believe the employee may be abusing drugs."

(5) Drug testing procedures. All drug testing will:

(A) At a minimum screen for marijuana, cocaine, opiates, amphetamines, and phencyclidine (PCP);

(B) Use one of the following drug-testing methods:

(i) A drug test performed by a certified laboratory;

(ii) A testing kit with proven rates of false positives below 2% and false negatives below 8% on all drugs screened; or

(iii) Another testing method for which there is scientific proof of accuracy comparable to either of the first two choices, such as saliva, hair, or spray drug testing;

(continued)

(C) Ensure the integrity and identity of the specimen collected from the time of collection to the time of disposal to minimize the opportunity for an employee to adulterate or substitute a specimen; and

(D) Preserve the privacy and rights of the person tested. This includes safeguarding the results of any test and maintaining them, so they remain confidential and free from unauthorized access.

(6) Discipline.

(A) An applicant or employee's consent to submit to drug testing is required as a condition of employment, and the refusal to consent may result in refusal to hire the applicant and disciplinary action, including discharge, against the employee for a refusal;

(B) An employee who is tested because there is "good cause to believe the employee may be abusing drugs," may be suspended pending receipt of written test results and further inquiries that may be required;

(C) An employee determined through drug testing to have abused drugs is subject to discipline, up to and including discharge;

(D) An applicant for employment or an employee determined through drug testing to have abused drugs may not be employed in a position with direct contact with children in care if the employee presents a risk of harm to children; and

(E) An employee determined through drug testing to have abused drugs may be offered the opportunity to complete a rehabilitation program at the employee's expense.

(7) Appeal. An applicant or employee whose drug test is positive may, at the employee's expense:

(A) Have an opportunity to explain and offer written documentation why there is another cause for the positive drug test;

(B) Request that the remaining portion of the sample that yielded the positive results, if available, be submitted for an additional independent test, including second tests to rule out false positive results; and/or

(C) Submit the written test result for an independent medical review.

(8) Documentation.

(A) All applicants that you intend to hire for employment and employees must be provided a copy of your drug testing policy and must sign a document consenting to these terms and conditions of employment**.**

(B) All drug test results will be kept for one year after an employee's last work day with the residential child-care operation, or until any investigation involving the person is resolved, whichever is later. The results must be available for review by Licensing Division within 24 hours of the request.

Standards Clarification Memorandum Series