TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 1. ADMINISTRATION

SUBCHAPTER 1. GENERAL INFORMATION

450:1-1-1.1. Definitions

The following words or terms, as defined below, when used in Chapters 1, 15, 16, 17, 18, 21, 23, 24, 27, 30, 50, 53, 55, 60, 65, ~~and~~ 70, and 75, shall have the following meaning, unless the context clearly indicates otherwise and will prevail in the event there is a conflict with definitions included elsewhere in Chapters 1, 15, 16, 17, 18, 21, 23, 24, 27, 30, 50, 53, 55, 60, 65, ~~and~~ 70, and 75:

"Administrative Hearing Officer" means an individual who is an attorney licensed to practice law in the State of Oklahoma and is appointed by the Commissioner of ODMHSAS to preside over and issue a proposed order in individual proceedings.

"AOA" means American Osteopathic Association.

"Behavioral Health Aide (BHA)" means individuals must have completed sixty (60) hours or equivalent of college credit or may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience, and:

(A) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(B) must be supervised by a bachelor's level individual with a minimum of two years case management experience or care coordination experience; and

(C) treatment plans must be overseen and approved by a LBHP or Licensure Candidate; and

(D) must function under the general direction of a LBHP, Licensure Candidate and/or systems of care team, with a LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

"Board" means the Oklahoma State Board of Mental Health and Substance Abuse Services.

"CARF" means Commission on Accreditation of Rehabilitation Facilities (CARF).

"Certification" means a status which is granted to a person or an entity by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS, and indicates the provider is in compliance with minimum standards as incorporated in OAC 450 to provide a particular service. In accordance with the Administrative Procedures Act, 75 O.S. § 250.3(8), certification is defined as a "license."

"Certified Alcohol and Drug Counselor (CADC)" means Oklahoma certification as an Alcohol and Drug Counselor.

"Certified Behavioral Health Case Manager" or "CM" means any person who is certified by the ODMHSAS as a Behavioral Health Case Manager pursuant to Oklahoma Administrative Code, Title 450, Chapter 50.

"Certified facility" means any facility which has received a certification status by the Oklahoma State Board of Mental Health and Substance Abuse Services or the ODMHSAS.

"Certification report" means a summary of findings documented by ODMHSAS related to an applicant's compliance with certification standards.

"COA" means the Council on Accreditation of Services for Families and Children, Inc.

"Consumer" means an individual who has applied for, is receiving or has received evaluation or treatment services from a facility operated or certified by ODMHSAS or with which ODMHSAS contracts and includes all persons referred to in OAC Title 450 as client(s) or patient(s) or resident(s) or a combination thereof.

"Critical incident" means an occurrence or set of events inconsistent with the routine operations of a facility, service setting, or otherwise routine care of a consumer. Critical incidents specifically include, but are not necessarily limited to the following: adverse drug events; self-destructive behavior; deaths and injuries to consumers, staff, and visitor; medication errors; residential consumers that have absent without leave (AWOL); neglect or abuse of a consumer; fire; unauthorized disclosure of information; damage to or theft of property belonging to consumers or the facility; other unexpected occurrences; or events potentially subject to litigation. A critical incident may involve multiple individuals or results.

"Critical standard" means a standard that ODMHSAS deems to have the potential to significantly impact the safety, well-being, and/or rights of consumers, or consumers' access to appropriate services.

"Discharge summary" means a clinical document in the treatment record summarizing the consumer's progress during treatment, with goals reached, continuing needs, and other pertinent information including documentation of linkage to aftercare.

"Contractor" or **"contractors"** means any person or entity under contract with ODMHSAS for the provision of goods, products or services.

"Employment Consultant (EC)" means an individual who (i) has a high school diploma or equivalent; and (ii) successful completion of Job Coach training.

"Entities" or **"entity"** means sole proprietorships, partnerships and corporations.

"Facilities" or **"facility"** means entities as described in 43A O.S. § 1-103(7), community mental health centers, residential mental health facilities, community-based structured crisis centers, certified services for the alcohol and drug dependent, programs of assertive community treatment, eating disorder treatment, gambling addiction treatment, and narcotic treatment programs.

"Family" means the parents, brothers, sisters, other relatives, foster parents, guardians, and others who perform the roles and functions of family members in the lives of consumers.

"Family Support and Training Provider (FSP)" means

(A) have a high school diploma or equivalent;

(B) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement;

(C) successful completion of Family Support Training according to a curriculum approved by the ODMHSAS and pass the examination with a score of 80% or better;

(D) pass OSBI background check;

(E) treatment plans must be overseen and approved by a LBHP or Licensure Candidate; and

(F) must function under the general direction of a LBHP, Licensure Candidate or systems of care team, with a LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

"Follow-up" means the organized method of systematically determining the status of consumers after they have been discharged to determine post-treatment outcomes and utilization of post-treatment referrals.

"Governing authority" means the individual or group of people who serve as the treatment facility's board of directors and who are ultimately responsible for the treatment facility's activities and finances.

"Individual proceeding" means the formal process employed by an agency having jurisdiction by law to resolve issues of law or fact between parties and which results in the exercise of discretion of a judicial nature.

"Institutional Review Board" or **"IRB"** means the ODMHSAS board established in accordance with 45 C.F.R. Part 46 for the purposes expressed in this Chapter.

"Intensive Case Manager (ICM)" means an individual who is designated as an ICM and carries a caseload size of not more than twenty-five (25) individuals. They are a LBHP, Licensure Candidate, CADC, or certified as a Behavioral Health Case Manager II, and have:

(A) a minimum of two (2) years Behavioral Health Case Management experience,

(B) crisis diversion experience, and

(C) successfully completed ODMHSAS ICM training.

"IRB approval" means the determination of the IRB that the research has been reviewed and may be conducted within the constraints set forth by the IRB and by other agency and Federal requirements.

"Levels of performance" or **"level of performance"** means units of service by types of service.

"Licensed Alcohol and Drug Counselor" or **"LADC"** means any person who is licensed through the State of Oklahoma pursuant to the provisions of the Licensed Alcohol and Drug Counselors Act.

"Licensed Behavioral Health Professional" or **"LBHP"** means:

(A) An Allopathic or Osteopathic Physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry;

(B) An Advanced Practice Registered Nurse licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided and certified in a psychiatric mental health specialty;

(C) A Clinical Psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists;

(D) A Physician Assistant who is licensed in good standing in Oklahoma and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions;

(E) A practitioner with a license to practice in the state in which services are provided issued by one of the following licensing boards:

(i) Social Work (clinical specialty only);

(ii) Professional Counselor;
(iii) Marriage and Family Therapist;
(iv) Behavioral Practitioner; or
(vi Alcohol and Drug Counselor.

"Licensed dietitian" means a person licensed by the Oklahoma Board of Medical Licensure and Supervision as a dietitian.

"Licensed mental health professional" or **"LMHP"** as defined in Title 43A §1-103(11).

"Licensed physician" means an individual with an M.D. or D.O. degree who is licensed in the state of Oklahoma to practice medicine.

"Licensed practical nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the State of Oklahoma to provide practical nursing services.

"Licensure candidate" means practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the following licensing boards:

(A) Psychology;
(B) Social Work (clinical specialty only);
(C) Professional Counselor;
(D) Marriage and Family Therapist;
(E) Behavioral Practitioner; or
(F) Alcohol and Drug Counselor.

"Minimal risk" means that the probability and magnitude of harm or discomfort anticipated in the research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests.

"Necessary standard" means a certification standard that ODMHSAS deems important for an entity's overall functioning but generally does not have a significant, immediate impact on consumers.

"ODMHSAS" or **"Department"** means the Oklahoma Department of Mental Health and Substance Abuse Services.

"Oklahoma Administrative Code" or **"OAC"** means the publication authorized by 75 O.S. § 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Paraprofessional" means a person who does not have an academic degree related to the scope of treatment or support services being provided but performs prescribed functions under the general supervision of that discipline.

"Peer Recovery Support Specialist" or "**PRSS**" means an individual certified by ODMHSAS as a Peer Recovery Support Specialist pursuant to requirements found in OAC 450:53.

"Performance improvement" means an approach to the continuous study and improvement of the processes of providing services to meet the needs of consumers and others.

"Probationary certification" means a certification status granted for a period less than three (3) years.

"Psychiatrist" means a licensed physician who specialized in the assessment and treatment of individuals having psychiatric disorders and who is fully licensed to practice medicine in the state in which he or she practices and is certified in psychiatry by the American Board of Psychiatry and Neurology, or has equivalent training or experience.

"Registered nurse" means an individual who is a graduate of an approved school of nursing and is licensed in the state of Oklahoma to practice as a registered nurse.

"Rehabilitative services" means face-to-face individual or group services provided by qualified staff to develop skills necessary to perform activities of daily living and successful integration into community life.

"Reimbursement rates" means the rates at which all contractors are reimbursed (paid) for services they provide under their ODMHSAS contract.

"Research" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this Chapter, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities.

"Respondent" means the person(s) or entity(ies) named in a petition for an individual proceeding against whom relief is sought**.**

"Sentinel event" means a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes a variation in approved processes which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to suicide, homicide, ~~criminal activity,~~ assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

"Service area" means a geographic area established by the Department of Mental Health and Substance Abuse Services for support of mental health [43A O.S. § 3-302(1)].

"Service Provider" means a person who is allowed to provide substance abuse services within the regulation and scope of their certification level or license.

"Site Review Protocol" means an ODMHSAS document developed as a work document in the certification site visit(s) that is based primarily upon the rules (standards/criteria) being reviewed. The Site Review Protocol is used in preparing the Certification Report, which is provided to the facility as well as to the Board for its consideration and action related to certification.

"Staff privileging" means an organized method for facilities and programs to authorize an individual to provide specific care and treatment services to consumers within well-defined limits, based on the evaluation of the individual's license, education, certification, training, experience, competence, judgment, and other credentials.

"Substantial compliance" means the demonstration of compliance by an entity subject to certification to ODMHSAS of a minimum percentage of all applicable critical and necessary standards in accordance with these rules. The determination of whether

an individual standard is deemed compliant may be done on a pass/fail basis or as a minimum percentage of required elements.

"Support Services Provider (SSP)" means an individual age eighteen (18) or older with a high school diploma or equivalent.

"TJC" means The Joint Commission formerly referred to as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO.

"Tobacco" means any nicotine delivery product or device that is not approved by the U.S. Food and Drug Administration (FDA) for the purpose of nicotine dependence treatment, including, but not limited to cigarettes, cigars, snuff, chewing tobacco, electronic cigarettes and vaping devices.

"Volunteer" means any person who is not on the program's payroll, but provides services and fulfills a defined role within the program and includes interns and practicum students.

450:1-1-2. Applicability

This, and all subsequent chapters are applicable, unless otherwise specifically noted in a chapter, subchapter, part or section of Oklahoma Administrative Code Title 450, to the Oklahoma Department of Mental Health and Substance Abuse Services, the State Board of Mental Health and Substance Abuse Services, and:

(1) all employees and institutions and facilities of ODMHSAS (43A O.S. §§ 3-101 and 3-107); and

(2) all facilities (43A O.S.§§ 1-103(7), 3-306.1, 3-315, 3-317, 3-319, 3-320, 3-222, 3-323A and 3-415) under contract with ODMHSAS; and

(3) all facilities subject to certification by ODMHSAS (43A O.S. §§ 3-306.1, 3-315, 3-317, 3-319, 3-320, 3-222, 3-415, 3-601); and

(4) institutions, organizations and individuals subject to certification by ODMHSAS to provide alcohol and drug substance abuse courses (43A O.S. §§ 3-451 through 3-453); and

(5) agencies and individuals subject to certification by ODMHSAS to provide alcohol and drug assessment and evaluation programs related to driver's license revocation [47 O.S. §§ 11-902(G) and 6-212.2; 43A O.S. § 3-460];

(6) individuals subject to certification to be a behavioral health case manager pursuant to 43A O.S. § 3-318; ~~and~~

(7) Individuals subject to certification to be recovery support specialist to 43A O.S. § 3-326~~.~~; and

(8) Individuals subject to certification to be a problem gambling treatment counselor pursuant to 43A O.S. § 3-322a.

450:1-1-3. Compliance with laws and rules

(a) Any statute of the United States or of the State of Oklahoma now existing, or duly enacted in the future, shall supersede any conflicting provision of the rules of this and all subsequent chapters to the extent of such conflict, but shall not affect the remaining provisions therein.

(b) All persons and organizations affected by the rules of this and all subsequent chapters and related laws shall be knowledgeable of the conduct pertinent in operating in accordance with all such rules and laws.

~~(c)New or amended rules promulgated through permanent rulemaking will be enforced as of November 1 of the year in which they become effective.~~

SUBCHAPTER 9. CERTIFICATION AND DESIGNATION OF FACILITY SERVICES

450:1-9-4. Reviewing authority

(a) The Board, or the Commissioner or designee, may certify community mental health centers, community residential mental health facilities, community-based structured crisis centers, eating disorder treatment programs, alcohol and drug treatment programs, outpatient mental health treatment programs (mental illness treatment programs), comprehensive addiction treatment centers, programs of assertive community treatment, gambling addiction treatment programs, and narcotic treatment programs as cited in Section 450:1-9-1, and directs that such shall be carried out as stated in this subchapter.

(b) The Board, or the Commissioner~~,~~ or designee, may also certify qualified individuals to perform within the scope of specific functions to provide treatment or support services related to behavioral health services. Certification of individuals shall be carried out as stated in OAC 450:-1 and in accordance with applicable requirements specified in other chapters of OAC 450.

(c) The Commissioner of ODMHSAS may grant or extend a Permit for Temporary Operations to respond to unplanned changes that create an emergency need for service provision in the public behavioral health delivery system for services operated by or funded by ODMHSAS.

(1) Provider Certification shall conduct a site review at the designated facility which must meet the minimal compliance requirements as cited in 450:1-9-7.

(2) The application procedure for completion of the certification process shall be accomplished in accordance with 450:1-9-6 and 450:1-9-7.

(3) The Permit for Temporary Operations emergency certification status granted to the facility by the Commissioner as described above must be presented at the next ODMHSAS Board meeting for Board review and confirmation. In the event the Board does not confirm the Temporary Certification status granted by the Commissioner, the Permit for Temporary Operations expire no later than thirty (30) days from the Board's action as stipulated in a written notice provided to the organization for which the Permit was denied.

450:1-9-5. Qualifications for certification of facilities, programs and individuals

(a) Qualifications for certification of facilities and programs providing mental health, substance related, or addictive disorder treatment services are as follows:

(1) ~~Compliance~~Substantial compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those Core Organizational Standards, Core Operational Standards and Quality Clinical Standards formally codified in Title 450 regulating the area for which certification is sought:

(A) Chapter 16, Standards and Criteria for Community Residential Mental Health Facilities;

(B) Chapter 17, Standards and Criteria for Community Mental Health Centers;

(C) Chapter 18, Standards and Criteria for Substance Related and Addictive Disorder Treatment Services;

(D) Chapter 23, Standards and Criteria for Community Based Structured Crisis Centers;

(E) Chapter 24, Standards and Criteria for Comprehensive Community Addiction Recovery Centers;

(F) Chapter 27, Standards and Criteria for Mental Illness Service Programs;

(G) Chapter 55, Standards and Criteria for Programs of Assertive Community Treatment;

(H) Chapter 60, Standards and Criteria for Certified Eating Disorder Treatment Programs;

(I) Chapter 65, Standards and Criteria for Gambling Treatment Programs; and

(2) Chapter 70, Standards and Criteria for Opioid Substitution Treatment Programs.

(2) ~~Compliance~~Substantial compliance with applicable Core Organizational Standards, Core Operational Standards and Quality Clinical Standards set forth in OAC 450:1-9-5.4, OAC 450:1-9-5.5 and OAC 450:1-9-5.6. Core Organizational Standards, Core Operational Standards and Quality Clinical Standards address separate requirements as follows:

(A) Core Organizational Standards address requirements necessary to assure the public and consumers of services that essential organizational functions are substantially in place at the facility and the facility is prepared to initiate services for which certification is being requested. These requirements can be verified prior to the initiation of services for which the organization is requesting certification.

(B) Core Operational Standards address other essential conditions and processes that must be in place to assure basic safety and protection of consumer rights. Some of these requirements can also be verified prior to the initiation of service. Others must be verified when an organization begins providing services.

(C) Quality Clinical Standards address actual services provided, qualifications of staff, clinical documentation, and processes designed to assure consistency in quality and efficacy of services. These requirements can only be verified after a reasonable time during which services have been provided.

(3) Substantial compliance with applicable Core Organizational Standards, Core Operational Standards and Quality Clinical Standards will be evaluated by assessing each program or facility's level of compliance with applicable standards. Standards will have separate minimum compliance thresholds based on their categorization as critical or necessary in accordance with 450:1-9-5.7. Critical and Necessary Standards are defined as follows:

(A) Critical Standards are standards that have the potential to significantly impact the safety, well-being, and/or rights of consumers, or consumers' access to appropriate services.

(B) Necessary Standards are standards that are important for the organization's overall functioning but generally do not have a significant, immediate impact on consumers.

~~(3)~~(4) Compliance with all applicable Core Organizational Standards, Core Operational Standards and Quality Clinical Standards will be evaluated in the manner

and methods prescribed by ODMHSAS. Compliance methods include, but are not limited to, on-site inspections and observation, staff interviews, and review of relevant records and documentation as determined by ODMHSAS. The determination of whether an individual standard is deemed compliant may be done on a pass/fail basis or as a minimum percentage of required elements. Failure to provide documentation or access requested by ODMHSAS will be grounds for disciplinary action. Failure to demonstrate substantial compliance with ~~any~~ applicable ~~standard~~standards will result in immediate suspension and/or revocation.

~~(4)~~(5) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure, other licenses, or permits required of organizational entities.

(b) A certified Community Mental Health Center that provides alcohol and drug treatment services in the course of its outpatient or inpatient services, but has no designated or specialized alcohol and drug abuse treatment program component, shall not be subject to additional certification under Chapter 18 of this Title.

(c) A certified Community Mental Health Center providing alcohol and drug abuse treatment services as a designated or specialized program component shall be subject to certification under Chapter 18 or Chapter 24 of this Title.

(d) Qualifications for certification of entities and individuals providing alcohol and drug course instruction or assessments are as follows:

(1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those formally codified in Title 450, Chapter 21, Alcohol and Drug Substance Abuse Courses (ADSAC) and Assessments.

(2) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure and other licenses or permits.

(e) Qualifications for certification of individual providers of mental health, substance use, or addictive disorder services are as follows:

(1) Compliance with applicable Standards and Criteria as authorized within the authority of Title 43A of the Oklahoma Statutes, including but not limited to those formally codified in Title 450 regulating the area for which certification is sought:

(A) Chapter 50, Standards and Criteria for Certified Behavioral Health Case Managers; ~~and~~

(B) Chapter 53, Standards and Criteria for Certified Peer Recovery Support Specialists~~.~~; and

(C) Chapter 75, Standards and Criteria for Certified Problem Gambling Treatment Counselors.

(2) An applicant for certification must also comply with all other applicable statutory licensing provisions, including but not limited to individual professional licensure and other licenses or permits.

450:1-9-5.4. Core organizational standards for facilities and programs

(a) **Governing Authority.** With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have documents of authority, which shall be available to the public and ODMHSAS upon request. Documents of authority shall identify

the duly constituted authority and governance structure for assuring legal responsibility and for requiring accountability for performance and operation of the facility (including all components and satellites). The documents of authority shall indicate:

(1) Eligibility criteria for governing body membership;

(2) The number and types of membership;

(3) The method of selecting members;

(4) The number of members necessary for a quorum;

(5) Attendance requirements for governing body membership;

(6) The duration of appointment or election for governing body members and officers; and

(7) The powers and duties of the governing body and its officers and committees or the authority and responsibilities of any person legally designated to function as the governing body.

(b) **Organizational Description.** All facilities and programs shall have a written organizational description which is ~~reviewed and~~ approved ~~annually~~ by its governing authority. The facility or program shall make the organizational description available to staff and, upon request, to the public. The organizational description shall minimally include descriptions of:

(1) Population(s) to be served;

(2) The overall program mission statement;

(3) The ~~annual~~ goals and objectives for the program, including the goal of continued progress in providing evidence-based practices; and

(4) The specific geographic area in which services are provided for programs certified under Chapter 55 of this Title.

(c) **Personnel Policies and Procedures.**

(1) All facilities and programs shall have written personnel policies and procedures. With the exception of facilities certified under Chapter 16 of this Title, these policies and procedures shall be approved by the governing authority.

(2) All employees shall have access to personnel policies and procedures, as well as other rules and regulations governing the conditions of their employment.

(3) The facility or program shall develop, adopt, and maintain policies and procedures at each provider location to provide for qualified personnel during all hours of operation.

(4) There shall be job descriptions for all positions setting forth minimum qualifications and duties of each position.

(d) **Utilization of Volunteers.**

(1) In facilities and programs where volunteers are utilized, specific policies and procedures shall be in place to define the purpose, scope, training, supervision and operations related to the use of volunteers.

(2) There shall be documentation to verify orientation of each volunteer which shall enable him or her to have knowledge of program goals, and familiarity with routine procedures.

(3) All volunteers must receive in-service training pursuant to OAC ~~450:1-9-5.3(b)~~450:1-9-5.6(b).

(e) **Information Analysis and Performance Improvement.**

(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have an ongoing information analysis and performance

improvement system in order to objectively and systematically monitor, evaluate, and improve consumer outcomes and organizational performance.

(2) The system shall also address the fiscal management of the facility or program.

(3) Each facility and program shall prepare a year-end management report annually which shall include, at a minimum:

(A) An analysis of consumer outcomes and organizational processes, including:

(i) A quarterly quality consumer record review to evaluate the quality of service delivery, including:

(I) Appropriateness of services;

(II) Patterns of service utilization;

(III) Consumer involvement in service planning;

(IV) Assessment processes;

(V) Service planning procedures and compliance;

(VI) Alignment between services provided and treatment goals;

(VII) Service documentation procedures and compliance; and

(VIII) Alignment between services provided and billed service encounters.

(ii) A review of staff privileging processes;

(iii) A review of critical and unusual incidents and consumer grievances and complaints;

(iv) An assessment of service provision, including the provision of trauma-informed, co-occurring capable, culturally competent, and consumer-driven services; and

(v) Consumer satisfaction.

(B) Identified areas of improvement; and

(C) Strategies that will be implemented to address areas of improvement.

(4) The management report shall be made available to consumers, staff, the governing authority and ODMHSAS upon request.

(f) **Special Populations.**

(1) Under Titles 11 and 111 of the Americans with Disabilities Act of 1990, all facilities shall comply with the "Accessibility Guidelines for Buildings and Facilities (ADAAG) for alterations and new construction." State and local standards for accessibility and usability may be more stringent. Facilities shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.

(2) All facilities and programs shall have written policy and procedures for providing or arranging for services for persons who fall under the protection of the Americans with Disabilities Act of 1990 and provide documentation of compliance with applicable Federal, state, and local requirements. A recommended reference is the "Americans with Disabilities Handbook" published the in U.S. Equal Employment Opportunities Commission and the U.S. Department of Justice.

(3) All facilities shall have a policy of non-discrimination against persons with Human Immunodeficiency Virus (HIV) and persons with Acquired Immunodeficiency Syndrome (AIDS).

450:1-9-5.5. Core operational standards for facilities and programs

(a) **Physical facility environment and safety.**

(1) All facilities shall have written policies and procedures to ensure the safety and protection of all persons within the facility's physical environment, including all leased or owned property and buildings.
(2) All facilities shall be in compliance with applicable fire and safety regulations, codes, and statutory requirements of the federal, state, and local government. This shall include, but not be limited to, the Universal Precautions for Transmission of Infectious Diseases from the Occupations Safety Health Administration (OSHA).
(3) All facilities shall have an annual fire and safety inspection from the State Fire Marshal or local fire department which documents approval for continued occupancy. All facilities shall keep a copy of the inspection documentation and any correspondence regarding any deficiency at the facility.
(4) All facilities shall have an emergency preparedness plan to meet the needs of consumers, visitors, and staff during a disaster. The emergency preparedness plan shall be evaluated annually and shall, at a minimum, address:
(A) Fires;
(B) Floods;
(C) Tornadoes;
(D) Explosions;
(E) Chemical spills; and
(F) Prolonged loss of heat, light, water, and air conditioning.
(5) All facilities shall have a designated Safety Officer.
(6) There shall be written plans and diagrams posted prominently noting emergency evacuation routes and shelter locations.
(7) All facilities shall have fire alarm systems. All alarms shall be in working order and have visual signals suitable for individuals with a hearing impairment.
(8) There shall be emergency power to supply lighting throughout each location where consumers receive services.
(9) Storage of dangerous substances (toxic or flammable substances) shall be in locked, safe areas or cabinets.
(10) There shall be a written plan for the protection and preservation of consumer records in the event of a disaster.
(11) If the facility serves children or adolescents in any form of residential care, there shall be outside play and recreational space and equipment provided which:
(A) Is protected and free from hazards;
(B) Is safely accessible from indoors;
(C) Has supplies and equipment maintained safely; and
(D) Has some shade provided.

(b) **Hygiene and sanitation.**

(1) Residential facilities shall provide the following services and applicable supporting documentation:
(A) Toilet facilities in a minimum ratio of one (1) per eight (8) resident beds. Each toilet facility shall include a sink in the same room or immediately adjacent thereto;
(B) Bathing facilities in a minimum ratio of one (1) tub or shower per each eight (8) resident beds;
(C) Sewage discharge into a municipal sewerage system or collected, treated, and disposed of in an independent sewerage system;

(D) Regular inspections and treatment by a licensed pest control operator;

(E) Solid waste disposal through public systems or in a manner approved by the local agency having jurisdiction and the OSDH or Department of Environmental Quality (DEQ), as necessary, with documentation from OSDH or DEQ that the solid waste disposal system is free from deficiencies if applicable;

(F) Water obtained from an approved public water supply or tested at least quarterly and treated as necessary, thereby maintaining a determination as an approved water supply by the authority having jurisdiction and the OSDH or DEQ, as necessary, with documentation from OSDH or DEQ that the solid waste disposal system is free from deficiencies if applicable;

(G) Linen in quantities adequate to provide at least two (2) changes of bedding each week; and

(H) Housekeeping services that provide a hygienic environment in the facility.

(2) Outpatient treatment facilities shall provide:

(A) Toilet facilities in a minimum ratio of one (1) per twenty (20) persons. Each toilet facility shall include a sink in the same room or immediately adjacent thereto;

(B) Water and sewerage in the same manner as prescribed for residential facilities; and

(C) Housekeeping services that provide a hygienic environment in the facility.

(c) **Tobacco-free campus.**

(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities shall provide a tobacco-free campus for its employees, consumers and visitors. Possession and use of any tobacco product is prohibited on the grounds of the facility by employees, consumers, volunteers and visitors.

(2) All facilities shall visibly post signs on the property notifying consumers, employees and visitors that the visible possession and use of tobacco products is prohibited.

(3) Facility employees shall not share tobacco or tobacco replacement products with consumers.

(4) The facility shall offer assistance to employees who are tobacco users while employed by the facility. The facility shall have written policies describing the types of assistance offered to employees.

(5) The facility shall ~~always~~ inquire about consumers' tobacco use status as part of the screening and treatment planning process and be prepared to offer treatment upon request of the consumer.

(d) **Technology.** With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have policies and procedures regarding the use of technology and systems to support and advance effective and efficient service and business practices. The plan shall include, but not be limited to:

(1) Hardware and software;
(2) Security;
(3) Confidentiality;
(4) Backup policies;
(5) Assistive technology;
(6) Disaster recovery preparedness; and
(7) Virus protection.

(e) **Confidentiality and information security.**

(1) All facilities and programs shall have written policies and procedures describing the conditions under which consumer information may be disclosed and the procedures for releasing such information. These conditions and procedures shall adhere to all applicable federal and state rules and statutes, including:

(A) 42 C.F.R., Part 2 and 45 C.F.R. §§ 160.101 et seq.;

(B) 43A O.S. § 1-109 and 63 O.S. § 1-502.2; and

(C) OAC 450:15-3-20.1, OAC 450: 15-3-20.2 and OAC 450:15-3-60.

(2) It shall be the responsibility of facility or program to safeguard client information against loss, theft, defacement, tampering, or use by unauthorized persons.

450:1-9-5.6. Quality clinical standards for facilities and programs

(a) **Staff qualifications.**

(1) All staff who provide clinical services within facilities and programs shall have documented qualifications or training specific to the clinical services they provide.

~~(2) Staff qualifications for contracted entities shall be in compliance with 450:1-1-1.1 and 450:1-3-5.~~

~~(3)~~(2) Each facility or program shall have policies and procedures for documenting and verifying the training, experience, education, and other credentials of service providers prior to their providing treatment services for which they were hired. All staff shall be documented as privileged prior to performing treatment services.

~~(4)~~(3) All direct care staff shall be at least eighteen (18) years old.

~~(5)~~(4) Each facility or program shall minimally perform a review each calendar year of current licensure, certifications, and current qualifications for privileges to provide specific treatment services.

(b) **Staff development and training.**

(1) All facilities and programs shall have a written staff development and training plan for all administrative, professional and support staff. This plan shall include, at a minimum:

(A) Orientation procedures;

(B) In-service training and education programs;

(C) Availability of professional reference materials;

(D) Mechanisms for ensuring outside continuing educational opportunities for staff members; and

(E) Performance improvement activities and their results.

(2) In-service training shall be conducted each calendar year and shall be required ~~upon hire~~within thirty (30) days of each employee's hire date and each calendar year thereafter for all employees on the following topics:

(A) Fire and safety, including the location and use of all fire extinguishers and first aid supplies and equipment;

(B) Universal precautions and infection control;

(C) Consumer's rights and the constraints of the Mental Health Patient's Bill of Rights;

(D) Confidentiality;

(E) Oklahoma Child Abuse Reporting and Prevention Act, 10 O.S. §§ 7101-7115;

(F) Facility policy and procedures;

(G) Cultural competence (including military culture if active duty or veterans are being served);
(H) Co-occurring disorder competency and treatment principles;
(I) Trauma informed service provision;
(J) Crisis intervention; ~~and~~
(K) Suicide risk assessment, prevention, and response; and
~~(K)~~(L) Age and developmentally appropriate trainings, where applicable.

(3) All clinical staff, direct care staff, and/or volunteers providing direct care shall have non-physical intervention training in techniques and philosophies addressing appropriate non-violent interventions for potentially physical interpersonal conflicts, staff attitudes which promote dignity and enhanced self-esteem, keys to effective communication skills, verbal and non-verbal interaction and non-violent intervention within thirty (30) days of being hired with updates each calendar year thereafter. This standard shall not apply to facilities or programs subject to Chapter 27 of this Title.

(4) The local facility Executive Director shall designate which positions and employees, including temporary employees, will be required to successfully complete physical intervention training. An employee or volunteer shall not provide direct care services to consumers until completing this training. This standard shall not apply to facilities or programs subject to Chapter 16 or Chapter 27 of this Title, or outpatient programs subject to Chapter 18 of this Title.

(5) The training curriculum for ~~(2) and~~ (3) and (4) of this subsection must be approved by the ODMHSAS commissioner or designee ~~in writing prior to conducting of any training pursuant to this provision~~.

(6) Each site shall have staff during all hours of operation who maintain current certification in basic first aid and Cardiopulmonary Resuscitation (CPR).

(c) **Clinical supervision.**

(1) With the exception of facilities certified under Chapter 16 of this Title, all facilities and programs shall have written policies and procedures, operational methods, and documentation of the provision of clinical supervision for all direct treatment and service staff. For facilities that employ only one service provider, supervision will be in the form of clinical consultation from a qualified service provider in the same field. These policies shall include, but are not limited to:
(A) Credentials required for the clinical supervisor;
(B) Specific frequency for case reviews with treatment and service providers;
(C) Methods and time frames for supervision of individual, group, and educational treatment services; and
(D) Written policies and procedures defining the program's plan for appropriate counselor-to-consumer ratio, and a plan for how exceptions may be handled.

(2) Ongoing clinical supervision shall be provided and shall address:
(A) The appropriateness of treatment selected for the consumer;
(B) Treatment effectiveness as reflected by the consumers meeting their individual goals; and
(C) The provision of feedback that enhances the clinical skills of service providers.

(d) **Clinical record keeping, basic requirements.**

(1) All facilities and programs shall establish and maintain an organized clinical record system for the collection and documentation of information appropriate to the treatment

processes; and which insures organized, easily retrievable, usable clinical records stored under confidential conditions and with planned retention and disposition.

(2) Each facility or program shall maintain an individual record for each consumer.

(3) The facility's or program's policies and procedures shall:

(A) Define the content of the consumer record in accordance with all applicable state and federal rules, requirements, and statutes;

(B) Define storage, retention and destruction requirements for consumer records in a manner that prevents unauthorized information disclosures;

(C) Require consumer records be maintained in locked equipment which is kept within a locked room, vehicle, or premise;

(D) Require legible entries in consumer records, signed with first name or initial, last name, and dated by the person making the entry;

(E) Require the consumer's name or unique identifier be typed or written on each page in the consumer record; or appear on each screen of an electronic record;

(F) Require a signed consent for treatment before a consumer is admitted on a voluntary basis; and

(G) ~~Require a signed consent for referral and payment, and for follow up before any contact after discharge is made.~~Require consent for release of information in accordance with federal and state laws, guidelines, and standards, including OAC 450:15-3-20.1 and OAC 450:15-3-20.2. For disclosure of information related to substance use disorder referral, payment, and follow up, a signed consent is required.

(4) If electronic clinical (medical) records are maintained, there shall be proof of compliance with all applicable state and federal rules and statutes related to electronic medical records, encryption, and other required features.

(5) ODMHSAS operated facilities shall comply with Records Dispositi9-5on Schedule 82-17 as approved by the Oklahoma Archives and Records Commission.

(6) The facility or program shall assure consumer records are readily accessible to all staff providing services to consumers. Such access shall be limited to the minimum necessary to carry out the staff member's job functions or the purpose for the use of the records.

(e) **Discharge summary.**

(1) A completed discharge summary shall be entered in each consumer's record within fifteen (15) days of the consumer completing, transferring, or discontinuing services. The summary shall be signed and dated by the staff member completing the summary. Consumers who have received no services for one hundred eighty (180) days shall be discharged if it is determined that services are no longer needed or desired.

(2) A discharge summary shall include, but not be limited to, the consumer's progress made in treatment, ~~the consumer's response to services rendered,~~ initial condition and condition of the consumer at discharge, diagnoses, summary of current medications, when applicable, and recommendations for referrals, if deemed necessary. It shall include a discharge plan which lists written recommendations and specific referrals for implementing aftercare services, including medications. Aftercare plans shall be developed with the knowledge and cooperation of the consumer, when possible. This standard shall not apply to facilities certified under Chapter 16 of this Title.

(3) The signature of the staff member completing the summary and the date of completion shall be included in the discharge summary.

(4) In the event of death of a consumer, in lieu of a discharge summary, a summary statement including applicable information shall be documented in the record**.**

(f) **Critical incidents.**

(1) All facilities and programs shall have written policies and procedures requiring documentation and reporting of critical incidents and analysis of the contributors to the incident to ODMHSAS.

(2) The documentation of critical incidents shall contain, at a minimum:

(A) Facility name and signature of the person(s) reporting the incident;

(B) Names of the resident(s), and/or staff member(s) involved;

(C) Time, date, and physical location of the incident;

(D) Time and date incident was reported and name of person within the facility to whom it was reported;

(E) Description of incident;

(F) Severity of each injury, if applicable. Severity shall be indicated as follows:

(i) No off-site medical care required or first aid care administered on-site;

(ii) Medical care by a physician or nurse or follow-up attention required; or

(iii) Hospitalization or immediate off-site medical attention was required;

(G) Resolution or action taken and date resolution or action was taken; and

(H) Signature of the facility administrator, or designee of the facility administrator. The designee must be previously identified in writing to the Department and designated within the facility's policy and procedures by the facility administrator. Only one designee per facility shall be permitted.

(3) Critical incidents shall be reported to ODMHSAS with specific timeframes, as follows:

(A) Critical incidents requiring medical care by a physician or nurse or follow-up attention and incidents requiring hospitalization or immediate off-site medical attention shall be delivered via fax, or ODMHSAS designated electronic system, to ODMHSAS within ~~twenty-four (24)~~seventy-two (72) hours of the incident ~~being documented~~.

(B) Critical incidents involving allegations constituting a sentinel event or resident abuse shall be reported to ODMHSAS immediately via telephone or fax, but within not more than twenty-four (24) hours of the incident. If reported by telephone, the report shall be followed with a written report within twenty-four (24) hours of the incident.

450:1-9-5.7. Types and duration of certification status for facilities and programs

(a) The ODMHSAS may grant the following types of certification for the durations specified below.

~~(1) **Permit for temporary operations.** Permits for temporary operations may be granted upon ODMHSAS's verification that the organization has complied with all Core Organizational Standards and Core Operational Standards applicable to the related type of services for which certification is sought. In addition, for facilities that have provided services for 30 days or longer applicable to this type of certification ODMHSAS may review compliance with applicable Quality Clinical Standards. The~~

~~Permit will expire at the end of six (6) months or if a subsequent certification is achieved by the organization and subsequently granted by ODMHSAS prior to the expiration of the Permit. ODMHSAS may extend a Permit for no more than 60 days in the event of extenuating circumstances as determined by ODMHSAS.~~

(1) **Permit for Temporary Operation.** A Permit for Temporary Operation may be granted upon ODMHSAS's verification that the organization has substantially complied with Core Organizational Standards and Core Operational Standards applicable to the type of services for which certification is sought. A Permit for Temporary Operation allows for the organization to begin operations so that compliance with Quality Clinical Standards may be assessed by the Department.

(A) A Permit for Temporary Operation will be granted for a maximum of six (6) months and will expire upon subsequent certification achieved by the organization or upon a determination by ODMHSAS that the organization is not in substantial compliance with Quality Clinical Standards.

(B) Organizations shall notify ODMHSAS in writing no later than fourteen (14) calendar days after initiating clinical services in order to begin the compliance review of Quality Clinical Standards. Failure to provide such notification within the required timeframe may result in immediate termination of the Permit for Temporary Operation.

(C) A Permit for Temporary Operation may not be renewed. ODMHSAS may extend a Permit for Temporary Operation for no more than ninety (90) days in the event of extenuating circumstances as determined by ODMHSAS.

(D) Organizations that do not achieve subsequent certification after obtaining a Permit for Temporary Operation must wait a minimum of ninety (90) days before making re-application.

~~(2) **Probationary certification.** Probationary Certification may be awarded for a one (1) year period by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 and when ODMHSAS verifies that all conditions in 450:1-9-5.7(a)(3) exist but the program initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required. Additionally, certified organizations that provide services out of a satellite prior to the satellite being approved by ODMHSAS will have their organization's certification reduced to a Probationary Certification. Organizations awarded Probationary Certification must apply for and be awarded Probationary Certification for two additional one (1) year terms, prior to being considered for other categories of ODMHSAS Certification.~~

(2) **Probationary Certification.** Probationary Certification may be awarded for a one (1) year period by ODMHSAS in cases where a program or facility has changed majority ownership or board composition but operations of the program or facility continue. Such programs or facilities must provide ODMHSAS with documentation of any changes in policies, procedures, personnel, services, and other documentation as requested by ODMHSAS. Upon determination by ODMHSAS that the program or facility meets the requirements of 450:1-9-5.7(a)(3) prior to expiration of the Probationary Certification, the program or facility may obtain applicable Certification.

(3) **Certification.** ODMHSAS may award Certification for a one (1) year or two (2) year period beyond the period approved for a Permit for Temporary Operations or as a renewal of a previously awarded Certification in accordance with applicable chapters

as stipulated in 450:1-9-5 and when ODMHSAS determines that the organization has met ~~minimal~~substantial compliance with ~~each type of standard (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards)~~applicable standards. To qualify for Certification, programs must meet the following:

~~(A) Demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS and within timeframes stipulated by ODMHSAS; and,~~

~~(B) For a two (2) year certification, demonstrate compliance with at least 75% of all Quality Clinical Standards on the initial site review, and file an acceptable plan of correction and demonstrate compliance with 100% of Quality Clinical Standards, as verified by ODMHSAS in accordance 450:1-9-7.1 and 450:1-9-7.3.~~

(A) Demonstrate compliance with a minimum of ninety percent (90%) of all Critical Standards as identified in the ODMHSAS Provider Certification Manual on the initial site review, file an acceptable plan of correction in the required timeframe addressing standards for which compliance was not achieved on the initial site review, and demonstrate compliance with one hundred percent (100%) of all Critical Standards after the initial site review.

(B) Demonstrate compliance with a minimum of seventy-five percent (75%) of all Necessary Standards as identified in the ODMHSAS Provider Certification Manual on the initial site review and file an acceptable plan of correction in the required timeframe addressing standards for which compliance was not achieved on the initial site review. ODMHSAS may verify compliance with standards identified in the plan of correction at its discretion.

(C) Programs with fewer than five (5) active cases for which clinical records could be reviewed must meet the requirements in (B) above, but can be considered for no more than a one (1) year certification.

(D) Community Residential Mental Health Programs can be considered for no more than a one (1) year certification.

(E) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(3) until all conditions of 450:1-9-5.7(2) have been satisfied.

(F) Programs found to have initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required shall obtain the necessary Permit for Temporary Operations to continue operations. Subsequently, these programs will be eligible for Certification for a one (1) year period only for the first two (2) years of Certification. Such programs that fail to obtain the necessary Permit for Temporary Operations shall be required to cease operations.

(4) **Certification with distinction.** Certification with Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied~~.~~:

(A) Programs must have provided services with an approved ODMHSAS Certification as described in ~~450:1-9-5.4(3)~~450:1-9-5.7(a)(3) for one (1) year or

longer in addition to the time services were provided under an approved Permit for Temporary Operations or a Probationary Certification.

~~(B) Programs must demonstrate compliance with all Core Organizational Standards and with all Core Operational Standards as verified by ODMHSAS; and,~~

~~(C) Programs must also demonstrate compliance with at least 90% of all Quality Clinical Standards on the initial renewal site visit and review as verified by ODMHSAS. Compliance may be determined during initial site reviews or during additional site reviews following the implementation of a plan of correction as required ODMHSAS, in accordance 450:1-9-7.1 and 450:1-9-7.3.~~

(B) Programs must demonstrate compliance with a minimum of ninety percent (90%) of all Critical Standards on the initial site review, file an acceptable plan of correction in the required timeframe addressing standards for which compliance was not achieved on the initial site review, and demonstrate compliance with one hundred percent (100%) of all Critical Standards after the initial site review.

(C) Programs must demonstrate compliance with a minimum of eighty-five percent (85%) of all Necessary Standards on the initial site review and file an acceptable plan of correction in the required timeframe addressing standards for which compliance was not achieved on the initial site review. ODMHSAS may verify compliance with standards identified in the plan of correction at its discretion.

~~(D) Programs for which ODMHSAS determines compliance with all standards as required in (a), (b), and (c) may be considered for Certification with Distinction for a three (3) year period.~~

~~(E)~~(D) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e. Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

~~(F)~~(E) Community Residential Mental Health Programs can be considered for no more than a one (1) year Certification with Distinction.

~~(G)~~(F) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(4) until all conditions of 450:1-9-5.7(2) have been satisfied.

(5) **Certification with special distinction.** Certification with Special Distinction may be awarded for up to three (3) years by ODMHSAS in accordance with applicable chapters as stipulated in 450:1-9-5 for programs seeking renewal of previously awarded certification when ODMHSAS verifies all of the following minimal conditions are satisfied.

(A) The program must meet all conditions for Certification with Distinction as outlined in 450:1-9-5.7(a)(4); and,

(B) The program has attained national accreditation (COA, CARF, or TJC) for the services to which ODMHSAS Certification applies.

(C) Certification with Special Distinction will be reduced by ODMHSAS to Certification with Distinction by ODMHSAS if during the certification period for which the Special Distinction was approved, the program fails to maintain national accreditation status.

(D) ODMHSAS may refund certification renewal application fees for organizations that demonstrate 100% compliance with all standards (i.e. Core Organizational

Standards, Core Operational Standards, and Quality Clinical Standards) during the initial renewal site visit and review.

(E) Community Residential Mental Health Programs can be considered for no more than a one (1) year Certification with Special Distinction.

(F) Programs awarded a Probationary Certification are not eligible for Certification under the conditions described in 450:1-9-5.7(a)(4) until all conditions of 450:1-9-5.7(a)(2) have been satisfied.

(b) Permits for Temporary Operations granted to applicants for initial certification of a facility, location, or level of service shall be for a period of six (6) months and shall become effective immediately upon approval by the ODMHSAS Board, the Commissioner or designee.

(c) Certification, other than Permits for Temporary Operations, granted to an applicant shall become effective the first day of the month following the date of the action by the Board, provided however, the Board may waive this requirement and make the Certification effective immediately.

450:1-9-5.8. Types and duration of certification of individuals

(a) Certification for organizations and individuals providing alcohol and drug abuse course instruction or assessments will be in accordance with requirements and procedures stipulated in OAC 450:21.

(b) Certification for Behavioral Health Case Managers will be in accordance with requirements and procedures stipulated in OAC 450:50.

(c) Certification for Recovery Support Specialists will be done in accordance with requirements and procedures stipulated in OAC 450:53.

(d) Certification for Problem Gambling Treatment Counselors will be done in accordance with requirement and procedures stipulated in OAC 450:75.

450:1-9-5.9. Additional conditions related to certification

~~(a) Certification granted by ODMHSAS is not transferable. A change of the ownership of a facility automatically terminates any certification status, requiring application for certification by the new ownership.~~

~~(1) If the certified facility is owned by a corporation the following applies:~~

~~(A) If the corporation is not-for-profit, a change in membership of the Board of Directors of more than fifty percent (50%) of the Directors in three (3) or less calendar months, unless such change was caused by the normal expiration of terms in accordance with the bylaws of the Board of Directors, shall require the facility to be recertified.~~

~~(B) If the corporation is other than not-for-profit, a change in the ownership of more than forty per cent (40%) of the stock in the corporation from the owners at the beginning of the period of certification shall require the facility to be recertified.~~

~~(2) It is the responsibility of the facility to notify the ODMHSAS of the occurrence of either of the conditions requiring recertification and to request the application materials for recertification.~~

~~(b)~~(a) Organizations granted certification, including Permits for Temporary Operation, shall only publically refer to ODMHSAS Certification in relationship to the specific services, locations, and dates applicable to each currently granted ODMHSAS

Certification. This includes all published materials, electronic media, and information posted within a facility. Failure to adhere to this restriction can be cause for action related to Certification in accordance with 1-5-4.

~~(c)~~(b) ODMHSAS ~~shall~~may conduct ~~at least one~~ unannounced additional certification site ~~visit~~visits ~~during each one (1) year term of~~at a program granted Probationary Certification and ~~each~~a program granted 1-Year Certification.

(1) A site visit report will be supplied to the program or facility within five (5) days of the site visit unless precluded by extenuating circumstances.

(2) If deficiencies are noted, the program or facility must file a Plan of Correction addressing all deficiencies within ten (10) days of receipt of the report.

(3) Deficiencies verified during the unannounced site visit that indicate danger to the health, safety and/or welfare of the clients will result in immediate suspension and/or revocation.

~~(d)~~(e) Certification may be suspended or revoked with the basis for such action being delineated in Section 450:1-9-9 of this Subchapter.

450:1-9-6. Procedures for application for certification

(a) Applications for certification as a ~~community mental health center, community residential mental health facility, community-based structured crisis center, comprehensive community addiction recovery centers, mental illness service programs, eating disorder treatment program, alcohol and drug treatment program, program of assertive community treatment, gambling addiction treatment program, and narcotic treatment~~facility or program must be made to ODMHSAS in writing on a form and in a manner prescribed by ~~the Commissioner of~~ ODMHSAS and include the following:

(1) A fully completed ODMHSAS application for certification form signed by authorized officials;

(2) The necessary written documentation or supporting evidence required on the application for certification form; and

(3) The required certification fee ~~in the form of a check or money order,~~ payable to the Oklahoma Department of Mental Health and Substance Abuse Services.

(4) The following fees are required:

(A) Application fee for all Treatment Programs is $1,000 per certification period.

(B) Application fee for Community Residential Mental Health Programs is $100 per certification period.

~~(5) The application for certification form, required written documentation and fee must be submitted to Oklahoma Department of Mental Health and Substance Abuse Services, Provider Certification Division, P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277.~~

~~(6)~~(5) The application may require a listing of all services provided by the applicant, as well as specifics about the applicant including but not limited to governing authority, administrative, fiscal, proof of status as a business entity recognized by the State of Oklahoma, Secretary of State, all locations or sites where applicant will provide services and types of services to be provided.

~~(7)~~(6) The application must include a listing of key personnel responsible for business and clinical operations of the facility. At a minimum, the application will require a listing of the following, along with current contact information:

(A) Agency director;
(B) Business director or financial officer;
(C) Clinical director, currently licensed in the clinical area(s) for which certification is sought.
(i) If both substance use disorder treatment and mental health treatment services will be provided by the entity, the Clinical Director must have evidence of dual license or additional training in the area for which they are not currently licensed.
(ii) The facility must also provide evidence that the Clinical Director will be employed to serve as Clinical Director a minimum of ten (10) hours per week.

~~(8)~~(7) ODMHSAS may refund certification fees based on exemplary performance during the Certification process for which the application has been submitted and based on guidelines established by ODMHSAS.

(b) Applications for certification or credentials as an individual provider must be made to ODMHSAS in writing on a form and in a manner prescribed by ~~the Commissioner of~~ ODMHSAS and, as applicable, in accordance with specific requirements stipulated in OAC 450:21, OAC 450:50, ~~and~~ OAC 450:53~~.~~, and OAC 450:75.

(c) Failure to provide required materials within sixty (60) days of receipt of the application will result in a denial of the application.

450:1-9-6.1. Expanding certification of facilities and programs to additional geographical areas~~; Adding new programs or levels of care~~

~~(a) Except for a Community Mental Health Center, a facility or program, after being certified, may request to add additional service locations within the State.~~

~~(b) A Community Mental Health Center, after being certified, may request to add a service location within its service area established by ODMHSAS in accordance with 43A O.S. § 3-302 (3).~~

~~(c) Approval may be granted by the Commissioner upon submission of the required documentation to the Provider Certification Division provided the organization is not certified under a Permit for Temporary Operations.~~

~~(1) The facility must notify ODMHSAS in writing of the plan to expand service locations on a form and in a manner prescribed by the Commissioner of ODMHSAS.~~

~~(2) The required written documentation or supporting evidence includes, but is not limited to:~~

~~(A) fire & safety inspection;~~
~~(B) facility policies and procedures;~~
~~(C) zoning compliance; and~~
~~(D) evidence of compliance with Title 43A O.S. §3-417.1, if applicable.~~

~~(d) At the time of the next review of the facility's main office certification, any location which extended service provision to a different location will require a separate certification application and may be reviewed on a schedule separate and apart from the certification schedule of the main office.~~

~~(e) If after being certified, a facility desires to offer a new type of service or new level of care, for which certification is required, the facility must submit an application for certification, the required documentation and fee to the ODMHSAS Provider Certification Division, P.O. Box 53277, Oklahoma City, Oklahoma 73152-3277.~~

(a) After initial certification, a facility or program may request to add additional service locations within the state. A Community Mental Health Center may only request to add additional Community Mental Health Center locations within its service area established by ODMHSAS in accordance with 43A O.S. § 3-302 (3).
(b) Such additional service locations do not require a Permit for Temporary Operation certification, provided that the organization has an existing certification(s) in good standing for the chapter(s) which cover the scope of services in the additional service locations. The existing certification(s) must not be a Permit for Temporary Operation.
(c) If the additional service locations will provide services not covered by the organization's existing certifications, the organization must first obtain a Permit for Temporary Operation for the applicable chapters.
(d) Approval for additional service locations specified in (b) above may be granted by the Commissioner or designee upon submission of the required documentation to ODMHSAS.

(1) The facility must notify ODMHSAS in writing of the plan to expand service locations on a form and in a manner prescribed by ODMHSAS.
(2) The required written documentation and supporting evidence includes, but is not limited to:

(A) fire & safety inspection;
(B) facility policies and procedures;
(C) zoning compliance; and
(D) evidence of compliance with Title 43A O.S. §3-417.1, if applicable.

(e) At the time of the next review of the facility's main office certification, additional service locations may be reviewed on a schedule separate and apart from the certification schedule of the main office.

450:1-9-6.2. Adding new programs or optional services

(a) After initial certification, a facility or program may request to add additional programs or optional services.
(b) Addition of new programs do not require a Permit for Temporary Operation certification, provided that:

(1) The organization has an existing certification(s) in good standing for the chapter(s) which cover the new program. The existing certification(s) must not be a Permit for Temporary Operation; and
(2) The new program is providing services that are the same or lower level of care than the program(s) currently certified with the organization. If the new program is providing services at a higher or more restrictive level of care, the organization must first obtain a Permit for Temporary Operation.

(c) A currently certified Community Mental Health Center service location may add a Certified Community Behavioral Health Clinic without a Permit for Temporary Operation certification.
(d) Organizations may add optional services to their existing certification, provided that the optional services are included in the scope of the existing certification Chapter. The existing certification must not be a Permit for Temporary Operation.

(e) Approval for additional programs that meet the requirements specified in (b) or (c) above may be granted by the Commissioner or designee upon submission of the required documentation to ODMHSAS.

(1) The facility must notify ODMHSAS in writing of the plan to add a program or level of care on a form and in a manner prescribed by ODMHSAS.

(2) The required documentation and supporting evidence includes, but is not limited to:

(A) description of new program or level of care and services provided;

(B) personnel and training information; and

(C) number of beds and physical facility changes, if applicable.

(3) If the new program or level of care will be provided at a new service location, the required written documentation and supporting evidence also includes, but is not limited to:

(A) fire & safety inspection;

(B) facility policies and procedures;

(C) zoning compliance; and

(D) evidence of compliance with Title 43A O.S. §3-417.1, if applicable.

(f) At the time of the next review of the organization's certification, new programs or optional services may be reviewed on a separate schedule.

450:1-9-7. Procedures for completion of the Permit for Temporary Operations certification process

(a) Completion of the certification process for a Permit for Temporary Operations will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) Each organization pursuing ODMHSAS certification shall initially apply for a Permit for Temporary Operations, with the exception of special circumstances specified in 450:1-9-5.7(a)(2).

(2) Upon receipt of an application ODMHSAS will provide all applicants for a Permit for Temporary Operations a document listing the Core Organizational Standards, Core Operational Standards and Quality Clinical Standards required for a Permit for Temporary Operations. For facilities or programs that have provided clinical services for 30 days or longer, at the time of the initial application, ODMHSAS may also review applicable Quality Clinical Standards.

(3) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed. Failure to provide required materials within 60 days of receipt of the application will result in a denial of the application.

(4) Any deficiencies of applicable Core Organizational Standards and Core Operational Standards, and Quality Clinical Standards cited as a result of the site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(5) The facility will have ten (10) working days from receipt of the deficiency report to correct deficiencies related to Core Organizational and Core Operational Standards ~~and provide to ODMHSAS proof of compliance.~~ categorized as Necessary Standards.

The facility will have three (3) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards categorized as Critical Standards. ODMHSAS may conduct an additional site visit(s) to verify proof of compliance with any deficiencies cited in the initial review. Compliance with all Critical Standards for which the facility was not compliant upon the initial review must be demonstrated through a follow up site visit or review.

(6) If any pending deficiencies in Core Organizational Standards and Core Operational Standards are identified following this ten (10) day correction period, the program will have five (5) additional working days from receipt of any subsequent report to correct and verify compliance with any pending deficiencies.

(7) The following additional procedures will apply to programs or facilities reviewed for Quality Clinical Standards pursuant to an application for Permit for Temporary Operation as referenced in 1-9-7 (2) above.

(A) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards categorized as Necessary Standards. The facility will have three (3) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards categorized as Critical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (5) above. Compliance with all in Quality Clinical Standards categorized Critical Standards for which the facility was not compliant upon the initial review must be demonstrated through a follow up review.

(B) Any deficiencies of applicable standards identified during the ~~additional site visit or~~follow up review referenced in (A) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards categorized as Critical Standards during the follow up site visit or review referenced in (A) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a certification report. Facilities desiring this additional review must do so in writing to ~~the Director of Provider Certification~~ODMHSAS within three (3) working days of receipt of the follow up report referenced in (A) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (A) above. If the applicant fails to demonstrate compliance with all Quality Clinical Standards categorized as Critical Standards during the additional site visit or review, the application will be denied.

(8) Facilities for which ODMHSAS can verify substantial compliance with ~~all~~ applicable Critical and Necessary Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards during the initial review, and subsequently submit required plans of correction and demonstrate compliance with all Critical Standards within the timeframes specified in ~~(3)~~(5) through (7) above may be considered for

Permit for Temporary Operation in accordance with guidelines established in 450:1-9-5.7.

(9) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(10) Failure of any applicant for a Permit for Temporary Operation to ~~clear deficiencies of all~~demonstrate compliance with applicable ~~Standards~~standards within timeframes stipulated in ~~(3)~~(5) through (7), shall result in a notice of denial of the application for a Permit for Temporary Operations

(b) Additional certification procedures related to a Permit for Temporary Operations.

(1) Re-application for a Permit can be accepted no sooner than six months after issuance of a notification of denial.

(2) If an applicant fails a second time to satisfy requirements for a Permit for Temporary Operations as stipulated in 450:1-9-7(a)(8), ODMHSAS can accept an additional re-application no sooner than twelve (12) months from time of the issue of the second notification of denial.

(3) Organizations granted a Permit for Temporary Operations must achieve a subsequent level of ODMHSAS certification prior to the expiration of a Permit for Temporary Operations. Failure to do so will result in a cancellation by ODMHSAS of the Permit for Temporary Operations. ODMHSAS will provide notice of the cancellation and stipulate to the organization that it is must discontinue services subject to any statutory provisions that mandate the applicable ODMHSAS Certification. Re-application for a Permit for Temporary Operations, following a cancellation by ODMHSAS or by the organization to which a Permit was issued, may occur after six months and in accordance with the requirements of 450:1-9-7 and 450:1-9-12.

450:1-9-7.1. Procedures for completion of additional certification processes subsequent to a Permit for Temporary Operations

(a) The following procedures apply for organizations awarded Permit for Temporary Operation pursuant to 450:1-9-7 that elect to progress to an additional certification by ODMHSAS. The process outline below will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

~~(1) Ninety (90) days prior to the expiration of a Permit for Temporary Operations, ODMHSAS will notify the permitted facility that a supplemental certification application form must be completed so the organization can be reviewed for a new certification level. Along with a request for a supplemental certification application, ODMHSAS will provide a document listing Quality Clinical Standards applicable to the new certification level. The document will also indicate the Core Organization Standards and Core Operational Standards for which continued compliance must be verified.~~

~~(2) Each organization desiring to be considered for certification subsequent to being awarded a Permit for Temporary Operations will complete a supplemental certification application form at least sixty (60) days prior to the expiration of the Permit for Temporary Operations.~~

~~(3) In the event an organization, after being awarded a Permit for Temporary Operations, fails to supply the supplemental certification application in accordance~~

with (1) and (2) above or elects to not pursue further ODMHSAS certification, the Permit for Temporary Operations will be allowed to expire.
(4) No additional fee, beyond that required for a Permit for Temporary Operation will be required along with the supplemental certification application.
(5) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed.
(6) Any deficiencies of applicable standards identified as a result of the subsequent certification site visit or documentation reviews requested by ODMHSAS will be identified and a report will provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.
(7) The facility will have ten (10) working days from receipt of the report to correct deficiencies of all Core Organizational Standards and Core Operational Standards and provide ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit(s) to determine of compliance with Core Organizational Standards and Core Operational Standards. The facility will have no more than twenty (20) working days from the certification site visit referenced in (6) above to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.
(8) The facility will also have ten (10) working days from receipt of the report to submit a plan for correction related to deficiencies in Quality Clinical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule a site visit or documentation review to determine compliance with Quality Clinical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in (6) above. The site visit or review may or may not be conducted in conjunction with a review to verify compliance with pending Core Organizational Standards, and Core Operational Standards.
(9) Any deficiencies of applicable standards identified during the site visit or review referenced in (8) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (8) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a report. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (9) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (9) above.
(10) Facilities for which ODMHSAS can verify compliance with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards, within the timeframes specified in 450:1-9-7.1 may be considered for a certification status in accordance with guidelines established in 450:1-9-5.7.
(11) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

~~(12) If the applicant fails to submit a plan of correction within a required time frame or fails to submit a timely or adequate revised plan of correction, denial of the application for subsequent certification shall be sent to the applicant by the Commissioner or designee and the current Permit for Temporary Operations be allowed to expire. Likewise, if the applicant fails to request an additional site visit or documentation review in accordance with timeframes stipulated in (9) above denial of the application for subsequent certification shall be sent to the applicant by the Commissioner or designee and the current Permit for Temporary Operations be allowed to expire~~

(1) No later than ninety (90) days prior to the expiration of a Permit for Temporary Operation, ODMHSAS will notify the facility of necessary records and documentation to verify compliance with applicable Quality Clinical Standards for Certification. The facility shall provide the required materials within thirty (30) days of notification from ODMHSAS.

(2) A site review of the facility or program will be scheduled and completed once the necessary records and documentation have been received.

(3) The facility shall provide ODMHSAS documentation regarding its policies and procedures prior to the site review. This documentation shall include an attestation that the facility's policies and procedures have or have not changed since the initial certification review. If the policies and procedures have changed, the facility shall provide documentation of each change to ODMHSAS for review.

(4) Any deficiencies of applicable Quality Clinical Standards cited as a result of the site visit or subsequent review(s) of documents requested by ODMHSAS will be identified and a report will be provided to the facility by ODMHSAS within five (5) working days of the site visit unless precluded by extenuating circumstances.

(5) The facility will have ten (10) working days from receipt of the deficiency report to correct deficiencies related to Quality Clinical Standards categorized as Necessary Standards. The facility will have three (3) working days from receipt of the report to submit a plan for correction related to cited deficiencies in Quality Clinical Standards categorized as Critical Standards. ODMHSAS may conduct an additional site visit(s) to verify proof of compliance. Compliance with all Quality Clinical Standards categorized as Critical Standards for which the facility was not compliant upon the initial review must be demonstrated through a follow up review.

(6) If any pending deficiencies in Quality Clinical Standards are identified following this ten (10) day correction period, the program will have five (5) additional working days from receipt of any subsequent report to correct and verify compliance with any pending deficiencies.

(7) Facilities for which ODMHSAS cannot determine compliance with all Quality Clinical Standards categorized as Critical Standards during the follow up site visit or review may request ODMHSAS to complete one additional site visit or review prior to the finalization of a report. Facilities desiring this additional review must do so in writing to ODMHSAS within three (3) working days of receipt of the follow up report and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of the follow up report. If the applicant fails to demonstrate compliance during the additional site visit or review, denial of the application for subsequent certification shall be sent to the applicant by the Commissioner or designee and the Permit for Temporary Operation will expire.

(8) Facilities for which ODMHSAS can verify substantial compliance with applicable Critical and Necessary Quality Clinical Standards during the initial review, and subsequently submit required plans of correction and demonstrate compliance with all Critical Quality Clinical Standards within the timeframes specified in (5) through (7) above may be considered for Certification in accordance with guidelines established in 450:1-9-5.7.

(9) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

(10) Failure of any applicant to demonstrate compliance with Standards within the timeframes specified in (5) through (7) above shall result in denial of the application for subsequent certification and the Permit for Temporary Operation will expire.

450:1-9-7.2. Procedures for renewal of certification

(a) The following procedures apply to organizations previously awarded certification pursuant to ~~450:1-9-7.1~~450:1-9-5.7 and organizations that have maintained Certification or Certification with Commendation awarded by ODMHSAS prior to November 1, 2010. The process outline below can result in an entity being awarded Certification, Certification with Distinction, or Certification with Special Distinction. The process will be done in cooperation between the applicant and ODMHSAS staff, and consists of the following:

(1) ~~Ninety~~No later than ninety (90) days prior to the expiration of a current Certification, ~~except a Permit for Temporary Operations,~~ ODMHSAS will provide the certified facility with a notice of certification expiration and advise the facility that a renewal certification application form must be completed so the organization can be reviewed for consideration for a renewal of certification. Along with the notice of certification expiration, ODMHSAS will provide a document listing Core Organization Standards, Core Operational Standards, and Quality Clinical Standards potentially applicable to the renewed certification.

(2) Each organization desiring to renew Certification must submit a completed certification application form, fees and other required materials in accordance with 450:1-9-6 and at least sixty (60) days prior to the expiration of the current Certification.

(3) In the event an organization, after being notified of the Certification expiration in accordance with (1) ~~and (2)~~ above fails to submit the renewal certification application, fees, or other materials as referenced in (2) above, the current Certification will be allowed to expire.

(4) The application shall be reviewed for completeness by ODMHSAS staff. If the application is deemed complete, a site review of the facility or program will be scheduled and completed.

(5) The facility shall provide ODMHSAS documentation regarding its policies and procedures prior to the site review. This documentation shall include an attestation that the facility's policies and procedures have or have not changed since the latest certification review. If the policies and procedures have changed, the facility shall provide documentation of each change to ODMHSAS.

~~(5)~~(6) Any deficiencies of applicable standards identified as a result of the renewal site visit or subsequent review(s) of documents requested by ODMHSAS will be identified

and a report will provided to the facility by ODMHSAS within five (5) working days of the initial renewal site visit unless precluded by extenuating circumstances.

~~(6)~~(7) The facility will have ten (10) working days from receipt of the report to correct deficiencies of all ~~Core Organizational Standards and Core Operational Standards~~Necessary Standards and provide to ODMHSAS proof of compliance with these standards. ODMHSAS may require an additional site visit to verify proof of compliance of ~~Core Organizational Standards and Core Operational Standards~~Necessary Standards. ~~If deficiencies continue, the facility will have no more than twenty (20) working days from the initial renewal site visit to achieve complete compliance with all Core Organizational Standards and Core Operational Standards.~~

~~(7)~~(8) The facility will ~~also~~ have ~~ten (10)~~three (3) working days from receipt of the report to submit a plan for correction related to cited deficiencies in ~~Quality Clinical~~Critical Standards. The plan of correction will indicate the earliest date by which ODMHSAS should schedule an additional ~~site visit or documentation~~ review to determine compliance with ~~Quality Clinical~~Critical Standards for which deficiencies were cited but not more than twenty (20) working days from receipt of report as referenced in ~~(5)~~(6) above. The site visit may or may not be conducted in conjunction with a site visit to verify compliance with pending ~~Core Organizational Standards, and Core Operational~~Necessary Standards. Compliance with all Critical Standards for which the facility was not compliant upon the initial review must be demonstrated through a follow up review.

~~(8)~~(9) Any deficiencies of applicable standards identified during the ~~additional site visit or~~follow up review referenced in ~~(7)~~(8) above will be identified by ODMHSAS and included in a report provided to the facility by ODMHSAS within three (3) working days of the site visit or review unless precluded by extenuating circumstances. ~~Facilities for which ODMHSAS cannot determine compliance with all pending Clinical Standards during the follow up site visit or review referenced in (8) above may request ODMHSAS to complete one additional site visit or review prior to the finalization of a report. Facilities desiring this additional review must do so in writing to the Director of Provider Certification within three (3) working days of receipt of the follow up report referenced in (8) above and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of report as referenced in (8) above.~~

(10) Facilities for which ODMHSAS cannot determine compliance with all Critical Standards during the follow up review may request ODMHSAS to complete one additional review prior to the finalization of a report. Facilities desiring this additional review must do so in writing to ODMHSAS within three (3) working days of receipt of the follow up report and indicate the earliest date by which ODMHSAS should schedule the final review but not more than fifteen (15) working days from receipt of the follow up report. If the applicant fails to demonstrate compliance with all Critical Standards during the follow up review, revocation proceedings will be initiated.

(11) Facilities for which ODMHSAS can verify substantial compliance with Critical and Necessary Standards upon the initial site review and demonstrate compliance with all Critical Standards within the timeframes specified in (7) through (10) above may be considered for Certification renewal in accordance with guidelines established in 450:1-9-5.7.

~~(10)~~(12) Anytime, during the process outlined above, ODMHSAS may request one or more written plan(s) of correction in a form and within a timeframe designated by ODMHSAS.

~~(11)~~(13) If the applicant fails to ~~submit a plan of correction within the required time frame, fails to submit a timely and adequate revised plan of correction, or fails to provide evidence of correction for all cited deficiencies~~demonstrate compliance with standards within the timeframes specified in (7) through (10) above, a recommendation to initiate revocation proceedings must be made to the Commissioner or designee. If the Commissioner or designee approves the initiation of revocation proceedings, the provisions of Subchapter 5 will be followed.

450:1-9-7.3. Additional certification procedures

(a) **Site reviews.** The following conditions will apply to site visits and other related certification reviews conducted by ODMHSAS.

(1) Initial, renewal or follow-up site reviews, based on the current certification status of the applicant, will be scheduled and conducted by designated representatives of the ODMHSAS at each location or site of the applicant. ODMHSAS may conduct virtual site visits at its discretion.

(2) ODMHSAS may require materials be submitted to Provider Certification, in a form determined by ODMHSAS, prior to on-site visits to verify compliance with ~~one or more~~ applicable Core Organizational Standards, Core Operational Standards, and/or Quality Clinical Standards.

(3) One or more site review(s) may be conducted to determine compliance with prior deficiencies as well as with standards not applicable during the prior certification visit(s).

(4) A minimum number of consumer records, as determined by ODMHSAS, shall be made available for review to determine compliance with applicable Quality Clinical Standards. For organizations~~,~~ unable to provide the required minimum of records, the current certification status, including a Permit for Temporary Operations, will be allowed to expire. ODMHSAS may require review of additional consumer records to assure a representative sample of records is evaluated to determine compliance with Quality Clinical Standards.

(5) A Site Review Protocol shall be completed during each certification review. Protocols shall contain the current ODMHSAS Standards and Criteria applicable to the facility.

(A) A facility must be prepared to provide evidence of compliance with each applicable standard.

(B) In the event the reviewer(s) identifies some aspect of facility operation that adversely affects consumer safety or health, the reviewer(s) shall notify the facility director and appropriate ODMHSAS staff. An immediate suspension of certification may be made by the Commissioner of ODMHSAS.

(b) **Accreditation status.** The ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation of Services for Families and Children, Inc. (COA), ~~or the American Osteopathic Association (AOA)~~ as compliance with certain specific ODMHSAS standards. For such accreditation to be considered, the facility shall make

application and submit evidence to the ODMHSAS of current accreditation status and scope. This evidence shall include documentation of the program or programs included in the most recent accreditation survey, including survey reports of all visits by the accrediting organization, any reports of subsequent actions initiated by the accrediting organization, any plans of correction, and the dates for which the accreditation has been granted. ODMHSAS may, at its discretion, conduct additional compliance monitoring and verification of standards deemed compliant based upon accreditation status.

(c) **Deficiencies.** A deficiency shall be cited for each rule not met by the facility.

(d) **Report to applicant and plan of correction.**

(1) During the course of the certification process, and prior to determination of certification status, ODMHSAS staff shall report the results of the certification review to the facility. The facility shall receive written notice of the deficiencies in a Certification Report in accordance with 450:1-9-7, 450:1-9-7.1, and ~~450:1-9-7.3~~450:1-9-7.2.

(2) The facility may be required to submit a written plan of correction as determined by 450:1-9-7, 450:1-9-7.1, and ~~450:1-9-7.3~~450:1-9-7.2. Approval of the plan of correction by Provider Certification may be required before a final report of findings can be presented to ODMHSAS or the Board.

(3) If a request for a revised plan of correction is necessary, the facility must submit an acceptable plan of correction within the required time frame to continue the certification process. Failure to submit a timely and adequate revised plan of correction shall result in either a notice of denial of the application, expiration of certification, or revocation of the certification status, as applicable.

(e) **Notification of consideration and possible action for certification.**

(1) After consideration of materials requested by ODMHSAS pursuant to certification procedures, and completion of the necessary review(s), ODMHSAS staff shall prepare a report that summarizes findings related to compliance with applicable certification standards.

(2) Reports regarding applications for Permit for Temporary Operations and Certification will be forwarded to the ODMHSAS Board, and/or the Commissioner~~,~~ or designee.

(3) Reports for ~~all other Certification applications will be forwarded to the ODMHSAS Board for consideration or~~individual certification applications will be handled in accordance with procedures outlined in OAC 450:21, OAC 450:50, ~~or~~ OAC 450:53~~.~~, or OAC 450:75.

(4) Prior to the ODMHSAS staff's presentation of its report related to the applicant's certification to the Board or the Commissioner or designee, the ODMHSAS staff shall notify the applicant of:

(A) the findings included in the report, and

(B) the date and time of the Board meeting at which the facility's ~~application, and the~~ certification will be considered, if applicable.

(5) Achievement of certain scores is a prerequisite for consideration of a specific certification status but may not be the sole determinant. Individual deficiencies that meet the criteria in 450:1-9-9 may be grounds for suspending or revoking certification or denying applications for certification.

(6) Consideration of certification may be deferred while additional information regarding a facility's compliance status is reviewed.

(7) The minimum conditions for compliance that must be verified by ODMHSAS for consideration of a certification status shall be stipulated in 450:1-9-5.7.

(f) **Recommendations for revocation of certification.** In the event ODMHSAS can not verify compliance with applicable certification standards in accordance with 450:1-9-5.7, except for Permits for Temporary Operations, ODMHSAS shall forward recommendation for revocation of certification to the Commissioner or designee. If the Commissioner or designee approves a recommendation to revoke certification, an individual proceeding shall be initiated pursuant to Subchapter 5. Applicants unable to demonstrate compliance with standards required for Permit for Temporary Operation are not subject to the provisions for revocation and are simply denied the Permit as stipulated in 450:1-9-7.

450:1-9-7.4. Actions on Non-Certified Providers

If at the initial site review it is found the facility is providing services prior to the granting of an ODMHSAS certification status, applicable for those services being provided and in violation of statutory requirements, including prior to the granting of a Permit for Temporary Operations, the following actions will be taken:

(1) The review will be continued and will include a review of all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards.

~~(2) The facility must comply with the requirements cited in 450:1-9-5. to continue the certification process. An organization providing services statutorily subject to ODMHSAS Certification prior to the issuance of a Permit for Temporary Operations cannot be considered for a Permit for Temporary Operations specific to those services. Such organizations are eligible only for a consideration of a Probationary Certification.~~

(2) Programs found to have initiated operations prior to the awarding of a Permit for Temporary Operations for the services for which certification is statutorily required shall obtain the necessary Permit for Temporary Operations to continue operations.

(3) The applicant must comply within twenty (20) working days of the initial certification visit, with all applicable Core Organizational Standards, Core Operational Standards, and Quality Clinical Standards for a report for consideration of ~~Probationary Certification~~Permit for Temporary Operation to be made to the Board. Failure to achieve the required compliance level ~~for Probationary Certification~~ shall result in a denial for Certification and an Order issued to cease the provision of services, if applicable.

(4) If the applicant achieves the required compliance level within the required time frame, a ~~Probationary Certification may be considered for no more than one (1) year~~Permit for Temporary Operation may be granted.

~~(5) Continued certification after the Probationary Certification period of one year will require the submission of a new application for each of the next two (2) years. The requirements in 450:1-9-5.7(a)(3) shall apply. If the applicant achieves the required compliance level within the required time frame, a Probationary Certification can be considered for no more than one (1) year for each of the next two years.~~

(5) Subsequent to the Permit for Temporary Operations, these programs will be eligible for Certification for a one (1) year period only for the first two (2) years of Certification.

450:1-9-8.1. Site reviews

ODMHSAS may conduct a site review or visit or an investigation, which may or may not be unannounced. Reasons for such review include but are not limited to:

(1) verification of continued compliance with Standards and Criteria and related regulations;

(2) determination of correction of cited deficiencies;

(3) receipt of a complaint;

(4) change in ownership, management, Board membership, or location;

(5) substantial change in either the service provided or new service(s) initiated;

(6) substantial turnover in staff at the executive or professional level;

(7) change in statutorily required licensure status; and

(8) change in or verification of external accreditation status.

450:1-9-13. Designated emergency examination sites

(a) ODMHSAS shall maintain a list of facilities designated by the Commissioner as appropriate to conduct emergency examinations to determine if emergency detention is warranted. All hospitals licensed by the Oklahoma State Department of Health who have a designated emergency department and who have an LMHP on staff, under contract, or on call, shall automatically be designated as an emergency examination site.

(b) The following types of facilities may be placed on the list of designated emergency examination facilities:

(1) Hospitals licensed by the Oklahoma State Department of Health;

(2) Community Mental Health Centers certified by the Board pursuant to Chapter 17 of Title 450 of the Oklahoma Administrative Code;

(3) Community-based Structured Crisis Centers certified by the Board pursuant to Chapter 23 of Title 450 of the Oklahoma Administrative Code;

(4) Facilities operated by ODMHSAS; or

(5) Hospitals accredited by JCAHO, CARF or ~~AOA~~the Accreditation for Health Care/Health Facility Accreditation Program (ACHC/HFAP).

(c) A facility may request the Commissioner to designate the facility as an emergency examination facility to be placed on the list. The facility shall make a request in writing to the Provider Certification Division of ODMHSAS and verify it has the ability to conduct emergency examinations as defined in 43A O.S. § 5-206(4) and has one or more licensed mental health professionals as defined in 43A O.S. § 1-103(11) capable of performing the functions set forth in 43A O.S. §§ 5-207 and 5-208.

(d) The facility shall receive a letter from the Commissioner notifying the facility whether its request to be placed on the list of designated emergency examination facilities has been granted.

450:1-9-14. Designated emergency detention sites

(a) ODMHSAS shall maintain a list of facilities designated by the Commissioner as appropriate for emergency detention. All hospitals licensed by the Oklahoma State

Department of Health who have an LMHP on staff, under contract, or on call and have designated beds for the treatment of mental health or substance abuse disorders, shall automatically be designated as an emergency detention site.

(b) The following types of facilities may be placed on the list of designated emergency detention facilities:

(1) Hospitals licensed by the Oklahoma State Department of Health;

(2) Community Mental Health Centers certified by the Board pursuant to Chapter 17 of Title 450 of the Oklahoma Administrative Code;

(3) Community-based Structured Crisis Centers certified by the Board pursuant to Chapter 23 of Title 450 of the Oklahoma Administrative Code; and

(4) Facilities operated by ODMHSAS; or

(5) Hospitals accredited by JCAHO, CARF or ~~AOA~~ACHC/HFAP.

(c) A facility may request the Commissioner to designate the facility as an emergency detention facility to be placed on the list. The facility shall make a request in writing to the Provider Certification Division of ODMHSAS and verify it has the ability to detain a person in emergency detention as defined in 43A O.S. § 5-206(5) and comply with 43A O.S. §§ 5-208 and 5-209.

(d) The facility shall receive a letter from the Commissioner notifying the facility whether its request to be placed on the list of designated emergency detention facilities has been granted.