

Agency	Greater San Marcos Youth Council
Program	Children's Shelter
San Marcos Service Address	1402 IH 35 North
Requested	\$15,000
Recommended	\$10,000

Application Completeness Check for HSAB	Greater San Marcos Youth Council Children's Shelter
Questions	
Are all questions answered?	Yes
Is the application signed? (this is a certification)	Yes
Does the program have measurable outcomes?	Yes
Is the agency a Human Services Agency?	Yes
Is the agency overseen by a Board of Directors?	Yes
Required Attachments	
BUDGETS	
1. Agency budget for current fiscal year	Yes
2. Agency budget proposed for next fiscal year	Yes
3. Program budget for current fiscal year	Yes
4. Program budget proposed for next fiscal year	Yes
5. Budget showing the exact uses of the HSAB funding	Yes
BOARD OF DIRECTORS INFORMATION	
6. Board of Directors membership roster	Yes
7. Board of Directors Meeting Attendance Record for current year	Yes
8. Board of Directors City of Residence	Yes
9. Board of Directors membership criteria	Yes
ORGANIZATION INFORMATION	
10. Organizational chart with names and titles of staff	Yes
11. Current IRS Form 990, pages 1 and 2 (not required for churches)	Yes
12. Non-discrimination policy statement	Yes
Preferred Attachments - 3 Letters of Support	
Letters of support from members of the San Marcos Community	Yes
Attachments if Applicable	
Latest audit or CPA signed review, if applicable	Yes
Policies and Procedures for the proposed Program, if available	Yes
Note: We are not requiring Texas Secretary of State registration	

CHECKLIST OF REQUIRED ATTACHMENTS

APPLICATION

- ☒ Completed and signed application
- ☒ Final Performance Report for 2023 Funding

BUDGETS

- ☒ Agency budget for current fiscal year
- ☒ Agency budget proposed for next fiscal year
- ☒ Program budget for current fiscal year
- ☒ Program budget proposed for next fiscal year
- ☒ NEW: Budget showing the proposed uses of HSAB funding

BOARD OF DIRECTORS INFORMATION

- ☒ Board of Directors membership roster – NEW must include city of residence for each Board member
- ☒ Board of Directors Meeting Attendance Record for the current fiscal year
- ☒ Board of Directors membership criteria

ORGANIZATION INFORMATION

- ☒ Organizational chart with names and titles of staff
- ☒ Current IRS Form 990, pages 1 and 2 (not required for churches)
- ☒ Non-discrimination policy statement
- ☒ Latest audit or CPA signed review, if applicable
- ☒ Policies and Procedures for the proposed Program, if available

LETTERS OF SUPPORT

- ☒ Letters of support from members of the San Marcos Community (prefer minimum of 3)

City of San Marcos Human Services Grants
FY 2025 Application

I. SUMMARY INFORMATION

Please spell out organization name and program name completely, without acronyms.

Applicant Organization: Greater San Marcos Youth Council

Contact Name: Julia Ramsay New Telephone: 512-754-0500

Contact E-Mail Address: jrnew@gsmyc.org Website: www.gsmyc.org

Mailing Address: P.O. Box 1455, San Marcos, Texas 78667

San Marcos Service Address for this Program: 1402 IH 35 North, San Marcos, Texas 78666

Who is authorized to execute program documents? (Name, Title) Julia Ramsay New, Executive Director

Program Name: Children's Shelter

Amount of Funds Requested: \$15,000.00

What percentage of the cost of this program is requested as funding through this application? 2%

II. QUESTIONS

All questions must be answered. Please type your answers.

OVERVIEW

1. What is the agency's or organization's mission?
The mission of the Greater San Marcos Youth Council is to shelter children and strengthen families.
2. Briefly summarize the program for which funding is being requested and the services it provides.
The Youth Council operates the only shelter for abused, abandoned, and neglected children in Hays County. Serving children ages 2-17, the shelter is licensed by the Department of Family and Protective Services and remains open around the clock, year-round. This allows local law enforcement to have easy access to the shelter when displaced children are in their care, as well as for youth and/or families who are in crisis to access services. In 2023, 146 children were served through the Children's Shelter with a 96% success rate.

COMMUNITY NEED AND JUSTIFICATION - 20 POINTS

1. Describe in detail the need for this program in San Marcos.
Despite efforts made to eradicate child abuse and neglect, 164 Texas children died in 2023 from maltreatment with 85 confirmed abuse and neglect related near fatalities. According to Every Texan (formerly the Center for Public Policy Priorities) Texas still fails its children, ranking 43rd for child well-being, 48th in overall child health and 47th in family and community support.

In 2023, there were 58,000 confirmed victims of child abuse/neglect among Texas children. There are currently 27,871 Texas children in foster care. We provide a safe alternative when placement in a foster or relative's home is not possible. Some communities in Texas do not have an emergency shelter for children and youth who are

victims of abuse and neglect, including runaways, abandoned youth, sex trafficking victims, and children who are with their parents when one or both parents are arrested.

San Marcos is the only city in Hays County with a Children's Shelter, as well as the only one in the three-county area where San Marcos residents live of Hays, Caldwell, and Guadalupe. We are one of 12 residential childcare facilities in the state providing emergency care services and assessments. Our license includes basic childcare as well and we are the only facility in Texas licensed for ages 2-17. We also operate the only facility for 16 children between the ages of 2-17, which enables us to keep sibling groups together and operate more like a home than a facility.

Child abuse and neglect and other adverse childhood experiences (ACEs) can have a tremendous impact on broader lifelong health and well-being outcomes if left untreated. For example, exposure to violence in childhood increases the risks of injury, future violence victimization and perpetration, substance abuse, sexually transmitted infections, delayed brain development, reproductive health problems, involvement in sex trafficking, non-communicable diseases, lower educational attainment, and limited employment opportunities (Center for Disease Control and Prevention).

In Hays County last year, there were 339 confirmed cases of abuse and neglect with 1,190 not confirmed. Of the 339, 296 were harmed by one of their parents and 482 were placed in the conservatorship of the Texas Department of Family and Protective Services. Currently, there are 73 Hays County children in foster care, up from 65 in 2023. According to the Child Welfare League of America, children spend 18 months in care and an average of two to five years waiting to be adopted.

Parents continue to be the most common perpetrators of child abuse and neglect and in Central Texas 98% of child victims were abused by someone they love and trust. 54,153 suffered neglect, 6,968 were physically abused, and 7,562 were sexually abused. In Hays County, there were 460 confirmed victims (statistics collected by the state only breakdown by county).

2. Has the need for this program been increasing in recent years?

There has been an increase in the need for residential childcare for sibling groups and teenagers. We have also seen an increase in lengths of stay and support after graduating high school. Recently, our contract manager with the Department of Family and Protective Services said during her annual site visit, "There will always be a need for your service".

In an effort to reduce the number of children entering the foster care system, the Texas Legislature recently took steps to decrease the number by ending anonymous reporting of suspected abuse/neglect to Texas Statewide Intake, overhauling child abuse investigations, and increasing funds to prevent child abuse and neglect. Embroiled in a lawsuit since 2011 where a federal judge ruled Texas does violate the rights of children in foster, the legislature chose to require backpacks for children in care and assistance in setting up bank accounts for children aging out of care.

Also of note, is the fact that the foster care system in Texas is changing completely from a level system to one of child-centered care to potentially improve outcomes for children. In place for over 30 years, the current system labels children as one of four behavior/diagnosis levels; basic, moderate, specialized and intense. The new system focuses on the specific needs of the child, rather than their behavior/diagnosis. We are uncertain if this shift will affect the need because it is possible many current foster care providers may choose not to participate (rollout scheduled for 2027).

3. Client Information

Definitions:

Direct Client - individuals or families immediately affected or personally served by the helping agency.

Questions:

- a. Describe the direct clients for this program.
Abused and neglected children ages 2-17 who have been removed from their homes, runaway from their homes, or have been abandoned or sex trafficked.
- b. How is the program marketed to direct clients? How do you find these clients?
The Youth Council is listed with 211 and the Texas Runaway Hotline. We maintain a toll-free crisis hotline as well and it is marketed to the community and schools in particular. Additionally, in operation for 38 years, our agency has a strong partnership with the Texas Department of Family and Protective Services' child placing units, contracting, and the residential childcare licensing division of Texas Health and Human Services. The former Chief Juvenile Probation officer is a founding member of our agency and the current Chief serves on our board of directors. Additionally, local school districts and law enforcement agencies are met with regularly to ensure they are aware of this local resource for children.
- c. Expected total annual unduplicated direct clients who are City of San Marcos residents: 6

IMPLEMENTATION - 15 POINTS

1. How exactly will these funds be used?
20% of the full-time Residential Program Director and Case Manager salaries.
Residential Program Director - \$8,484.25
Case Manager - \$6,515.75
Total \$15,000
2. What specific, measurable outcomes or results do you hope to achieve with this program?
Children who are physically hurt or ill will heal. Children will grow to feel secure in the setting so they can focus on themselves. Provide a safe, nurturing environment with highly trained individuals who provide consistency and exhibit genuine caring. In the care of our agency, children can grow healthy and learn by continuing their education through the public school system and participating in learning opportunities provided by shelter staff and agency counselors.
3. List the title of each position for which funding is requested and the activities associated with those positions.
The Residential Program Director is responsible for hiring, training, and the supervision of the direct care staff. This individual is also responsible for ensuring compliance with licensing and contract standards and maintaining the expected high-quality care for the children. Our Case Manager is responsible for ensuring each child receives the medical, dental, psychological, and/or psychiatric care required during their stay with us. This individual is also responsible for scheduling any assessments required for each child.

If funding is not available at the requested amount, what is the minimum Human Services Grant funding needed to be able to run this program? \$10,000

IMPACT AND COST EFFECTIVENESS - 25 POINTS

1. Programs can provide value by deeply impacting the lives of a few, with effects that may ripple through generations, or by providing smaller but meaningful impact to a larger group. Describe in detail the impact this program will have on the identified need and on San Marcos residents.
Considerable research by a multitude of entities has been conducted on the consequences of child abuse and neglect with results that are consistently disturbing. The effects of child abuse and neglect include, but are certainly not limited to impaired brain development, cognitive difficulties, chronic health conditions, and poor mental and emotional health. It also results in promiscuity, high rates of pregnancy, incarceration, alcohol/drug abuse, domestic violence, post-traumatic stress disorder, and decreased economic productivity (Child Welfare Information Gateway).

Abused children are more likely to repeat the cycle as adults and according to multiple studies, approximately 1 in 3 victims of childhood abuse group to continue a pattern of neglectful and abusive parenting. However, the cycle of abuse can be broken if access to prevention programs is increased, particularly with children under the age of 14. Being removed from home can further traumatize a child victim of abuse and neglect. However, to ensure the safety of the child, a brief stay in a small, well-run agency such as our shelter, with highly skilled tenured caregivers is extremely beneficial. The benefits are not only for each child but for society as a whole.

Shielded from further abuse and neglect, children arrive at our emergency shelter where they live until other arrangements are made. For many children, our shelter is often their first out-of-home placement while for others, shelter placement is an answer to a foster home breakdown or other types of rejection. Therefore, a primary goal of the adults who care for the children is to develop a trusting relationship with each child so that he/she will know that not all grown-ups will hurt them and that they are worthy of love and respect.

Children are cared for as if the shelter were a large, family home. Highly trained individuals serve as surrogates who work to meet each child's emotional and physical needs. The children attend public school where they can participate in extracurricular activities and school sports; they play games, go to the movies, ride bikes, and try their very best to be brave and not worry about what they will call "home" next.

While out-of-home placement is not an ideal situation for a child, a brief stay in a small, well-run agency with highly skilled, tenured caregivers is extremely beneficial. The benefits are not only for each child but also for society. Children are exposed to a safe environment with genuine adults who can be trusted. Each child receives proper nutrition and learns the benefits of a healthy diet, as well as the benefits of daily activity. Children attend public school during their stay, and many begin catching up academically, as well as experiencing the satisfaction derived from participating in school.

Child abuse and neglect and other adverse childhood experiences (ACEs) can also have a tremendous impact on broader lifelong health and well-being outcomes if left untreated. For example, exposure to violence in childhood increases the risks of injury, future violence, victimization and perpetration, substance abuse, sexually transmitted infections, delayed brain development, reproductive health problems, involvement in sex trafficking, non-communicable diseases, lower educational attainment, and limited employment opportunities (Center for Disease Control and Prevention).

2. Discuss the amount of overhead compared to program costs.

Our agency is managed frugally and ethically with unwavering accountability to those who provide fiscal and in-kind support toward our mission. The percentage of overhead costs of our agency has not exceeded 16% in over 30 years. Last year, our administrative costs were 7% of our total budget. The majority of our expenses are for program staff. Our buildings are paid for, as are the vehicles we use to transport the children in our care.

3. Provide a brief description of other funding sources, volunteers, or in-kind donations that are expected to be used with this program.

Volunteers support the work of our staff and provide valuable services that enhance the quality of our programs and lessen the financial burden. We use volunteers from the community, universities, local schools, civic organizations, churches, and local businesses. These are also the sources for assistance with fundraising, collecting both in-kind and monetary donations, toward offsetting the costs of serving our community.

Through the contract, we maintain with the Department of Family and Protective Services, a per diem is reimbursed for each day a child is in our care. This is only for those children in the custody of the state. Last year, the reimbursed amount was 63% of the actual cost. The cost to care for children who are not wards of the state is not reimbursed and must be secured through other means, such as city, county, and United Way funding awards.

4. What has your organization done in the past two years to raise different funding for this program?
We increased our social media presence, updated our website, grew our annual fundraiser, collaborated with 2 university groups to raise funds, reinstituted regular attendance at San Marcos Chamber of Commerce events and we are working with Tanger Outlets to create additional fundraisers. We continuously search for foundation and corporate awards our agency is eligible to apply for.

COMMUNITY SUPPORT – 10 POINTS

1. Please submit 3-5 letters of reference that indicate strong local support for the program and the agency's ability to implement it as described in the application.
Attached.
2. How is the Board of Directors selected?
3. Our agency began with a group of community leaders recognizing the need for a youth shelter and they comprised the original board. Local citizens who have expertise, experience, and/or education beneficial to the organization are nominated by the nominating committee and elected by the existing board members. The current board of directors represents a vast array of experience and expertise with the majority residing in San Marcos.
4. How often does the Board meet?
Our board of directors meets monthly except for November or December depending upon which days holidays fall on for the year.
5. What actions do Board members take to support the programs of the agency or organization?
Each board member contributes monetarily and participates in fundraising events. Board members donate in kind by volunteering their time and/or expertise to clients and staff in support of our programs. Board members recruit donors and volunteers and share their experience with others in the community.
6. How many volunteers does your agency or organization have and how many hours do they spend on the program requesting funding?
42 volunteers spent 396 hours in our Children's Shelter.

COUNCIL PRIORITIES - 30 POINTS

1. How long has this program served San Marcos residents? (10 points if at least 2 years)
38 years. In 1986, we first opened our doors in response to a legislative mandate regarding the housing of homeless and runaway teenagers. After a brief merger with a similar organization in New Braunfels, TX, the board of directors reorganized and created the Greater San Marcos Youth Council, Inc. (1989).
2. Does the agency have an office in San Marcos? (10 points if yes)
Yes, and only in San Marcos since our inception. In 1989, our location moved from Smith Lane (behind Cuevas Produce) to the current location on land leased from the City of San Marcos.
3. Describe how this funding creates an increase in services or an increase in the number of people served. (10 points)
In addition to runaways, throwaways, children whose parents have been arrested, and sex trafficking victims, there are children in the community who would greatly benefit from respite care. In fact, the entire family would benefit from it.

II. FUNDING RESTRICTIONS

By signing this application I certify the following to be true:

1. All Human Services Grant funding will be spent on San Marcos residents, except for school-based programs, in which case it may be spent within the San Marcos Consolidated Independent School District boundary.

2. Funding requested is not more than 50% of the total funding for the agency.
3. Funding will not be used to fund more than 20% of a full time position.
4. Agency has been in existence for at least 2 years. (This can include serving communities other than San Marcos.)

SUBMITTED AND APPROVED BY:

Julia R. New
Signature

07/25/2024
Date

Julia Ramsay New
Printed Name

Executive Director
Title



HUMAN SERVICES ADVISORY BOARD GRANT 2023 FINAL PERFORMANCE REPORT

Agency Name: Greater San Marcos Youth Council

Program Name: Children's Shelter

Program Year: 2023

Reporting Period: January – December, 2023 (preferred deadline January 31, 2024)

NOTE ON DEADLINE: This report must be received by October 24, 2024, or your organization's application for 2025 funding for this program will not be considered.

PROGRAM STATUS

Please provide a brief written description of actions taken this period and how they helped achieve your program goals.

There has been an increase in need for residential childcare for sibling groups and teenagers. We have also seen an increase in lengths of stay and support after graduating high school. Recently, our contract manager with the Department of Family and Protective Services said during her annual site visit, "there will always be a need for your service". In June of last year, there are 24,875 alleged victims of child abuse/neglect in Texas, 4,707 of them from our region, Region 7, a 2.3% increase from the same time last year.

Children are cared for as if the shelter were a large, family home. Highly trained individuals serve as surrogates who work to meet each child's emotional and physical needs. The children attend public school where they can participate in extracurricular activities and school sports; they play games, go to the movies, ride bikes, and try their very best to be brave and not worry about where they will call "home" next.

While out of home placement is not an ideal situation for a child, a brief stay in a small, well-run agency with highly skilled, tenured caregivers is extremely beneficial. The benefits are not only to each child, but also to society. Children are exposed to a safe environment with genuine adults who can be trusted. Each child receives proper nutrition and learns the benefits of a healthy diet, as well as the benefits of daily activity. Children attend public school during their stay, and many begin catching up academically, as well as experiencing the satisfaction derived from participating in school.

In 2023 the Residential Program Director was responsible for hiring, training and supervision of the direct care staff. This individual is also responsible for ensuring compliance with licensing and contract standards and maintaining the expected high-quality care for the children. Our Case Manager is responsible for ensuring each child receives the medical, dental, and psychological and/or psychiatric care required during their stay with us. This individual is also responsible for scheduling any assessments required for each child.

PROGRAM BENEFICIARIES

For the program that received HSAB funding, please report either number of unduplicated individuals served or number of unduplicated households served.

Check one: ☒ Unduplicated Individuals ☐ Unduplicated Households

	Jan – Dec, 2023
Total # Served	48
# San Marcos Residents Served	3
% San Marcos Residents	6.25%

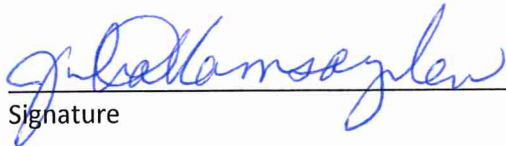
PROGRAM EXPENDITURES

For the final report of the year, please provide a bulleted list that briefly summarizes what the HSAB funding was spent on.

- Program Salaries and Benefits
-
-
-
-

Certification:

I certify that to the best of my knowledge and belief the information reported in this Quarterly Performance Report is factual and accurate.


Signature

1-18-24
Date

Julia Ramsay New
Printed name

Executive Director
Title

Greater San Marcos Youth Council, Inc.

FY24 Budget Overview

Accrual Basis

September 1, 2023 through August 31, 2024

	Sep '23 - Aug 24
Ordinary Income/Expense	
Income	
4100 · Grant/Contract Revenue	
4125 · TANF	0.00
4100 · Grant/Contract Revenue - Other	1,375,439.56
Total 4100 · Grant/Contract Revenue	1,375,439.56
4120 · Contributions Income	
Donated Goods & Services	35,000.00
4122 · Unrestricted	126,757.00
Total 4120 · Contributions Income	161,757.00
4140 · Fundraisers	55,000.00
4150 · Miscellaneous Income	160.00
Total Income	1,592,356.56
Gross Profit	1,592,356.56
Expense	
NFSN Expense	6,000.00
TANF Expense	0.00
5000 · Personnel	
5001 · 403B Contributions	6,000.00
5002 · Compensated Absences	2,000.00
5005 · Winter Storm Pay	0.00
5006 · Payroll Processing Fees	3,000.00
5007 · Overtime Pay	52,500.00
5100 · Salaries	998,520.00
5100.1 · Longevity	3,500.00
5105 · Bonus	0.00
5110 · Payroll Taxes	78,000.00
5115 · Texas Unemployment Tax	10,800.00
5122 · Insurance - Health/Dental/Life	52,850.62
5000 · Personnel - Other	3,000.00
Total 5000 · Personnel	1,210,170.62
5102 · Contract Labor	0.00
5120 · Insurance	
5125 · Insurance-Prof Liability	18,816.00
5130 · Insurance-Building	11,158.68
5135 · Insurance-Vehicle	11,722.00
5140 · Insurance Worker's Compensation	5,292.00
5120 · Insurance - Other	0.00
Total 5120 · Insurance	46,988.68
5200 · Materials and Supplies	
5200.1 · Office Supplies	6,540.00
5210 · School	100.00
5211 · Educational/Informational	2,520.00
5220 · Food	40,800.00
5225 · Shelter	14,175.00
5230 · Hygiene	900.00
5235 · Clothing	7,800.00
5240 · Janitorial	4,500.00
5250 · Program	8,100.00
5251 · Computer	4,200.00
5315 · Grounds Maintenance	6,600.00
5320 · Telephone	
5321 · Cell Phones	1,320.00
5322 · Phone System	0.00
5320 · Telephone - Other	3,720.00
Total 5320 · Telephone	5,040.00

Greater San Marcos Youth Council, Inc.

FY24 Budget Overview

September 1, 2023 through August 31, 2024

Accrual Basis

	Sep '23 - Aug 24
5333 · Utilities - All	
5335 · Utilities-Cable	2,640.00
5336 · Utilities-Electric	25,200.00
5340 · Utilities-Dumpster	3,000.00
Total 5333 · Utilities - All	30,840.00
5345 · Postage	480.00
5355 · Transportation - Maintenance	1,800.00
5356 · Transportation - Parking	60.00
5360 · Transportation - Mileage	504.00
5365 · Transportation - Fuel	8,100.00
6170 · Equipment Rental	500.00
5200 · Materials and Supplies - Other	0.00
Total 5200 · Materials and Supplies	143,559.00
5330 · Other Costs	
5300 · Repairs	
5302 · Equipment Repairs/Maintenance	1,500.00
5310 · Building Repairs	30,000.00
5312 · Computer Repairs	504.00
5300 · Repairs - Other	9,960.20
Total 5300 · Repairs	41,964.20
5313 · Miscellaneous	250.00
5318 · Security System	1,200.00
5370 · Expense Reimbursement	1,800.00
5400 · Printing and Advertisement	10,500.00
5410 · Staff Development and Education	6,600.00
5420 · Dues and Subscriptions	1,320.00
5425 · Licenses and Permits	0.00
5430 · Recreation/Entertainment/Act.	6,000.00
5440 · Community Enrichment	200.00
5700 · Accounting and Auditing Fees	10,200.00
5710 · Legal Fees	500.00
5720 · Prof. Fees and Memberships	1,500.00
5730 · Medical Fees and Expenses	300.00
5800 · Computer/Software Maintenance	300.00
5815 · Web Hosting	400.00
6110 · Automobile Expense	300.00
6120 · Financial Institution Charges	10,020.00
6235 · Administration Fee	275.00
6670 · Program Expense	4,200.00
Total 5330 · Other Costs	97,829.20
5850 · Capital Expenditures	
5900 · Purchase of Furniture	5,000.00
5910 · Purchase of Equipment	5,000.00
5915 · Purchase of Vehicle	20,000.00
5920 · Campus Improvements	50,000.00
5990 · Depreciation Expense	29,000.00
5850 · Capital Expenditures - Other	18,000.00
Total 5850 · Capital Expenditures	127,000.00
6230 · Finance Charges	5.83
66900 · Reconciliation Discrepancies	0.01
Total Expense	1,631,553.34
Net Ordinary Income	(39,196.78)
Other Income/Expense	
Other Income	
Unrealized Gains/Losses on Inve	(9,334.10)
7000 · Gain on Sale of Asset	5,000.00

Greater San Marcos Youth Council, Inc.
FY24 Budget Overview
September 1, 2023 through August 31, 2024

Accrual Basis

	Sep '23 - Aug 24
7010 · Interest Income	25,000.00
7030 · Other Income	1,780.27
Total Other Income	22,446.17
Other Expense	
8010 · Other Expenses	7,500.00
Total Other Expense	7,500.00
Net Other Income	14,946.17
Net Income	(24,250.61)

GREATER SAN MARCOS YOUTH COUNCIL INC

Budget Overview: FY_2024_2025 - FY25 P&L

September 2024 - August 2025

	TOTAL
Income	
4100 Grant/Contract Revenue	1,444,211.40
4125 TANF	0.00
Total 4100 Grant/Contract Revenue	1,444,211.40
4120 Contributions Income	
4122 Unrestricted	133,094.85
Donated Goods & Services	40,000.00
Total 4120 Contributions Income	173,094.85
4140 Fundraisers	60,000.00
4150 Miscellaneous Income	200.00
Total Income	\$1,677,506.25
GROSS PROFIT	\$1,677,506.25
Expenses	
5000 Personnel	500.00
5001 403B Contributions	6,000.00
5002 Compensated Absences	2,000.00
5005 Disaster Pay	0.00
5006 Payroll Processing Fees	3,000.00
5007 Overtime Pay	52,500.00
5100 Salaries	1,048,446.00
5100.1 Longevity	4,500.00
5110 Payroll Taxes	78,000.00
5115 Texas Unemployment Tax	8,000.00
5122 Insurance - Health/Dental/Life	55,493.15
Total 5000 Personnel	1,258,439.15
5102 Contract Labor	0.00
5120 Insurance	
5125 Insurance-Prof Liability	18,816.00
5130 Insurance-Building	11,716.61
5135 Insurance-Vehicle	11,722.00
5140 Insurance Worker's Compensation	5,292.00
Total 5120 Insurance	47,546.61
5200 Materials and Supplies	
5200.1 Office Supplies	6,540.00
5210 School	100.00
5211 Educational/Informational	2,520.00
5220 Food	40,800.00
5225 Shelter	17,175.00
5235 Clothing	7,800.00
5240 Janitorial	4,500.00
5250 Program	1,500.00
5251 Computer	4,200.00
5315 Grounds Maintenance	6,600.00

GREATER SAN MARCOS YOUTH COUNCIL INC

Budget Overview: FY_2024_2025 - FY25 P&L

September 2024 - August 2025

	TOTAL
5320 Telephone	3,720.00
5321 Cell Phones	1,320.00
5322 Phone System	0.00
Total 5320 Telephone	5,040.00
5333 Utilities - All	
5335 Utilities-Cable	2,640.00
5336 Utilities-Electric	26,460.00
5340 Utilities-Dumpster	3,150.00
Total 5333 Utilities - All	32,250.00
5345 Postage	480.00
5355 Transportation - Maintenance	10,000.00
5356 Transportation - Parking	60.00
5360 Transportation - Mileage	504.00
5365 Transportation - Fuel	6,000.00
6170 Equipment Rental	500.00
Total 5200 Materials and Supplies	146,569.00
5330 Other Costs	
5300 Repairs	
5302 Equipment Repairs/Maintenance	1,750.00
5310 Building Repairs	15,000.00
5312 Computer Repairs	1,000.00
Total 5300 Repairs	17,750.00
5313 Miscellaneous	250.00
5318 Security System	2,000.00
5370 Expense Reimbursement	1,800.00
5400 Printing and Advertisement	8,500.00
5410 Staff Development and Education	6,600.00
5420 Dues and Subscriptions	3,000.00
5425 Licenses and Permits	0.00
5430 Recreation/Entertainment/Act.	3,000.00
5440 Community Enrichment	200.00
5700 Accounting and Auditing Fees	15,000.00
5710 Legal Fees	500.00
5720 Prof. Fees and Memberships	500.00
5730 Medical Fees and Expenses	300.00
5800 Computer/Software Maintenance	800.00
5815 Web Hosting	500.00
6110 Automobile Expense	300.00
6120 Financial Institution Charges	12,000.00
6235 Administration Fee	275.00
6670 Program Expense	1,500.00
Total 5330 Other Costs	74,775.00
5850 Capital Expenditures	18,000.00
5900 Purchase of Furniture	5,000.00

GREATER SAN MARCOS YOUTH COUNCIL INC

Budget Overview: FY_2024_2025 - FY25 P&L

September 2024 - August 2025

	TOTAL
5910 Purchase of Equipment	5,000.00
5915 Purchase of Vehicle	25,000.00
5920 Campus Improvements	50,000.00
5990 Depreciation Expense	29,000.00
Total 5850 Capital Expenditures	132,000.00
6230 Finance Charges	5.83
66900 Reconciliation Discrepancies	0.01
TANF Expense	0.00
Total Expenses	\$1,659,335.60
NET OPERATING INCOME	\$18,170.65
Other Income	
7000 Gain on Sale of Asset	5,000.00
7010 Interest Income	25,000.00
7030 Other Income	1,780.27
Unrealized Gains/Losses on Inve	-9,334.10
Total Other Income	\$22,446.17
Other Expenses	
8010 Other Expenses	7,500.00
Total Other Expenses	\$7,500.00
NET OTHER INCOME	\$14,946.17
NET INCOME	\$33,116.82

Greater San Marcos Youth Council, Inc.
GSMYC FY25 Proposed Shelter Budget
September 2024 through August 2025

Expense

Maintenance of Equipment	\$1,229.29
Payroll Expenses	\$661,500.00
Insurance - Health/Dental/Life	\$31,972.50
Insurance-Prof Liability	\$6,945.75
Insurance-Building	\$6,063.75
Insurance-Vehicle	\$4,410.00
Insurance Worker's Compensation	\$452.03
Supplies	\$44,100.00
Clothing	\$3,858.75
Repairs	\$11,025.00
Grounds Maintenance	\$1,653.75
Security System	\$1,323.00
Telephone	\$1,323.00
Utilities-Cable	\$2,756.25
Utilities	\$22,050.00
Utilities-Dumpster	\$2,756.25
Transportation - Maintenance	\$1,102.50
Transportation - Parking	\$55.13
Transportation - Mileage	\$551.25
Transportation - Fuel	\$2,756.25
Expense Reimbursement	\$1,378.13
Printing and Advertisement	\$2,756.25
Staff Development and Education	\$3,858.75
Dues and Subscriptions	\$413.44
Recreation/Entertainment/Act.	\$3,858.75
Medical Fees and Expenses	\$551.25
Bank Service Charges	\$11.03
6670 - Program Expense	\$551.25
Reconciliation Discrepancies	\$11.03

Total Expense	\$821,274.30

Children Shelter

Budget Item	City General Funds
Residential Program Director	\$ 8,484.25
Case Manager	\$ 6,515.75
	\$ -
	\$ -
Total	\$ 15,000.00

GSMYC Board of Directors

President-Jeff Caldwell
405 Cascade Trail
San Marcos, TX 78666
jdc_78666@yahoo.com
*Attended 9 out of 9 meetings

512-396-2951 (h)
512-665-7491 (c)

Vice-President-Rebecca Dickey
Texas State University-San Marcos
700 Hugo Rd
San Marcos, TX 78666
rebeccadickey@txstate.edu
*Attended 9 out of 9 meetings

512-245-9648 (w)
512-738-0811 (c)

Treasurer-Vickie Dorsett
Hays County Historical Courthouse
111 E. San Antonio St., Ste. 204
San Marcos, TX 78666
vickie.dorsett@co.hays.tx.us
*Attended 6 out of 9 meetings

512-393-2275 (w)
512-757-5917 (c)

Secretary-Crystal Dixon
Edward Jones, Crystal Dixon
4610 Jack C Hays Trail
Mountain City, TX 78610
crystalgenchurch@yahoo.com
*Attended 6 out of 9 meetings

512-757-3681 (c)

Matt Murphree
Randall Morris & Associates
1025 Tate Trail
San Marcos, TX 78666
mmurphree@yahoo.com
*Attended 4 out of 9 meetings

512-878-2967 (h)
512-393-1491 (c)

John Schramm
Recently retired from Thermon
2120 Annes Trail
San Marcos, TX 78666
john.schramm@thermon.com
*Attended 4 out of 9 meetings

512-5561793 (c)

Lisa Day
Hays County Juvenile Probation
712 S. Stagecoach Tr. Suite 1268
San Marcos, TX 78666
lisa@co.hays.tx.us
*Attended 8 out of 9 meetings

830-660-7065 (c)
512-393-7755 (w)

Clint Pulpan, Lt. Hays Co. Sheriff
1307 Uhland Rd.
San Marcos, TX 78666
Clint.pulpan@co.hays.tx.us
*Attended 7 out of 9 meetings

512-749-1182 - x9342
512-781-5383 (c)

Sebastian Hernandez, Area Loss Prevention & Security Mgr. 361-537-5694 (c)
HEB
203 Mineral Springs Dr.
Kyle, TX 78640
hernandez.zenon@heb.com
New Board Member Attended all but one meeting since elected to serve (4)

Our agency began with a group of community leaders recognizing the need for a youth shelter and they comprised the original board. Local citizens who have expertise, experience, and/or education beneficial to the organization are nominated by the nominating committee and elected by the existing board members. The current board of directors represents a vast array of experience and expertise with the majority residing in San Marcos.

Attorney-Charmaine Wilde
133 W. San Antonio St., Ste 400
San Marcos, TX 78666
Charmaine@mcglothlinlaw.com

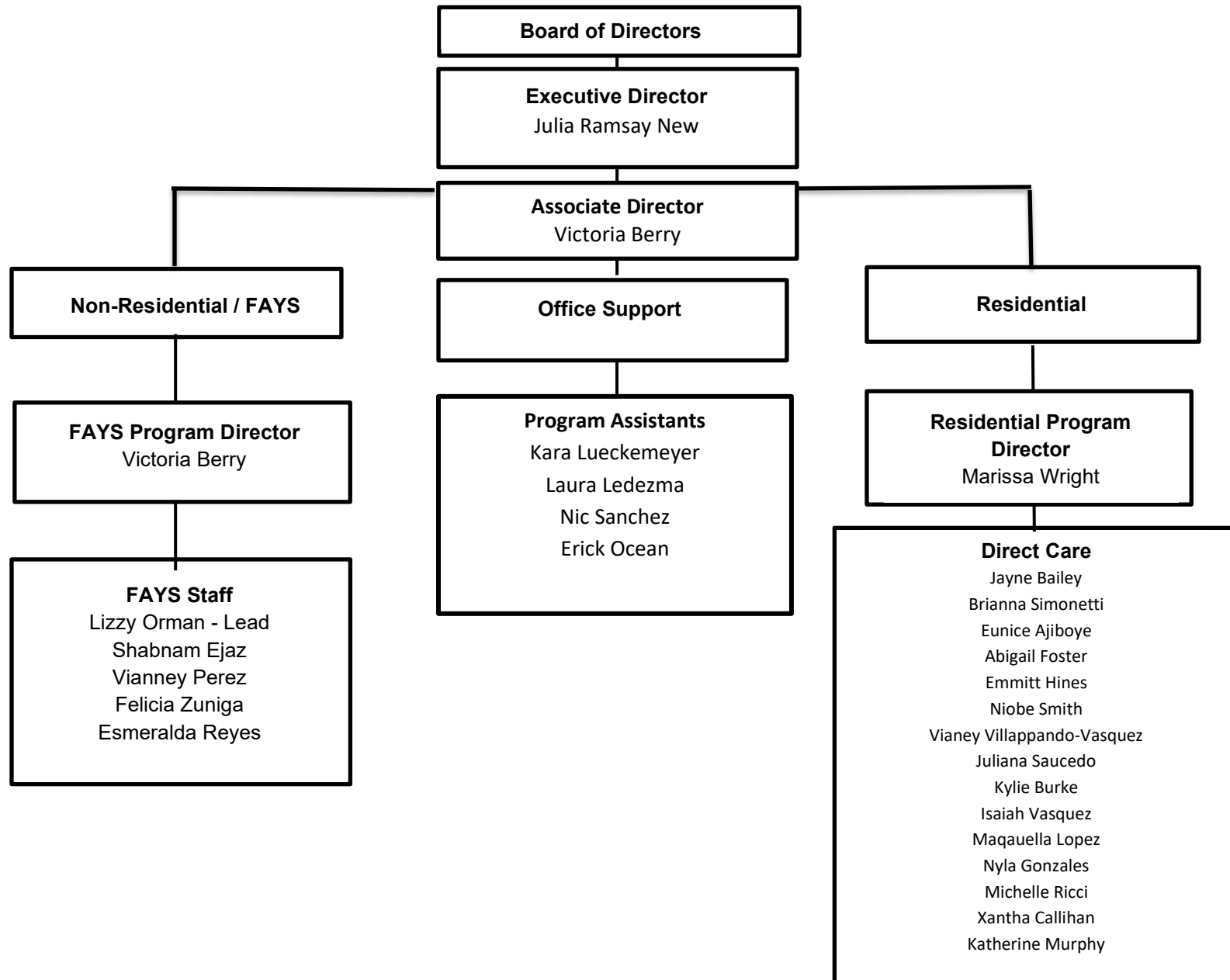
512-392-7510 (w)

Honorary Board Members

Berry James
Mike Martin
Dawn Mallory
David Williams (founding member)
Shelly Williams (founding member, no relation to D. Williams)
Vickie Strong
Maria Fedrick (founding member)
Becky Sierra (founding member)
Anna Lopez
Ray Hernandez
Harry Stewart
Rodney van Oudekerke
AJ Wolpman
Melanie Mendez

Greater San Marcos Youth Council

Agency Organizational Chart



Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2022

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public.

Go to www.irs.gov/Form990 for instructions and the latest information.

A For the 2022 calendar year, or tax year beginning Sep 1, 2022, and ending Aug 31, 2023

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Final return/terminated ☐ Amended return ☐ Application pending	C Name of organization Greater San Marcos Youth Council, Inc.		D Employer identification number 74-2553659
	Doing business as		E Telephone number (512) 754-0500
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	
	P.O. Box 1455		
	City or town, state or province, country, and ZIP or foreign postal code San Marcos, TX 78667-1455		G Gross receipts \$1,831,598.
F Name and address of principal officer: Julia Ramsay-New, 2305 Ledgerock Road, Wimberley, TX 78676			H(a) Is this a group return for subordinates? ☐ Yes ☒ No H(b) Are all subordinates included? ☐ Yes ☐ No If "No," attach a list. See instructions.
I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () (Insert no.) ☐ 4947(a)(1) or ☐ 527			
J Website: www.gsmyc.org			
K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other			L Year of formation: 1986
M State of legal domicile: TX			

Part I Summary

Activities & Governance	1	Briefly describe the organization's mission or most significant activities: <u>Youth at risk and emergency shelter</u>		
	2	Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	9
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	9
	5	Total number of individuals employed in calendar year 2022 (Part V, line 2a)	5	44
Revenue	6	Total number of volunteers (estimate if necessary)	6	200
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
	b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.
	8	Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9	Program service revenue (Part VIII, line 2g)	912,544.	1,211,975.
Expenses	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	531,841.	471,675.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,431.	147,861.
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	1,940.	87.
	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,449,756.	1,831,598.
	14	Benefits paid to or for members (Part IX, column (A), line 4)		
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	961,375.	1,133,446.
	b	Total fundraising expenses (Part IX, column (D), line 25)		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	325,711.	293,356.
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	1,287,086.	1,426,802.
Net Assets or Fund Balances	19	Revenue less expenses. Subtract line 18 from line 12	162,670.	404,796.
	20	Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21	Total liabilities (Part X, line 26)	1,551,558.	1,967,938.
	22	Net assets or fund balances. Subtract line 21 from line 20	23,117.	34,701.

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here	Signature of officer	Date
	<i>Julia Ramsay-New</i>	01/16/2024
Type or print name and title		
Julia Ramsay-New, Executive Director		

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
	Julie Bryant				P01269961
	Firm's name	Business ServicesGO, LLC			Firm's EIN
	Firm's address	1535 S 145th East Ave, Tulsa, OK 74108			87-1611081
Phone no. (512) 964-3533					

May the IRS discuss this return with the preparer shown above? See instructions ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. BAA

REV 05/17/23 PRO

Form 990 (2022)

Part III Statement of Program Service AccomplishmentsCheck if Schedule O contains a response or note to any line in this Part III ☐**1** Briefly describe the organization's mission:Youth at risk and emergency shelter**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O.

4 Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.**4a** (Code:) (Expenses \$ 876,877. including grants of \$ 0.) (Revenue \$ 1,154,988.)Co-ed crisis shelter for homeless and runaway children ages 2-17 years**4b** (Code:) (Expenses \$ 481,316. including grants of \$ 0.) (Revenue \$ 528,551.)At risk non resident programs designed for family intervention and prevention**4c** (Code:) (Expenses \$ including grants of \$) (Revenue \$)**4d** Other program services (Describe on Schedule O.)

(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses 1,358,193.

GSMYC will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship. If at any time employees have a complaint or inquiry regarding this policy, the Executive Director should be contacted immediately. Employees should understand they can raise concerns and make reports without fear of reprisal. Anyone found to be engaging in any type of unlawful discrimination would be subject to disciplinary action.

Immigration Reform and Control Act of 1986

Under the U.S. Immigration Act, we have a continuing duty to assure that all employees have valid documentation of a right to work in the United States. We will also verify the right to work in other international locations of assignment. Therefore, employees will be asked to verify their immigration status and social security number from time to time if employed in the United States.

At-Will Employment Relationship

This manual is not intended to create or constitute an expressed or implied contract between GSMYC and any one or all of its employees. The Agency or the employee may terminate the employment relationship at any time, without prior notice. This is called “At-Will Employment.”

Commitment to Employer

- I shall work to improve the effectiveness and efficiency of services provided by the agency.
- I shall act to prevent and eliminate discrimination in work assignments or in personnel policies.
- I shall abide by all state licensing standards, agency policies, procedures, and management decisions.
- I shall support the integrity and reputation of the agency.
- I shall exercise special care when making my professional recommendations of opinions public through testimony or other public statements.

Code of Ethics and Harassment

A signed copy of the Code of Ethics will be kept in each employee's file.

Harmonious Work Environment

In support of our service values, GSMYC is committed to a harmonious work environment. Rude, abrasive, argumentative, condescending behavior and spreading of rumors will not be tolerated.

Comments and gossip about another employee's performance will not be tolerated. Participating in this type of behavior is detrimental to the quality of care of the people we serve. This type of behavior could result in disciplinary action up to and including termination of employment.

Employees who behave in a manner that creates a hostile work environment or poor public image will be subject to disciplinary action, up to and including termination of employment.

Equal Opportunity, Anti-Discrimination, Harassment, and Bullying Policy

GSMYC is committed to providing a workplace free of all forms of discrimination and harassment including bullying. It aims for equality of opportunity for all employees – staff, contracted and temporary – and is consistent with our policy of merit-based selection and promotion. By effectively implementing our Equal Employment Opportunity (EEO) Policy, we will attract talented people and use their abilities to maximum advantage for both the organization and the employee.

EEO programs are increasingly part of what best-practice companies do to ensure the maximum contribution from their people by managing diversity effectively. GSMYC seeks to make this best practice approach an integral part of our organization's culture.

It is the responsibility of management to provide a working environment free from discrimination, harassment, and bullying. To this end, GSMYC will take all practicable steps to ensure our residents provide a similar working environment.

In addition, Management and their delegates are to ensure all complaints are treated confidentially, seriously, and sympathetically. Thus, we have developed a Grievance Procedure to assist our employees who raise issues of concern. Relevant disciplinary action will be taken against anyone found to have breached this policy.

No employee will be penalized or disadvantaged as a result of raising concerns or complaints relating to discrimination or harassment.

What is Discrimination?

Unlawful discrimination occurs when a person considers they have been treated unfavorably due to an attribute (listed below).

Protected attributes include, but are not limited to:

- Age
- Disability/impairment
- Marital status, including defacto
- Physical features
- Political belief or activity
- Pregnancy/breastfeeding
- Race
- Religious belief or activity
- Sexual Orientation
- Gender
- Status as a parent or care giver
- Personal association with someone of the above attributes

Employees with Disabilities Act

The Americans with Disabilities Act of 1990, as amended, prohibits discrimination on the basis of disability, and protects qualified applicants and employees with disabilities from discrimination in hiring, promotion, discharge, pay, job training, fringe benefits, and other terms and conditions of employment. The law also requires that covered entities provide qualified applicants and employees with disabilities, as defined by the Act, with appropriate reasonable accommodation, if such accommodation does not impose an undue hardship. If you believe that you have been discriminated against based upon a disability, or you have a disability and require some accommodation, you should contact your supervisor or the Executive Director immediately. For more information on this Act, please reference the Americans with Disabilities Act of 1990 and amendments.

What is Harassment?

Harassment is an unwanted behavior and can take many forms. It may involve inappropriate actions, behavior, comments, or physical contact that is objectionable or

GREATER SAN MARCOS YOUTH COUNCIL

FINANCIAL STATEMENTS

AUGUST 31, 2023

With Independent Auditor's Report

GREATER SAN MARCOS YOUTH COUNCIL

Table of Contents

Independent Auditor's Report.....	1-2
Financial Statements	
Statement of Financial Position.....	3
Statement of Activities.....	4
Statement of Functional Expenses.....	5
Statement of Cash Flows.....	6
Notes to Financial Statements.....	7-11



Independent Auditor's Report

To the Board of Directors of
Greater San Marcos Youth Council

Opinion

I have audited the accompanying financial statements of Greater San Marcos Youth Council, (not-for-profit organization), which comprise the statement of financial position as of August 31, 2023, and the related statements of activities, functional expenses, and cash flows for the year then ended, and the related notes to the financial statements.

In my opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Greater San Marcos Youth Council as of August 31, 2023, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

I conducted the audit in accordance with auditing standards generally accepted in the United States of America. My responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of the report. I am required to be independent of Greater San Marcos Youth Council and to meet other ethical responsibilities in accordance with the relevant ethical requirements relating to my audit. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Greater San Marcos Youth Council's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

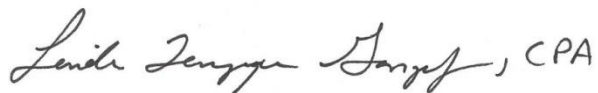
Auditor's Responsibilities for the Audit of the Financial Statements

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, I:

- Exercise professional judgement and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Greater San Marcos Youth Council's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in my judgement, there are conditions or events, considered in the aggregate, that raise substantial doubt about Greater San Marcos Youth Council's ability to continue as a going concern for a reasonable period of time.

I am required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that I identified during the audit.



San Marcos, Texas
December 15, 2023

GREATER SAN MARCOS YOUTH COUNCIL
STATEMENT OF FINANCIAL POSITION
AUGUST 31, 2023

ASSETS	
CURRENT ASSETS	
Cash and cash equivalents	\$ 65,515
Grants receivable	79,669
Prepaid expenses	2,783
TOTAL CURRENT ASSETS	<u>147,967</u>
INVESTMENTS	<u>1,605,648</u>
PROPERTY AND EQUIPMENT, net of accumulated depreciation	<u>214,323</u>
TOTAL ASSETS	<u><u>\$ 1,967,938</u></u>
LIABILITIES AND NET ASSETS	
LIABILITIES	
Accrued expenses	<u>\$ 34,701</u>
TOTAL LIABILITIES	<u>34,701</u>
NET ASSETS	
Without donor restrictions	1,815,237
With donor restrictions	<u>118,000</u>
TOTAL NET ASSETS	<u>1,933,237</u>
TOTAL LIABILITIES AND NET ASSETS	<u><u>\$ 1,967,938</u></u>

The accompanying notes are an integral part of these financial statements.

GREATER SAN MARCOS YOUTH COUNCIL
STATEMENT OF ACTIVITIES
FOR THE YEAR ENDED AUGUST 31, 2023

	Without Donor Restrictions	With Donor Restrictions	Total
SUPPORT AND REVENUE			
Grants and contracts	\$ 134,750	\$ 1,177,571	\$ 1,312,321
Contributions	304,480	-	304,480
Fundraising	53,589	-	53,589
Inkind contributions	13,260	-	13,260
Interest income	29,208	-	29,208
Unrealized gain	118,653	-	118,653
Other income	87	-	87
TOTAL SUPPORT AND REVENUE	654,027	1,177,571	1,831,598
Net assets released from restrictions, restrictions satisfied by payment	1,059,571	(1,059,571)	-
TOTAL SUPPORT AND REVENUE	\$ 1,713,598	\$ 118,000	\$ 1,831,598
EXPENSES			
Program services	\$ 1,358,193	\$ -	\$ 1,358,193
Supporting services			
Management and general	68,609	-	68,609
Fundraising	-	-	-
TOTAL EXPENSES	1,426,802	-	1,426,802
CHANGE IN NET ASSETS	286,796	118,000	404,796
NET ASSETS, BEGINNING OF YEAR	1,528,441	-	1,528,441
NET ASSETS, END OF YEAR	\$ 1,815,237	\$ 118,000	\$ 1,933,237

The accompanying notes are an integral part of these financial statements.

GREATER SAN MARCOS YOUTH COUNCIL
STATEMENT OF FUNCTIONAL EXPENSES
FOR THE YEAR ENDED AUGUST 31, 2023

	Program Services		Total	Supporting Services			Total	
	Nonresidential	Residential	Program Services	Management and General	Fundraising	Supporting Services		Total
Payroll expenses	\$ 356,981	\$ 685,288	\$ 1,042,269	\$ 34,622	\$ -	\$ 34,622		\$ 1,076,891
Employee benefits	20,570	28,017	48,587	11,020	-	11,020		59,607
Insurance-non health	18,022	16,629	34,651	246	-	246		34,897
Depreciation expense	17,657	10,586	28,243	-	-	-		28,243
Dues and licenses	2,162	290	2,452	-	-	-		2,452
Office expenses	5,621	2,238	7,859	1,095	-	1,095		8,954
Equipment purchases	-	1,053	1,053	-	-	-		1,053
Financial fees/charges	100	150	250	11,795	-	11,795		12,045
Computer expenses	1,969	1,583	3,552	390	-	390		3,942
Materials and supplies	5,619	58,996	64,615	-	-	-		64,615
Printing and advertising	8,049	862	8,911	-	-	-		8,911
Professional fees	2,360	1,454	3,814	9,207	-	9,207		13,021
Program expenses	16,229	1,675	17,904	-	-	-		17,904
Recreation	150	10,280	10,430	-	-	-		10,430
Repairs/maintenance	5,728	24,897	30,625	-	-	-		30,625
Security	175	538	713	-	-	-		713
Staff development	2,969	1,956	4,925	-	-	-		4,925
Transportation	173	9,991	10,164	70	-	70		10,234
Utilities	16,782	20,394	37,176	164	-	164		37,340
	<u>\$ 481,316</u>	<u>\$ 876,877</u>	<u>\$ 1,358,193</u>	<u>\$ 68,609</u>	<u>\$ -</u>	<u>\$ 68,609</u>		<u>\$ 1,426,802</u>

The accompanying notes are an integral of these financial statements.

GREATER SAN MARCOS YOUTH COUNCIL
STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED AUGUST 31, 2023

CASH FLOWS FROM OPERATING ACTIVITIES	
Change in net assets	\$ 404,796
Adjustments to reconcile change in net assets to net cash provided (used) by operating activities:	
Depreciation expense	28,243
Unrealized gain investments	(118,653)
Change in receivables	78,048
Change in prepaids	142
Change in liabilities	13,039
NET CASH PROVIDED BY OPERATING ACTIVITIES	<u>405,615</u>
CASH FLOWS FROM INVESTING ACTIVITIES	
Transfers to investments	(465,087)
Reinvestment of investment income	(29,066)
Investment in capital assets	(18,000)
NET CASH USED BY INVESTING ACTIVITIES	<u>(512,153)</u>
NET DECREASE IN CASH AND CASH EQUIVALENTS	(106,538)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	<u>172,053</u>
CASH AND CASH EQUIVALENTS AT END OF YEAR	<u><u>\$ 65,515</u></u>

The accompanying notes are an integral part of these financial statements.

GREATER SAN MARCOS YOUTH COUNCIL
NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED AUGUST 31, 2023

NOTE A - ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Greater San Marcos Youth Council is a nonprofit corporation incorporated in 1985, under the laws of the State of Texas. The organization was organized exclusively for charitable and educational purposes. The organization's mission is to create a safe haven for homeless youth. As a crisis facility, children are provided temporary housing until permanent living arrangements are made. In addition to the residential shelter, the counseling and resource center offers a variety of prevention and intervention programs designed to help families in crisis stay together. The organization relies primarily on grants for operating revenue. Therefore, the combined operation of the organization depends on its ability to obtain sufficient grant funds from its various funding sources.

Basis of presentation

The financial statements of Greater San Marcos Youth Council have been prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP), which require the organization to report information regarding its financial position and activities to the following net asset classifications:

Net assets without donor restrictions: Net assets that are not subject to donor-imposed restrictions and may be expended for any purpose in performing the primary objectives of the organization. These net assets may be used at the discretion of Greater San Marcos Youth Council's management and the board of directors.

Net assets with donor restrictions: Net assets subject to stipulations imposed by donors, and grantors. Some donors' restrictions are temporary in nature; those restrictions will be met by actions of Greater San Marcos Youth Council's or by the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity.

Donor restricted contributions are reported as increases in net assets with donor restrictions. When a restriction expires, net assets are reclassified from net assets with donor restrictions to net assets without donor restrictions in the statement of activities.

Cash and cash equivalents

For purposes of the statements of cash flows, the organization considers all highly liquid investments available for current use with an initial maturity of three months or less to be cash equivalents. As of August 31, 2023, the organization's cash and cash equivalents totaled \$65,515.

GREATER SAN MARCOS YOUTH COUNCIL
NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED AUGUST 31, 2023

NOTE A - ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING
POLICIES-CONTINUED

Fair Value Measurements

The organization reports its fair value measures using a three-level hierarchy that prioritizes the inputs used to measure fair value. The hierarchy, established by GAAP, requires that entities maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The three levels of inputs used to measure fair value are as follows:

Level 1 Inputs that are quoted prices in active markets for identical assets or liabilities that the reporting entity has the ability to access at the measurement date.

Level 2 Inputs other than quoted prices included in level 1 that are observable for the asset or liability, either directly or indirectly.

Level 3 Inputs that are unobservable for the asset or liability.

A financial instrument's level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement.

The carrying amount of cash and cash equivalents, prepaids, accounts payables and accrued expenses approximates fair market value due to the short-term maturities of these investments.

Accounting for Contributions

Contributions received are recorded as net assets without donor restrictions or net assets with donor restrictions, depending on the existence and/or nature of any donor-imposed restrictions. Contributions that are restricted by the donor are reported as an increase in net assets without donor restrictions if the restriction expires in the reporting period in which the contribution is recognized. All other donor restricted contributions are reported as an increase in net assets with donor restrictions, depending on the nature of restriction. When a restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the statements of activities as net assets released from restrictions.

Contributed property and equipment are recorded at fair value at the date of donation. Contributions with donor-imposed stipulations regarding how long the contributed assets must be used are recorded as net assets with donor restrictions; otherwise, the contributions are recorded as net assets without donor restrictions.

Gifts Received for Specific Beneficiaries

As required by ASC 958-605-25, when acting as an agent, the organization does not recognize gifts as revenues if the gifts are designated for specific beneficiaries unless the donor specifies variance power with the gift.

GREATER SAN MARCOS YOUTH COUNCIL
NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED AUGUST 31, 2023

NOTE A - ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING
POLICIES-CONTINUED

Expense Recognition and Allocation

The cost of providing the organization's programs and other activities is summarized on a functional basis in the statement of activities and statement of functional expenses. Expenses that can be identified with a specific program or support service are charged directly to that program or support service. Costs common to multiple functions have been allocated among the various functions benefited.

General and administrative expenses include those costs that are not directly identifiable with any specific program, but which provide for the overall support and direction of the organization.

Fundraising costs are expenses as incurred, even though they may result in contributions received in future years. The organization generally does not conduct its fundraising activities in conjunction with its other activities. In the few cases in which it does, such as when the annual report or donor acknowledgements contain requests for contributions, joint costs have been allocated between fundraising and management and general expenses in accordance with standards for accounting for costs of activities that include fundraising. Additionally, advertising costs are expensed as incurred.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of revenues and expenses during the reporting period and the reported amounts of assets and liabilities at the date of the financial statements. On an ongoing basis, the organization's management evaluates the estimates and assumptions based upon historical experience and various other factors and circumstances. The organization's management believes that the estimates and assumptions are reasonable in the circumstances; however, the actual results could differ from those estimates.

Tax Status

The organization is incorporated exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code (IRC), though it would be subject to tax on income unrelated to its exempt purposes. The tax year is still open to audit for both federal and state purposes.

New Accounting Pronouncement

In February 2016, FASB issued ASU No. 2016-02, *Leases* (Topic 842), which requires lessees to recognize leases on the balance sheet and disclose key information about leasing arrangements. The new standard requires the lessee to recognize lease liability on the statement of financial position for leases greater than 12 months. Leases will be classified as finance or operating, with classification affecting the pattern and classification of the expense recognition in the statement of activities. The effective date for this standard has been delayed to annual reporting periods beginning after December 15, 2021.

GREATER SAN MARCOS YOUTH COUNCIL
NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED AUGUST 31, 2023

NOTE B - INVESTMENTS

As of August 31, 2023, the organization's investments included:

	<u>Edward Jones</u>
Cash	\$ 18,000
Money market/CDs	312,195
Securities	<u>1,275,453</u>
	\$ 1,605,648
Interest/dividend income	29,066
Unrealized gain	\$ 118,653

Investments were measured at fair value using the market approach and inputs were considered to be level 1 under the fair value hierarchy.

NOTE C - LEASES

Greater San Marcos Youth Council entered into a 30-year lease agreement with the City of San Marcos in 1989 for the property to construct a children's shelter. In 2019 the lease agreement was renewed for an additional 30 years. Greater San Marcos Youth Council leases the land on which the youth shelter is located from the City of San Marcos for \$1 per year.

NOTE D - COMMITMENTS AND CONTINGENCIES

Greater San Marcos Youth Council, Inc. continues to participate in the federal and state funded programs. Under the terms of these contracts, the organization is subject to program compliance audits by the grantor or its representatives. Accordingly, the organization's compliance with applicable contract requirements could be established as some future date. If future program compliance audits result in questioned or disallowed costs, reimbursements would have to be made to the granting agencies. Accordingly, the amounts, if any, of such expenditures which might be disallowed by the grantor agencies cannot be determined as this time; however, the organization's management believes such amounts, if any, would be immaterial.

NOTE E - CONCENTRATIONS OF REVENUE

Grants and contracts from government agencies represent approximately 72% of the organization's total support for the year ended August 31, 2023.

GREATER SAN MARCOS YOUTH COUNCIL
NOTES TO FINANCIAL STATEMENTS
FOR THE YEAR ENDED AUGUST 31, 2023

NOTE F - RETIREMENT PLAN

The organization has established a 403(b) retirement plan for employees. Employees are able to contribute a portion of their salary to their retirement account and the organization will match 3% of what the employees contributes. The organization's contributions for the year ended, August 31, 2023 totaled \$9,273.

NOTE G - LIQUIDITY AND AVAILABILITY OF FINANCIAL RESOURCES

The following reflects the organization's financial assets as of the financial position date, reduced by amounts not available for general use due to donor-stipulated restrictions.

	<u>2023</u>
Cash and cash equivalents	\$ 65,515
Grants receivables	79,669
Investments	<u>1,605,648</u>
Total financial assets	1,750,832
Donor restrictions	<u>118,000</u>
Financial assets available to meet cash needs for expenditures within one year	<u>\$1,632,832</u>

The organization's primary sources of cash flows during the year are related to grant awards and state payments program/shelter services. These revenue sources provide a consistent inflow of cash throughout the year.

NOTE H - RELATED PARTY TRANSACTIONS

Greater San Marcos Youth Council hold investments with Edward Jones-Financial Advisors. A Greater San Marcos Youth Council board member is the spouse of the listed financial advisor on the Edward Jones account. As of year end, total Edward Jones investments totaled \$1,605,648.

NOTE I - SUBSEQUENT EVENTS

Management has evaluated subsequent events through December 15, 2023, which is the date the financial statements were available to be issued.

Minimum Standards for General Residential Operations

Child Care Regulation

Texas Health and Human
Services Commission

October 2021



TEXAS
Health and Human
Services

Table of Contents

Table of Contents	2
Introduction	6
Minimum Standards	6
Deficiencies	6
Weights	6
Maintaining Compliance	7
The Inspection	7
Technical Assistance.....	7
Investigations	8
Your Rights and Entitlements.....	8
For Further Information	8
Subchapter A, Purpose and Scope	9
Subchapter B, Definitions and Services	12
Division 1, Definitions.....	12
Division 2, Services.....	23
Subchapter C, Organization and Administration	30
Division 1, Plans and Policies Required For the Application Process.....	30
Division 2, Operational Responsibilities and Notifications	45
Division 3, General Fiscal Requirements	50
Division 4, Required Postings.....	50
Subchapter D, Reports and Record Keeping	51
Division 1, Reporting Serious Incidents and Other Occurrences	51
Division 2, Operation Records	67
Division 3, Personnel Records	69
Division 4, Child Records.....	71
Division 5, Record Retention.....	73
Division 6, Unauthorized Absences	73
Subchapter E, Personnel	79
Division 1, General Requirements.....	79
Division 2, Child-Care Administrator	81
Division 3, Professional Level Service Providers	84
Division 4, Treatment Director	91
Division 5, Caregivers.....	93
Division 6, Normalcy	96
Division 7, Contract Staff and Volunteers.....	99
Subchapter F, Training and Professional Development	102
Division 1, Definitions.....	102
Division 2, Orientation	103

Division 3, Pre-Service Experience and Training	104
Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy	109
Division 5, Pre-Service Training Regarding Emergency Behavior Intervention	112
Division 6, Annual Training.....	114
Division 7, First-Aid and CPR Certification	126
Subchapter G, Child /Caregiver Ratios	129
Subchapter H, Child Rights.....	128
Subchapter I, Admission, Service Planning, and Discharge	137
Division 1, Admission	125
Division 2, Emergency Admission	141
Division 3, Educational Services	144
Division 4, Service Plans	146
Division 5, Service Plan Reviews and Updates.....	158
Division 6, Discharge and Transfer Planning	161
Division 7, Release of Child	165
Subchapter J, Child Care	166
Division 1, Dental Care	166
Division 2, Medical Care	168
Division 3, Communicable Diseases	175
Division 4, Protective Devices	177
Division 5, Supportive Devices	180
Division 6, Tobacco and E-Cigarette Use	182
Division 7, Nutrition and Hydration	182
Division 8, Additional Requirements for Infant Care	196
Division 9, Additional Requirements for Toddler Care	206
Division 10, Additional Requirements for Pregnant and Parenting Children	208
Subchapter K, Operations That Provide Care for Children and Adults	211
Division 1, Scope	211
Division 2, General Requirements.....	211
Subchapter L, Medication	215
Division 1, Administration of Medication	215
Division 2, Self-Administration of Medication	218
Division 3, Medication Storage and Destruction.....	219
Division 4, Medication Records.....	221
Division 5, Medication and Label Errors	223
Division 6, Side Effects and Adverse Reactions to Medication	225
Division 7, Use of Psychotropic Medication	227
Division 8, Unassigned Epinephrine Auto-Injectors	231
Subchapter M, Discipline and Punishment.....	232

Subchapter N, Emergency Behavior Intervention	236
Division 1, Definitions.....	236
Division 2, Types of Emergency Behavior Intervention That May Be Administered	236
Division 3, Orders	240
Division 4, Responsibilities During Administration of Any Type of Emergency Behavior Intervention	244
Division 5, Additional Responsibilities During Administration of a Personal Restraint.....	247
Division 6, Additional Responsibilities During Administration of Seclusion..	249
Division 7, Additional Responsibilities During Administration of a Mechanical Restraint.....	250
Division 8, Successive Use and Combinations of Emergency Behavior Intervention	252
Division 9, Time Restrictions for Emergency Behavior Intervention	255
Division 10, General Caregiver Responsibilities, Including Documentation, After the Administration of Emergency Behavior Intervention	259
Division 11, Triggered Reviews	263
Division 12, Overall Operation Evaluation	266
Subchapter O, Safety and Emergency Practices	268
Division 1, Sanitation and Health Practices.....	268
Division 2, Natural Gas and Liquefied Petroleum	273
Division 3, Fire Safety Practices	275
Division 4, Heating Devices	279
Division 5, Carbon Monoxide Safety Practices.....	280
Division 6, Emergency Evacuation and Relocation	281
Division 7, First-Aid Kits.....	284
Subchapter P, Physical Site	286
Division 1, Grounds and General Requirements.....	286
Division 2, Interior Space.....	290
Division 3, Toilet and Bath Facilities	297
Division 4, Poisons.....	300
Division 5, Food Preparation, Storage, and Equipment	300
Division 6, Play Equipment and Safety Requirements.....	304
Division 7, Playground Use Zones.....	308
Division 8, Protective Surfacing	311
Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs.....	313
Subchapter Q, Recreation Activities	316
Division 1, General Requirements.....	316
Division 2, Swimming Activities.....	322
Division 3, Watercraft Activities.....	326
Division 4, Wilderness Hiking and Camping Excursions.....	328
Division 5, Trampoline Use	339
Division 6, Weapons, Firearms, Explosive Materials, and Projectiles	341

Subchapter R, Transportation	343
Division 1, General Requirements.....	343
Division 2, Safety Restraints.....	347
Division 3, Vehicle and Vehicle Maintenance	350
Division 4, Transportation Records.....	350
Subchapter S, Additional Requirements for Operations That Provide	
Emergency Care Services.....	351
Division 1, Service Management.....	352
Division 2, Admission Assessment	355
Division 3, Respite Child-Care Services.....	357
Subchapter T, Additional Requirements for Operations That Provide an	
Assessment Services Program	361
Division 1, Regulation.....	361
Division 2, Admission	361
Division 3, Assessment Plan	362
Division 4, Assessment Report	364
Subchapter U, Additional Requirements for Operations That Provide	
Therapeutic Camp Services.....	368
Division 1, Definitions.....	368
Division 2, Activities Requiring Spotting or Belaying	370
Division 3, Primitive Camping Excursions.....	371
Subchapter V, Additional Requirements for Operations that Provide	
Trafficking Victim Services	375
Division 1, Definitions and Scope.....	375
Division 2, Policies and Procedures	377
Division 3, Personnel.....	379
Division 4, Training	380
Division 5, Child/Caregiver Ratios.....	386
Division 6, Admission and Service Planning	387
Appendix A: Definitions.....	393
Appendix B, Vaccine-Preventable Diseases	398

Introduction

Minimum Standards

These minimum standards tell you (the child care operation permit holder) what requirements you, your employees, and your caregivers must follow.

These minimum standards:

- were developed by the Texas Health and Human Services Commission (HHSC) with the assistance of child-care operations, parents, stakeholders, and other experts in a variety of fields;
- reflect what the citizens of Texas consider to be reasonable and minimum; and
- meet the guidelines set forth in Chapter 42 of the Texas Human Resources Code (law) for what must be included in the minimum standards.

The Administrative Procedure and Texas Register Act requires that proposed standards be published for public comment before they are adopted as rules. All members of the public, including providers, are encouraged to provide input when proposed minimum standards are published for comment. The commission considers recommendations from interested persons or groups in formulating the final draft, which is filed as rules with the Secretary of State.

Deficiencies

A deficiency is any failure to comply with a minimum standard, rule in Texas Administrative Code Chapter 745, law, specific term of the permit, or specific condition of probation or suspension.

Weights

The minimum standards are weighted based on a common understanding of the risk to children presented if the standard or rule is violated. The weights are: high, medium-high, medium, medium-low, and low. The assigned weights do not change based on the scope or severity of an actual deficiency. Scope and severity are assessed by Child Care Regulation (CCR) staff, documented, and considered in conjunction with the weight when making CCR decisions. You will see the *weight is noted at the end of each standard or subsection in green. Only those minimum standards which can be cited as a deficiency are weighted. For example, the minimum standard prohibiting physical discipline is weighted but minimum standards that are definitions are not weighted.*

Maintaining Compliance

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

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

The Inspection

Various aspects of regulated operations are evaluated for compliance with the minimum standards, rules, and laws during regular inspections. The emphasis on these inspections is to prevent risk to children in care. The frequency of inspections will fluctuate depending on the type of permit and the operation's history of compliance with the minimum standards, rules, and law.

During any inspection, if we find that your operation does not meet minimum standard, rule, or law, the deficiencies are discussed with the person in charge at the time of the inspection. You will be given the opportunity to correct deficiencies within a specified period of time. If you have questions, concerns, or disagree with the citation, we encourage you to talk with us before we leave your operation. If your concerns are not resolved, you may request an administrative review.

Technical Assistance

We are available to offer consultation to potential applicants, applicants, and permit holders regarding how to comply with minimum standards, rules, and laws. While we most often provide technical assistance during inspections and investigations, technical assistance can be requested at any time.

The Child Care Regulation section of the HHSC web site has a Technical Assistance Library that allows you to view or download information about a variety of topics related to child care. You can view it by going to <https://hhs.texas.gov/doing-business-hhs/provider-portals/protective-services-providers/child-care-licensing> and selecting *Technical Assistance Library* from the Resources section.

A feature of the minimum standards publication are the Helpful Information and Best Practice Suggestion boxes following certain minimum standards that provide additional guidance, clarification, resources, and/or best practices.

Investigations

When a report alleges a violation of minimum standards, rule, or law, CCR staff must investigate the report, notify you of the investigation, and provide a written report to you of the investigation results within prescribed time frames.

Your Rights and Entitlements

Waivers and Variances

You may request a waiver If your operation is unable to comply with a standard for economic reasons. You may request a variance if your operation wishes to meet the intent of a standard in a way that is different from what the standard specifies. Waiver and variance requests are submitted through your online provider account or made in writing to your assigned CCR inspector.

Administrative Review

If you disagree with a CCR decision or action, you may request an administrative review, during which you are given an opportunity to show compliance with applicable minimum standard, rule, law, action, permit restriction(s) and/or permit conditions.

Appeal Hearing

You may request an appeal hearing on a CCR decision to deny an application, revoke, suspend, or refuse to renew a permit or a condition placed on the permit after initial issuance.

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

For Further Information

It is important that you, your employees, and your caregivers clearly understand the purpose of minimum standards and the reasons for CCR's inspections and investigations. Do not hesitate to ask us questions that will help you understand any aspect of our regulation. You may obtain information about minimum standards or procedures by calling your local CCR office or by visiting the HHSC web site at <https://hhs.texas.gov/doing-business-hhs/provider-portals/protective-services-providers/child-care-licensing>.

Subchapter A, Purpose and Scope

§748.1. What is the purpose of this chapter?

Subchapter A, Purpose and Scope

January 2007

The purpose of this chapter is to set forth rules that apply to General Residential Operations and Residential Treatment Centers.

§748.3. Who is responsible for complying with these minimum standards?

Subchapter A, Purpose and Scope

January 2017

- (a) For a licensed general residential operation, the permit holder must ensure compliance with the minimum standards in this chapter at all times, with the exception of those minimum standards identified for specific types of services that your operation does not offer. For example, if we license your operation to offer emergency care services only, you do not have to comply with the minimum standards that apply to treatment services for a child with an emotional disorder, treatment services for a child with an intellectual disability, or a transitional living program; however, you must comply with all other applicable minimum standards of this chapter. [High]
- (b) For an unlicensed general residential operation that is subject to Licensing's regulation, the operation's administrator, owner, or operator or any other controlling person who has the ability to influence or direct the operation's management, expenditures, or policies must ensure compliance with all the minimum standards in this chapter at all times, with the exception of those minimum standards identified for specific types of services that the unlicensed operation does not offer. [High]

§748.5. How do Residential Treatment Centers comply with the rules of this chapter?

Subchapter A, Purpose and Scope

September 2010

Residential Treatment Centers (RTCs) are general residential operations that provide treatment services to children with emotional disorders. RTCs, by definition, must always comply with the rules of this chapter as if 100% of the children in their care require treatment services for emotional disorders. This includes, but is not limited to, services to individual children, personnel requirements, and child/caregiver ratio requirements.

§748.7. How are these regulations applied to family residential centers?

Subchapter A, Purpose and Scope

March 2016

- (a) Definition. A family residential center is one that meets all of the following requirements:
 - (1) The center is operated by or under a contract with United States Immigration and Customs Enforcement;
 - (2) The center is operated to enforce federal immigration laws;
 - (3) Each child at the center is detained with a parent or other adult family member, who remains with the child at the center; and
 - (4) A parent or family member with a child provides the direct care for the child except for specific circumstances when the child is cared for directly by the center or another adult in the custody of the center.
- (b) Classification. A family residential center is a general residential operation (GRO) and must comply with all associated requirements for GROs, unless the family residential center is approved for an individual waiver or variance or an exception is provided in this section. The department is responsible for regulating the provision of childcare as authorized by Chapters 40 and 42, Texas Human Resources Code and Chapter 261, Texas Human Resources Code. The department does not oversee requirements that pertain to other law, including whether the facilities are classified as secure or in compliance with any operable settlement agreements or other state or federal restrictions.

- (c) Exceptions. A family residential center is not required to comply with all terms of the following Minimum Standards:
- (1) the limitation of room occupants to four in §748.3357 of this title (relating to What are the requirements for floor space in a bedroom used by a child?), except that nothing in this exception shall be construed to require fewer than 60 square feet per child;
 - (2) the limitation on a child sharing a bedroom with an adult in §748.3361 of this title (relating to May a child in care share a bedroom with an adult?), if the bedroom is being shared in order to allow a child to remain with the child's parent or other family member; and
 - (3) the limitations on children of the opposite gender sharing a room in §748.3363 of this title (relating to May children of opposite genders share a bedroom?), except that nothing in this exception shall be construed to permit children from different families who are over the age of six and members of the opposite gender to share a bedroom.
- (d) Limitation of exception. Notwithstanding subsection (c) of this section, and as further described in §745.8313 of this title (relating to Is a waiver or variance unconditional?), the department retains the authority for placing conditions on the scope of the exceptions authorized for a family residential center, including conditions related to limiting occupancy in accordance with fire safety standards, limitations related to allowing children and adults of the opposite gender to occupy the same room only if they are part of the same family, and any other limitation determined by the department to be necessary to the health, safety, or welfare of children in care.
- (e) Division of responsibility. In addition to the application materials described in §745.243(6) of this title (relating to What does a completed application for a permit include?), an applicant for a license under this section must submit the policies, procedures, and any other documentation that the department deems necessary to clarify the division of supervisory and caretaking responsibility between employees of the facility and the parents and other adult family members who are housed with the children. The department must approve the documentation during the application process and any subsequent amendments to the policies and procedures.

Subchapter B, Definitions and Services

Division 1, Definitions

§748.41. What do certain pronouns mean in this chapter?

Subchapter B, Definitions and Services

Division 1, Definitions

January 2007

The following words have the following meanings in this chapter:

- (1) I, my, you, and your – An applicant or permit holder, unless otherwise stated.
- (2) We, us, our, and Licensing – The Licensing Division of the Department of Family and Protective Services (DFPS).

§748.43. What do certain words and terms mean in this chapter?

Subchapter B, Definitions and Services

Division 1, Definitions

January 2017

The words and terms used in this chapter have the meanings assigned to them under §745.21 of this title (relating to What do the following words and terms mean when used in this chapter?), unless another meaning is assigned in this section or unless the context clearly indicates otherwise. The following words and terms have the following meanings unless the context clearly indicates otherwise:

- (1) Accredited college or university – An institution of higher education accredited by one of the following regional accrediting entities:
 - (A) The Southern Association of Colleges and Schools Commission on Colleges, a subdivision of the Southern Association of Colleges and Schools;
 - (B) The Middle States Commission on Higher Education, a component of the Middle States Association of Colleges and Schools;
 - (C) The Commission on Institutions of Higher Education, a subdivision of the New England Association of Schools and Colleges;

- (D) The Higher Learning Commission (formerly part of the North Central Association of Colleges and Schools);
- (E) The Northwest Commission on Colleges and Universities;
- (F) The Accrediting Commission for Senior Colleges and Universities, a subdivision of the Western Association of Schools and Colleges; or
- (G) The Accrediting Commission for Community and Junior Colleges, a subdivision of the Western Association of Schools and Colleges.

(2) Activity space – An area or room used for child activities.

(3) Adaptive functioning – Refers to how effectively a person copes with common life demands and how well the person meets standards of personal independence expected of someone in his particular age group, sociocultural background, and community setting.

(4) Adult – A person 18 years old or older.

(5) Caregiver – A person counted in the child/caregiver ratio, whose duties include the direct care, supervision, guidance, and protection of a child. This does not include a contract service provider who:

- (A) Provides a specific type of service to your operation for a limited number of hours per week or month; or

- (B) Works with one particular child.

(6) Certified lifeguard – A person who has been trained in rescue techniques, lifesaving, and water safety by a qualified instructor from a recognized organization that awards a certificate upon successful completion of the training. A certified lifeguard ensures the safety of persons by preventing and responding to water related emergencies.

(7) Chemical restraint – A type of emergency behavior intervention that uses chemicals or pharmaceuticals through topical application, oral administration, injection, or other means to immobilize or sedate a child as a mechanism of control. The use of a medication is not a chemical restraint under this chapter if the medication:

- (A) Is prescribed by a treating health-care professional;

- (B) Is administered solely for medical or dental reasons; and

- (C) Has a secondary effect of immobilizing or sedating a child.

(8) Child/caregiver ratio – The maximum number of children for whom one caregiver can be responsible.

- (9) Childhood activities – Activities that are generally accepted as suitable for children of the same chronological age, level of maturity, and developmental level as determined by a reasonable and prudent parent standard as specified in §748.705 of this title (relating to What is the “reasonable and prudent parent standard”?). Examples of childhood activities include extracurricular activities, in-school and out-of-school activities, enrichment activities, cultural activities, and employment opportunities. Childhood activities include unsupervised childhood activities.
- (10) Child in care – A child who is currently admitted as a resident of a general residential operation, regardless of whether the child is temporarily away from the operation, as in the case of a child at school or at work. Unless a child has been discharged from the operation, the child is considered a child in care.
- (11) Child passenger safety seat system – An infant or child passenger restraint system that meets the federal standards for crash-tested restraint systems as set by the National Highway Traffic Safety Administration.
- (12) Corporation or other type of business entity – May include an association, corporation, nonprofit association, nonprofit corporation, nonprofit association with religious affiliation, nonprofit corporation with religious affiliation, limited liability company, political subdivision, or state agency. For purposes of this chapter, this definition does not include any type of “partnership”, which is defined separately.
- (13) Cottage or cottage home – A living arrangement for children who are not receiving treatment services in which:
- (A) Each group of children has separate living quarters;
 - (B) 12 or fewer children are in each group;
 - (C) Primary caregivers live in the children’s living quarters, 24 hours per day for at least four days a week or 15 days a month; and
 - (D) Other caregivers are used only to meet the child-to-caregiver ratio in an emergency or to supplement care provided by the primary caregivers.
- (14) Counseling – A procedure used by professionals from various disciplines in guiding individuals, families, groups, and communities by such activities as delineating alternatives, helping to articulate goals, processing feelings and options, and providing needed information. This definition does not include career counseling.
- (15) Days – Calendar days, unless otherwise stated.
- (16) De-escalation – Strategies used to defuse a volatile situation, to assist a child to regain behavioral control, and to avoid a physical restraint or other behavioral intervention.
- (17) Department – The Department of Family and Protective Services (DFPS).

- (18) Discipline – A form of guidance that is constructive or educational in nature and appropriate to the child’s age, development, situation, and severity of the behavior.
- (19) Emergency Behavior Intervention (EBI) – Interventions used in an emergency situation, including personal restraints, mechanical restraints, emergency medication, and seclusion.
- (20) Emergency medication – A type of emergency behavior intervention that uses chemicals or pharmaceuticals through topical application, oral administration, injection, or other means to modify a child’s behavior. The use of a medication is not an emergency medication under this chapter if the medication:
- (A) Is prescribed by a treating health-care professional;
 - (B) Is administered solely for a medical or dental reason (e.g. Benadryl for an allergic reaction or medication to control seizures); and
 - (C) Has a secondary effect of modifying a child’s behavior.

Helpful Information

The distinguishing variable between a PRN (as needed) psychotropic medication and an emergency medication is the circumstances under which the medication is given. A medication given to help a child manage his/her behavior or to de-escalate a child who is having trouble managing his/her behavior is regulated only as a PRN psychotropic medication. However, if the medication is given in response to an emergency situation, it is an emergency medication.

For example, a child becomes increasingly agitated after a family visit, to the point of screaming and becoming verbally abusive to caregivers and other children. The child is not able to use self-calming techniques. If the child is offered a PRN psychotropic medication under these circumstances, it is not regulated as emergency medication, because there is no emergency situation. The medication serves to help the child manage the behavior before it escalates into an emergency.

However, if the child had escalated to the point of physically assaulting someone and requiring physical restraint, then a medication offered during the restraint to help the child calm would be regulated as an emergency medication.

(21) Emergency situation – A situation in which attempted preventative de-escalatory or redirection techniques have not effectively reduced the potential for injury, so that intervention is immediately necessary to prevent:

- (A) Imminent probable death or substantial bodily harm to the child because the child attempts or continually threatens to commit suicide or substantial bodily harm; or
- (B) Imminent physical harm to another because of the child's overt acts, including attempting to harm others. These situations may include aggressive acts by the child, including serious incidents of shoving or grabbing others over their objections. These situations do not include verbal threats or verbal attacks.

(22) Family members – An individual related to another individual within the third degree of consanguinity or affinity. For the definitions of consanguinity and affinity, see Chapter 745 of this title (relating to Licensing). The degree of the relationship is computed as described in Government Code, §573.023 (relating to Computation of Degree of Consanguinity) and §573.025 (relating to Computation of Degree of Affinity).

Helpful Information: Relationship of Consanguinity AND Affinity		
Person Related within 1 st Degree	Person Related within 2 nd Degree	Person Related within 3 rd Degree
• Parent; • Child; • Spouse; • Mother-In-Law and Father-In-Law; and • Daughter-In-Law and Son-In-Law. *Step and half relationships (step- brother, step-father, half- sister, etc.) are considered to be the same as blood relationships.	• Grandparent; • Grandparent-In-Law; • Grandchild; • Grandchild-In-Law; • Sister or Brother; and • Sister/Brother-In- Law.	• Great-Grandparent; • Great-Grandparent- In-Law; • Grandchild; • Grandchild-In-Law; • Niece/Nephew; • Niece/Nephew-In- Law; • Aunt/Uncle; and • Aunt/Uncle-In-Law.

(23) Field trip – A group activity conducted away from the operation.

- (24) Food service – The preparation or serving of meals or snacks.
- (25) Full-time – At least 30 hours per week.
- (26) Garbage – Food or items that when deteriorating cause offensive odors and/or attract rodents, insects, and other pests.
- (27) General Residential Operation – A residential child-care operation that provides child care for 13 or more children or young adults. The care may include treatment services and/or programmatic services. These operations include formerly titled emergency shelters, operations providing basic child care, residential treatment centers, and halfway houses.
- (28) Governing body – A group of persons or officers of the corporation or other type of business entity having ultimate authority and responsibility for the operation.
- (29) Group of children – Children assigned to a specific caregiver or caregivers. Generally, the group stays with the assigned caregiver(s) throughout the day and may move to different areas throughout the operation, indoors and out. For example, children who are assigned to specific caregivers occupying a unit or cottage are considered a group.
- (30) Health-care professional – A licensed physician, licensed advanced practice registered nurse, physician’s assistant, licensed vocational nurse (LVN), licensed registered nurse (RN), or other licensed medical personnel providing health care to the child within the scope of the person’s license. This does not include medical doctors or medical personnel not licensed to practice in the United States.
- (31) High-risk behavior – Behavior of a child that creates an immediate safety risk to self or others. Examples of high-risk behavior include suicide attempt, self-abuse, physical aggression causing bodily injury, chronic running away, substance abuse, fire-setting, and sexual aggression or perpetration.
- (32) Human services field – A field of study that contains coursework in the social sciences of psychology and social work including some counseling classes focusing on normal and abnormal human development and interpersonal relationship skills from an accredited college or university. Coursework in guidance counseling does not apply.

- (33) Immediate danger – A situation where a prudent person would conclude that bodily harm would occur if there were no immediate interventions. Immediate danger includes a serious risk of suicide, serious physical injury to self or others, or the probability of bodily harm resulting from a child running away if less than 10 years old chronologically or developmentally. Immediate danger does not include:
- (A) Harm that might occur over time or at a later time; or
 - (B) Verbal threats or verbal attacks.
- (34) Infant – A child from birth through 17 months.
- (35) Livestock – An animal raised for human consumption or an equine animal.
- (36) Living quarters – A structure or part of a structure where a group of children reside, such as a building, house, cottage home, or unit.
- (37) Mechanical restraint – A type of emergency behavior intervention that uses the application of a device to restrict the free movement of all or part of a child's body in order to control physical activity.
- (38) Mental health professional – Refers to:
- (A) A psychiatrist licensed by the Texas Medical Board;
 - (B) A psychologist licensed by the Texas State Board of Examiners of Psychologists;
 - (C) A master's level social worker or higher licensed by the Texas State Board of Social Work Examiners;
 - (D) A professional counselor licensed by the Texas State Board of Examiners of Professional Counselors;
 - (E) A marriage and family therapist licensed by the Texas State Board of Examiners of Marriage and Family Therapists; and
 - (F) A master's level or higher nurse licensed as an Advanced Practice Registered Nurse by the Texas Board of Nursing and board certified in Psychiatric/Mental Health.
- (39) Non-ambulatory – A child that is only able to move from place to place with assistance, such as a walker, crutches, a wheelchair, or prosthetic leg.
- (40) Non-mobile – A child that is not able to move from place to place, even with assistance.
- (41) Operation – General residential operations, including residential treatment centers.
- (42) Owner – The sole proprietor, partnership, or corporation or other type of business entity who owns the operation.

- (43) Parent – A person who has legal responsibility for or legal custody of a child, including the managing conservator or legal guardian.
- (44) Partnership – A partnership may be a general partnership, (general) limited liability partnership, limited partnership, or limited partnership as limited liability partnership.
- (45) Permit holder – The owner of the operation that is granted the permit.
- (46) Permit is no longer valid – For purposes of this chapter, a permit remains valid through the renewal process. A permit only becomes invalid when your operation voluntarily closes or is required to close through an enforcement action in Subchapter L of Chapter 745 (relating to Enforcement Actions).
- (47) Person legally authorized to give consent – The person legally authorized to give consent by the Texas Family Code or a person authorized by the court.
- (48) Personal restraint – A type of emergency behavior intervention that uses the application of physical force without the use of any device to restrict the free movement of all or part of a child’s body in order to control physical activity. Personal restraint includes escorting, which is when a caregiver uses physical force to move or direct a child who physically resists moving with the caregiver to another location.
- (49) Physical force – Pressure applied to a child’s body that reduces or eliminates the child’s ability to move freely.
- (50) PRN – A standing order or prescription that applies “pro re nata” or “as needed according to circumstances.”
- (51) Prone restraint – A restraint in which the child is placed in a chest-down hold.
- (52) Psychosocial assessment – An evaluation by a mental health professional of a child’s mental health that includes a:
 - (A) Clinical interview of the child;
 - (B) Diagnosis from the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5), or statement that rules out a DSM-5 diagnosis;
 - (C) Treatment plan for the child, including whether further evaluation of the child is needed (for example: is a psychiatric evaluation needed to determine if the child would benefit from psychotropic medication or hospitalization; or is a psychological evaluation with psychometric testing needed to determine if the child has a learning disability or an intellectual disability); and
 - (D) Written summary of the assessment.

- (53) Re-evaluate – Re-assessing all factors required for the initial evaluation for the purpose of determining if any substantive changes have occurred. If substantive changes have occurred, these areas must be fully evaluated.
- (54) Regularly – On a recurring, scheduled basis. Note: For the definition for “regularly or frequently present at an operation” as it applies to background checks, see §745.601 of this title (relating to What words must I know to understand this subchapter?).
- (55) Residential Treatment Center (RTC) – A general residential operation for 13 or more children or young adults that exclusively provides treatment services for children with emotional disorders.
- (56) Sanitize – The use of a product (usually a disinfecting solution) registered by the Environmental Protection Agency (EPA) that substantially reduces germs on inanimate objects to levels considered safe by public health requirements. Many bleach and hydrogen peroxide products are EPA-registered. You must follow the product’s labelling instructions for sanitizing (paying particular attention to any instructions regarding contact time and toxicity on surfaces likely to be mouthed by children, such as toys and crib rails). For an EPA-registered sanitizing product or disinfecting solution that does not include labelling instructions for sanitizing (a bleach product, for example), you must conduct these steps in the following order:
- (A) Washing with water and soap;
 - (B) Rinsing with clear water;
 - (C) Soaking in or spraying on a disinfecting solution for at least two minutes. Rinsing with cool water only those items that a child is likely to place in his mouth; and
 - (D) Allowing the surface or item to air-dry.
- (57) School-age child – A child five years old or older who will attend school in August or September of that year.
- (58) Seat belt – A lap belt and any shoulder strap included as original equipment on or added to a motor vehicle.
- (59) Seclusion – A type of emergency behavior intervention that involves the involuntary separation of a child from other residents and the placement of the child alone in an area from which the resident is prevented from leaving by a physical barrier, force, or threat of force.

- (60) Service plan – A plan that identifies a child’s basic and specific needs and how those needs will be met.
- (61) Short personal restraint – A personal restraint that does not last longer than one minute before the child is released.
- (62) State or local fire inspector – A fire official who is authorized to conduct fire safety inspections on behalf of the city, county, or state government.
- (63) State or local sanitation official – A sanitation official who is authorized to conduct environmental sanitation inspections on behalf of the city, county, or state government.
- (64) Substantial physical injury – Physical injury serious enough that a reasonable person would conclude that the injury needs treatment by a medical professional, including dislocated, fractured, or broken bones; concussions; lacerations requiring stitches; second and third degree burns; and damages to internal organs. Evidence that physical injury is serious includes the location and/or severity of the bodily harm and/or age of the child. Substantial physical injury does not include minor bruising, the risk of minor bruising, or similar forms of minor bodily harm that will resolve healthily without professional medical attention.
- (65) Supplements – Includes vitamins, herbs, and any supplement labeled dietary supplement.
- (66) Supine restraint – Placing a child in a chest up restraint hold.
- (67) Swimming activities – Activities related to the use of swimming pools, wading/splashing pools, hot tubs, or other bodies of water.
- (68) Toddler – A child from 18 months through 35 months.
- (69) Trafficking victim – A child who has been recruited, harbored, transported, provided or obtained for the purpose of forced labor or commercial sexual activity, including any child subjected to an act or practice as specified in Penal Code §20A.02 or §20A.03.
- (70) Trauma informed care (TIC) – Care for children that is child-centered and considers the unique culture, experiences, and beliefs of the child. TIC takes into consideration:
 - (A) The impact that traumatic experiences have on the lives of children;
 - (B) The symptoms of childhood trauma;
 - (C) An understanding of a child’s personal trauma history;

(D) The recognition of a child's trauma triggers; and

(E) Methods of responding that improve a child's ability to trust, to feel safe, and to adapt to changes in the child's environment.

(71) Treatment director – The person responsible for the overall treatment program providing treatment services. A treatment director may have other responsibilities and may designate treatment director responsibilities to other qualified persons.

(72) Universal precautions – An approach to infection control where all human blood and certain human bodily fluids are treated as if known to be infectious for HIV, HBV, and other blood-borne pathogens.

(73) Unsupervised childhood activities – Childhood activities that a child in care participates in away from the operation and the caregivers. Childhood activities that an operation sponsors, conducts, or supervises are not unsupervised childhood activities.

Unsupervised childhood activities may include playing sports, going on field trips, spending the night with a friend, going to the mall, or dating. Unsupervised childhood activities may last one or more days.

(74) Vaccine-preventable disease – A disease that is included in the most current recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(75) Volunteer – A person who provides:

(A) Child-care services, treatment services, or programmatic services under the auspices of the operation without monetary compensation; or

(B) Any type of services under the auspices of the operation without monetary compensation when the person has unsupervised access to a child in care.

(76) Young adult – An adult whose chronological age is between 18 and 22 years, who is currently in a residential child-care operation, and who continues to need child-care services.

Division 2, Services

§748.61. What types of services does Licensing regulate?

Subchapter B, Definitions and Services

Division 2, Services

January 2017

We regulate the following types of services:

- (1) Child-Care Services – Services that meet a child’s basic need for shelter, nutrition, clothing, nurture, socialization and interpersonal skills, care for personal health and hygiene, supervision, education, and service planning;
- (2) Treatment Services – In addition to child-care services, a specialized type of child-care services designed to treat and/or support children:
 - (A) With Emotional Disorders who have a current DSM-5 diagnosis, such as mood disorders, psychotic disorders, or dissociative disorders, and demonstrate two or more of the following:
 - (i) Major self-injurious actions, including a suicide attempt within the last 12 months;
 - (ii) Difficulties that present a significant risk of harm to others, including frequent or unpredictable physical aggression; or
 - (iii) An additional DSM-5 diagnosis of substance-related and/or addictive disorder with severe impairment;

Helpful Information
Regarding subsection (2)(A), neither attending counseling nor taking a psychotropic medication factors into a child being eligible for treatment services for an emotional disorder. Only the indicators noted above are considered when determining eligibility for treatment services. However, you may offer treatment services to a child you assess as needing those services, regardless of the indicators above.

(B) With a DSM-5 diagnosis of Intellectual Disability that is characterized by prominent, severe deficits and pervasive impairment in one or more of the following areas:

- (i) Conceptual, social, and practical adaptive skills to include daily living and self-care;
- (ii) Communication, cognition, or expressions of affect;
- (iii) Self-care activities or participation in social activities;
- (iv) Responding appropriately to an emergency; or
- (v) Multiple physical disabilities, including sensory impairments;

Helpful Information
Regarding subsection (2)(B), a DSM-5 diagnoses of Intellectual Disability also requires a severity level (mild, moderate, severe, or profound). If a severity level is provided, the severity information may be helpful in determining whether the child is characterized by prominent, severe deficits and pervasive impairment.

(C) With a DSM-5 diagnosis of Autism Spectrum Disorder that is characterized by prominent, severe deficits and pervasive impairment in one or more of the following areas of development:

- (i) Conceptual, social, and practical adaptive skills to include daily living and self-care;
- (ii) Communication, cognition, or expressions of affect;
- (iii) Self-care activities or participation in social activities;
- (iv) Responding appropriately to an emergency; or
- (v) Multiple physical disabilities including sensory impairments;

Helpful Information

Regarding subsection (2)(C), the Autism Spectrum Disorder includes previous DSM-IV diagnoses of autistic disorder, Asperger's disorder, pervasive development disorder-not otherwise specified, and similar disorders associated with a known medical or genetic disorder (e.g. Rett's Disorder). This newly titled disorder is a single continuum of mild to severe (Levels 1 - 3) impairments in the two domains of social communication and restrictive repetitive behaviors/interests. A DSM-5 diagnosis does not mandate a severity level; however, if a severity level is provided, then the severity information may be helpful in determining whether the child is characterized by prominent, severe deficits and pervasive impairment.

(D) With Primary Medical Needs, who cannot live without mechanical supports or the services of others because of life-threatening conditions, including:

- (i) The inability to maintain an open airway without assistance.
This does not include the use of inhalers for asthma;
- (ii) The inability to be fed except through a feeding tube, gastric tube, or a parenteral route;
- (iii) The use of sterile techniques or specialized procedures to promote healing, prevent infection, prevent cross-infection or contamination, or prevent tissue breakdown; or
- (iv) Multiple physical disabilities including sensory impairments; and

(E) Determined to be a trafficking victim, including a child:

- (i) Determined to be a trafficking victim as the result of a criminal prosecution or who is currently alleged to be a trafficking victim in a pending criminal investigation or prosecution;
- (ii) Identified by the parent or agency that placed the child in the operation as a trafficking victim; or
- (iii) Determined by the operation to be a trafficking victim based on reasonably reliable criteria, including one or more of the following:
 - (I) The child's own disclosure as a trafficking victim;

- (II) The assessment of a counselor or other professional; or
 - (III) Evidence that the child was recruited, harbored, transported, provided to another person, or obtained for the purpose of forced labor or commercial sexual activity; and
- (3) Additional Programmatic Services, which include:
- (A) Emergency Care Services – A specialized type of child-care services designed and offered to provide short-term child care to children who, upon admission, are in an emergency constituting an immediate danger to the physical health or safety of the child or the child’s offspring;
 - (B) Transitional Living Program – A residential services program designed to serve children 14 years old or older for whom the service or treatment goal is basic life skills development toward independent living. A transitional living program includes basic life skills training and the opportunity for children to practice those skills. A transitional living program is not an independent living program;
 - (C) Assessment Services Program – Services to provide an initial evaluation of the appropriate placement for a child to ensure that appropriate information is obtained in order to facilitate service planning;
 - (D) Therapeutic Camp Services – A camping program to augment an operation’s treatment services with an experiential curriculum exclusively for a child with an emotional disorder who has difficulty functioning in his home, school, or community. Therapeutic camp services are only available to children 13 years old and older; and
 - (E) Respite Child-Care Services – See §748.73 of this title (relating to What are respite child-care services?).

§748.63. Can I provide each type of service that Licensing regulates?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

You may provide each type of service that we regulate under the following conditions:

- (1) On your permit, we list the type of service that you have been approved to provide [Medium]; and
- (2) Your operational policies and procedures ensure:
 - (A) Children are admitted appropriately [Medium-High];
 - (B) The needs of all children in care are met [Medium-High];
 - (C) Children are appropriately supervised [Medium-High];
 - (D) Children are protected from one another, if appropriate [Medium-High]; and
 - (E) You meet the applicable rules of this chapter. [Medium-High]

§748.65. What children are eligible to participate in a transitional living program?

Subchapter B, Definitions and Services

Division 2, Services

January 2017

For a child to be eligible to participate in a transitional living program, the child must:

- (1) Be 14 years old or older [Medium-Low]; and
- (2) Not be receiving therapeutic camp services. [Medium-Low]

§748.67. What are the requirements for a transitional living program?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

A transitional living program must have a training program for children that develops competency in the following areas [Medium-Low]:

- (1) Health, general safety, and fire safety practices [Medium];
- (2) Money management [Low];
- (3) Transportation skills [Low];
- (4) Accessing community and other resources [Low]; and
- (5) Child health and safety, child development, and parenting skills, if the child is a parent of a child living with him. [Medium]

§748.69. What is an “independent living program”?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

An “independent living program” is a program that provides case management services to a child who lives independently, without supervision and child/caregiver ratio, and the constant presence of an on-site caregiver.

§748.71. May I have an independent living program?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

Your operation may not provide an independent living program for a child in care under 18 years old. [Medium-Low]

§748.73. What are respite child-care services?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

Respite child-care services are planned alternative 24-hour care that an operation provides for a child as part of the regulated child care.

§748.75. May I use or provide respite child-care services?

Subchapter B, Definitions and Services

Division 2, Services

January 2007

Only general residential operations that offer emergency care services may provide respite child-care services. Other operations may not provide respite child-care services, and no operation may use respite child-care services. The purpose of respite child-care services is to provide relief to a child's biological or foster parent, not an employee. Respite for an employee is provided through time off, vacations, holidays, and sick leave. [Medium-Low]

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

§748.101. What **plans must I submit for Licensing's approval as part of the application process?**

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

In addition to the relevant application forms required by §745.243 of this title (relating to What does a completed application for a permit include?), as part of the application process, you must submit the following plans to us for approval:

- (1) A business plan that includes [Low]:
 - (A) The location and telephone numbers of all of your general residential operations [Low]; and
 - (B) A list of persons or officers and their titles who comprise the governing body, if applicable [Low];
- (2) A fiscal plan that includes [Medium-Low]:
 - (A) A detailed estimate of the operating costs of the operation for the first three months [Medium-Low];
 - (B) Documentation of reserve funds or available credit at least equal to operating costs for the first three months [Medium];
 - (C) An estimated 12-month budget of income and expenses [Medium-Low]; and
 - (D) Predictable funds sufficient for the first year of operation [Medium];
- (3) A sketch of the operation's floor plan showing the dimensions and the purpose of all rooms and specifying where children and caregivers, if applicable, will sleep [Low]; and
- (4) An emergency evacuation and relocation plan that complies with Division 6 of Subchapter O (relating to Emergency Evacuation and Relocation).

§748.103. What policies and procedures must I submit for Licensing's approval as part of the application process?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

- (a) You must develop the policies and procedures identified in subsection (b) of this section. Your policies and procedures must comply with or exceed the minimum standards specified in this chapter, Chapter 42 of the Human Resources Code, and Chapter 745 of this title (relating to Licensing), and any other applicable law. [Medium]
- (b) As part of the application process, you must submit the following policies and procedures to us for our approval:
- (1) Policies and procedures related to record keeping, including where the records will be located. The policies must be consistent with Subchapter D of this chapter (relating to Reports and Records Keeping) [Medium];
 - (2) Personnel policies and procedures consistent with §748.105 of this title (relating to What are the requirements for my personnel policies and procedures?) [Medium];
 - (3) Conflict of interest policies consistent with §748.107 of this title (relating to What must my conflict of interest policies include?) [Medium];
 - (4) Admission policies consistent with §748.109 of this title (relating to What must my admission policies include?) [Medium];
 - (5) Child-care policies consistent with §748.111 of this title (relating to What child-care policies must I develop?) [Medium];
 - (6) Emergency behavior intervention policies consistent with §748.113 of this title (relating to What emergency behavior intervention policies must I develop if my operation is permitted to use emergency behavior intervention?) [Medium-High];
 - (7) Discipline policies consistent with §748.115 of this title (relating to What are the requirements for my discipline policies for children in care?) [Medium];
 - (8) Policies for a transitional living program, if applicable, consistent with §748.117 of this title (relating to What policies for a transitional living program must I develop?) [Medium-Low];

- (9) Volunteer policies consistent with §748.119 of this title (relating to What policies must I develop if I use volunteers?) [Medium-Low];
- (10) Abuse and neglect policies consistent with §748.121 of this title (relating to What abuse and neglect policies must I develop?) [Medium-High];
- (11) Employee policies and procedures that protect children from vaccine-preventable diseases. The policies must be consistent with §748.123 of this title (relating to What must an employee policy for protecting children from vaccine-preventable diseases include?) [Medium];
- (12) A weapons, firearms, explosive materials, and projectiles policy consistent with Division 6 of Subchapter Q (relating to Weapons, Firearms, Explosive Materials, and Projectiles) [High]; and
- (13) A tobacco and e-cigarette policy consistent with §748.1661 of this title (relating to What policies must I enforce regarding tobacco products and e-cigarettes?). [Medium-High]

§748.105. What are the requirements for my personnel policies and procedures?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

Your personnel policies and procedure must [Medium]:

- (1) Include an organizational chart showing the administrative, professional, and staffing structures and lines of authority [Medium];
- (2) Include written job descriptions, including minimum qualifications and job responsibilities for each position [Medium];
- (3) Include a written professional staffing plan that [Medium]:
 - (A) Demonstrates that the number, qualifications, and responsibilities of professional positions, including the child-care administrator, are appropriate for the size and scope of your services and that workloads are reasonable enough to meet the needs of the children in care [Medium];

- (B) Describes in detail the qualifications, duties, responsibilities, and authority of professional positions. For each position, the plan must show whether employment is on a full-time, part-time, or continuing consultative basis. For part-time and consulting positions, the plan must specify the number of hours and/or frequency of services [Medium];
- (C) Documents your staffing patterns, including your child/caregiver ratios, hours of coverage, and plans for providing backup caregivers in emergencies [Medium]; and
- (D) Identifies, if you provide treatment services, your:
 - (i) Ability to have enough caregivers, including caregivers who are awake throughout the night to supervise children 24 hours a day, including frequent one- to-one monitoring whenever necessary to meet the needs of a particular child [Medium]; and
 - (ii) Staffing patterns, including your child/caregiver ratios, hours of coverage, and plans for providing backup caregivers in emergencies [Medium];
- (4) Include written training requirements for employees and caregivers [Medium];
- (5) Include policies on whether your operation allows individual caregivers to take children away from the operation for day or overnight visits. The policy must require obtaining the parent's written approval prior to allowing overnight visits with staff. The policy must also address the issue outlined in §748.685(e) of this title (relating to What responsibilities does a caregiver have when supervising a child or children?) [Medium];
- (6) Comply with background check requirements outlined in Subchapter F of Chapter 745 of this title (relating to Background Checks) [High];
- (7) Require your employees to report serious incidents and suspected abuse, neglect, or exploitation. An employee who suspects abuse, neglect, or exploitation must report their suspicion directly to us and may not delegate this responsibility, as directed by Texas Family Code §261.101(b) [High];
- (8) Require that all employees and consulting, contracting, and volunteer professionals who work with a child and others with access to information about a child be informed in writing of their responsibility to maintain child confidentiality [Medium]; and
- (9) Include either the model drug testing policy or a written drug testing policy that meets or exceeds the criteria in the model policy provided in §745.4151 of this title (relating to What drug testing policy must my residential child-care operation have?). [Medium-High]

§748.107. What must my conflict of interest policies include?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

Your conflict of interest policies must include [Medium]:

- (1) A code of conduct on the relationship between your operation's owners (including members of the governing body, if applicable), employees, contract service providers, children in placement, and children's families, including required parameters for entering into independent financial relationships or transactions [Medium]; and
- (2) For corporations or other types of business entities, a statement that the majority of the voting members of the governing body must consist of persons who do not have a conflict of interest that would potentially interfere with objective decision making. Persons who have such a conflict of interest include the following [Medium]:
 - (A) Family members of:
 - (i) An officer of the governing body;
 - (ii) The administrator or executive director of the operation; or
 - (iii) Any person with a controlling interest in the entity's stock; or
 - (B) If the governing body is a non-profit entity, persons who benefit financially from the operation, including persons employed by or working at the operation, paid consultants, subcontractors, and vendors. [Medium]

Helpful Information
The definition of "family members" is found at §748.43(22).

§748.109. What must my admission policies include?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

Your admission policies must include a description of each program you offer, including [Medium]:

- (1) The program's goals and services provided, including whether the program accepts emergency admissions [Medium]; and
- (2) The characteristics of the population the program serves, such as gender, age range, behaviors, and diagnoses. If the program includes treatment services, your policy must describe the type of treatment services the program is designed to treat, including emotional disorders, intellectual disability, autism spectrum disorder, primary medical needs, or trafficking victim services. [Medium]

§748.111. What child-care policies must I develop?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

You must develop policies that describe [Medium]:

- (1) Visitation rights between the child and family members and the child and friends [Medium];
- (2) The child's right to correspond by mail with family members and friends, including any policies regarding mail restrictions and receipt of electronic messages and mail [Medium];
- (3) The child's right to correspond by telephone with family members and friends [Medium-Low];
- (4) The child's right to receive and give gifts to family, friends, employees, or other children in care, including any restrictions on gifts [Medium-Low];
- (5) How a child obtains clothing [Medium-Low];
- (6) Personal possessions a child is or is not allowed to have, where the possessions may be stored, and search policies [Medium-Low];

- (7) Emergency behavior intervention techniques if the use of emergency behavior intervention is permitted in your operation. The policy must be consistent with §748.113(5) of this title (relating to What emergency behavior intervention policies must I develop if my operation is permitted to use emergency behavior intervention?) [Medium-High];
- (8) Any religious program or activity that you offer, including whether children must participate in the program or activity [Medium-Low];
- (9) The plans for meeting the educational needs of each child [Medium-Low];
- (10) When trips with caregivers away from the operation are allowed and what protocols will be used [Medium];
- (11) Program expectations and rules that apply to all children, including an overview of your discipline policy [Medium];
- (12) Child grievance procedures [Medium];
- (13) The types and frequency of reports to parents [Medium];
- (14) Procedures for routine and emergency diagnosis and treatment of medical and dental problems [Medium];
- (15) Routine health care relating to pregnancy and childbirth, if you admit and/or care for a pregnant child [Medium];
- (16) Your plan for providing health-care services to a child with primary medical needs [Medium];
- (17) Transitional living policies, if applicable [Medium-Low]; and
- (18) If applicable, how you will determine whether it is appropriate for a child to use weapons, firearms, explosive materials, and projectiles. This information must be consistent with §748.103(b)(12) of this title (relating to What policies and procedures must I submit for Licensing's approval as part of the application process?). [Medium]

§748.113. What emergency behavior intervention policies must I develop if my operation is permitted to use emergency behavior intervention?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

At a minimum, you must develop emergency behavior intervention policies to implement the requirements in Subchapter N of this chapter (relating to Emergency Behavior Intervention). The policies must include the following [Medium-High]:

- (1) A complete description of emergency behavior interventions that you permit caregivers to use [Medium-High];
- (2) The specific techniques that caregivers can use [Medium-High];
- (3) The qualifications for caregivers who assume the responsibility for emergency behavior intervention implementation, including required experience and training, and an evaluation component for determining when a specific caregiver meets the requirements of a caregiver qualified in emergency behavior intervention. You must have an on-going program to evaluate caregivers qualified in emergency behavior intervention and the use of emergency behavior interventions [Medium-High];
- (4) Your requirements for and restrictions on the use of permitted emergency behavior interventions [Medium-High];
- (5) For the orientation required in §748.1209(b)(6) of this title (relating to What orientation must I provide a child?), how you will:
 - (A) Explain and document to a child in a manner that the child can understand [Medium-High]:
 - (i) Who can use an emergency behavior intervention [Medium-High];
 - (ii) The actions a caregiver must first attempt to defuse the situation and avoid the use of emergency behavior intervention [Medium-High];
 - (iii) The situations in which emergency behavior intervention may be used [Medium-High];

- (iv) The types of emergency behavior intervention you permit [Medium-High];
- (v) When the use of an emergency behavior intervention must cease [Medium-High];
- (vi) What action the child must exhibit to be released from the emergency behavior intervention [Medium-High];
- (vii) The way to report an inappropriate emergency behavior intervention [Medium-High];
- (viii) The way to provide voluntary comments during or after an emergency behavior intervention [Medium]; and
- (ix) The process for making written comments after an emergency behavior intervention, such as comments regarding the incident that led to the emergency behavior intervention, the manner in which a caregiver intervened, and the manner in which the child was the subject or to which they were a witness. You may create a standardized form that is easily accessible or give children the permission to submit comments on regular paper [Medium]; and

(B) Obtain each child's input on preferred de-escalation techniques that caregivers can use to assist the child in the de-escalation process [Medium-High];

(6) That you will either [Medium-High]:

(A) Post in a place where children and adult clients can view them, the emergency behavior interventions that you permit at your operation; or

(B) Provide the children and adult clients at admission a personal copy of the operation's emergency behavior intervention policies;

(7) Requirements that caregivers must attempt less restrictive and less intrusive emergency behavior interventions as preventive measures and de-escalating interventions to avoid the use of emergency behavior intervention [Medium-High];

(8) Training for emergency behavior intervention. The policy must include a description of the emergency behavior intervention training curriculum that meets the requirements in the rules of this chapter, the amount and type of training required for different levels of caregivers (if applicable), training content, and how the training will be delivered [Medium-High]; and

(9) Prohibitions for discharging or otherwise retaliating against:

(A) An employee, child in care, adult client, resident, or other person for filing a complaint, presenting a grievance, or otherwise providing in good faith information relating to the misuse of emergency behavior intervention at the operation [Medium-High]; or

(B) A child in care, adult client, or resident because someone on behalf of the client or resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of emergency behavior intervention at the operation. [Medium-High]

§748.115. What are the requirements for my discipline policies for children in care?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

The discipline policies you develop for children in care must be consistent with Subchapter M of this chapter (relating to Discipline and Punishment). The discipline policies you develop must also:

(1) Guide caregivers and employees in the methods used for the discipline of children [Medium];

(2) Integrate trauma informed care into the care, treatment, and management of each child [Medium];

(3) Include measures for positive responses to appropriate behavior [Medium];

(4) Include the importance of nurturing behavior, stimulation, and promptly meeting the child's needs [Medium]; and

(5) Include a statement that discipline of any type is not allowable for infants. [Medium]

§748.117. What policies for a transitional living program must I develop?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

For operations who offer a transitional living program, you must develop policies that address the following [Medium-Low]:

- (1) Criteria used to select participants for the program [Medium-Low];
- (2) Supervision of participants consistent with §748.1019 of this title (relating to What are the supervision requirements for a transitional living program?) and §748.1021 of this title (relating to When does a child who is in a transitional living program not need supervision?) [Medium-Low];
- (3) Expected behaviors of participants and consequences for failure to comply [Medium];
- (4) Training, education, and experiences to be achieved in the program [Low]; and
- (5) Roles of participants, employees, contract staff, and caregivers. [Medium-Low]

§748.119. What policies must I develop if I use volunteers?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

If you use volunteers, you must develop policies that [Medium-Low]:

- (1) Include job descriptions and/or responsibilities for the volunteers [Medium-Low];
- (2) Address qualifications, screening, and selection procedures for the volunteers [Medium-Low];
- (3) Address orientation and training programs for the volunteers [Medium-Low];
- (4) Address supervision of volunteers [Medium-Low]; and
- (5) Address volunteer contact with children in care. [Medium-Low]

§748.121. What abuse and neglect policies must I develop?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

You must develop policies on preventing, recognizing, and responding to abuse and neglect of children, including [Medium-High]:

- (1) Required annual training for employees [Medium-High];
- (2) Methods for increasing employee awareness of issues regarding child abuse and neglect, including warning signs that a child may be a victim of abuse or neglect [Medium-High];
- (3) Methods for increasing employee awareness of prevention techniques for child abuse and neglect [Medium-High];
- (4) Strategies for coordination between the operation and appropriate community organizations [Medium-High]; and
- (5) Actions that the parent of a child who is a victim of abuse or neglect should take to obtain assistance and intervention. [Medium-High]

§748.123. What must an employee policy for protecting children from vaccine- preventable diseases include?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

A policy for protecting the children in your care from vaccine-preventable diseases must [Medium]

- (1) Specify any vaccines that you have determined an employee must have for vaccine-preventable diseases based on the level of risk the employee presents to children by the employee's routine and direct exposure to children [Medium];
- (2) Require each employee to receive each specified vaccine that the employee is not exempt from having [Medium-High];
- (3) Include procedures for verifying whether an employee has complied with your policy [Medium];
- (4) Include procedures for an employee to be exempt from having a required vaccine because of [Medium]:

(A) Medical conditions identified as contraindications or precautions by the Centers for Disease Control and Prevention (CDC) [Medium]; or

(B) Reasons of conscience, including a religious belief [Medium];

(5) Include procedures that an exempt employee must follow to protect children in your care from exposure to disease, such as the use of protective medical equipment, including gloves and masks, based on the level of risk the employee presents to children by the employee's routine and direct exposure to children [Medium-High];

(6) Prohibit discrimination or retaliatory action against an exempt employee, except that required use of protective medical equipment, including gloves and masks, may not be considered retaliatory action for purposes of this section [Medium-Low];

(7) Outline how you will maintain a written or electronic record of each employee's compliance with or exemption from your policy [Medium]; and

(8) State the disciplinary actions you may take against an employee who fails to comply with your policy. [Medium]

§748.125. What are the general requirements for my operation's policies and procedures?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

(a) The requirements for policies only apply to the operation's policies that are required or governed by this chapter.

(b) All employees and caregivers must be aware of and follow your policies and procedures. [Medium]

§748.127. What requirements must I follow when adopting my operation's plans, policies, and procedures?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

(a) Your operation's plans, policies, and procedures must indicate the date on which you adopted them and their effective date. [Medium-Low]

(b) You must formalize the adoption of your operation's plans, policies, and procedures as appropriate for your type of ownership:

- (1) If you are a sole proprietor, you must sign them [Medium-Low];
- (2) If you are a partnership, each partner must sign them [Medium-Low]; or
- (3) If you are a corporation or other type of business entity, the governing body must take a written action to adopt (sometimes this may be an order or the adoption may be included in the minutes of the governing body). [Medium-Low]

§748.129. Can Licensing cite my operation for a deficiency if I fail to operate according to my approved plans, policies, and procedures?

Subchapter C, Organization and Administration

Division 1, Plans and Policies Required For the Application Process

January 2017

Yes, if you violate plans, policies, or procedures, then we may cite the relevant standard in Division 1 of this Subchapter (relating to Plans and Policies Required for the Application Process) as a deficiency;

Helpful Information

- Licensing only enforces plans, policies, and procedures required by the minimum standards. For example, Licensing does not enforce your policies on purchase approvals. In addition, Licensing will not cite this standard if you meet a specific minimum standard but do not meet your policy that requires more than the minimum standard. For example, if your policy requires caregivers to complete 12 hours of general pre-service training and inspection results indicate an employee only completed ten hours of training, we will not cite you for failing to meet your policy.
- If this chapter contains another relevant minimum standard, then that standard would be cited for failure to comply with a policy. For example and using the same example as above, if an employee only completed six hours of general pre-service training, we will cite §748.863(a)(1) because the minimum standards require eight hours of general pre- service training. However, if there isn't another relevant minimum standard, then we would cite the relevant standard in Division 1. For example, if your professional staffing plan became outdated, then we would cite §748.105(3).

Division 2, Operational Responsibilities and Notifications

§748.151. What are my operational responsibilities?

Subchapter C, Organization and Administration
Division 2, Operational Responsibilities and Notifications
January 2017

While you are operating, you must:

- (1) Have a designated full-time child-care administrator who meets the minimum qualifications of §748.531 of this chapter (relating to What qualifications must a child-care administrator meet?) [Medium];
- (2) Operate according to your approved plans, policies, and procedures [Medium];
- (3) Maintain current, true, accurate, and complete records [Medium];
- (4) Allow us to inspect your operation during its hours of operation [Medium-High];
- (5) Not offer unrelated types of services that conflict or interfere with the best interests of a child in care, a caregiver’s responsibilities, or operation space. If you offer more than one type of service, you must determine and document that no conflict exists [Medium-High];
- (6) Complying with the liability insurance requirements in this division [Medium]; and
- (7) Prepare the annual budget and control expenditures and ensure compliance with Division 3 of this Subchapter (relating to General Fiscal Requirements). [Medium]

Helpful Information
Regarding subsection (2), Licensing only enforces this requirement for plans, policies, and procedures required by the minimum standards. For example, Licensing does not enforce your policies on purchase approvals. In addition, Licensing will not cite this standard if you meet a specific minimum standard but do not meet your policy that requires more than the minimum standard. For example, if your policy requires caregivers to complete 12 hours of general pre-service training and inspection results indicate an employee only completed ten hours of training, we will not cite you for failing to meet your policy. But if an employee only completed six hours of training, we will cite you for a deficiency because the minimum standards require eight hours of general pre-service training.

§748.153. What changes must I notify Licensing about regarding my operation?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

January 2017

You must provide written notification to your Licensing Representative:

- (1) As soon as possible, but at least 30 days before you:
 - (A) Change the legal structure of your operation or your governing body, if applicable [Medium-Low];
 - (B) Move your operation to another location [Medium-High]; or
 - (C) Change your operating hours [Medium-Low]
- (2) As soon as possible, but at least 15 days before:
 - (A) You make changes to the policies and procedures required in §748.103(b) of this title (relating to What policies and procedures must I submit for Licensing's approval as part of the application process?) [Medium-Low];
 - (B) Changes are made to the operation's floor plan showing the dimensions and the purpose of all rooms and specifying where children and caregivers, if applicable, will sleep [Medium-Low]; and
 - (C) Construction begins on adding a swimming pool or other permanent body of water [Medium];
- (3) As soon as possible, but no later than two days after:
 - (A) You change your child-care administrator [Medium-High];
 - (B) A new individual becomes a controlling person at your operation [Medium-High];
 - (C) An individual ceases to be a controlling person at your operation [Medium-High]; or
 - (D) There is a significant change in the information we maintain about a controlling person, such as a name change or mailing address change [Medium-Low]; and
- (4) Within 24 hours of the child's placement, if you provide emergency care services and exceed capacity according to §748.155(b) of this title (relating to May I exceed my operation's capacity?). [Medium]

Helpful Information

Licensing does not automatically approve an action when you provide the required notice to your Licensing Representative. Additional action may need to be taken by you or Licensing. For example, changing the legal structure of your operation may require a new license.

§748.155. May I exceed my operation's capacity?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

January 2017

- (a) The number of children and young adults in your care must not exceed the capacity stated on your permit, except as described in subsection (b) of this section. [Medium-High]
- (b) If you are licensed to provide emergency care services, you may temporarily exceed your licensed capacity for not more than 48 hours to provide temporary care for a child needing emergency care services.
- (c) For the purpose of determining whether you exceed your capacity, the number of children in your care includes a caregiver's own children who are at the operation, if they share general living space, bedroom, and/or bathroom space with children in care, and any children receiving respite child-care services at an operation providing emergency care services.

§748.157. May I provide child day care services?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

January 2017

You may provide child day care services under the following conditions:

- (1) You don't provide treatment services to children with emotional disorders [Medium];
- (2) You care for and supervise children who receive day care services separately from the children receiving residential services [Medium]; and
- (3) You have separate administrative employees and caregivers for each program. [Medium]

§748.158. What are the liability insurance requirements?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

April 2021

Unless you have an acceptable reason not to have the insurance, you must:

- (1) Maintain liability insurance coverage in the amount of \$300,000 for each occurrence of negligence that covers injury to a child while the child is on your premises or in your care [Medium]; and
- (2) Provide proof of coverage to Licensing each year by the anniversary date of the issuance of your permit. [Medium]

§748.159. What are acceptable reasons not to have liability insurance?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

April 2021

- (a) You do not have to have liability insurance that meets the requirements of §748.158 of this division (relating to What are the liability insurance requirements?) if you cannot carry insurance because:
 - (1) Of financial reasons;
 - (2) You are unable to locate an underwriter who is willing to issue a policy to the operation; or
 - (3) You have already exhausted the limits of a policy that met the requirements.
- (b) If you cannot carry liability insurance or stop carrying the insurance because of a reason listed in subsection (a) of this section, you must send written notification to Licensing by the anniversary date of the issuance of your permit. Your notification must include the reason that you cannot carry the insurance. [Medium]

§748.160. When must I notify parents that I do not carry liability insurance?

Subchapter C, Organization and Administration

Division 2, Operational Responsibilities and Notifications

April 2021

- (a) If you do not carry liability insurance that meets the requirements of §748.158 of this division (relating to What are the liability insurance requirements?), then you must notify the parent of each child in your care in writing that you do not carry liability insurance before you admit the child into your care. [Medium-High]
- (b) If you previously carried the liability insurance and subsequently stop carrying the liability insurance, then you must notify the parent of each child in your care in writing that you do not carry the insurance within 14 days after you stop carrying it. [Medium-High]
- (c) You may use the Form 2962, Verification of Liability Insurance, located on the Licensing provider website, to notify parents. Regardless of whether you use this form, you must be able to demonstrate that you provided written notice to the parents of each child in your care.

Helpful Information

It is important that parents both understand and acknowledge whether your operation carries liability insurance. Possible means of communicating this requirement include:

- Using a form specific to liability insurance that requires a parent signature that you maintain in the child's file;
- Including a statement or addendum about liability insurance in your operational policies or parent handbook, and maintain in the child's file a document with a parent signature or initials specifically acknowledging the liability insurance information; or
- Maintaining a copy of any electronic communication sent to a parent regarding liability insurance, including the date and address to which the communication was sent.

Division 3, General Fiscal Requirements

§748.161. What are my fiscal requirements?

Subchapter C, Organization and Administration

Division 3, General Fiscal Requirements

January 2017

- (a) You must establish and maintain your operation on a sound fiscal basis, including [Medium]
 - (1) Paying your employees timely [Medium]; and
 - (2) Making sure the needs of children in care are being met. [Medium]
- (b) You must maintain complete financial records that comply with Generally Accepted Accounting Principles, including accounting for a child's money separately from the funds of your operation. You may not use a child's personal earnings, allowances, or gifts to pay for the child's room and board, unless such use is a part of the child's service plan and the child's parent approves it in writing. You must give or send the child's money to the child, parent, or next placement within 30 days of the child's discharge. [Medium-Low]

Division 4, Required Postings

§748.191. What items must I post at my operation?

Subchapter C, Organization and Administration

Division 4, Required Postings

January 2017

The items listed below must be posted in a prominent and publicly accessible place where employees, children, parents, and others may easily view them at all times:

- (1) Your permit. An operation does not have to post its permit in its cottage homes, as long as it posts the permit at the main office location [Medium-Low];
- (2) The Licensing notice *Keeping Children Safe* [Medium-Low]; and
- (3) Emergency and evacuation relocation plans posted in each building and living quarters used by children. [Medium-High]

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

§748.301 What do certain terms mean in this subchapter?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

June 2020

These terms have the following meanings in this subchapter:

- (1) Serious incident--A non-routine occurrence that has or may have dangerous or significant consequences for the care, supervision, or treatment of a child. The different types of serious incidents are noted in §748.303 of this division (relating to When must I report and document a serious incident?).
- (2) Triggered review of a child's unauthorized absences--A review of a specific child's pattern of unauthorized absences when the child has had three unauthorized absences within a 60- day timeframe.
- (3) Unauthorized absence--A child is absent from the grounds of an operation without permission from a caregiver and cannot be located. This includes when an unauthorized person has removed the child from the operation.

Helpful Information

Regarding paragraph (3): Operations should use their best judgment based on the totality of the circumstances on a case by case basis to determine if there is an unauthorized absence. Example 1: if a teenager is routinely late in returning to the operation from an extracurricular activity, the operation would likely take the child's routine into account when assessing the possibility of an unauthorized absence. Example 2: If a teenager is on an unsupervised activity and calls and informs the staff that he/she will be late in returning to the operation, this situation is not likely to be an unauthorized absence.

§748.303. When must I report and document a serious incident?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

April 2021

- (a) You must report and document the following types of serious incidents involving a child in your care. The reports must be made to the following entities, and the reporting and documenting must be within the specified time frames:

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(1) A child dies while in your care.	(A)(i) YES (A)(ii) Within 2 hours after the child's death. [Medium-High]	(B)(i) YES (B)(ii) Within 2 hours after the child's death. [Medium-High]	(C)(i) YES (C)(ii) Immediately, but no later than 1 hour after the child's death. [Medium-High]
(2) A substantial physical injury or critical illness that a reasonable person would conclude needs treatment by a medical professional or hospitalization.	(A)(i) YES (A)(ii) Report as soon as possible, but no later than 24 hours after the incident or occurrence. [Medium-High]	(B)(i) YES (B)(ii) Immediately after ensuring the safety of the child. [Medium-High]	(C)(i) NO (C)(ii) Not Applicable.
(3) Allegations of abuse, neglect, or exploitation of a child; or any incident where there are indications that a child in care may have been abused, neglected, or exploited.	(A)(i) YES (A)(ii) As soon as you become aware of it. [Medium-High]	(B)(i) YES (B)(ii) Immediately after ensuring the safety of the child. [Medium-High]	(C)(i) NO (C)(ii) Not applicable.

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(4) Physical abuse committed by a child against another child. For the purpose of this subsection, physical abuse occurs when there is substantial physical injury, excluding any accident; or failure to make a reasonable effort to prevent an action by another person that results in substantial physical injury to a child.	(A)(i) YES (A)(ii) As soon as you become aware of it. [Medium-High]	(B)(i) YES (B)(ii) As soon as you become aware of it. [Medium]	(C)(i) NO (C)(ii) Not applicable.

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(5) Sexual abuse committed by a child against another child. For the purpose of this subsection, sexual abuse is: conduct harmful to a child's mental, emotional or physical welfare, including nonconsensual sexual activity between children of any age, and consensual sexual activity between children with more than 24 months difference in age or when there is a significant difference in the developmental level of the children; or failure to make a reasonable effort to prevent sexual conduct harmful to a child.	(A)(i) YES (A)(ii) As soon as you become aware of it. [Medium-High]	(B)(i) YES (B)(ii) As soon as you become aware of it. [Medium]	(C)(i) NO (C)(ii) Not applicable.

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(6) A child is indicted, charged, or arrested for a crime, not including being issued a ticket at school by law enforcement or any other citation that does not result in the child being detained; or when law enforcement responds to an alleged incident at the operation.	(A)(i) YES (A)(ii) As soon as possible, but no later than 24 hours after you become aware of it. [Medium]	(B)(i) YES (B)(ii) As soon as you become aware of it. [Medium]	(C)(i) NO (C)(ii) Not applicable.
(7) The unauthorized absence of a child who is developmentally or chronologically under 6 years old.	(A)(i) YES (A)(ii) Within 2 hours of notifying law enforcement. [Medium-High]	(B)(i) YES (B)(ii) Within 2 hours of notifying law enforcement. [Medium]	(C)(i) YES (C)(ii) Immediately upon determining the child is not on the premises and the child is still missing. [Medium-High]
(8) The unauthorized absence of a child who is developmentally or chronologically 6 to 12 years old.	(A)(i) YES (A)(ii) Within 2 hours of notifying law enforcement, if the child is still missing. [Medium-High]	(B)(i) YES (B)(ii) Within 2 hours of determining the child is not on the premises, if the child is still missing. [Medium]	(C)(i) YES (C)(ii) Within 2 hours of determining the child is not on the premises, if the child is still missing. [Medium-High]

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(9) The unauthorized absence of a child who is 13 years old or older.	(A)(i) YES (A)(ii) No later than 6 hours from when the child's absence is discovered and the child is still missing. However, you must report the child's absence immediately if the child has previously been alleged or determined to be a trafficking victim, or you believe the child has been abducted or has no intention of returning to the operation. [Medium]	(B)(i) YES (B)(ii) No later than 6 hours from when the child's absence is discovered and the child is still missing. However, you must report the child's absence immediately if the child has previously been alleged or determined to be a trafficking victim, or you believe the child has been abducted or has no intention of returning to the operation. [Medium]	(C)(i) YES (C)(ii) No later than 6 hours from when the child's absence is discovered and the child is still missing. However, you must report the child's absence immediately if the child has previously been alleged or determined to be a trafficking victim, or you believe the child has been abducted or has no intention of returning to the operation. [Medium]
(10) A child in your care contracts a communicable disease that the law requires you to report to the Department of State Health Services (DSHS) as specified in 25 TAC Chapter 97, Subchapter A, (relating to Control of Communicable Diseases).	(A)(i) YES, unless the information is confidential. (A)(ii) As soon as possible, but no later than 24 hours after you become aware of the communicable disease. [Medium]	(B)(i) YES, if their child contracted the communicable disease or has been exposed to it. (B)(ii) As soon as possible, but no later than 24 hours after you become aware of the communicable disease. [Medium]	(C)(i) NO (C)(ii) Not applicable.

Serious Incident	(i) To Licensing? If so, when?	(i) To Parents? (ii) If so, when?	(i) To Law Enforcement? (ii) If so, when?
(11) A suicide attempt by a child.	(A)(i) YES (A)(ii) As soon as you become aware of the incident. [Medium-High]	(B)(i) YES (B)(ii) As soon as you become aware of the incident. [Medium]	(C)(i) NO (C)(ii) Not applicable.

(b) If there is a medically pertinent incident, such as a seizure, that does not rise to the level of a serious incident, you do not have to report the incident but you must document the incident in the same manner as a serious incident, as described in §748.311 of this division (relating to How must I document a serious incident?).

[Medium]

(c) You must document an unauthorized absence that does not meet the reporting time requirements defined in subsection (a)(7) - (9) of this section within 24 hours after you become aware of the unauthorized absence. You must document the absence [Medium]

(1) In the same manner as for a serious incident, as described in §748.311 of this division; and;

(2) Complete an addendum to the serious incident report to finalize the documentation requirements, if the child returns to an operation after 24 hours.

(d) If there is a serious incident involving an adult resident, you do not have to report the incident to Licensing, but you must document the incident in the same manner as a serious incident. You do have to report the incident to:

(1) Law enforcement, as outlined in the chart above;

(2) The parents, if the adult resident is not capable of making decisions about the resident's own care; and

(3) Adult Protective Services through the Texas Abuse and Neglect Hotline, if there is reason to believe the adult resident has been abused, neglected or exploited.

(e) You must report and document the following types of serious incidents involving your operation, an employee, a professional level service provider, contract staff, or a volunteer to the following entities within the specified time frame:

Serious Incident	(i) To Licensing? (ii) If so, when?	(i) To Parents? (ii) If so, when?
(1) Any incident that renders all or part of your operation unsafe or unsanitary for a child, such as a fire or a flood.	(A)(i) YES (A)(ii) As soon as possible, but no later than 24 hours after the incident. [Medium]	(B)(i) YES (B)(ii) As soon as possible, but no later than 24 hours after the incident. [Medium]
(2) A disaster or emergency that requires your operation to close.	(A)(i) YES (A)(ii) As soon as possible, but no later than 24 hours after the incident. [Medium]	(B)(i) YES (B)(ii) As soon as possible, but no later than 24 hours after the incident. [Medium]
(3) An adult who has contact with a child in care contracts a communicable disease noted in 25 TAC 97, Subchapter A, (relating to Control of Communicable Diseases).	(A)(i) YES, unless the information is confidential. (A)(ii) As soon as possible, but no later than 24 hours after you become aware of the communicable disease. [Medium]	(B)(i) YES, if their child has contracted the communicable disease or has been exposed to it. (B)(ii) As soon as possible, but no later than 24 hours after you become aware of the communicable disease. [Medium]
(4) An allegation that a person under the auspices of your operation who directly cares for or has access to a child in the operation has abused drugs within the past seven days.	(A)(i) YES (A)(ii) Within 24 hours after learning of the allegation. [Medium]	(B)(i) NO (B)(ii) Not applicable.
(5) An investigation of abuse or neglect by an entity (other than Licensing) of an employee, professional level service provider, contract staff, volunteer, or other adult at the operation.	(A)(i) YES (A)(ii) As soon as possible, but no later than 24 hours after you become aware of the investigation. [Medium]	(B)(i) NO (B)(ii) Not applicable.

Serious Incident	(i) To Licensing? (ii) If so, when?	(i) To Parents? (ii) If so, when?
(6) An arrest; indictment; a county or district attorney accepts an "Information" regarding an official complaint against an employee, professional level service provider, contract staff, volunteer, or other adult at the operation alleging commission of any crime as provided in §745.661 of this title (relating to What types of criminal convictions may affect a subject's ability to be present at an operation?); or when law enforcement responds to an alleged incident to the operation.	(A)(i) YES (A)(ii) As soon as possible, but no later than 24 hours after you become aware of the situation. [Medium]	(B)(i) NO (B)(ii) Not applicable.

Helpful Information

Regarding subsection (a)(2), not every trip to a hospital or emergency clinic must be reported as a serious incident. Only those incidents involving a “substantial physical injury or critical illness” must be reported and documented as a serious incident. The definition of “substantial physical injury” contains some examples of reportable serious incidents. Visits to the emergency room or emergency clinic (that did not result in hospitalization) for a common illness such as the flu, for a chronic illness such as an asthma attack, or for a routine medical exam would not warrant reporting as a serious incident.

Also, it is the nature of the injury or illness that determines whether it is reportable as a serious incident, not the venue in which it is treated. Taking a child to the emergency clinic or doctor’s office for stitches is still reportable as a serious incident, even though the treatment did not occur at an emergency room or hospital.

Regarding children receiving treatment services for primary medical needs, planned admissions to the hospital are not reportable as serious incidents. If the child sustains a substantial physical injury or contracts a critical illness, a serious incident report is required. However, ongoing treatment for the child’s chronic illnesses or conditions is not reportable as a serious incident.

In addition, admission to a psychiatric hospital only warrants a serious incident report if the admission is precipitated by a reportable incident, such as a suicide attempt. The admission itself is not reportable as a serious incident.

§748.305. What constitutes a suicide attempt by a child?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

September 2010

A suicide attempt is a child’s attempt to take his own life using means or methods for causing his death, including any act a child commits intending to cause his death, but excluding suicidal gestures where it is clear that the act was unlikely to cause death. Suicidal thoughts are not reportable as a suicide attempt.

§748.309. How do I make a report of a serious incident or occurrence to Licensing?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

January 2017

All serious incident reports must be made directly to the Texas Abuse and Neglect Hotline.
[Medium]

§748.311. How must I document a serious incident?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

January 2007

A serious incident must be documented in a written report that includes the following information [Medium]:

- (1) The name of the operation, physical address, and telephone number [Medium];
- (2) The time and date of the incident [Medium];
- (3) The name, age, gender, and date of admission of the child or children involved [Medium];
- (4) The names of all adults involved and their role in relation to the child(ren) [Medium];
- (5) The names or other means of identifying witnesses to the incident, if any [Medium];
- (6) The nature of the incident [Medium];
- (7) The circumstances surrounding the incident [Medium];
- (8) Interventions made during and after the incident, such as medical interventions, contacts made, and other follow-up actions [Medium];
- (9) The treating licensed health-care professional's name, findings, and treatment, if any [Medium]; and
- (10) The resolution of the incident. [Medium]

Helpful Information

Regarding subsection (3), this requirement is not intended to conflict with confidentiality laws or rights. Identifying information for one child should not be placed in the record of another child. You may choose to 1) write one incident report that is filed centrally (not in each child's record) and de-identified when released as part of a child's record, 2) write one incident report that is filed in each child's record, with each copy de-identified to not show the full name of other children involved in the incident, or 3) write a separate incident report for each child, with only the first name or initials of each other child involved.

Regarding subsection (5), witnesses to the incident are persons who were present when the incident occurred and can give a first-hand account of what they experienced during the incident. A person is not automatically a witness because he lives in the same unit or cottage as the child involved in the incident. Witnesses may also be persons unaffiliated with the operation, such as a visitor to the operation who was present at the time of the incident.

§748.313. What additional documentation must I include with a written serious incident report?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

June 2020

You must include the following additional documentation with a written serious incident report, as applicable:

Weight	Serious Incident	Documentation
[Medium]	(1) Child death, substantial physical injury, or a suicide attempt reportable under §748.303(a)(1), (2), and (11) of this division (relating to When must I report and document a serious incident?).	Any emergency behavior interventions implemented on the child within 48 hours prior to the serious incident.

Weight	Serious Incident	Documentation
[Medium-High]	(2) Any substantial physical injury reportable under §748.303(a)(2) of this division that resulted from a short personal restraint.	Documentation of the short personal restraint, including the precipitating circumstances and specific behaviors that led to the emergency behavior intervention.
[Medium]	(3) Unauthorized absence of a child.	(A) Any efforts made to locate the child; (B) The date and time you notified the parent(s) and the appropriate law enforcement agency and the names of the persons with whom you spoke regarding the child's absence and subsequent location or return to the operation; (C) If the parent cannot be located, dates and times of all efforts made to notify the parent regarding the child's absence and subsequent location or return to the operation; (D) Whether the child has returned to the operation, and if so, the length of time the child was gone from the operation; and (E) If the child returns to the operation after 24 hours, an addendum to the report that documents the child's return.
[Medium]	(4) Any physical or sexual abuse committed by a child against another child reportable under §748.303(a)(4) or (5) of this division.	The difference in size, age, and developmental level of the children involved in the physical or sexual abuse.

§748.315. How long must I keep incident reports?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

January 2017

You must keep the incident reports on file at the operation for two years. The reports must be easily accessible to Licensing upon request. [Medium-Low]

§748.317. What are the notification requirements when Licensing finds my operation deficient in a standard related to safe sleeping or the abuse, neglect, or exploitation of a child?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

April 2021

(a) You must notify the parent of each child residing at your child-care operation of a deficiency in:

- (1) A safe sleeping standard noted in subsection (b) of this section [Medium-High]; or
- (2) The abuse, neglect, or exploitation standard in §748.1101(b)(1)(B) of this chapter (relating to What rights does a child in care have?). [Medium-High]

(b) The following are safe sleeping standards requiring notification:

- (1) §748.1751(a)(1) of this chapter (relating to What specific safety requirements must my cribs meet?);
- (2) §748.1753(a)(2)(A) of this chapter (relating to Are play yards allowed?);
- (3) §748.1757(a)(5) and (b) of this chapter (relating to What types of equipment are not allowed for use with infants?);
- (4) §748.1763 of this chapter (relating to What are the specific sleeping requirements for infants?);
- (5) §748.1765 of this chapter (relating to May I allow infants to sleep in a restrictive device?); and

(6) §748.1767 of this chapter (relating to May I swaddle an infant to help the infant sleep?).

§748.319. How must I notify parents of a safe sleeping deficiency or an abuse, neglect, or exploitation deficiency?

Subchapter D, Reports and Record Keeping

Division 1, Reporting Serious Incidents and Other Occurrences

April 2021

- (a) Within five days after you receive notification of a deficiency described in §748.317 of this division (relating to What are the notification requirements when Licensing finds my operation deficient in a standard related to safe sleeping or the abuse, neglect, or exploitation of a child in care?), you must notify the parents of each child residing at your child-care operation at the time of notification, including a child who may not have been in care on the day of the actual incident. [Medium-High]
- (b) If the deficiency is for a safe sleeping standard, you must notify the parents using Form 2970, Notification of Safe Sleeping Deficiency, located on the Licensing provider website. [Medium]
- (c) If the deficiency is for the standard related to the abuse, neglect, or exploitation of a child in care, you must notify the parents using Form 7266, Notification of Abuse/Neglect/Exploitation Deficiency, located on the Licensing provider website. [Medium]
- (d) You must maintain and make available for our review, upon request, proof that you have notified parents in writing of deficiencies in safe sleeping and abuse, neglect, or exploitation, as required by subsection (a) of this section. [Medium-High]

Helpful Information

- Regarding paragraph (a), “parent” refers to a person who has legal responsibility for a child, as defined in 748.43(43) of this chapter (relating to What do certain words and terms mean in this chapter?). For example, if you are caring for children in the conservatorship of DFPS, you must notify each child’s DFPS caseworker.
- Regarding paragraph (d), you may maintain the documentation in a manner that is consistent with your policies for record keeping, as long as you can verify that you have notified each parent as required. Possible ways to maintain proof of notification include:
 - Keeping a copy of the notification in each child’s individual file;
 - Keeping a single file of all notifications, with a list of the parents whom you notified attached to each notification form; or
 - Maintaining a copy of any notification sent to a parent electronically, including the date and address to which you sent the notification.

Division 2, Operation Records

§748.341. What are the retention requirements for my operation's policies?

Subchapter D, Reports and Record Keeping

Division 2, Operation Records

January 2017

- (a) You must maintain a copy of your policies and procedures at the operation. They must be available for review by employees, contract staff, caregivers, Licensing, or your clients, upon request. [Medium]
- (b) You must maintain copies of all current and previous policies for at least two years. [Medium-Low]

§748.343. What policies and procedures must I have for protecting records?

Subchapter D, Reports and Record Keeping

Division 2, Operation Records

January 2017

You must have policies and procedures for:

- (1) Protecting paper and electronic records from destruction and loss [Medium-Low]; and
- (2) Clarifying the persons:
 - (A) Within your operation who are authorized to access records [Medium-Low]; and
 - (B) Outside of your operation who are authorized by law to have access to records. [Medium-Low]

§748.345. What additional policies and procedures must I have for electronic records?

Subchapter D, Reports and Record Keeping

Division 2, Operation Records

January 2017

If you keep electronic records, you must develop policies and procedures in addition to the requirements in §748.343 of this title (relating to What policies and procedures must I have for protecting records?). These policies and procedures must address:

- (1) What records must be in the external paper file and what records can be stored in the electronic file [Low];
- (2) Computer security systems, including confidentiality, passwords, and employee procedures to ensure the security of the system [Medium-Low];
- (3) Requirements for routine back-up of data [Medium-Low];
- (4) Anti-virus protection systems [Medium-Low]; and
- (5) Limit access to your electronic files to persons within your operation authorized to see specific information in an electronic file. [Low]

748.347. Are electronic signatures allowed?

Subchapter D, Reports and Record Keeping

Division 2, Operation Records

January 2017

Yes, you may use electronic and digital signatures, including approvals by e-mail and electronic approvals.

Division 3, Personnel Records

§748.361. Where must I maintain personnel records?

Subchapter D, Reports and Record Keeping

Division 3, Personnel Records

January 2017

- (a) You must maintain all active personnel records at the operation. [Medium-Low]
- (b) You must maintain archived personnel records at the operation and/or in a designated location, as long as they are available for our review within 48 hours. [Medium-Low]
- (c) You may archive entire closed personnel records electronically.
- (d) Your system for maintaining all personnel records must be uniform throughout the operation. [Medium-Low]
- (e) You must maintain in the main office of the operation a master list of active and archived personnel records with a notation of the location of those records. [Medium-Low]

§748.363. What information must the personnel record of an employee include?

Subchapter D, Reports and Record Keeping

Division 3, Personnel Records

January 2017

For each employee, the personnel record must include:

- (1) Documentation showing the date of employment [Medium];
- (2) Documentation showing how the person meets the minimum age and qualifications for the position [Medium];
- (3) A current job description [Medium];
- (4) Evidence of any valid professional licensures, certifications, or registrations the person must have to meet qualifications for the position, such as a current renewal card or a letter from the credentialing entity verifying that the person has met the required renewal criteria [Medium];
- (5) A copy of the record of tuberculosis screening conducted prior to the person having contact with children in care showing that the employee is free of contagious tuberculosis as provided in §748.1583 of this title (relating to Who must have a tuberculosis (TB) examination?) [Medium];

- (6) A notarized Licensing *Affidavit for Applicants for Employment* form as specified in Human Resources Code, §42.059 [Medium];
- (7) A statement signed and dated by the employee documenting that the employee has read a copy of the operational policies required by §748.103 of this title (relating to What policies and procedures must I submit for Licensing’s approval as part of the application process?) [Medium];
- (8) A statement signed and dated by the employee indicating the employee must immediately report any suspected incident of child abuse, neglect, or exploitation to the Texas Abuse and Neglect Hotline and to the operation’s administrator or administrator’s designee [Medium];
- (9) Proof of request for background checks required by Chapter 745, Subchapter F of this title (relating to Background Checks) [High];
- (10) For each person who transports a child, a copy of:
 - (A) The person’s valid driver’s license [Medium]; or
 - (B) A driver’s license check conducted through the Texas Department of Public Safety within the last 12 months [Medium];
- (11) A record of training, including the date of the training, the number of training hours, and the curriculum covered [Medium];
- (12) Any documentation of the person’s performance with the operation [Medium-Low]; and
- (13) The date and reason for the person’s separation, if applicable. [Medium-Low]

§748.365. What information regarding personnel must be kept confidential?

Subchapter D, Reports and Record Keeping

Division 3, Personnel Records

September 2010

All background check results must be kept confidential, in accordance with HRC §40.005, subsections (d) and (e). Background check results must be protected from unauthorized access or release. [Low]

Division 4, Child Records

§748.391. What is an active child record?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2007

An active child record consists of the child's record for the most recent 12 months of service.

[Medium]

§748.393. How must I maintain an active child record?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2017

(a) You must keep active child records at the operation where the child is receiving services.

This may include electronic records. [Medium-Low]

(b) On an on-going basis, you must ensure that each child's record:

- (1) Includes the child's full name and another method of identifying the child, such as a client number [Medium];
- (2) Includes documentation of known allergies and chronic health conditions on the exterior of the child's record or in another place where the information is clearly visible to persons with access to the record, including a notation of "no known allergies" when applicable [Medium-High];
- (3) Is kept accurate and current [Medium];
- (4) Is locked and kept in a safe location [Medium]; and
- (5) Is kept confidential as required by law. [Medium]

§748.395. How current must a child's record be?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2017

All documentation must be in the record:

- (1) No later than 30 days after the occurrence or event [Low]; or
- (2) As otherwise specified in this chapter. [Low]

§748.397. Who must consent to the release of a child's record?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2007

Unless you are releasing the record to the parents, to us, or as required by law, you may not release any portion of a child's record to any agency, organization, or individual without the written consent of the person legally authorized to consent to the release. [Medium-Low]

§748.399. Must I make records available for Licensing to review?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2007

- (a) You must make all active records available for our immediate review and reproduction. [Medium]
- (b) We must have reasonable access to your storage and file areas in order to monitor your record keeping. [Medium]

§748.401. How must I maintain a child's record that is not active?

Subchapter D, Reports and Record Keeping

Division 4, Child Records

January 2007

These records must be available for our review within 48 hours. Otherwise, the records may be archived electronically or kept anywhere and in any manner, as long as they are safe from damage or destruction. [Medium-Low]

Division 5, Record Retention

§748.431. How long must I maintain personnel records?

Subchapter D, Reports and Record Keeping

Division 5, Record Retention

January 2007

- (a) You must maintain annual training records for current personnel for the last full training year and current training year. [Medium-Low]
- (b) With the exception of subsection (a) of this section, you must maintain personnel records for a year after an employee's last day of employment or until any investigation involving the employee is resolved, whichever is longer. [Medium-Low]

§748.433. How long must I maintain child records?

Subchapter D, Reports and Record Keeping

Division 5, Record Retention

September 2010

You must maintain a child's complete record from admittance to discharge for two years from the date of discharge, or until the resolution of any investigation involving the child, whichever is longer. [Medium-Low]

Division 6, Unauthorized Absences

§748.451. What additional requirements are there for unauthorized absences of children from my operation?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) For each unauthorized absence of a child, you must:
 - (1) Document the unauthorized absence in an annual summary log, as required by §748.453 of this division (relating to What documentation must be included in an annual summary log for a child who has an unauthorized absence?); and
 - (2) Debrief the child, as required by §748.455 of this division (relating to What are the requirements for debriefing a child after an unauthorized absence?).

- (b) If a child has three unauthorized absences within a 60-day timeframe, you must conduct a triggered review of the child's unauthorized absences that is consistent with the rules in this division; and
- (c) You must conduct an overall operation evaluation for unauthorized absences every six months, as required by §748.463 of this division (relating to What is an overall operation evaluation for unauthorized absences?).

§748.453. What documentation must be included in an annual summary log for a child who has an unauthorized absence?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) For each unauthorized absence during the relevant year, you must document the following information in an annual summary log:
 - (1) The name, age, gender, and date of admission of the child who was absent [Medium];
 - (2) The time and date the unauthorized absence was discovered [Medium];
 - (3) How long the child was gone or if the child did not return [Medium];
 - (4) The name of the caregiver responsible for the child at the time the child's absence was discovered [Medium];
 - (5) The intake report number, if a report was made to Licensing or the Department of Family and Protective Services [Medium]; and
 - (6) Whether law enforcement was contacted, including the name of any law enforcement agency that was contacted and the number of the police report, if applicable. [Medium]
- (b) You must maintain each annual summary log for five years. [Medium]
- (c) You must make the annual summary logs available to Licensing for review and reproduction, upon request. [Medium]

§748.455. What are the requirements for debriefing a child after an unauthorized absence?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) After a child returns to an operation from an unauthorized absence, the caregiver, or other appropriate person, must conduct a debriefing with the child as soon as possible, but no later than 24 hours after the child's return. The purpose of the debriefing is for the child and the caregiver, or other appropriate person, to discuss the following [Medium-High]:
- (1) The circumstances that led to the child's unauthorized absence [Medium];
 - (2) The trauma informed strategies the child can use to avoid future unauthorized absences and how the operation can support those strategies [Medium];
 - (3) The child's condition [Medium]; and
 - (4) What occurred while the child was away from the operation, including where the child went, who was with the child, the child's activities, and any other information that may be relevant to the child's health and safety. [Medium]
- (b) The caregiver must allow the child to return to routine activities, excluding any activity that the caregiver determines would be inappropriate because of the child's condition following the unauthorized absence or something that occurred during the unauthorized absence. [Medium]
- (c) The debriefing must be documented in the child's record, including any routine activity that would be inappropriate for the child to return to and the explanation for why the activity is inappropriate. [Medium]

Helpful Information

- While debriefing a child of any age, a caregiver or other person conducting the debriefing should respect the wishes of the child and allow the child to decline the debriefing or to ask for a different person to conduct the debriefing.
- Regarding Paragraph (a)(4), if a child discloses that abuse or neglect may have occurred during an unauthorized absence, the caregiver or other person conducting the debriefing must make a report to the Department of Family and Protective Services and should not ask additional questions regarding the abuse or neglect. The caregiver or other person conducting the debriefing must complete any other remaining requirements of the debriefing.

§748.457. When must a triggered review of a child's unauthorized absences occur?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) A triggered review of a child's unauthorized absences must occur as soon as possible, but no later than 30 days after the child's third unauthorized absence within a 60-day timeframe. [Medium-High]
- (b) A regularly scheduled review of the child's service plan can serve as the triggered review of a child's unauthorized absences, if the regularly scheduled review [Medium-High]:
- (1) Meets the requirements in §748.461 of this division (relating to What must the triggered review of a child's unauthorized absences include?); and
 - (2) Takes place no later than 30 days after the child's third unauthorized absence within a 60-day timeframe.

§748.459. Who must participate in a triggered review of a child's unauthorized absences?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) The triggered review of a child's unauthorized absences must include the following participants [Medium-High]:
 - (1) The child;
 - (2) An individual designated to make decisions regarding the child's participation in childhood activities, as described in §748.707 of this chapter (relating to Who makes the decision regarding a foster child's participation in childhood activities?); and
 - (3) The child's case manager.
- (b) You must notify the child's parent at least two weeks before the triggered review of a child's unauthorized absences, so the parent will have an opportunity to participate in the review. [Medium-High]

§748.461. What must a triggered review of a child's unauthorized absences include?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

A triggered review of a child's unauthorized absences must include the following [Medium-High]:

- (1) A review of the child's records documenting previous unauthorized absences, including previous debriefings [Medium];
- (2) A review of service plan elements identified in §748.1337(b)(1)(D) and (H) and, as applicable, §748.1337(b)(2) and (3) of this chapter (relating to What must a child's initial service plan include?) [Medium];
- (3) An examination of trauma informed alternatives to minimize the unauthorized absences of the child [Medium-High]; and
- (4) A written plan to reduce the unauthorized absences of the child, which you must document in the child's record. [Medium-High]

§748.463. What is an overall operation evaluation for unauthorized absences?

Subchapter D, Reports and Record Keeping

Division 6, Unauthorized Absences

June 2020

- (a) Every six months, you must conduct an overall operation evaluation for unauthorized absences that have occurred at your operation during that time period. [Medium]
- (b) The objectives of the evaluation are to:
 - (1) Develop and maintain a trauma informed environment that supports positive and constructive behaviors by children in care [Medium]; and
 - (2) Ensure the overall safety and well-being of children in care. [Medium]
- (c) The evaluation must include:
 - (1) The frequency and patterns of unauthorized absences of children in your operation [Medium]; and
 - (2) Specific trauma informed strategies to reduce the number of unauthorized absences in your operation. [Medium]
- (d) You must maintain the results of each six-month overall operation evaluation for unauthorized absences for five years. [Medium]
- (e) You must make the results of each overall operation evaluation for unauthorized absences available to Licensing for review and reproduction, upon request. [Medium]

Subchapter E, Personnel

Division 1, General Requirements

§748.503. Does education received outside of the United States count toward educational qualifications?

Subchapter E, Personnel

Division 1, General Requirements

January 2007

Yes, however you must provide supporting information indicating that the education is equivalent to the minimum educational qualifications for the position for which the person is applying. Documents written in a foreign language must be translated into English. [Medium-Low]

§748.505. What minimum qualifications must all employees meet?

Subchapter E, Personnel

Division 1, General Requirements

January 2017

- (a) An employee's behavior or health status must not present a danger to children in care. [Medium-High]
- (b) Each employee must:
 - (1) Meet the requirements in Subchapter F of Chapter 745 of this title (relating to Background Checks) [High];
 - (2) Have a record of a tuberculosis screening showing the employee is free of contagious TB as provided in §748.1583 of this title (relating to Who must have a tuberculosis (TB) examination) [Medium];
 - (3) Be physically, mentally, and emotionally capable of performing assigned tasks and have the skills necessary to perform assigned tasks [Medium]; and
 - (4) Complete a notarized Licensing *Affidavit for Applicants for Employment* form, as specified in Human Resources Code, §42.059. [Medium]

§748.507. What general responsibilities do all employees have?

Subchapter E, Personnel

Division 1, General Requirements

September 2010

Regardless of whether the employee is counted in the child/caregiver ratio, each employee must:

- (1) In the absence of a more specific rule requirement, demonstrate competency, prudent judgment, and self-control in the presence of children and when performing assigned responsibilities [Medium-High];
- (2) Report suspected abuse, neglect, and exploitation to the Child Abuse Hotline and to the designated employee or administrator [Medium-High]; and
- (3) Know and comply with rules of this chapter, Chapter 42 of the Human Resources Code, Chapter 745 of this title (relating to Licensing), and any other laws which are relevant to the person's duties. [Medium-High]

Helpful Information

Regarding subsection (1), this is only cited by Licensing when a more specific rule requirement does not apply to the incident. For example, if a caregiver loses their temper and inappropriately disciplines a child in care, this would be cited using §748.2301(b), or another relevant standard in Subchapter M (relating to Discipline and Punishment). This subsection is not cited when a more specific rule is cited regarding the incident.

§748.509. What are the requirements for tuberculosis screening?

Subchapter E, Personnel

Division 1, General Requirements

January 2007

Before having contact with children in care, all caregivers, employees, volunteers, and contract service providers must be screened for tuberculosis as provided in §748.1583 of this title (relating to Who must have a tuberculosis (TB) examination?). [Medium]

Division 2, Child-Care Administrator

§748.531. What qualifications must a child-care administrator meet?

Subchapter E, Personnel

Division 2, Child-Care Administrator

September 2010

(a) A child-care administrator must:

- (1) Meet the qualifications established by the operation's governing body [Medium-Low];
- (2) Be a Licensed Child-Care Administrator according to Chapter 43 of the Human Resources Code and Subchapter N of this title (relating to Administrator's Licensing) [Medium]; and
- (3) Be a full-time employee of the operation. [Medium]

(b) If acting as the administrator for two residential child-care operations under §748.533 of this title (relating to Can a child-care administrator be an administrator for two residential child-care operations?), the administrator must split a full-time schedule between the two operations as described in the professional staffing plans for each operation. [Medium]

§748.533. Can a child-care administrator be an administrator for two residential child-care operations?

Subchapter E, Personnel

Division 2, Child-Care Administrator

January 2017

(a) Except as provided in subsection (b) of this section, a child-care administrator can be an administrator for two residential child-care operations, including a child-placing agency, if:

- (1) Both operations are in good standing with Licensing [Medium];
- (2) The size and scope of the operations are manageable by one person, which is clarified in the written professional staffing plans [Medium];
- (3) The child-placing agency, if applicable, is not managing more than 25 foster homes [Medium];

(4) The person also holds a valid Child-Placing Agency Administrator License, if applicable [Medium]; and

(5) The general residential operations and/or RTCs are contiguous. A child-placing agency does not have to be contiguous. [Medium-Low]

(b) An operation that provides emergency care services must designate an employee in the staffing plan that is solely responsible for administering those services. This employee must have the experience and background to be able to perform the child-care administrator responsibilities. See §748.535 of this title (relating to What responsibilities must the child-care administrator have?). A designated employee, other than the child-care administrator for the operation, is not required if the emergency care services program has a capacity of not more than 30 children. [Medium]

§748.535. What responsibilities must the child-care administrator have?

Subchapter E, Personnel

Division 2, Child-Care Administrator

January 2017

The child-care administrator must:

(1) Have daily supervision and on-site administrative responsibility for the overall operation [Medium]; and

(2) Be responsible for or assign responsibility for:

(A) Overseeing staffing patterns to ensure the supervision and the provision of child-care services that meet the needs of children in care [Medium-High];

(B) Ensuring the provision of planned but flexible program activities designed to meet the developmental needs of children [Medium];

(C) Having a system in place to ensure an employee is available to handle emergencies [Medium];

(D) Assigning tasks to caregivers that do not conflict or interfere with caregiver responsibilities [Medium-High];

(E) Administering and managing the operation according to your policies [Medium];

(F) Ensuring that the operation complies with applicable rules of this chapter, Chapter 42 of the Human Resources Code, Chapter 745 of this title (relating to Licensing), and other applicable laws [Medium];

(G) Ensuring a child in care does not act as a caregiver [Medium]; and

- (H) Ensuring persons whose behavior or health status presents a danger to children are not allowed at the operation. [Medium-High]

§748.537. What must the system for ensuring that an employee is available to handle emergencies include?

Subchapter E, Personnel

Division 2, Child-Care Administrator

January 2007

- (a) A person designated to handle emergencies must be on call and accessible to your caregivers. [Medium-High]
- (b) You must inform all caregivers and us of the system and how to contact the person on call in case of an emergency. [Medium-High]
- (c) The employee is not required to be a Licensed Child-Care Administrator.

§748.539. Who must have overall administrative responsibility when the child-care administrator is absent on a frequent and/or extended basis?

Subchapter E, Personnel

Division 2, Child-Care Administrator

January 2017

When the child-care administrator is absent on a frequent and/or extended basis, the administrator must designate an employee that has a Child-Care Administrator's License to be responsible for the overall administration of the operation while the administrator is absent. [Medium]

Division 3, Professional Level Service Providers

§748.561. What professional level service activities must a professional level service provider perform at my operation?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2007

A professional level service provider must perform the following functions:

- (1) Completing an admission assessment or any other evaluation of a child for placement [Medium-Low];
- (2) Developing, reviewing, and updating of service plans for a child in care [Medium];
- (3) Completing a discharge or transfer summary for a child [Medium-Low];
- (4) Approving any restrictions that will be imposed on a child for more than seven days that have not been reviewed and approved by the treatment director or service planning team, and any monthly re-evaluations of restrictions that continue for more than 30 days [Medium-Low];
- (5) Approving any restrictions to communication and visitation with the child's family that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team, including monthly re-evaluations of restrictions that continue for more than 30 days [Medium-Low]; and
- (6) Approving any restrictions to a particular room or building for more than 24 hours that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team. [Medium-Low]

§748.563. What professional qualifications must a professional level service provider have in order to perform professional level service activities?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2017

- (a) If you provide treatment services to 25 or more children with emotional disorders, or if more than 30% of the children in your care receive treatment services for emotional disorders, a professional level service provider must have the following qualifications [Medium]:

Educational qualifications	Professional qualifications
A master's degree or higher from an accredited college or university in social work or other human services field and nine credit hours in graduate level courses that focus on family and individual function and interaction.	One year of documented full-time work experience in a treatment setting serving children, including RTCs, child-placing agencies providing treatment services, psychiatric hospitals serving children, etc.

- (b) If you provide treatment services to 25 or more children with primary medical needs, or if more than 30% of the children in your care receive treatment services for primary medical needs, a professional level service provider must have the following qualifications [Medium]:

Educational qualifications	Professional qualifications
A nurse's degree or higher.	One year of documented full-time work experience in a medical or residential setting serving children with primary medical needs.

- (c) To provide services for any other children, a professional level service provider must have the following qualifications [Medium]:

Options	Educational qualifications	Professional qualifications
Option 1	A master's degree or higher from an accredited college or university; or a bachelor's degree from an accredited college or university in social work or other human services field.	One year of documented full-time work experience in a residential child-care operation, or related field of child and family services.

Options	Educational qualifications	Professional qualifications
Option 2	A bachelor's degree from an accredited college or university.	Two years of documented full-time work experience in a residential child-care operation, or related field of child and family services.

§748.565. How must a professional level service provider document approval of professional level service functions?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2007

A professional level service provider must sign and date the following documents to indicate review and approval or disapproval:

- (1) Admission assessments or any other evaluation of a child for placement [Medium-Low];
- (2) Initial service plans, updates, and reviews [Medium-Low];
- (3) Discharge or transfer summaries [Medium-Low];
- (4) Any restrictions that will be imposed on a child for more than seven days that have not been reviewed and approved by the treatment director or service planning team [Medium-Low];
- (5) Any restrictions to communication and visitation with the child's family that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team [Medium-Low]; and
- (6) Any restrictions to a particular room or building for more than 24 hours that are imposed on a child, but have not been reviewed and approved by the treatment director or service planning team. [Medium-Low]

§748.567. What are the requirements for the caseloads of a professional level service provider?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2007

There is not a maximum caseload for a professional level service provider; however, you must ensure manageable caseloads that allow professional level service providers to meet the needs of children on their caseload. [Medium]

§748.569. Must I have health-care professionals on staff or on contract if I provide services to children with primary medical needs?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

September 2010

If you provide treatment services to 25 or more children with primary medical needs or if more than 30% of the children in your care receive treatment services for primary medical needs:

- (1) You must have a licensed registered nurse on staff or on contract to respond to emergencies, questions, or other medical issues. A registered nurse must work full-time at the operation. A registered nurse in this position may be relieved on days off by a licensed registered nurse or by a licensed vocational nurse with appropriate supervision as defined in Tex. Occ. Code §301.353. [Medium-High]
- (2) You must arrange for:
 - (A) 24-hour availability of nursing, medical, and psychiatric services [Medium-High];
 - (B) Licensed nursing services, including 24-hour nursing direction or supervision [Medium-High];
 - (C) Assistance with mobility [Medium-High];
 - (D) Routine adjustments or replacement of medical equipment [Medium-High]; and
 - (E) As needed, caregiver supervision of children during the provision of medical and dental services. [Medium-High]
- (3) You must ensure that a physician on staff or on contract recommends and approves services at each initial diagnosis and at each review. [Medium-High]

§748.571. What are the responsibilities of a registered nurse at an operation that provides services to a child with primary medical needs?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2017

The responsibilities of a registered nurse include:

- (1) Performing a nursing assessment of the child to include documentation of the child's diagnosed medical needs and selection of placement [Medium];
- (2) Leading or participating in the service planning process for the child's care [Medium];
- (3) Directing the health care training of unlicensed caregivers, such as care of a permanently placed feeding tube [Medium-High];
- (4) Ensuring non-mobile children are turned every two hours to increase circulation and to prevent bedsores or contractures, unless medical orders are to the contrary. This procedure must be documented in the child's record [Medium-High];
- (5) Reviewing medical records [Medium];
- (6) Contacting other professionals, as needed, for the child's care [Medium];
- (7) On-site visits for nursing assessments and child record reviews, including compliance with written physician orders [Medium];
- (8) Monitoring the implementation of the child's service plan [Medium]; and
- (9) Documenting outcomes for interventions used in the child's care. [Medium]

§748.573. What are the requirements for other nursing personnel for an operation that provides treatment services to 25 or more children with primary medical needs, or for an operation in which more than 30 % of the children in care receive treatment services for primary medical needs?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2007

Your nursing personnel must:

- (1) Be awake and available at the operation on a 24-hour basis [Medium-High];
- (2) Be under the direction of a registered nurse who is licensed to practice in Texas [Medium-High]; and
- (3) Include a licensed vocational nurse or registered nurse. [Medium-High]

§748.575. In what circumstances may a physician or registered nurse (including an advanced practice registered nurse) delegate nursing tasks to unlicensed caregivers?

Subchapter E, Personnel

Division 3, Professional Level Service Providers

January 2017

The physician or registered nurse may delegate nursing tasks to unlicensed caregivers only if all delegation criteria are met for the task to be delegated, including, but not limited to [Medium]:

- (1) The nursing task is one that a reasonable and prudent physician or registered nurse would find is within the scope of sound nursing judgment to delegate [Medium];
- (2) The physician or registered nurse determines that the nursing task can be properly and safely performed by the unlicensed caregiver without jeopardizing the child's welfare [Medium];
- (3) The operation employing or contracting with the unlicensed caregivers develops and follows a protocol, with input from a physician or registered nurse, for the instruction and training of unlicensed caregivers performing nursing tasks. The protocol must address [Medium]:

- (A) An established mechanism for identifying those individuals to whom nursing tasks may be designated [Medium];
 - (B) The manner in which the instruction addresses the complexity of the delegated task [Medium];
 - (C) The manner in which the unlicensed caregivers demonstrate the competency of the delegated task [Medium]; and
 - (D) The mechanism for re-evaluation of the competency [Medium];
- (4) The training protocol recognizes that the final decision as to what nursing tasks can be safely delegated in any specific situation is within the specific scope of the physician's or registered nurse's judgment [Medium]; and
- (5) A physician or registered nurse must instruct unlicensed caregivers in performing nursing tasks. [Medium]

Division 4, Treatment Director

§748.601. Must I have a treatment director?

Subchapter E, Personnel

Division 4, Treatment Director

January 2007

You must have a treatment director if you provide treatment services to 25 or more children, or to more than 30% of the children in your care. Your treatment director must be a full-time employee of your operation. [Medium-High]

§748.603. What are the responsibilities of a treatment director?

Subchapter E, Personnel

Division 4, Treatment Director

January 2007

(a) The treatment director:

- (1) Is responsible for the overall treatment program, including clinical responsibility for the management of your operation's therapeutic interventions [Medium]; and
- (2) Provides direction and overall management of your treatment program. [Medium]

(b) When assigning responsibilities to your treatment director, you must ensure that the treatment director can oversee the treatment of all children receiving treatment services. [Medium]

§748.605. What qualifications must a treatment director have?

Subchapter E, Personnel

Division 4, Treatment Director

January 2017

(a) A treatment director that provides or oversees treatment services for children with intellectual disabilities or children with autism spectrum disorder must be [Medium]:

- (1) Licensed as a psychiatrist, psychologist, professional counselor, clinical social worker, marriage and family therapist, or registered nurse; or

(2) Certified by the Texas Education Agency as an education diagnostician, have a master's degree in special education or a human services field, and have three years of experience working with children with intellectual disabilities or autism spectrum disorder.

(b) A treatment director that provides or oversees treatment services for children with primary medical needs must be a physician or a licensed registered nurse. [Medium]

(c) A treatment director that provides or oversees treatment services for children with emotional disorders must [Medium]:

(1) Be a psychiatrist or psychologist;

(2) Have a master's degree in a human services field from an accredited college or university and three years of experience providing treatment services for children with an emotional disorder, including one year in a residential setting; or

(3) Be a licensed master social worker, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist, and have three years of experience providing treatment services for children with an emotional disorder, including one year in a residential setting.

§748.607. If I provide more than one type of treatment service, can I have one treatment director?

Subchapter E, Personnel

Division 4, Treatment Director

January 2007

Yes, you can have one treatment director if he meets the required qualifications for the most prevalent treatment services your operation offers. [Medium]

Helpful Information

If you provide multiple treatment services, you may want to consider hiring more than one treatment director. Otherwise, your treatment director must either meet minimum qualifications for all treatment services that you provide or must meet minimum qualifications for your most prevalent treatment service. If there is no clear prevalence, you will need to base the qualifications for this position on the treatment service that your operation intends or predicts to be the most prevalent (and manage your admissions accordingly), or manage your admissions based on the qualifications of your treatment director.

Division 5, Caregivers

§748.681. What minimum qualifications must a caregiver meet?

Subchapter E, Personnel

Division 5, Caregivers

January 2017

Each employee must meet the following qualifications before you can count the employee in the child/caregiver ratio [Medium]:

(1) Be at least:

- (A) 18 years old if all the children in the group the caregiver serves are under 13 years old [Medium]; or
- (B) 21 years old if at least one child in the group the caregiver serves is 13 years old or older [Medium-Low];

(2) Have either [Medium]:

- (A) A high school diploma or high school equivalency, such as a General Educational Development (GED) from a program recognized by the Texas Education Agency (TEA), the Texas Private School Accreditation Commission (TPSAC), or other similar educational entity from another state; or
- (B) Documentation to verify high school equivalency from home schooling. The documentation must adequately address basic competencies that would be otherwise met by a high-school diploma or a GED, including basic reading, writing, and math skills; and

(3) Be able to read, write, and communicate with co-workers, medical personnel, and other persons necessary to care for the child's needs. [Medium]

§748.683. What are the general requirements for supervising caregivers?

Subchapter E, Personnel

Division 5, Caregivers

January 2007

You must provide oversight of caregivers, including volunteers to:

- (1) Protect children's health, safety, and well-being [Medium]; and
- (2) Ensure that assigned duties are performed adequately. [Medium]

§748.685. What responsibilities does a caregiver have when supervising a child or children?

Subchapter E, Personnel

Division 5, Caregivers

January 2017

(a) The caregiver is responsible for:

- (1) Knowing which children they are responsible for [Medium];
- (2) Child care services for each assigned child [Medium];
- (3) Being aware of and accountable for each child's on-going activity [High];
- (4) Providing the level of supervision necessary to ensure each child's safety and well being, including auditory and/or visual awareness of each child's on-going activity as appropriate [High]; and
- (5) Being able to intervene when necessary to ensure each child's safety. [High]

(b) In deciding how closely to supervise a child, the caregiver must take into account:

- (1) The child's age [Medium-High];
- (2) The child's individual differences and abilities [Medium-High];
- (3) The indoor and outdoor layout of the operation [Medium-High];
- (4) Surrounding circumstances, hazards, and risks [Medium-High]; and
- (5) The child's physical, mental, emotional, and social needs. [Medium-High]

(c) Caregivers must:

- (1) Be aware of the children's habits, interests, and any special needs, including any special supervision needs [Medium-High];
- (2) Provide a safe environment [High];

- (3) Cultivate developmentally appropriate independence in children through planned but flexible program activities [Medium];
 - (4) Positively reinforce children's efforts and accomplishments [Medium];
 - (5) Ensure continuity of care for children by sharing with incoming caregivers information about each child's activities during the previous shift and any verbal or written information or instructions given by the parent or other professionals [Medium-High]; and
 - (6) Implement and follow the children's service plans. [Medium]
- (d) If a child is participating in an unsupervised childhood activity, the caregiver must:
- (1) Know where the child will be [Medium-High];
 - (2) Give the child a specific time to return to the operation or the caregiver's location [Medium-High];
 - (3) Provide, arrange, or confirm an appropriate method of transportation to and from the activity [Medium-High];
 - (4) Give the child a way to contact the caregiver in an emergency [Medium-High]; and
 - (5) Be available to respond if the child contacts the caregiver and needs immediate assistance. [Medium-High]
- (e) Caregivers that supervise a child receiving treatment services for an emotional disorder must maintain daily progress notes for the child. Caregivers must sign and date each progress note at the time the progress note is completed. [Medium]
- (f) If a child or children are allowed overnight visits with staff, the child(ren) must be properly fed, lodged, and supervised, and their health, safety, and well-being protected. The person(s) responsible for the child(ren) must be given information about obtaining emergency medical care. [Medium-High]

Helpful Information

Regarding subsection (d), children may also be away from the operation and caregivers in order to participate in an activity supervised by adults not affiliated with the operation, such as an event sponsored by a religious youth group, Boy Scout or similar event, school-sponsored social event (like a dance), etc. The same expectations outlined in subsection (d) of this rule apply to these types of activities.

Division 6, Normalcy

§748.701. What is “normalcy”?

Subchapter E, Personnel

Division 6, Normalcy

January 2017

Normalcy is the ability of a child in care to live as normal a life as possible, including engaging in childhood activities that are suitable for children of the same age, level of maturity, and developmental level as determined by a reasonable and prudent parent standard.

§748.703. Are children in care required to participate in childhood activities?

Subchapter E, Personnel

Division 6, Normalcy

January 2017

- (a) Children in care must participate in childhood activities, including unsupervised childhood activities, as much as possible. [Medium-High]
- (b) Service planning meetings, and any decision making regarding the child’s need for supervision, must include discussions on how normalcy for the child can be achieved, and discussions, if applicable, regarding a child’s refusal to participate in childhood activities. The child’s service plan must specify whether there are any restrictions on the child’s participation in these activities and whether the activities may extend into sleeping hours. [Medium-High]

§748.705. What is the “reasonable and prudent parent standard”?

Subchapter E, Personnel

Division 6, Normalcy

January 2017

- (a) The reasonable and prudent parent standard is the standard of care that a parent of reasonable judgment, skill, and caution would use to maintain the health, safety, and best interest of the child and encourage the emotional and social growth and development of the child.
- (b) When using the reasonable and prudent parent standard, a person must take into consideration the following when deciding whether a child may participate in childhood activities:

- (1) The child's age and level of maturity [Medium];
- (2) The child's cognitive, social, emotional, and physical development level [Medium];
- (3) The child's behavioral history and ability to safely participate in a proposed activity [Medium];
- (4) The child's overall abilities [Medium];
- (5) Whether the activity is a normal childhood activity for a child of that age and level of maturity [Medium];
- (6) The child's desires [Medium];
- (7) The surrounding circumstances, hazards, and risks of the activity [Medium];
- (8) Outside supervision of the activity, if available and appropriate [Medium];
- (9) The supervision instructions in the child's service plan [Medium]; and
- (10) The importance of providing the child with the most normal family-like living experience possible. [Medium]

§748.707. Who makes the decision regarding a foster child's participation in childhood activities?

Subchapter E, Personnel

Division 6, Normalcy

January 2017

- (a) A General Residential Operation (GRO) must designate one or more persons to make decisions regarding a child's participation in childhood activities, except as otherwise provided in subsection (c) of this section. [Medium-High]
- (b) When making decisions regarding a child's participation in childhood activities, a designated person must follow the reasonable and prudent parent standard. [Medium-High]
- (c) The service plan may not require the prior approval of the parent before a designated person may consent to a child's participation in childhood activities. However, if the parent provides notice in advance that the child is prohibited from participating in a specific activity, a designated person must follow the parent's decision. [Medium-High]

§748.709. Are there any restrictions on who can be a designated **person that makes decisions regarding a child’s participation in childhood activities?**

Subchapter E, Personnel

Division 6, Normalcy

January 2017

- (a) Caregivers hired after August 31, 2016 may not be a designated person that makes decisions regarding a child’s participation in childhood activities until the caregiver completes either a two hour pre-service training regarding normalcy or the annual training specific to normalcy. [Medium-High]
- (b) A designated person that makes decisions regarding a child’s participation in childhood activities must:
 - (1) Work at the location where the child resides [Medium-High]; and
 - (2) Be knowledgeable about the child’s current needs and history. [Medium-High]
- (c) The name of each designated person must be documented on the face sheet of the child’s record. [Medium]

Division 7, Contract Staff and Volunteers

§748.721. What are the requirements for a volunteer?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2017

- (a) You must maintain a personnel record for each volunteer. [Medium-Low]
- (b) The personnel record must include a statement signed and dated by the volunteer indicating the volunteer must immediately report any suspected incident of abuse, neglect, or exploitation to the Texas Abuse and Neglect Hotline and the operation's administrator or administrator's designee. An internal reporting policy may not require or allow a person to delegate the person's responsibility to report suspected abuse, neglect, or exploitation. [Medium]

§748.723. Are there additional requirements for a volunteer or contractor that performs employee functions?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2007

- (a) A volunteer or contractor that performs any employee function must meet the same requirements as an employee who performs that function. [Medium]
- (b) You must maintain records documenting how these requirements are met. [Medium]

§748.724. When is a volunteer or contractor who is a part of another organization subject to my policies and procedures?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2017

- (a) A volunteer or contractor who is part of another organization is subject to your policies and procedures unless that organization provides screening, training, and supervision to the volunteer/contractor that are adequate to protect the health and safety of children. Before the volunteer/contractor can have contact with children [Medium-Low]:

- (1) The volunteer/contractor must meet the relevant requirements of your policies and procedures; or
- (2) You must confirm the organization provides adequate screening, training, and supervision.

(b) An organization may be another licensed operation.

§748.725. Can a volunteer, a volunteer's family, or a sponsoring family take a child in care for an overnight or weekend visit?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2017

- (a) Yes, but when a volunteer, a volunteer's family, or a sponsoring family takes a child who is in care for an overnight or weekend visit, this is a volunteer activity.
- (b) Neither the volunteer nor the family would have to comply with employee or caregiver requirements, but:
 - (1) The volunteer and/or the family would have to meet the relevant background checks [High]; and
 - (2) In order for a volunteer or a family to take a child out of care for more than 48 hours, you must get written approval from the parent. [Medium]

§748.729. What must I do when a child in care visits a volunteer or sponsoring family for a day or overnight?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2017

If a child has a day or overnight visit with a volunteer, a volunteer's family, or sponsoring family, you must ensure that:

- (1) The child is properly supervised, properly fed and hydrated, and provided with safe housing accommodations, if applicable [Medium-High];
- (2) The child's health, safety, and well-being are protected [Medium-High]; and
- (3) Prior to the visit, the person responsible for the child during the visit has to receive the same information that you as a respite child-care services provider would receive, as specified in §748.4265 of this title (relating to What information regarding a child must I receive prior to providing respite child-care services to that child?). [Medium-High]

§748.731. May a person perform community service hours at my operation?

Subchapter E, Personnel

Division 7, Contract Staff and Volunteers

January 2017

A person may not perform community service hours at your operation. For the purposes of this rule, community service includes service a person must perform because the person is on probation, parole, or otherwise required to perform the service through the courts because of criminal activity. [Medium-High]

Subchapter F, Training and Professional Development

Division 1, Definitions

§748.801. What do certain words and terms mean in this subchapter?

Subchapter F, Training and Professional Development

Division 1, Definitions

January 2017

The words and terms used in this subchapter have the following meanings:

- (1) CPR – Cardiopulmonary resuscitation.
- (2) Hours – Clock hours.
- (3) Instructor-led training – Training that is characterized by the communication and interaction that takes place between the student and the instructor. It must include an opportunity for the student to interact with the instructor to obtain clarifications and information beyond the scope of the training material. For such an opportunity to exist, the instructor must be able to answer questions, provide feedback on skills practice, provide guidance or information on additional resources, and proactively interact with students. Examples of this type of training include classroom training, on-line distance learning, video-conferencing, or other group learning experiences.
- (4) Self-instructional training – Training designed to be used by one individual working alone and at the individual's own pace to complete lessons or modules. An example of this type of training is web-based training. Self-study training is also a type of self-instructional training.
- (5) Self-study training – Non-standardized training where an individual reads written materials, watches a training video, or listens to a recording to obtain certain knowledge that is required for annual training. Self-study training is limited to three hours, see 748.937(d) of this title (relating to What types of hours or instruction can be used to complete the annual training requirements?).

Division 2, Orientation

§748.831. What is the orientation requirement for employees?

Subchapter F, Training and Professional Development

Division 2, Orientation

January 2007

- (a) Prior to beginning job duties or having contact with children in care, each employee must have orientation that includes [Medium]:
 - (1) An overview of the relevant and applicable rules of this chapter [Medium];
 - (2) Your philosophy, organizational structure, policies, and a description of the services and programs you offer [Medium]; and
 - (3) The needs and characteristics of children that you serve. [Medium]
- (b) You must document the completion of the orientation in the appropriate personnel record. [Medium-Low]

§748.833. Must I provide orientation to an employee who has previously worked as an employee?

Subchapter F, Training and Professional Development

Division 2, Orientation

January 2007

- (a) You do not have to provide orientation to an employee who has worked as an employee at your operation during the past 12 months. However, if you assign this employee to be the only caregiver for a group of children, then before you may assign the employee you must:
 - (1) Discuss with the employee any changes in your services or programs that have occurred since the previous employment [Medium]; and
 - (2) Ensure the employee has received training during the past 12 months from your operation on preventing, identifying, treating, and reporting child abuse, neglect, and exploitation. [Medium]
- (b) You must document this discussion and previous training in the caregiver's personnel record. [Medium-Low]

Division 3, Pre-Service Experience and Training

§748.861. What are the pre-service experience requirements for a caregiver?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2017

- (a) If less than 25 children and less than 30% of your total population of children in care are receiving treatment services, then there are no pre-service experience requirements.
- (b) If 25 or more children or 30% or more of your total population of children in care are receiving treatment services, then a caregiver must have 40 hours of supervised child-care experience in your operation and/or another operation that provides the same treatment services. Until the caregiver has met this 40-hour experience requirement, the caregiver [Medium]:
 - (1) May not be assigned as the only caregiver responsible for a group of children [Medium];
 - (2) Must be supervised at all times by another caregiver who has already satisfied the 40-hour experience requirement [Medium]; and
 - (3) The supervised child-care experience must be documented in the appropriate personnel record. [Low]

§748.863. What are the pre-service hourly training requirements for caregivers and employees?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2017

- (a) Caregivers and certain employees must complete the following training hours before the noted time frame:

Weight	Who is required to receive the training?	What type of pre-service training?	How many hours of training are required?	When must the training be completed?
[Medium]	(1) All caregivers	General pre-service training	8 hours	Before the person can be the only caregiver responsible for a child in care
[Medium]	(2) Child care administrators, professional level service providers, treatment directors, and case managers	Pre-service training regarding normalcy	2 hours	Before the person can be a designated person that makes decisions regarding a child's participation in childhood activities, or within 90 days of beginning job duties, whichever occurs earlier
[Medium-High]	(3) Caregivers caring for children receiving only child care services or programmatic services	Pre-service training regarding emergency behavior intervention	8 hours	At least 4 hours of training before the person can be the only caregiver responsible for a child in care, and all 8 hours of training within 90 days of being responsible for a child in care
[Medium-High]	(4) Caregivers caring for children receiving treatment services, except for those exclusively caring for children receiving treatment services for primary medical needs	Pre-service training regarding emergency behavior intervention	16 hours, however, if your operation prohibits the use of emergency behavior intervention, then only 8 hours of training are needed	At least half of the required hours of training before the person can be the only caregiver responsible for a child in care, and all of the required hours of training within 90 days of being responsible for a child in care

Weight	Who is required to receive the training?	What type of pre-service training?	How many hours of training are required?	When must the training be completed?
[Medium]	(5) Child care administrators, professional level service providers, treatment directors, and case managers except those exclusively assigned to children receiving treatment services for primary medical needs	Pre-service training regarding emergency behavior intervention	8 hours	All 8 hours of training within 90 days of beginning job duties

(b) You must document the completion of each training requirement in the appropriate personnel record. [Medium-Low]

Helpful Information
• A caregiver may not administer any form of emergency behavior intervention until the caregiver's pre-service training is complete, except the short personal restraint of a child. §748.2453 requires that only a caregiver qualified in emergency behavior intervention may administer emergency behavior interventions, except a short personal restraint. A caregiver is not considered qualified until/unless the caregiver's training is complete. • Caregivers exclusively caring for children receiving treatment services for primary medical needs are exempt from pre-service emergency behavior intervention training requirements.

§748.865. Can time spent in orientation training count towards pre-service training?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2007

No, the orientation training must be separate from the pre-service training requirement.

[Medium-Low]

Helpful Information
Orientation is focused on providing new employees with information about your organization and how it operates. Pre-service training is focused on preparing new employees to do their job competently. This is the reason that these requirements are separate in the minimum standards and that orientation may not be counted toward pre-service or annual training requirements.

§748.867. Must I provide pre-service training to a caregiver or an employee who has previously worked in an operation?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2017

- (a) A caregiver is exempt from completing the eight hours of general pre-service training if the caregiver has been employed as a caregiver in a general residential operation during the past 12 months.
- (b) A caregiver or an employee does not have to complete the pre-service training regarding emergency behavior intervention if the caregiver or employee:
 - (1) Has been employed in a general residential operation during the past 12 months;
 - (2) Has received training during the past 12 months in the types of emergency behavior intervention used at your operation; and
 - (3) Can demonstrate knowledge and competency of the training material both in writing and in physical techniques.
- (c) You must document the exemption factors in the appropriate personnel record.

[Medium-Low]

§748.868. Must I provide pre-service training regarding normalcy to a child-care administrator, professional level service provider, treatment director, or case manager who was previously employed by a residential child-care operation?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2017

- (a) A child-care administrator, professional level service provider, treatment director, or case manager is exempt from completing the pre-service training regarding normalcy if the person:
 - (1) Has been employed by a residential child-care operation during the past 12 months;
 - (2) Has received training during the past 12 months on normalcy; and
 - (3) Can document that the training has been received.
- (b) You must document the exemption factors in the appropriate personnel record. [Medium-Low]

§748.869. What are the instructor requirements for providing pre-service training?

Subchapter F, Training and Professional Development

Division 3, Pre-Service Experience and Training

January 2017

- (a) The training must be instructor-led. [Medium]
- (b) A qualified instructor must deliver the pre-service training. A qualified instructor must hold a generally recognized credential or possess documented knowledge and/or experience relevant to the training the instructor will provide. [Medium]
- (c) A health-care professional or a pharmacist must provide training in administering psychotropic medication. The trainer must assess each participant after the training to ensure that the participant has learned the course content. [Medium-High]
- (d) To provide training in emergency behavior intervention the:
 - (1) Instructor must be certified in a recognized method of emergency behavior intervention, or be able to document knowledge of [Medium-High]:
 - (A) The emergency behavior intervention [Medium-High];
 - (B) The course material [Medium-High];

(C) Training delivery methods and techniques [Medium-High]; and

(D) Training evaluation or assessment methods and techniques [Medium-High]; and

(2) Training must be competency-based and require participants to demonstrate skill and competency at the end of the training. [Medium-High]

Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy

§748.881. What curriculum components must be included in the general pre-service training?

Subchapter F, Training and Professional Development

Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy

January 2017

The general pre-service training curriculum must include the following components:

- (1) Topics appropriate to the needs of children for whom the caregiver will be providing care, such as developmental stages of children, fostering children's self-esteem, constructive guidance and discipline of children, water safety, strategies and techniques for monitoring and working with these children, and age-appropriate activities for the children [Medium];
- (2) Measures to prevent, identify, treat, and report suspected occurrences of child abuse (including sexual abuse), neglect, and exploitation [Medium-High];
- (3) Procedures to follow in emergencies, such as weather-related emergencies, volatile persons, and severe injury or illness of a child or adult [Medium-High];
- (4) Preventing the spread of communicable diseases [Medium-High];
- (5) The location and use of fire extinguishers and first-aid equipment [Medium-High];
- (6) Trauma-informed care [Medium]; and
- (7) Normalcy. [Medium]

§748.882. What curriculum components must be included in the pre-service training regarding normalcy?

Subchapter F, Training and Professional Development

Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy

January 2017

The pre-service training regarding normalcy must include the following components:

- (1) A discussion of the definitions of normalcy and the reasonable and prudent parent standard [Medium-High];
- (2) The developmental stages of children, including a discussion of the cognitive, social, emotional, and physical development of children [Medium];
- (3) Age appropriate activities for children, including unsupervised childhood activities [Medium];
- (4) The benefits of childhood activities to a child's well-being, mental health, and social, emotional, and developmental growth [Medium];
- (5) How to apply the reasonable and prudent parent standard to make decisions [Medium-High]; and
- (6) The child's and the caregiver's responsibilities when participating in childhood activities. [Medium-High]

Helpful Information

A caregiver's specific responsibilities for a child that participates in unsupervised activities are listed at §748.685(d) of this title (relating to What responsibilities does a caregiver have when supervising a child or children?).

§748.883. What additional general pre-service training requirements are there for a caregiver who will care for children younger than two years old?

Subchapter F, Training and Professional Development

Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy

January 2017

You must ensure that each caregiver who provides care for children younger than two years old receives general pre-service training on:

- (1) Recognizing and preventing shaken baby syndrome [Medium-High];
- (2) Understanding safe sleep environments and preventing sudden infant death syndrome [Medium-High]; and
- (3) Understanding early childhood brain development. [Medium]

§748.885. What additional general pre-service training requirements are there for a caregiver that administers psychotropic medication?

Subchapter F, Training and Professional Development

Division 4, General Pre-Service Training and Pre-Service Training Regarding Normalcy

January 2017

Before a caregiver is permitted to administer psychotropic medication, you must ensure that each caregiver that administers psychotropic medication receives general pre-service training on:

- (1) Identification of psychotropic medications [Medium-High];
- (2) Basic pharmacology (the actions and side effects of, and possible adverse reactions to, various psychotropic medications) [Medium-High];
- (3) Techniques and methods of administering medications [Medium-High];
- (4) Who is legally authorized to provide consent for the psychotropic medication [Medium]; and
- (5) Any related policies and procedures. [Medium]

Helpful Information

- The online psychotropic medication training of the Child Protective Services Division of DFPS satisfies this general pre-service training requirement as long as caregivers also get instructor-led training that covers:
- Policies and procedures on administering medication; and
- Who may consent to using psychotropic medications for children who are not in the conservatorship of DFPS.

Division 5, Pre-Service Training Regarding Emergency Behavior Intervention

§748.901. If I do not allow the use of emergency behavior intervention, what curriculum components must be included in the pre-service training regarding emergency behavior intervention?

Subchapter F, Training and Professional Development

Division 5, Pre-Service Training Regarding Emergency Behavior Intervention

February 2017

If you do not allow the use of emergency behavior intervention, your pre-service training curriculum regarding emergency behavior intervention must focus on early identification of potential problem behaviors and strategies and techniques of less restrictive interventions, including the following components [Medium]:

- (1) Developing and maintaining an environment that supports positive and constructive behaviors [Medium];
- (2) The causes of behaviors potentially harmful to children, including aspects of the environment [Medium];
- (3) Early signs of behaviors that may become dangerous to the child or others [Medium-High];
- (4) Strategies and techniques the child can use to avoid harmful behaviors [Medium-High];
- (5) Teaching children to use the strategies and techniques of your operation's de-escalation protocols to avoid harmful behavior, and supporting the children's efforts to progress into a state of self-control [Medium-High];

- (6) Less restrictive strategies caregivers can use to intervene in potentially harmful behaviors [Medium-High];
- (7) Less restrictive strategies caregivers can use to work with oppositional children [Medium];
- (8) Addressing circumstances when all de-escalation strategies fail [Medium]; and
- (9) The risks associated with the use of prone or supine restraints, including positional, compression, or restraint asphyxia. [Medium-High]

§748.903. If I allow the use of emergency behavior intervention, what curriculum components must be included in the pre-service training regarding emergency behavior intervention?

Subchapter F, Training and Professional Development

Division 5, Pre-Service Training Regarding Emergency Behavior Intervention

September 2010

- (a) If you allow the use of emergency behavior intervention, at least 75% of the required hours of pre-service training regarding emergency behavior intervention must focus on early identification of potential problem behaviors and strategies and techniques of less restrictive interventions, including the components listed in §748.901 of this title (relating to If I do not allow the use of emergency behavior intervention, what curriculum components must be included in the pre-service training regarding emergency behavior intervention?). [Medium-High]
- (b) The training does not have to address the use of any emergency behavior intervention that your policies do not allow.
- (c) The other 25% of the pre-service training regarding emergency behavior intervention must include the following components:
 - (1) Different roles and responsibilities of caregivers qualified in emergency behavior intervention versus employees or volunteers who are not qualified in emergency behavior intervention [Medium-High];
 - (2) Escape and evasion techniques to prevent harm to the child and caregiver without requiring the use of an emergency behavior intervention [Medium-High];
 - (3) Safe implementation of the restraints and/or seclusion techniques and procedures that are appropriate for the age and weight of children served and permitted by the rules in this chapter and your policies and procedures [Medium-High];
 - (4) The physiological impact of emergency behavior intervention [Medium-High];

- (5) The psychological impact of emergency behavior intervention, such as flashbacks from prior abuse [Medium-High];
- (6) How to adequately monitor the child during the administration of an emergency behavior intervention to prevent injury or death [Medium-High];
- (7) Monitoring physical signs of distress and obtaining medical assistance [Medium-High];
- (8) Health risks for children associated with the use of specific techniques and procedures [Medium-High];
- (9) Drawings, photographs, or videos of each personal or mechanical restraint permitted by your policy. For mechanical restraints, this must include the manufacturer's complete specifications for each device permitted, an explanation of modifications to the manufacturer's specifications, and a copy of the approval of the modification from a licensed psychiatrist [Medium-High]; and
- (10) Strategies for re-integration of children into the environment after the use of emergency behavior intervention, including the debriefing of caregivers and the child. [Medium]

Division 6, Annual Training

§748.931. What are the annual training requirements for caregivers and employees?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

- (a) Caregivers and certain employees must complete the following training hours:

Who is required to receive the annual training?	How many hours of annual training are required?
(1) Caregivers where an operation has less than 25 children in care that are receiving treatment services and less than 30% of their total population of children in care are receiving treatment services	(A) [Medium] 20 hours. (B) Of the 20 hours, the training must include: (i) [Medium-High] Two hours of training specific to trauma informed care; (ii) [Medium-High] Two hours of training specific to normalcy; (iii) [Medium-High] Four hours of training, every six months, specifically related to the emergency behavior intervention techniques that you allow. The caregiver must have this training within 180 days from the date that the caregiver last received such training; and (iv) [Medium-High] Two hours of transportation safety training if the caregiver transports a child in care whose chronological or developmental age is younger than nine years old.
(2) Caregivers where an operation has 25 or more children in care that are receiving treatment services or 30% or more of their total population of children in care are receiving treatment services	(A) [Medium] 50 hours. (B) Of the 50 hours, the training must include: (i) [Medium-High] Two hours of training specific to trauma informed care; (ii) [Medium-High] Two hours of training specific to normalcy; and (iii) [Medium-High] Four hours of training, every six months, specifically related to the emergency behavior intervention techniques that you allow. The caregiver must have this training within 180 days from the date that the caregiver last received such training; and (iv) [Medium-High] Two hours of transportation safety training if the caregiver transports a child in care whose chronological or developmental age is younger than nine years old.

Who is required to receive the annual training?	How many hours of annual training are required?
(3) Caregivers in a cottage home	(A) [Medium] 20 hours. (B) Of the 20 hours, the training must include: (i) [Medium-High] Two hours of training specific to trauma informed care; (ii) [Medium-High] Two hours of training specific to normalcy; and (iii) [Medium-High] Four hours of training specifically related to the emergency behavior intervention techniques that you allow. The caregiver must have this training within 12 months from the date that the caregiver last received such training; and (iv) [Medium-High] Two hours of transportation safety training if the caregiver transports a child in care whose chronological or developmental age is younger than nine years old.
(4) Child-care administrators, professional level service providers, treatment directors, and case managers who hold a relevant professional license	(A) [Medium] 15 hours. (B) Of the 15 hours, the training must include: (i) [Medium] Two hours of training on normalcy if the person is a designated person that makes decisions regarding any child's participation in childhood activities; and (ii) [Medium] Two hours of transportation safety training if the person transports a child in care whose chronological or developmental age is younger than nine years old. (C) Annual training hours used to maintain a person's relevant professional license may be used to complete these hours, as long as they include the necessary components of subsection (B) or those components are completed separately. (D) [Medium-High] There are no annual training requirements for emergency behavior intervention. However, if there is a substantial change in techniques, types of intervention, or operation policies regarding emergency behavior intervention, then the staff must be re-trained in emergency behavior intervention.

Who is required to receive the annual training?	How many hours of annual training are required?
(5) Professional level service providers, treatment directors, and case managers who do not hold a relevant professional license	(A) [Medium] 20 hours. (B) Of the 20 hours, the training must include: (i) [Medium] Two hours of training specific to trauma informed care; (ii) [Medium] Two hours of training specific to normalcy; and (iii) [Medium] Two hours of transportation safety training if the person transports a child in care whose chronological or developmental age is younger than nine years old. (C) [Medium] There are no annual training requirements for emergency behavior intervention. However, if there is a substantial change in techniques, types of intervention, or operation policies regarding emergency behavior intervention, then the staff must be re-trained in emergency behavior intervention.

(b) Caregivers exclusively caring for children receiving treatment services for primary medical needs are exempt from emergency behavior intervention training requirements.

§748.935. When must a person complete the annual training?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

(a) Each person must complete the annual training:

- (1) Within 12 months from the when you hire the person [Medium]; and
- (2) During each subsequent 12-month period after the anniversary date of hire.
[Medium]

(b) Alternately, you have the option of prorating the person's annual training requirements from the date of hire to the end of the calendar year or the end of the operation's fiscal year and then beginning a new 12-month period that coincides with the calendar or fiscal year.

(c) The method for completing annual training requirements must be consistent throughout your operation. [Medium-Low]

§748.937. What types of hours or instruction can be used to complete the annual training requirements?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

(a) If the training complies with the other rules in this division (relating to Annual Training), annual training may include hours or Continuing Education Units earned through [Medium-Low]:

- (1) Workshops or courses offered by local school districts, colleges or universities, or Licensing;
- (2) Conferences or seminars;
- (3) Self-instructional training, excluding training on emergency behavior intervention and CPR [Medium-High];
- (4) Planned learning opportunities provided by child-care associations or Licensing [Medium-Low];
- (5) Planned learning opportunities provided by a professional contract service provider, child-care administrator, professional level service provider, treatment director, or caregiver who meets minimum qualifications in the rules of this chapter; or
- (6) Completed college courses for which a passing grade is earned, with three college credit hours being equivalent to 50 clock hours of required training. College courses do not substitute for required CPR or first-aid certification or required annual training on emergency behavior intervention or psychotropic medication.

(b) For annual training hours, you may count:

- (1) The hours of annual training that a person received at another residential child-care operation, if the person [Medium-Low]:
 - (A) Received the training within the time period you are using to calculate the person's annual training; and
 - (B) Provides documentation of the training;
- (2) Annual emergency behavior intervention training;

- (3) First-aid and CPR training;
 - (4) Any hours of pre-service training that the person earned in addition to the required pre-service hours, although you may not carry over more than 10 hours of a person's pre-service training hours for use as annual training hours during the upcoming year [Medium-Low];
 - (5) Half of the hours spent developing initial training curriculum that is relevant to the population of children served. No additional credit hours for training curriculum development are permitted for repeated training sessions [Medium]; and
 - (6) One-fourth of the hours spent updating and making revisions to training curriculum that is relevant to the population of children served. [Medium-Low]
- (c) For annual training hours, you may not count:
- (1) Orientation training [Medium-Low];
 - (2) Required pre-service training [Medium-Low];
 - (3) The hours involved in case staffings and conferences with the supervisor [Medium-Low]; or
 - (4) The hours presenting training to others. [Medium-Low]
- (d) No more than one-half of the required annual training hours may come from self-instructional training. No more than three of those self-instructional hours may come from self-study training. [Medium-Low]
- (e) If a person earns more than the minimum number of training hours required during a particular year, the person can carry over to the next year a maximum of 10 training hours. [Medium-Low]

Helpful Information

Here are two examples to clarify (b)(4): (1) if a person completes a total of 35 hours of pre-service training and is required to complete a total of 18 hours of pre-service training, then that person may only carry over a maximum of 10 of the hours toward annual training requirements even though the person completed 17 extra hours of non-required, pre-service training; and (2) if a person completes a total of 35 hours of pre-service training and is required to complete a total of 26 hours of pre-service training, then that person may only carry over 9 hours toward annual training requirements because the person completed 9 extra hours of non-required, pre-service training.

§748.939. Does Licensing approve training resources or trainers for annual training hours?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

- (a) No. We do not approve or endorse training resources or trainers for training hours.
- (b) However, you must ensure the employees receive reliable training relevant to the population of children served. [Medium]
- (c) Instructor-led training and self-instructional training, excluding self-study training, must include:
 - (1) Specifically stated learning objectives [Medium-Low];
 - (2) A curriculum, which includes experiential or applied activities [Medium-Low];
 - (3) An evaluation/assessment tool to determine whether the person has obtained the information necessary to meet the stated objectives [Medium]; and
 - (4) A certificate, letter, or a signed and dated statement of successful completion from the training source. [Medium-Low]

§748.941. What are the instructor requirements for providing annual training?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

- (a) Except for transportation safety training, the annual training instructors must meet the same requirements in §748.869(a), (c) and (d) of this title (relating to What are the instructor requirements for providing pre-service training?). [Medium]
- (b) Transportation safety training must be instructor-led and provided by [Medium]:
 - (1) A training provider registered with the Texas Early Care and Education Career Development System's Texas Trainer Registry, maintained by the Texas Head Start State Collaboration Office;

- (2) An instructor who teaches early childhood development or another relevant course at a secondary school or institution of higher education accredited by a recognized accrediting agency;
- (3) An employee of a state agency with relevant expertise;
- (4) A physician, psychologist, licensed professional counselor, social worker, or registered nurse;
- (5) A person who holds a generally recognized credential or possesses documented knowledge relevant to the training the person will provide; or
- (6) A person who has at least two years of experience working in child development, a child development program, early childhood education, a childhood education program, or a Head Start or Early Head Start program and:
 - (A) Has been awarded a Child Development Associate credential; or
 - (B) Holds at least an associate's degree in child development, early childhood education, or a related field.

§748.943. What areas or topics are appropriate for annual training?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

Other than the mandated topics, annual training must be in areas appropriate to the needs of children for whom the operation or employee will be providing care, which may include

[Medium]:

- (1) Developmental stages of children;
- (2) Constructive guidance and discipline of children;
- (3) Fostering children's self-esteem;
- (4) Positive interaction with children;
- (5) Strategies and techniques for working with the population of children served;
- (6) Supervision and safety practices for children in care;
- (7) Preventing the spread of communicable diseases;
- (8) Water safety; or
- (9) Administration of medication.

Helpful Information

- A person should attempt to attend trainings in new topic areas every year or attend topics where the person believes there is a need for improvement or need for additional knowledge. A person should avoid attending the same training every year, unless there is a specific need for information regarding that topic.
- Here are some examples of annual training topics:
 - Helping children cope with separation, such as from parents, family, and placement;
 - Helping or preparing children for re-integration into a family, community, or subsequent placement;
 - Stages of child development, including normal behavioral reactions to stress at the various ages of children served by the program;
 - Healthy personal boundaries and professional relationship boundaries;
 - Protecting self and others from false allegations;
 - Training to perform special tasks such as the care of gastric tubes or lifeguard certification training, if applicable;
 - For a caregiver who provides care to children receiving treatment services for emotional disorders, training on cognitive distortions and how they apply to the children; or
 - Special needs of children in care, which may include areas such as sexualized behavior, trauma, medical needs, and/or Autism Spectrum Disorder.

§748.944. What curriculum components must be included in the annual normalcy training?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

- (a) The annual training regarding normalcy must include the curriculum components covered in the pre-service training regarding normalcy, see §748.882 of this title (relating to What curriculum components must be included in the pre-service training regarding normalcy?). [Medium-High]

- (b) Subsequent annual training regarding normalcy should further develop and refine an employee's knowledge and understanding of normalcy and how it should be implemented. [Medium]

§748.945. For a caregiver who administers psychotropic medication, what annual training is required?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2017

If you permit a caregiver to administer psychotropic medication:

- (1) The caregiver's annual training must meet the psychotropic medication training requirements in §748.885 of this title (relating to What additional general pre-service training requirements are there for a caregiver that administers psychotropic medication?) [Medium]; and
- (2) The caregiver must obtain the annual psychotropic medication training no later than 12 months after the caregiver's last psychotropic medication training. [Medium-Low]

Helpful Information

- The online psychotropic medication training for the Child Protective Services Division of DFPS satisfies this annual training requirement as long as caregivers also get instructor-led training that covers:
 - Policies and procedures on administering medication; and
 - Who may consent to using psychotropic medications for children who are not in the conservatorship of DFPS.

§748.947. What must annual training regarding emergency behavior intervention include?

Subchapter F, Training and Professional Development

Division 6, Annual Training

January 2007

- (a) The annual training regarding emergency behavior intervention must reinforce basic principles covered in pre-service training, see §748.901 of this title (relating to If I do not allow the use of emergency behavior intervention, what curriculum components must be included in the pre-service training regarding emergency behavior intervention?) and §748.903 of this title (relating to If I allow the use of emergency behavior intervention, what curriculum components must be included in the pre-service training regarding emergency behavior intervention?), and develop and refine the employee's skills. [Medium-High]
- (b) You may determine the content of the training based on your evaluation of your emergency behavior interventions.
- (c) The training may repeat pre-service training components, including training in the proper use and implementation of emergency behavior intervention.

Helpful Information

Annual emergency behavior intervention training is not intended to be an exact replica of pre-service emergency behavior intervention training. While some review of previous content may be needed to ensure that caregivers retain necessary skills, you are expected and encouraged to use your emergency behavior intervention data to craft annual training that can most effectively improve the use of de-escalation techniques and emergency behavior interventions at your operation. This may include techniques caregivers can use to proactively avoid crisis situations and any necessary actions once all de-escalation attempts have failed.

§748.949. What documentation must I maintain for annual training?

Subchapter F, Training and Professional Development

Division 6, Annual Training

September 2010

- (a) You must keep documentation verifying completion of annual training in the appropriate personnel record. The documentation may be a certificate, letter, or a signed and dated statement of successful completion from the training source. The documentation may also be a transcript from an accredited college or university. [Medium-Low]
- (b) The documentation for training other than college courses must include the following information:
 - (1) The participant's name [Medium-Low];
 - (2) Date of the training [Medium-Low];
 - (3) Title or subject of the training;
 - (4) The trainer's name and qualifications, or the source of the training for self-instructional training [Medium-Low]; and
 - (5) Length of the training in hours. [Medium-Low]

Division 7, First-Aid and CPR Certification

§748.981. Who must have first-aid and CPR certification?

Subchapter F, Training and Professional

Development Division 7, First-Aid and CPR Certification

September 2010

- (a) Each caregiver must:
 - (1) Have a current certification in first-aid [Medium-High]; and
 - (2) Be able to immediately respond to emergencies. [Medium-High]
- (b) At all times, at least one caregiver counted in child/caregiver ratio must:
 - (1) Have current certification in CPR appropriate for the children that you serve [Medium-High]; and
 - (2) Be able to immediately respond to emergencies. [Medium-High]
- (c) Any new caregiver not currently certified in first-aid must be trained and certified within 90 days of employment. [Medium-High]

§748.983. When must a caregiver renew first-aid and CPR certification?

Subchapter F, Training and Professional Development

Division 7, First-Aid and CPR Certification

September 2010

- (a) Each caregiver must complete any new first-aid training as required to maintain a current certification. [Medium-High]
- (b) The caregiver in the child/caregiver ratio who must have a current certification in CPR must also complete any new CPR training as required to maintain a current certification. [Medium-High]

§748.985. Who can provide first-aid and CPR certification?

Subchapter F, Training and Professional Development

Division 7, First-Aid and CPR Certification

January 2017

(a) The following may provide first-aid and CPR certification [Medium-High]:

- (1) The American Red Cross, American Heart Association, or a training program that has been approved by the local Emergency Medical Services Authority, or is offered through a local hospital; or
- (2) A person with a current certification to provide the training.

(b) A caregiver may not obtain CPR certification through self-instructional training. [Medium]

§748.987. What must the CPR training include?

Subchapter F, Training and Professional Development

Division 7, First-Aid and CPR Certification

January 2017

- (a) CPR training/certification and re-certification must consist of a curriculum that includes both written and hands-on skill-based instruction, practice is through the use of a CPR mannequin, and testing. [Medium-High]
- (b) CPR training/certification and recertification must include CPR for children and adults. For operations that care for infants and/or admit children with infants, the training must also include CPR for infants. [Medium-High]

§748.989. What documentation must I maintain for first-aid and CPR certification?

Subchapter F, Training and Professional Development

Division 7, First-Aid and CPR Certification

January 2007

- (a) You must document the completion of each training requirement in the appropriate personnel records. The documentation may be a certificate, letter, or a statement of successful completion, that is signed and dated, from the training source. A photocopy of the original first-aid and/or CPR certificate or letter may be maintained in the personnel record, as long as the employee can provide an original document upon request by Licensing. [Medium-Low]

(b) The documentation must include the following information:

- (1) The participant's name [Medium-Low];
- (2) Date of the training [Medium-Low];
- (3) Title or subject of the training [Medium-Low];
- (4) The trainer's name and qualifications [Medium-Low];
- (5) The expiration date of the certification as determined by the organization providing the certification [Medium-Low]; and
- (6) Length of the training in hours. [Medium-Low]

Subchapter G, Child/Caregiver Ratios

§748.1001. What is the child/caregiver ratio?

Subchapter G, Child/Caregiver Ratios

January 2007

The child/caregiver ratio is the maximum number of children for whom one caregiver can be responsible.

§748.1003. For purposes of the child/caregiver ratio, how many children can a single caregiver care for during the **children's waking hours**?

Subchapter G, Child/Caregiver Ratios

January 2017

- (a) The number of children that a single caregiver may care for during waking hours depends on the ages and treatment service needs of the children in the group. A single caregiver may care for five children if at least one child in the group requires treatment services, or eight children if none of the children in the group require treatment services. Children younger than five years old count as two children.

[Medium-High]

- (b) You may separate children into groups based on age and/or treatment services in order to vary the child/caregiver ratio required for each group, as long as [Medium]:

- (1) The groups remain easily distinguishable and separated, such as by cottage or unit; and

- (2) The child/caregiver ratio is re-calculated any time groups intermingle, such as on a field trip or in the dining room.

- (c) A cottage home may be out of ratio during waking hours for short periods to enable a normal home-like routine as long as the care and supervision needs of the children continue to be met. Staff or other caregivers must be on the premises and available to respond in an emergency. These additional staff or caregivers must be specifically addressed in the written professional staffing plan. [Medium]

- (d) A child does not count in the child/caregiver ratio while participating in an approved unsupervised childhood activity.

Helpful Information

Examples of how to calculate ratio:

Children in the group are 4, 6, 7, 8, 9, and 11 years old. None of the children require treatment services, so the ratio is 1:8. Even though the 4-year-old counts as two children, only one staff person is needed.

If you added another 4-year-old to this group, two staff would be needed:

- 4-year-old counts as 2 children
- 4-year-old counts as 2 children
- 6-year-old counts as 1 child
- 7-year-old counts as 1 child
- 7-year-old counts as 1 child
- 9-year-old counts as 1 child
- 11-year-old counts as 1 child

This is a total of 9 children, so a second caregiver is needed to comply with the 1:8 ratio.

Children in the group are 4, 6, 7, 8, and 9 years old. One of the children requires treatment services, so the ratio is 1:5. Since the 4-year-old counts as two children, two staff are needed.

A group of children is determined largely by the layout of the building and/or campus. For example, the children in a cottage home are counted as one group. Since building structures vary greatly, each facility is assessed on a case-by-case basis.

§748.1005. Can child/caregiver ratios be averaged on an operation-wide basis?

Subchapter G, Child/Caregiver Ratios

September 2010

Each group of children must have sufficient caregivers to meet the required child/caregiver ratio for that group of children. A person may not be counted in the ratio for a group of children if he is caring for children outside the group or working in an administrative capacity. [Medium-High]

§748.1007. For purposes of the child/caregiver ratio, how many children can a single caregiver care for when children are asleep at night?

Subchapter G, Child/Caregiver Ratios

September 2010

- (a) The number of children that a single caregiver may care for during night-time sleeping hours depends on whether the caregiver stays awake or sleeps during these hours and on the ages and treatment service needs of the children in the group. Children younger than five years old count as two children.
[Medium-High]
- (b) If the caregiver stays awake, the caregiver may care for:
 - (1) 15 children if at least one child in the group requires treatment services
[Medium-High]; or
 - (2) 24 children if none of the children in the group require treatment services. [Medium-High]
- (c) If the caregiver sleeps, the caregiver may care for:
 - (1) 10 children if at least one child in the group requires treatment services
[Medium-High]; or
 - (2) 16 children if none of the children in the group require treatment services.
[Medium-High]
- (d) You may separate children into groups based on age and/or treatment services in order to vary the child/caregiver ratio required for each group, as long as [Medium]:
 - (1) The groups remain easily distinguishable and separated, such as by cottage or unit; and
 - (2) The child/caregiver ratio is re-calculated any time groups intermingle, such as on a field trip.
- (e) A cottage home may be out of ratio during night-time sleeping hours for short periods to enable a normal home-like routine as long as the care and supervision needs of the children continue to be met. Staff or other caregivers must be on the premises and available to respond in an emergency. These additional staff or caregivers must be specifically addressed in the written professional staffing plan.
[Medium]

Helpful Information		
Here is a chart depicting the night-time sleeping ratios:		
Supervising Staff:	No treatment services	Treatment Services
Awake	1:24	1:15
Asleep	1:16	1:10

HOWEVER, remember that children younger than five years old always count as two children.

§748.1009. How many caregivers must I employ?

Subchapter G, Child/Caregiver Ratios

January 2017

You must employ an adequate number of qualified caregivers to meet the needs of children, taking into account each child's age, medical, physical, and mental condition and other factors that affect the amount of supervision the child requires, including enough caregivers to meet [High]:

- (1) Child/caregiver ratios [High]; and
- (2) All of their responsibilities required in §748.685 of this title (relating to What responsibilities does a caregiver have when supervising a child or children?). [High]

§748.1011. What employees can be counted as a caregiver in the child/caregiver ratio?

Subchapter G, Child/Caregiver Ratios

January 2007

The child/caregiver ratio only includes qualified caregivers who are working directly with a child or group of children. [Medium-High]

§748.1013. How does a caregiver care for a child needing constant supervision during sleeping hours?

Subchapter G, Child/Caregiver Ratios

January 2017

- (a) A caregiver must always be awake when caring for a child needing constant supervision, such as a medically fragile child or a child that is an immediate danger to self or others. [High]
- (b) To facilitate continuous care for a child, the caregiver may move a child to a location where the caregiver can directly and continuously supervise a child until there is no longer an immediate danger to self or others. The caregiver must provide comfortable sleeping arrangements for the child. [Low]

§748.1015. How does the child/caregiver ratio apply if I provide care for both children in care and children of caregivers, or for both children and adult residents?

Subchapter G, Child/Caregiver Ratios

January 2007

- (a) The child/caregiver ratio applies to the children of caregivers who are present with children in care. [Medium-High]
- (b) For both children and adult residents, you must maintain the ratio as outlined in §748.1935 of this title (relating to How does the child/caregiver ratio apply if I provide care to both children and adults?). [Medium-High]

§748.1017. How does the child/caregiver ratio apply to activities that occur away from my operation?

Subchapter G, Child/Caregiver Ratios

January 2007

- (a) The child/caregiver ratio applies to activities sponsored or conducted by the operation, including field trips, higher risk recreational activities, and appointments that occur away from the operation. [Medium-High]
- (b) You must have additional caregivers to meet the special needs of children when there are activities away from your operation, for example a non-ambulatory child. [Medium-High]

§748.1019. What are the supervision requirements for a transitional living program?

Subchapter G, Child/Caregiver Ratios

January 2007

A caregiver counted in the child/caregiver ratio who is responsible for supervising children of the same gender in a transitional living program must:

- (1) Reside in or within close physical proximity of the children’s living quarters [Medium];
- (2) Be onsite at the operation during times when children are awake, but the caregiver is not physically present with the children [Medium];
- (3) Be physically available to the children at all times [Medium-High];
- (4) Be capable of responding quickly in an emergency [Medium-High]; and
- (5) Be capable of monitoring the comings and goings of the children in the program. [Medium]

Helpful Information

In this rule, “same gender” means that the children and young adults in care are all the same gender. This language is not related to the gender of the caregiver. See §748.1023 for expectations regarding children of both genders sharing living quarters.

§748.1021. When does a child who is in a transitional living program not need supervision?

Subchapter G, Child/Caregiver Ratios

January 2017

- (a) The child must be 16 years old or older. [Medium]
- (b) You must evaluate each child in a transitional living program to determine whether the child needs supervision. The evaluation must [Medium]:
 - (1) Include a written plan defining the periods of time the child may be left unsupervised [Medium-Low];
 - (2) Include a written plan for addressing behavioral problems that a child may have while in the transitional living program [Medium-Low]; and
 - (3) Identify how the child may contact the caregivers when caregivers are not physically present with the child, such as being available to the child by telephone or other means of contact. [Medium]

(c) The child's service planning team must approve the evaluation. [Medium-Low]

(d) You must document the evaluation of the child and the approval in the child's record. You must review and update the evaluation during the child's service planning meetings.

[Medium-Low]

§748.1023. Is my operation permitted to have a transitional living program with living quarters, a cottage, or a house with both male and female residents?

Subchapter G, Child/Caregiver Ratios

January 2007

You must not have living quarters, a cottage, or a house with both male and female residents, unless caregivers are always present when children are at the living quarters, cottage, or house of the transitional living program. [Medium-High]

Subchapter H, Child Rights

§748.1101. What rights does a child in care have?

Subchapter H, Child Rights

January 2017

- (a) A child's rights are cumulative of any other rights granted by law or other Licensing rules. [Medium-Low]
- (b) The following categories include the child's rights that you must adhere to:
 - (1) Safety and care, including:
 - (A) The right to good care and treatment that meets the child's needs in the most family-like setting possible [Medium-High];
 - (B) The right to be free from abuse, neglect, and exploitation [High]; and
 - (C) The right to fair treatment [Medium-High];
 - (2) Family contacts, including the right to maintain regular contact with the child's parents and siblings, unless restrictions are necessary because of the child's best interest, the decision of an appropriate professional, or a court order [Medium];
 - (3) Living a normal life, including:
 - (A) The right to be able to communicate in a language or any other means that is understandable to the child at admission or within a reasonable time after an emergency admission, if applicable, such as having a plan for an interpreter, having at least one person at the operation at all times who can communicate with the child in the child's own language, or other means to communicate with the child in the child's own language [Medium];
 - (B) The right to receive educational services appropriate to the child's age and developmental level [Medium-Low];
 - (C) The right to have the child's religious needs met [Medium-High];
 - (D) The right to participate in childhood activities, including unsupervised childhood activities away from the operation and the caregivers, that are appropriate for the child's age, maturity, and developmental level [Medium];

- (E) The right to privacy, including sending and receiving unopened mail, making and receiving phone calls, keeping a personal journal, and having visitors, unless the child's best interest, appropriate professionals, or court order necessitates restrictions [Medium];
 - (F) The right to personal care, hygiene, and grooming equipment and supplies and training in how to use them [Medium];
 - (G) The right to have comfortable clothing, which is suitable to the child's age and size and similar to the clothing of other children in the community. Teenagers should have reasonable opportunities to select the clothing [Medium];
 - (H) The right to clothing that protects the child against the weather [Medium-High];
 - (I) The right to have personal items in the child's room and to get additional items within reasonable limits [Medium-Low];
 - (J) The right to personal space in the child's bedroom to store the child's clothes and belongings [Medium-Low];
 - (K) The right to be informed of search policies and be free of unreasonable searches and unreasonable removal of personal items [Medium-Low];
 - (L) Depending on the child's age and maturity, the right to seek employment, keep the child's own money, have a bank account in the child's name, and get paid for any work done for the operation as part of the child's service plan or vocational training, with the exception of assigned routine duties that relate to the child's living environment, such as cleaning the child's room, or other chores, or work assigned as a disciplinary measure [Medium-Low];
 - (M) The right to consent in writing before taking part in any publicity or fund raising activity for the operation, including the use of the child's photograph [Medium-Low];
 - (N) The right to refuse to make public statements showing gratitude to the operation [Medium-Low]; and
 - (O) The right to not be pressured to get an abortion, give up her child for adoption, or parent her child, if applicable [High];
- (4) Discipline, including:
- (A) The right to be free from any harsh, cruel, unusual, unnecessary, demeaning, or humiliating treatment or punishment. This means the child must not be [High]:
 - (i) Shaken [High];

- (ii) Subjected to or threatened with corporal punishment, including spanking or hitting the child [High];
- (iii) Forced to do unproductive work that serves no purpose except to demean the child, such as moving rocks from one pile to another or digging a hole and then filling it in [Medium];
- (iv) Denied food, sleep, a bathroom, mail, or family visits as punishment [High];
- (v) Subjected to remarks that belittle or ridicule the child or the child's family [Medium-High];
- (vi) Threatened with the loss of placement or shelter as punishment [Medium]; and
- (vii) Subjected to demeaning behavior to embarrass, control, harm, intimidate, or isolate the child. "Demeaning behavior" may include using physical force, rumors, threats, or inappropriate comments [Medium-High];
- (B) The right to discipline that is appropriate to the child's age, maturity, and developmental level [Medium-High]; and
- (C) The right to have restrictions or disciplinary policies explained to the child at admittance and when the measures are imposed [Medium];
- (5) Plans for the child while in care, including:
 - (A) The right to have a comprehensive service plan that addresses the child's needs, including transitional and discharge planning [Medium]; and
 - (B) The right to actively participate in the development of the child's service plan within the limits of the child's comprehension and ability to manage the information. The child has the right to a copy or summary of the plan. A child 14 years of age or older has the right to review and sign the service plan, unless there is a reason not to provide the plan [Medium];
- (6) Medical care and records, including:
 - (A) The right to medical, dental, vision, and mental health care and developmental services that adequately meet the child's needs. The right to request that the care or services be separate from adults (other than young adults) who are receiving services [Medium];
 - (B) The right to be free of unnecessary or excessive medication [Medium-High]; and

- (C)The right to confidential care and treatment, including keeping medical records and operation records private and only discussing them when it is about the child's care [Medium-Low]; and
- (7)Complaints, including the right to make calls, reports, or complaints without interference, coercion, punishment, retaliation, or threats of punishment or retaliation. The child may make these calls, reports, or complaints anonymously. Depending upon the nature of the complaint, the child has the right to call, report, or complain to [High]:
 - (A) The DFPS Texas Abuse/Neglect Hotline at 1-800-252-5400;
 - (B) The HHSC Ombudsman for Children and Youth Currently in Foster Care at 1- 844-286-0769;
 - (C) The DFPS Office of Consumer Affairs at 1-800-720-7777; or
 - (D) Disability Rights of Texas at 1-800-252-9108.

§748.1103. How must I inform a child and the child's parents of their rights?

Subchapter H, Child Rights

January 2017

- (a)Within seven days after you admit a child into your operation, you must review the child's rights with the child and a child's parent, unless the parent's consent is not required. You must also provide the child and a child's parent with a written copy of the child's rights. [Medium]
- (b)Child rights must be written in:
 - (1)Simple, non-technical terms [Medium]; and
 - (2)English, unless the person does not understand English. The child's rights must be written in the person's primary language, if possible. [Medium]
- (c) If the person you are informing has a visual or auditory impairment, you must explain the child's rights in a manner that is understandable to the person. [Medium]
- (d)The person you are informing of the child's rights must sign a statement indicating that the person has read and understands these rights. A copy of a timely signed "CPS Rights of Children and Youth in Foster Care" will meet this standard. You must put the signed copy in the child's record. [Medium]

§748.1107. What right does a child have regarding contact with his parent(s)?

Subchapter H, Child Rights

January 2007

- (a) You must allow contact between a child and his parent(s) whose parental rights have not been terminated according to [Medium]:
 - (1) Your policies [Medium-Low]; and
 - (2) The provisions of a court order or any visitation agreements. [Medium]
- (b) You must document in the child's record:
 - (1) Any plans for contact between the child and a parent [Medium-Low]; and
 - (2) Any decision to limit contact with a parent. [Medium]
- (c) Before the service planning team, treatment director, or professional level service provider can temporarily restrict ongoing contacts or communication between the child and a parent, you must:
 - (1) Explain the reasons for the restrictions to the child and the child's parent [Medium-Low]; and
 - (2) Document the reasons in the child's record. [Medium-Low]
- (d) Restrictions imposed by you that continue for more than 30 days must be re-evaluated monthly by a professional level service provider, who also must [Medium]:
 - (1) Explain the reasons for the continued restrictions to the child and the child's parents [Medium-Low]; and
 - (2) Document the reasons in the child's record. [Medium-Low]
- (e) If you limit communications or visits with a parent for practical reasons, such as geographical distance or expense, you must discuss the limits with the child and the child's parents. You must document the limits in the child's record. [Medium-Low]

§748.1109. What right does a child have regarding contact with siblings?

Subchapter H, Child Rights

January 2017

- (a) A child must have a reasonable opportunity for sibling visits and contacts in an effort to preserve sibling relationships. [Medium]
- (b) You must address plans for sibling visits and contacts in the child's record. [Medium-Low]
- (c) When you restrict sibling contact, you must include justification in the child's record. Restrictions imposed by you that continue for more than 60 days must be re-evaluated every 60 days by a professional level service provider, who also must [Medium]:
 - (1) Explain the reasons for the continued restrictions to the child [Medium]; and
 - (2) Document the reasons in the child's record. [Medium-Low]
- (d) If barriers to visits exist, such as unavoidable geographic distance and expense issues, the operation must make provisions for sibling contact through letters, telephone calls, or some other means. [Medium]

§748.1111. What right to privacy does a child have in his contact with others?

Subchapter H, Child Rights

September 2010

- (a) Except as determined by the child's service planning team, treatment director, professional level service provider, or parent, you may not:
 - (1) Open or read the child's incoming or outgoing mail, including electronic mail, unless necessary to assist the child with reading or writing [Medium]; or
 - (2) Listen to or screen the child's telephone calls unless the child needs assistance with using the telephone. [Medium]
- (b) You must document in the child's record:
 - (1) Any reason for restrictions on the child's mail or telephone calls that you impose [Medium-Low]; and
 - (2) A list of the mail or telephone calls that you restrict. [Medium-Low]

(c) You must inform the child and his parent about restrictions you place on the child.

[Medium-Low]

(d) Restrictions imposed by you that continue for more than 30 days must be re-evaluated monthly by a professional level service provider, who also must [Medium]:

(1) Explain the reasons for the continued restrictions to the child [Medium-Low]; and

(2) Document the reasons in the child's record. [Medium-Low]

Helpful Information

Minimum standards §§748.1107, 748.1109, and 748.1111 apply only to contact restrictions imposed by you. Limitations or restrictions on contact imposed by the court or by the child's parent(s) are not subject to the explanation, documentation, and re-evaluation requirements in these rules. However, it is recommended that you retain written notice of any contact restrictions imposed by the court or parent(s), so that you will have documentation of who imposed the restrictions.

§748.1113. Under what circumstances may I conduct a search for prohibited items or items that endanger a child's safety?

Subchapter H, Child Rights

September 2010

(a) A child's possessions must be free of unreasonable searches and unreasonable removal of personal items. [Medium-Low]

(b) You may search a child, his possessions, or his room when you have reasonable suspicion [Medium-Low]:

(1) Of the presence of a prohibited item or an item that endangers the child's safety;

(2) That the child made suicidal threats or threatened to hurt himself or others; or

(3) That the child was involved in theft.

(c) Residential treatment centers and emergency care services programs may conduct routine searches (such as upon return from a home visit or return from school) as long as the routine searches are:

(1) Justified in your policies [Medium-Low];

(2) Conducted uniformly [Medium-Low]; and

(3) Do not involve the removal of clothing, other than outer clothing, such as coats, jackets, hats, gloves, shoes, or socks. [Medium-High]

(d) Only a caregiver of the same gender as the child may conduct a search that involves the removal of clothing, other than outer clothing, such as coats, jackets, hats, gloves, shoes, or socks. [Medium-High]

(e) If a search involves the removal of clothing (other than outer clothing), a second caregiver must witness the search. [Medium-High]

(f) The caregiver must ensure that other children do not witness a search that involves the removal of clothing, other than outer clothing. [Medium-High]

§748.1115. May a caregiver conduct a body cavity search of a child in care?

Subchapter H, Child Rights

January 2007

With the exception of a child's mouth, a caregiver may not conduct a body cavity search of a child in care. [High]

§748.1117. What must I document regarding a search?

Subchapter H, Child Rights

January 2017

You must document the following in the child's record when you conduct a search under §748.1113(b) of this title (relating to Under what circumstances may I conduct a search for prohibited items or items that endanger a child's safety?) [Medium-Low]:

- (1) The date of the search [Medium-Low];
- (2) The name of the child [Medium-Low];
- (3) Reason for the search [Low];
- (4) A description of what you searched [Low];
- (5) The clothing removed, if applicable [Medium-Low];
- (6) The name of the caregivers conducting the search [Medium-Low];
- (7) The name of the witness, if applicable [Medium-Low];
- (8) The results of the search [Low]; and
- (9) The resolution of the issue with the child, including increased supervision, additional counseling, or disciplinary consequences. [Medium-Low]

§748.1119. What techniques am I prohibited from using on a child?

Subchapter H, Child Rights

January 2017

Certain techniques must not be used on a child, including:

- (1) Chemical restraints. For more information on emergency behavior intervention, see Subchapter N of this chapter (relating to Emergency Behavior Intervention) [\[High\]](#);
- (2) Aversive conditioning, which includes, but is not limited to, any technique designed to or likely to cause a child physical pain, the application of startling stimuli, and the release of noxious stimuli or toxic sprays, mists, or substances in proximity to the child's face [\[High\]](#);
- (3) Pressure points [\[High\]](#);
- (4) Rebirthing therapy [\[High\]](#);
- (5) Hug and/or holding therapy [\[High\]](#); and
- (6) Tazor or stun guns. [\[High\]](#)

Subchapter I, Admission, Service Planning, and Discharge

Helpful Information

The admission information and admission assessment requirements vary based on the circumstances of the child's admission. Here are the applicable minimum standards based on the type of admission:

1. Regular Admission:
 - a. Admission information per 748.1205
 - b. Admission assessment per 748.1217
 - i. Subsection (b) prior to admission
 - ii. Subsection (c) within 40 days
2. Emergency Admission:
 - a. Admission information per 748.1271
 - b. Admission assessment per 748.1217
 - i. Subsection (b) within 40 days
 - ii. Subsection (c) within 40 days
3. Emergency Care Services Admission:
 - a. Admission information per 748.1205
 - b. Admission assessment per 748.4231.

Division 1, Admission

§748.1201. May children receiving different types of service live in the same living quarters?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

September 2010

- (a) Except as provided by subsection (c) of this section, children receiving different types of service may reside in the same living quarters as long as:
 - (1) A professional level service provider completes an evaluation of the living quarters for each child that you place in the living quarters [Medium]; and
 - (2) In each evaluation, the professional level service provider ensures that:
 - (A) There is no conflict of care with the best interests of any of the children placed in the living quarters [Medium];
 - (B) Placing the child with different service or treatment needs in the living quarters will not adversely impact the other children in the living quarters [Medium];
 - (C) The number of children in the living quarters is appropriate at all times based on the needs of all children in the living quarters [Medium];
 - (D) Caregivers can appropriately supervise all children in the living quarters at all times [Medium]; and
 - (E) You can meet the needs of all children in the living quarters. [Medium]
- (b) If the treatment or service needs of any children in the living quarters changes, the professional level service provider must evaluate the needs of each child in the living quarters to ensure there is no conflict of care. [Medium-Low]
- (c) Children admitted for emergency care services must receive any therapeutic services (such as group therapy or art therapy) separate from children admitted for non-emergency care and must have separate living quarters, such as a separate wing of an operation, or a separate cottage. Children admitted for emergency care services may be combined with children in non-emergency care for meals, recreation, and transportation. [Medium-Low]

Helpful Information

Examples of conflicts in care are placements that:

- Place one child at serious risk for harm by another child;
- Significantly compromise the care and supervision of any child in care;
- Require a level of expertise from the caregivers that they do not possess; or
- Create an environment that is appropriately restrictive for one child but inappropriate for another.

§748.1203. Who may I admit?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

September 2010

- (a) You may only admit children or young adults who meet your admission policy guidelines and whose needs you can meet. If you adopt a change in your admission policies that requires a change in the conditions of your permit, you must request an amendment to your permit with us. [Medium]
- (b) Each placement must meet the child's physical, medical, recreational, educational, and emotional needs as identified in the child's admission assessment. [Medium-High]

§748.1205. What information must I document in the child's record at admission?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) You must include the following in the child's record at admission:
- (1) The child's name, gender, race, religion, and date of birth [Medium-Low];
 - (2) The name, address, and telephone number of the managing conservator, the primary caregivers for the child, any person with whom the child is allowed to leave the operation, and any other individual who has the legal authority to consent to the child's medical care [Medium-Low];
 - (3) The names, addresses, and telephone numbers of biological or adoptive parents, unless parental rights have been terminated [Low];

- (4) The names, addresses, and telephone numbers of siblings [Low];
 - (5) The date of admission [Low];
 - (6) Medication the child is taking [Medium-High];
 - (7) The child's immunization record [Medium-Low];
 - (8) Allergies, such as food, medication, sting, and skin allergies [Medium-High];
 - (9) Chronic health conditions, such as asthma or diabetes [Medium-High];
 - (10) Known contraindications to the use of restraint [Medium];
 - (11) Identification of the child's treatment needs, if applicable, and any additional treatment services or programmatic services the child is receiving [Medium];
 - (12) Identification of the child's high-risk behavior(s), if applicable, and the safety plan staff and caregivers will implement related to the behavior(s) [High];
 - (13) A copy of the placement agreement, if applicable [Low]; and
 - (14) Documentation of the attempt to notify the parent of the child's location as required by §748.1211(c)(3) of this title (relating to What information must I share with the parent at the time of placement?), if applicable. [Medium]
- (b) If you admit a child for emergency care services, you must document the information:
- (1) Regarding the reason for admission in the child's record upon admission [Low]; and
 - (2) In subsection (a) of this section within 72 hours after you admit the child. If any information is not available within that time frame, you must document in the child's record reasonable efforts made to obtain the information. [Medium-Low]
- (c) For emergency admissions, as opposed to a child receiving emergency care services, you must meet the requirements in Division 2 of this subchapter (relating to Emergency Admission).

§748.1207. What is a placement agreement?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) A placement agreement is your agreement with a child's parent or the child that defines your roles and responsibilities and authorizes you to obtain or provide services for the child. The placement agreement must include:
- (1) Authorization permitting you to care for the child [Medium-Low];

- (2) A medical consent form signed by a person legally authorized by the Texas Family Code to provide consent [High]; and
- (3) The reason for placement and anticipated length of time in care. [Low]
- (b) A placement agreement must be signed by the child's parent, except as provided in subsection (c). [Medium]
- (c) For a transitional living program, a child 16 years of age or older may sign the placement agreement on the child's own behalf, as provided in the Texas Family Code §32.203, without the consent of the child's parent if the child [Medium]:
 - (1) Resides separate and apart from the child's parent and manages the child's own financial affairs;
 - (2) Is unmarried and pregnant; or
 - (3) Is unmarried and a parent.

§748.1209. What orientation must I provide a child?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) Within seven days of admission, you must provide orientation to each newly admitted child who is five years old or older. You must gear orientation to the intellectual level of the child. [Medium-Low]
- (b) Orientation must include information about your policies on the following:
 - (1) Visitation, including family visitation and overnight visitation [Medium-Low];
 - (2) Mail [Medium-Low];
 - (3) Telephone calls [Medium-Low];
 - (4) Gifts [Low];
 - (5) Personal possessions, including any limits placed on the possessions the child may or may not have [Low];
 - (6) Emergency behavior intervention, including your policies and practices on the use of personal restraint and the child's input on preferred de-escalation techniques that caregivers can use to assist the child in the de-escalation process [Medium-High];
 - (7) Discipline [Medium-High];

- (8) The religious program and practices [Low];
- (9) The educational program [Low];
- (10) Trips away from the operation [Low];
- (11) Program expectations and rules [Medium-Low];
- (12) A general daily schedule for routine activities for children in care [Medium-Low];
- and
- (13) Internal grievance procedures. [Medium-Low]

(c) Orientation must include information on how to:

- (1) Make complaints to outside agencies [Medium-High]; and
- (2) Contact parties to a child's case (i.e. caseworker, attorney ad litem, guardian ad litem, CASA worker, etc.). [Medium]

(d) You must document in the child's record when the orientation occurred, any items that the orientation did not include, and the reason that the orientation did not include that item. [Low]

§748.1211. What information must I share with the parent at the time of placement?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

(a) At admission, you must provide the following policies to the parent placing the child [Medium]:

- (1) Fee policies [Low];
- (2) Emergency behavior intervention policies [Medium-Low];
- (3) Discipline policies [Medium-Low]; and
- (4) Any other policies required by us, upon request of the parent. [Medium-Low]

(b) At admission, you must provide and explain the following written information and policies to the parent placing the child:

- (1) Information about the policies that you would present a child during orientation
Medium-Low;
- (2) Your policies regarding the:
 - (A) Use of volunteers or sponsoring families, if applicable [Low];

- (B) Type and frequency of notifications made to parents [Medium-Low]; and
 - (C) Involvement of the child in any publicity and/or fund raising activity for the operation [Low]; and
- (3) Information about the parent's right to refuse to or withdraw consent for a child to participate in:
 - (A) Research programs [Medium-Low]; and/or
 - (B) Publicity and/or fund raising activities for the operation. [Low]
- (c) If you sign a placement agreement for a transitional living program with a child as specified in §748.1207 of this title (relating to What is a placement agreement?), then you:
 - (1) Must share the policies noted in subsection (a) with the child, instead of the parent [Medium-Low];
 - (2) Do not have to comply with subsection (b), but you must provide and explain to the child your policies regarding the:
 - (A) Use of volunteers or sponsoring families, if applicable Low;
 - (B) Involvement of the child in any publicity and/or fund raising activity for the operation [Low]; and
 - (C) Child's right to refuse to or withdraw consent to participate in:
 - (i) Research programs [Medium-Low]; and/or
 - (ii) Publicity and/or fund raising activities for the operation [Low]; and
 - (3) Must attempt to notify the child's parent of the child's location, if the child was admitted without the consent of the parent. [Medium-High]

§748.1213. What information must I provide caregivers when I admit a child?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) By the day you admit the child for care, you must provide caregivers responsible for the child's care with information about the child's immediate needs such as enrolling the child in school or obtaining needed medical care or clothing. [Medium]

- (b) You must inform appropriate caregivers of any special needs, such as medical or dietary needs or conditions or supervision needs, and document that you shared the information with the caregiver. [Medium-High]

§748.1215. When must I complete the admission assessment?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) You must complete a non-emergency admission assessment prior to admission.
- (b) A professional level service provider must sign and date each assessment, which must be in the child's record. [Low]

§748.1217. What information must an admission assessment include?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) An admission assessment must provide an initial evaluation of the appropriate placement for a child and ensure that you obtain the information necessary for you to facilitate service planning. [Medium]
- (b) Prior to a child's non-emergency admission, an admission assessment must be completed which includes:
 - (1) The child's legal status [Low];
 - (2) A description of the circumstances that led to the child's referral for substitute care [Medium];
 - (3) A description of the child's behavior, including appropriate and maladaptive behavior, and any high-risk behavior [Medium-High];
 - (4) Any history of physical, sexual, or emotional abuse or neglect [Medium-High];
 - (5) Current medical and dental status, including the available results of any medical and dental examinations [Medium];
 - (6) Current mental health and substance abuse status, including available results of any psychiatric evaluation, psychological evaluation, or psychosocial assessment [Medium];
 - (7) The child's current developmental level of functioning [Medium];
 - (8) The child's current educational level and any school problems [Medium-Low];

- (9) Any applicable requirements of §748.1219 of this title (relating to What are the additional admission requirements when I admit a child for treatment services?) [Medium];
- (10) Documentation indicating efforts made to obtain any of the information in paragraphs (1)-(9) of this subsection, if any information is not obtainable [Medium-Low];
- (11) The services you plan to provide to the child [Medium-Low];
- (12) Immediate goals of placement [Medium-Low];
- (13) The parent's expectations for placement, duration of the placement, and family involvement [Low];
- (14) The child's understanding of the placement [Low]; and
- (15) A determination of whether and how you can meet the needs of the child. [Medium-Low]

(c) Prior to completing a child's initial service plan, the following information must be added to the admission assessment:

- (1) The child's social history. The history must include information about past and existing relationships with the child's birth parents, siblings, extended family members, and other significant adults and children, and the quality of those relationships with the child [Low];
- (2) A description of the child's home environment and family functioning [Low];
- (3) The child's birth and neonatal history [Low];
- (4) The child's developmental history [Medium-Low];
- (5) The child's mental health and substance abuse history [Medium-Low];
- (6) The child's school history, including the names of previous schools attended and the dates the schools were attended, grades earned, and special achievements [Low];
- (7) The child's history of any other placements outside the child's home, including the admission and discharge dates and reasons for placement [Medium-Low];
- (8) The child's criminal history, if applicable [Medium-Low];
- (9) The child's skills and special interests [Medium-Low];
- (10) Documentation indicating efforts made to obtain any of the information in paragraphs (1)-(9) of this subsection, if any information is not obtainable [Low];

(11) The services you plan to provide to the child, including long-range goals of placement [Medium-Low];

(12) Recommendations for any further assessments and testing [Medium-Low];

(13) A recommended behavior management plan [Medium]; and

(14) A determination of whether and how you can meet the needs of the child, based on an evaluation of the child's special strengths and needs. [Medium-Low]

(d) You must attempt to obtain a signed authorization, so you can subsequently request in writing materials from the child's current or most recent placement, such as the admission assessment, professional assessments, and the discharge summary. You must consider information from these materials when you complete your admission assessment if they are made available to you. [Medium-Low]

(e) This rule does not apply to children receiving emergency care services. See §748.4231 of this title (relating to What information must an admission assessment include for a child needing emergency care services, including respite child-care services?).

§748.1219. What are the additional admission assessment requirements when I admit a child for treatment services?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

When you admit a child for treatment services, you must do the following, as applicable:

If:	Then:
(1) You intend to provide treatment services for a child with an emotional disorder or autism spectrum disorder	(A) [Medium-High] The admission assessment must include a written, dated, and signed: (i) [Medium-High] Psychiatric evaluation or psychological evaluation including the child's diagnosis; or (ii) [Medium-High] Psychosocial assessment as defined in §748.43 of this title (relating to What do certain words and terms mean in this chapter?). (B) [Medium] A psychiatric evaluation, psychological evaluation, or psychosocial assessment must have been completed within: (i) [Medium] 14 months of the date of admission, if the child is coming from another regulated placement; or (ii) [Medium] Six months of the date of admission, if the child is not coming from another regulated placement. (C) [Low] The admission assessment must include the reason(s) for choosing treatment services for the child. (D) [Medium-Low] The admission assessment must include consideration given to any history of inpatient or outpatient treatment.

If:	Then:
(2) You intend to provide treatment services for a child with an intellectual disability	(A) [Medium-High] The admission assessment must include a written, dated, and signed: (i) [Medium-High] Psychological evaluation with psychometric testing, including the child's diagnosis; or (ii) [Medium-High] Psychosocial assessment as defined in §748.43 of this title. (B) [Medium] A psychological evaluation or psychosocial assessment must be completed within 14 months of the date of admission. (C) A psychological evaluation must: (i) [Medium] Be performed by a licensed psychologist who has experience with intellectual disabilities or published scales; (ii) [Medium] Include the use of standardized tests to determine the intellectual functioning of a child. The test results must be documented in the evaluation; (iii) [Medium] Determine and document the child's level of adaptive functioning; and (iv) [Medium-Low] Indicate manifestations of an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5). (D) [Low] The admission assessment must include the reason(s) for choosing treatment services for the child. (E) [Medium-Low] The admission assessment must include consideration given to any history of inpatient or outpatient treatment.

If:	Then:
(3) You intend to provide treatment services for a child with primary medical needs	(A) [Medium-High] The admission assessment must have a licensed physician's signed, written orders as the basis for the child's admission. An evaluation from a health care professional must confirm that the child can be cared for appropriately in a general residential operation. (B) [Medium-High] The written orders and/or hospital discharge must include orders for: (i) [Medium-High] Medications; (ii) [Medium-High] Treatments; (iii) [Medium-High] Diet; (iv) [Medium-High] Range-of-motion program at stated intervals; (v) [Medium-High] Habilitation, as appropriate; and (vi) [Medium-High] Any special medical or developmental procedures. (C) [Medium-High] The admission assessment must include the reason(s) for choosing treatment services for the child. (D) [Medium-High] The admission assessment must include consideration given to any history of inpatient or outpatient treatment.

If:	Then:
(4) The child's behavior and/or history within the last two months indicates that the child is an immediate danger to self or others	(A) [Medium-High] The admission assessment must include a written, dated, and signed: (i) [Medium-High] Psychiatric evaluation or psychological evaluation, including the child's diagnosis; or (ii) [Medium-High] Psychosocial assessment as defined in §748.43 of this title. (B) A psychiatric evaluation or psychological evaluation must include: (i) [Medium] The child's diagnosis, if applicable; (ii) [Medium-High] An assessment of the child's needs and potential danger to self or others; and (iii) [Medium-High] Recommendations for care, treatment, and further evaluation. If the child is admitted, the recommendations must become part of the child's service plan and must be implemented. (C) [Medium] A psychiatric evaluation, psychological evaluation, or psychosocial assessment must have been completed within: (i) [Medium] 14 months of the date of admission, if the child is coming from another regulated placement; or (ii) [Medium-High] Six months of the date of admission, if the child is not coming from another regulated placement.

§748.1221. What must I do if I cannot obtain the required information for an admission assessment?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2007

- (a) You must make reasonable efforts to obtain all required information. [Medium]
- (b) If you and the child’s parent determine that attempting to get information at the time of placement would not be in the child’s best interests, you may postpone attempting to acquire the information. [Medium-Low]
- (c) In the child’s admission assessment, you must document why a:
 - (1) Particular piece of information is unavailable [Low]; or
 - (2) Delay in obtaining a piece of information is necessary, including efforts made to obtain the information. [Low]

Helpful Information

Regarding subsection (a), Licensing expects documentation of at least three attempts to comply with a minimum standard requiring “reasonable effort” to obtain information. Efforts should be reasonably spaced, allowing enough time for a person to respond yet not unreasonably delaying the acquisition of the requested information.

Example: Calling a CPS caseworker or parent three times in one day would not be considered three separate “reasonable efforts” to obtain needed information, as this does not allow the person reasonable time to respond to each of the requests.

Example: Calling a CPS caseworker or parent once every three months to obtain information needed for an admission assessment would not be considered reasonable effort to obtain the information, as the third attempt would be made at least six months after the child was placed.

Example: Calling a CPS caseworker or parent once a week for three weeks to obtain information needed for an admission assessment would be considered reasonable effort to obtain the information, as this gives ample time for the person to respond to each call, and also seeks to obtain the information within one month of admission. No further attempts would be expected if the information was not obtained after these three attempts.

§748.1223. What are the medical requirements when I admit a child into care?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) You must ensure that the child has a medical examination by a health-care professional within 30 days after the date of admission. This exam is not required if you have documentation that the child has had a medical examination within the past year, including documentation in the child’s health passport if the child is in the department’s conservatorship. [Medium]
- (b) If you admit a child with primary medical needs, you must provide the child with a medical examination by a health-care professional within seven days before or three days after the date of admission. [High]
- (c) If a child admitted shows symptoms of abuse or illness, a health-care professional must examine the child immediately. [Medium-High]
- (d) The report and findings of any medical examination must be documented in the child’s record, according to §748.1531(b) and (c) of this title (relating to What general medical requirements must my operation meet?). [Medium-Low]

Helpful Information
Regarding subsection (a), there is one exception for those operations that contract with Child Protective Services. A child new to state conservatorship must receive a medical exam (Texas Health Steps Checkup) within 30 days after the date of admission into the foster care system. This must occur even if the child’s health passport indicates that the child received a medical exam prior to entering the foster care system.

§748.1225. What are the dental requirements when I admit a child into care?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2017

- (a) If the child is younger than three years old and a health-care professional recommends a dental examination, then you must ensure that a dentist examines the child. [Medium-Low]

- (b) A child three years old or older must have a dental appointment scheduled with a dentist within 30 days after the date of admission, and the examination must occur within 90 days after the date of admission. A dental examination is not required if you have documentation that the child has had a dental examination within the past year, including documentation in the child's health passport if the child is in the department's conservatorship. [Medium-Low]
- (c) The report and findings of the dental examination must be documented in the child's record, according to §748.1501(b) and (c) of this title (relating to What general dental requirements must my operation meet?). [Medium-Low]

§748.1227. What must I document when I re-admit a child for care?

Subchapter I, Admission, Service Planning, and Discharge

Division 1, Admission

January 2007

For re-admission, you must complete the admission documentation as if the child was never in your care; or for children that were discharged from your operation within the last 12 months, you may update the previous admission documentation. [Medium-Low]

Division 2, Emergency Admission

§748.1261. For which of my programs may I accept emergency admissions?

Subchapter I, Admission, Service Planning, and Discharge

Division 2, Emergency Admission

January 2007

Neither a transitional living program nor a therapeutic camp program may accept emergency admissions. All other programs may accept emergency admissions. [Medium]

§748.1263. What constitutes an emergency admission to my operation?

Subchapter I, Admission, Service Planning, and Discharge

Division 2, Emergency Admission

July 26, 2018

It is an emergency admission if:

- (1) You must place the child within 72 hours;
- (2) The child was removed from a situation involving alleged abuse or neglect;
- (3) The child is an alleged perpetrator of abuse and cannot be served in the child's current placement due to the child's perpetrating behaviors;
- (4) The child displays behavior that is an immediate danger to self or others and cannot function or be served in his current setting;
- (5) The child was abandoned and after exercising reasonable efforts, the child's identity cannot be immediately determined. You must document the efforts made to obtain information on the child's identity in the child's record;
- (6) The child was removed from the child's home or placement, and there is an immediate need to find a residence for the child;
- (7) A law enforcement officer released the child to your operation that is licensed to provide emergency care services; or
- (8) The child is otherwise without adult care.

§748.1265. May I take possession of a child from a law enforcement officer?

Subchapter I, Admission, Service Planning, and Discharge

Division 2, Emergency Admission

July 26, 2018

You may take possession of a child from a law enforcement officer only if you meet the requirements of 40 TAC Chapter 745, Subchapter H, Division 2 (relating to Taking Possession of a Child Directly from a Law Enforcement Officer). [Medium-Low]

§748.1269. For an emergency admission, when must I complete all of the requirements for an admission assessment?

Subchapter I, Admission, Service Planning, and Discharge

Division 2, Emergency Admission

January 2017

- (a) For an emergency admission, you must complete all of the requirements (see Division 1 of this subchapter (relating to Admission)) for an admission assessment within 40 days from the date of the child's admission. [Medium]
- (b) In an emergency admission of a child receiving treatment services, the child must not continue in care for more than 30 days after the date of admission or 10 days after the date of admission for a residential treatment center, unless the child has received the psychiatric evaluation, psychological evaluation, psychosocial assessment, or medical evaluation that is required by §748.1219 of this title (relating to What are the additional admission assessment requirements when I admit a child for treatment services?), and the evaluation or assessment indicates manifestations of the disorder requiring treatment services. All evaluations and assessments must be signed, dated, and documented in the child's record. [Medium]

§748.1271. At the time of an emergency admission, what information must I document in the child’s record?

Subchapter I, Admission, Service Planning, and Discharge

Division 2, Emergency Admission

September 2010

At the time of the emergency admission you must document in the child’s record:

- (1) A brief description of the circumstances necessitating the emergency admission [Medium-Low];
- (2) The date of admission [Low];
- (3) Any allergies, such as food, medication, sting, and skin allergies [Medium-High];
- (4) Any chronic health conditions, such as asthma or diabetes [Medium-High];
- (5) Known contraindications to the use of restraint [High];
- (6) Identification of the child’s high-risk behavior(s), if applicable, and the safety plan staff and caregivers will implement related to the behavior(s) [High]; and
- (7) For the purpose of providing treatment services:
 - (A) A brief description of the child’s history [Medium];
 - (B) The child’s current behavior [Medium]; and
 - (C) Your evaluation of how the placement will meet the child’s needs and best interests. [Medium-Low]

Division 3, Educational Services

§748.1301. What responsibilities do I have for the education of a child in care?

Subchapter I, Admission, Service Planning, and Discharge

Division 3, Educational Services

January 2007

- (a) You must arrange an appropriate education for each child, including [Low]:
- (1) Ensuring the child in care attends an educational facility or program that is approved or accredited by the Texas Education Agency, the Southern Association of Colleges and Schools, the Texas Private School Accreditation Commission or by the out-of- state school district funding the child [Medium-Low];
 - (2) Ensuring a school-age child has the training and education in the least restrictive setting necessary to meet the child's needs and abilities [Medium-Low];
 - (3) Ensuring a child in care attends an educational facility or program that implements a special education student's individual education plan (IEP) [Medium-Low]; and
 - (4) Advocating that a school-age child receives the educational and related services to which he is entitled under provisions of federal and state law and regulations. [Medium-Low]
- (b) For children receiving treatment services you must designate a liaison between the agency and the child's school. [Medium-Low]

§748.1303. What responsibilities do I have for a child's individual educational needs?

Subchapter I, Admission, Service Planning, and Discharge

Division 3, Educational Services

January 2017

You must:

- (1) Review report cards and other information received from teachers or school authorities with the child and provide necessary information to caregivers [Low];
- (2) Counsel and assist the child regarding adequate classroom performance [Low];
- (3) Permit, encourage, and make reasonable efforts to involve the child in extracurricular activities to the extent of the child's interests and abilities and in accordance with the child's service plan [Low];

- (4) Provide a quiet, well-lighted space for the child to study and allow regular times for homework and study [Medium-Low];
- (5) Know what emergency behavior interventions are permitted and being used with the child [Medium-High];
- (6) Let the parent know that an IEP (Individual Education Plan) meeting should be requested if you are concerned with the child's educational program or if the child does not appear to be making progress [Medium-Low]; and
- (7) Attend IEP meetings and other school staffings and conferences, if requested by the parent, to represent the child's educational best interests, including the child being evaluated for and provided with related services needed to benefit from educational services, and positive behavior supports designed to decrease the need for negative disciplinary techniques or interventions. [Medium-Low]

§748.1305. If I have an educational program, what information must I provide to a child's parent about that program?

Subchapter I, Admission, Service Planning, and Discharge

Division 3, Educational Services

January 2007

If you have an educational program, you must include the following information in the discussion and in the written material you give to parents when you admit the child:

- (1) The name of any educational program operated on the premises of your operation [Low];
- (2) Whether the program is accredited [Low];
- (3) Whether the Texas Education Agency has approved the program [Low];
- (4) Whether the educational course work is transferable to public schools [Low]; and
- (5) The credentials of the teachers, if the teachers are not approved and regulated by the State Board of Educator Certification (SBEC). [Low]

Division 4, Service Plans

Helpful Information

You may combine admission and service plan documentation, as long as the documentation meets the content requirements and time frames required by the applicable minimum standards. For example, you may combine an admission assessment and initial service plan for a child admitted as an emergency admission, as long as the content of the document complies with both §748.1217 and §748.1337 and the document is complete within 40 days of admission. A preliminary service plan would still be needed within 72 hours of admission, per §748.1331.

§748.1331. What are the requirements for a preliminary service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

- (a) You must complete a preliminary service plan that addresses the immediate needs of a child within 72 hours, such as supervision requirements, enrolling the child in school, or obtaining needed medical care or clothing. [Medium-Low]
- (b) In addition, for a child receiving treatment services the preliminary service plan must include:
 - (1) A description of the child's immediate treatment and care needs [Medium-Low];
 - (2) A description of the child's immediate educational, medical, and dental needs, including possible side effects of medications or treatment prescribed to the child [Medium-Low];
 - (3) A description of how you will meet the child's needs, including any necessary increased supervision or follow-up actions of possible side effects of medication or treatment provided to the child [Medium-Low];

(4)The identification of any issues or concerns the child may have that could escalate a child’s behavior. Identification of a child’s issues or concerns must serve to avoid the use of unnecessary emergency behavior interventions with the child. Child concerns may include issues with food, eye contact, physical touch, personal property, or certain topics [Medium]; and

(5)A designation of who will be responsible for meeting each of the child’s needs. [Medium-Low]

(c) The plan must be compatible with the information included in the child’s admission assessment. [Medium-Low]

(d) You must document the plan in the child’s record. [Low]

(e) You must inform each professional level service provider and caregiver working with a child about the child’s preliminary service plan. [Medium]

(f) You must implement and follow the preliminary service plan. [Medium]

Helpful Information

It is a good idea to include in service plans specific information about the situations that trigger significant emotional responses for the child (e.g., enclosed spaces, darkness, bedtime), successful intervention strategies to effectively de-escalate those responses, anger and anxiety management options to assist the child in calming, techniques for self-management, and specific goals that address the targeted behaviors that most often lead to emergency behavior interventions for the child.

§748.1333. Who must be involved in developing the preliminary service plan for children receiving treatment services?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2007

The treatment director or a professional level service provider must develop, sign, and date the preliminary service plan for children receiving treatment services. [Medium]

§748.1335. When must I complete an initial service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

You must complete the initial service plan within 45 days after you admit the child. [Medium-Low]

§748.1337. What must a child's initial service plan include?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

- (a) You must base the child's initial service plan on the child's needs identified in the child's admission assessment and integrate trauma informed care in the care, treatment, and management of each child. The service planning team may prioritize the child's service planning goals and objectives based on the child's admission assessment. However, any required service plan components not initially addressed must have a justification for the delay in addressing the needs. [Medium-Low]
- (b) The child's initial service plan must be documented in the child's record and include those items that a preliminary plan must include (see §748.1331 of this title (relating to What are the requirements for a preliminary service plan?)), and the items noted below for each specific type of service that you provide the child [Medium-Low]:

Type of Service	Items that must be included:
(1) Child-care services	(A) The child's needs identified in the admission assessment, in addition to basic needs related to day-to-day care and development, including [Medium-Low]: (i) Medical needs, including scheduled medical exams and plans for recommended follow-up treatment [Medium-Low]; (ii) Dental needs, including scheduled dental exams and plans for recommended follow-up treatment [Medium-Low]; (iii) Intellectual functioning, including any testing and plans for recommended follow-up [Medium-Low];

Type of Service	Items that must be included:
	(iv) Developmental functioning, including any developmental delays and plans to improve or remediate developmental functioning [Medium-Low]; (v) Educational needs and how those needs will be met, including planning for high school completion and post-secondary education and training, if appropriate, and any school evaluations or recommendations [Medium-Low]; (vi) Plans for normalcy, including: (I) Social, extracurricular, recreation, and leisure activities [Medium]; and (II) Integrating the child into the community and community activities, as appropriate [Medium]; (vii) Therapeutic needs, including plans for psychiatric evaluation, psychological evaluation, psychosocial assessment or follow-up treatment, testing, and the use of psychotropic medications [Medium]; and (viii) Cultural identity needs, including assisting children in connecting with their culture in the community [Low]; (B) Plans for maintaining and improving the child's relationship with family members, including recommendations for visitation and contacts between the child and the child's parents, the child and the child's siblings, and the child and the child's extended family [Low]; (C) Recent information from the current caregiver's evaluation of the child's behavior and level of functioning [Medium-Low]; (D) Specific goals and strategies to meet the child's needs, including instructions to caregivers responsible for the care of the child. Instructions must include specific information about [Medium]: (i) The child's personal trauma history [Medium]; (ii) Level of supervision required [Medium-High]; (iii) The child's trauma triggers [Medium];

Type of Service	Items that must be included:
	(iv) Methods of responding that improve a child’s ability to trust, to feel safe, and to adapt to changes in the child’s environment [Medium]; (v) Discipline techniques [Medium-High]; (vi) Behavior intervention techniques [Medium-High]; (vii) Plans for trips and visits away from the operation [Medium-Low]; and (viii) Any actions the caregivers must take or conditions the caregivers must be aware of to meet the child’s special needs, such as medications, medical care, dietary needs, therapeutic care, how to communicate with the child, and reward systems [Medium]; (E) If the child is 13 years old or older, a plan for educating the child in the following areas: (i) Healthy interpersonal relationships [Low]; (ii) Healthy boundaries [Low]; (iii) Pro-social communication skills [Low]; (iv) Sexually transmitted diseases [Medium-Low]; and (v) Human reproduction [Medium-Low]; (F) If the child is 14 years old or older, plans for the caregivers to assist the child in obtaining experiential life-skills training to improve the child’s transition to independent living. Plans must [Medium]: (i) Be tailored to a child’s skills and abilities [Medium]; and (ii) Include training in practical activities that include, but are not limited to, grocery shopping, meal preparation, cooking, using public transportation, performing basic household tasks, and money management, including balancing a checkbook [Medium]; (G) For children 16 years old and older, preparation for independent living, including employment opportunities, if appropriate [Medium]; (H) For children who exhibit high-risk behaviors:

Type of Service	Items that must be included:
	(i) Plans to minimize the risk of harm to the child or others, such as special instructions for caregivers, sleeping arrangements, or bathroom arrangements [Medium-High]; and (ii) A specific safety contract developed between the child and staff that addresses how the child’s safety needs will be maintained [Medium-High]; (I) Expected outcomes of placement for the child and estimated length of stay in care [Low]; (J) Plans for discharge [Low]; (K) The names and roles of persons who participated in the development of the child’s service plan [Low]; (L) The date the service plan was developed and completed [Low]; (M) The effective date of the service plan [Low]; and (N) The signatures of the service planning team members that were involved in the development of the service plan. [Low]
(2) Treatment services	For children receiving treatment services, the plan must address all of the child’s waking hours and include: (A) The child-care services planning requirements noted in paragraph (1) of this subsection [weight is the weight of the missing element, if any, noted in paragraph (1)]; (B) A description of the emotional, behavioral, and physical conditions that require treatment services [Medium-Low]; (C) A description of the emotional, behavioral, and physical conditions the child must achieve and maintain to function in a less restrictive setting, including any special treatment program and/or other services and activities that are planned to help the child achieve and to function in a less restrictive setting [Medium-Low]; and (D) A list of emotional, physical, and social needs that require specific professional expertise, and plans to obtain the

Type of Service	Items that must be included:
	appropriate professional consultation and treatment for those needs. Any specialized testing, recommendations, and/or treatment must be documented in the child's record. [Medium-Low]
(3) Treatment services for children with an intellectual disability	(A)The child-care and treatment services planning requirements noted in paragraphs (1) and (2) of this subsection [weight is the weight of the missing element, if any, noted in paragraphs (1) and (2)]; (B)A minimum of one hour per day of visual, auditory and tactile stimulation to enhance the child's physical, neurological, and emotional development [Medium-Low]; (C)An educational or training plan encouraging normalization appropriate to the child's functioning [Medium-Low]; and (D)Career planning for older adolescents who are not receiving treatment services for a severe or profound intellectual disability. [Medium-Low]
(4) Transitional living program	(A)Child-care service planning requirements noted in paragraph (1) of this subsection [weight is the weight of the missing element, if any, noted in paragraph (1)]; (B)Plans for encouraging the child to participate in community life and to form interpersonal relationships/friendships outside the transitional living program, such as extra-curricular recreational activities [Low]; (C)Plans for education related to meal planning, meal preparation, grocery shopping, public transportation, searching for an apartment, and obtaining utility services [Low]; (D) Career planning, including assisting the child in enrolling in an educational or vocational job training program [Medium]; (E)Money management and assisting the child in establishing a personal bank account [Low];

Type of Service	Items that must be included:
	(F) Assisting the child with how to access resources, such as medical and dental care, counseling, mental health care, an attorney, the police, and other emergency assistance [Medium]; (G) Assisting the child in obtaining the child's social security number, birth certificate, and a driver's license or a Department of Public Safety identification card, as needed [Medium]; and (H) Problem-solving, such as assessing personal strengths and needs, stress management, reviewing options, assessing consequences for actions taken and possible short-term and long-term results, and establishing goals and planning for the future. [Medium]

§748.1339. Who must be involved in developing an initial service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

- (a) A service planning team must develop the service plan. The team must consist of [Low]:
 - (1) At least one of the child's current caregivers [Low];
 - (2) A person designated to make decisions regarding a child's participation in childhood activities [Low]; and
 - (3) At least one professional level service provider who provides direct services to the child. [Low]
- (b) If you are providing treatment services to the child, the team must also consist of two of the following professions, which may or may not include additional members [Low]:
 - (1) A licensed professional counselor;
 - (2) A psychologist;
 - (3) A psychiatrist or physician;
 - (4) A licensed registered nurse;
 - (5) A licensed masters level social worker;
 - (6) A licensed or registered occupational therapist; or

(7) Any other person in a related discipline or profession that is licensed or regulated in accordance with state law.

- (c) The child, if verbal and developmentally able to participate, and the parents must be invited to a service planning meeting and should participate and provide input into the development of the service plan, including discussions regarding the child's participation in childhood activities. [Low]

§748.1340. Can the service planning team discuss to develop a child's service plan in separate meetings?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

Yes, the service planning team may meet in one meeting, two or more meetings, or in separate meetings, provided that each service planning team member is informed of the discussions and comments regarding the child's service plan that were made in each meeting. [Medium-Low]

§748.1341. When must I inform the child's parent(s) of an initial service plan meeting?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

- (a) The child's parent must have at least two weeks advance notice of the initial service plan meeting. [Low]
- (b) The child's record must include documentation of the notice and any responses from the parents. [Low]

§748.1343. Must a professional level service provider or a professional who must participate in a child's service plan be an employee of my operation?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2007

No. You may employ or contract with a professional level service provider or any other professional who participates in a child's service plan.

§748.1345. What roles do professional level service providers have in service planning?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

The roles of professional level service providers in service planning include:

Type of Treatment Service	The roles of professional level service providers in service planning include:
(1) Emotional disorder and autism spectrum disorder	(A) Reviewing the child's diagnoses [Medium-Low]; (B) Reviewing the identified needs and the plan for treatment based on the child's diagnoses [Medium-Low]; (C) Reviewing the techniques, strategies, and therapeutic interventions that are planned for the child to improve adaptive functioning [Medium-Low]; and (D) Reviewing any medications prescribed for a child with special review of psychotropic medications; the presence or absence of medication side effects, including the effects of the medications on the child's behavior; laboratory findings; and any reason the child should not use a medication. [Medium]
(2) Intellectual disability	(A) Assessing the child's educational needs and progress toward meeting those needs [Medium-Low]; (B) Ensuring coordination between educators, caregivers, operation employees, and other professionals involved in the child's treatment [Medium-Low]; and (C) Providing information to the education system on the strategies and techniques used with the child in the operation. [Low]
(3) Primary medical needs	(A) Reviewing any medications prescribed for a child [Medium]; (B) Recommending any special equipment needed by a child [Medium]; and (C) Reviewing special instructions and training to caregivers for the daily care of the child. [Medium]

§748.1347. What must I document regarding a professional level service **provider's participation in the development of an initial service plan?**

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2007

- (a) You must document the professional level service provider's:
 - (1) Name [Low]; and
 - (2) Date of participation. [Low]
- (b) The professional level service provider must sign and date the document. If the provider disagrees with any portion of the plan, the provider must document the issue(s) of contention before signing it. [Low]

§748.1349. To whom do I **provide a copy of the child's initial service plan?**

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

- (a) You must give a copy or summary of the initial service plan to the:
 - (1) Child, when appropriate. At a minimum, you must give a copy or summary of the plan to a child 14 years of age or older, unless there is justification for not providing the plan [Low];
 - (2) Child's parents [Low]; and
 - (3) Child's caregivers. [Medium-Low]
- (b) If you provide a copy or summary of the initial service plan to a child:
 - (1) The child must review the plan [Low];
 - (2) The child must sign the plan, or you must document the child's refusal to sign it [Low]; and
 - (3) You must document if the child disagrees with the plan. [Low]
- (c) If you do not provide a copy or summary of the initial service plan to a child, you must document your justification for not sharing the plan in the child's record. [Low]
- (d) You must document in the child's record that you provided a copy or summary of the initial service plan to the child's parents. [Low]

§748.1351. When must I implement a service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 4, Service Plans

January 2017

You must implement and follow an initial service plan as soon as all of the service planning team members have reviewed and signed the plan, but no later than 15 days after the date of the scheduled service-planning meeting involving the parents and the child. [Medium-Low]

Division 5, Service Plan Reviews and Updates

§748.1381. How often must I review and update a service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2017

Except for when the child's placement within your operation changes because of a change in the child's needs, you must review and update the service plan as follows:

Weight	Type of Service	Review and Update
[Medium-Low]	(1) Child-care services	At least 180 days from the date of the child's last service plan.
[Medium-Low]	(2) Treatment services for emotional disorder, autism spectrum disorder, or primary medical needs	At least 90 days from the date of the child's last service plan.
[Medium-Low]	(3) Treatment services for intellectual disabilities	In the first year of care, the plan must be reviewed at least every 180 days from the date of the child's last service plan. Thereafter, the plan must be reviewed at least annually from the date of the child's last service plan review.

§748.1383. How does a child's transfer affect the timing of the review of a child's service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2007

- (a) You must review a child's service plan whenever the child's placement changes because of a change in the child's needs. [Medium-Low]
- (b) If the child's placement changes for another reason:
 - (1) The child's service planning team must approve the decision not to review the plan [Low]; and
 - (2) You must document the decision not to review the plan. [Low]

§748.1385. How do I review and update a service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2017

To review and update a service plan, you must:

- (1) Evaluate the child's progress and the effectiveness of strategies and techniques used toward meeting identified needs, including educational progress reports and medical interventions [Medium-Low];
- (2) Identify any new needs and strategies or techniques to meet these needs, including instructions to appropriate employees [Medium-Low];
- (3) Document any achieved or changed objectives [Medium-Low];
- (4) If the review shows no progress towards meeting the identified needs of the child, document reasons for continued placement [Medium-Low];
- (5) Evaluate the possible effectiveness and side effects in the use of psychotropic medications prescribed for the child, any change in psychotropic medications during the period since the last review, and the behaviors and reactions of the child observed by caregivers, professional level service providers, and parents, if applicable [Medium];
- (6) Document visitation and contacts between the child and the child's parents, the child and the child's siblings, and the child and the child's extended family [Low];
- (7) Update the estimated length-of-stay and discharge plans, if changed [Low];
- (8) Evaluate the use and effectiveness of emergency behavior intervention techniques, if used, since the last service plan. If applicable, this evaluation must focus on [Medium-High]:
 - (A) The frequency, patterns, and effectiveness of types of emergency behavior interventions [Medium];
 - (B) Strategies to reduce the need for emergency behavior interventions overall [Medium]; and
 - (C) Specific strategies to reduce the need for use of personal and mechanical restraints, emergency medication, and/or seclusion, where applicable [Medium];
- (9) Document in the child's record the review and update of the plan [Medium-Low]; and
- (10) Document the names of the persons participating in the review and update. [Low]

§748.1386. Can an operation continue to review and update a child's previous service plan without creating a new service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2017

Yes, a single service plan that continues throughout the time a child is in residential child care is acceptable, as long as you:

- (1) Complete a preliminary service plan as required by §748.1331 of this title (relating to What are the requirements for a preliminary service plan?) each time a child is admitted into your care [Medium-Low]; and
- (2) Continue to comply with the service plan review and update requirements in this division of this subchapter (relating to Service Plan Reviews and Updates). [Medium-Low]

§748.1387. Are the notification, participation, implementation, and documentation requirements for a service plan review and update the same as for an initial service plan?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2007

Yes, the same requirements found in Division 4 of this subchapter (relating to Service Plans) apply to a service plan review and update. [Medium-Low]

§748.1389. How often must I re-evaluate the intellectual functioning of a child receiving treatment services for intellectual disabilities?

Subchapter I, Admission, Service Planning, and Discharge

Division 5, Service Plan Reviews and Updates

January 2017

- (a) Each child's intellectual functioning must be re-evaluated at least every three years by a psychologist qualified to provide psychological testing [Medium-Low]; or
- (b) A psychologist must determine the need and frequency for a specific child's intellectual functioning to be re-evaluated, such as a young child who may require more frequent testing. This determination, including justification for the time frame, must be documented in the child's record annually by the service planning team. [Medium-Low]

Division 6, Discharge and Transfer Planning

§748.1431. What **does a “transfer” of a child in care mean?**

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

September 2010

A transfer refers to a child in care who is moved from one of your programs to another one of your programs that you operate under the same permit or at the same location. For example, you may transfer a child from your emergency care services program to your transitional living services program, if the programs are under the same permit or at the same location. You may also transfer a child from your general residential operation to your child-placing agency, if your child-placing agency office is located on the same property as your general residential operation.

Helpful Information

A transfer must comply with §§748.1433, 748.1435, and 748.1437. A transfer does not require:

- A discharge summary
- An admission assessment
- A preliminary or initial service plan

See §748.1383 regarding service plan updates related to transfers.

§748.1433. Who must plan a child’s non-emergency discharge or transfer?

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

January 2017

- (a) You must involve the following persons in planning the child’s non-emergency discharge or transfer:
- (1) At least one of the child’s current caregivers [Low]; and
 - (2) At least one professional level service provider involved in the child’s service planning. [Low]
- (b) You must invite the following persons to participate in planning the child’s non-emergency discharge or transfer, if appropriate:
- (1) The child [Low];
 - (2) The child’s parent(s) [Low]; and
 - (3) Any other person pertinent to the child’s care. [Low]

- (c) If you are unable to plan the transfer or discharge with the persons as required in subsections (a) and (b) of this section, you must document in the child's record the reason why. For example, an emergency transfer or discharge was necessary or the child met the requirements to consent for emergency care services and decided not to include his parents in planning for the child's transfer or discharge. [Low]
- (d) If a child in your care is not receiving treatment services, you must inform the child of the non-emergency discharge or transfer at least four days prior to the date of the discharge or transfer, unless your licensed child-care administrator or a professional level service provider has clear justification for not giving the child such notice. The licensed child-care administrator or professional level service provider who determines the justification for the child not having the advance notice of the discharge or transfer, must put the justification in writing and sign and date it. The justification must be in the child's record. [Low]
- (e) If a child in your care is receiving treatment services, you must inform the child of the non-emergency discharge or transfer at least four days prior to the date of the discharge or transfer, unless your treatment director, three members of the child's service planning team, or the child's psychiatrist or psychologist has justification for not giving the child such notice. Whoever determines the justification for the child not having the advance notice of the discharge or transfer must put the justification in writing and sign and date it. The justification must be in the child's record. [Low]

§748.1435. How do I discharge or transfer a child who is an immediate danger to self or others?

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

January 2017

An employee of your operation must accompany the child to the receiving operation, agency, or person unless the child's parent or law enforcement transports the child. [Medium-High]

§748.1437. What must I document in the child's record at the time of a discharge or transfer?

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

January 2017

At the time of a discharge or transfer, you must document the following:

- (1) The date and circumstances of the discharge or transfer [Medium-Low];
- (2) Date and time the child was informed of his discharge or transfer, if applicable [Low];
- (3) For discharge, the name, address, telephone number, and relationship of the person to whom you discharge the child, unless the child legally consents to a discharge. If the child legally consents to a discharge and does not want to involve the child's parent(s), you must document this in the child's record [Medium-Low];
- (4) The child's service plans while in your care for the past 12 months [Medium-Low];
- (5) A list of medications the child is taking, the dosage, frequency, and reason the medication was prescribed [Medium];
- (6) Any treatment for a physical condition that is in progress and requires continuing or follow-up medical care [Medium-High]; and
- (7) For emergency discharge or transfer, the explanation given to the child regarding the reason for the discharge or transfer and the child's reaction to the discharge or transfer. [Medium-Low]

§748.1439. When I discharge a child, what information must I provide to the next placement or caregiver?

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

September 2010

- (a) On or before the child's discharge, you must attempt to obtain legal consent to release the information in subsection (b) of this section. If consent is not obtained, your attempt to obtain consent must be documented in the child's record. If consent is obtained, the information must be provided to the receiving placement or caregiver within 15 days of the date the child is discharged. [Medium-Low]

(b) If not already provided at the time of discharge, copies of the following documentation must be provided to the next placement or caregiver:

- (1) A written discharge summary, which must include [Medium-Low]:
 - (A) Services provided to the child while in your care [Medium-Low];
 - (B) Accomplishments of the child while in your care [Medium-Low];
 - (C) An assessment of the child's remaining needs [Medium-Low];
 - (D) Recommendations about the services to meet the child's remaining needs [Medium-Low];
 - (E) Support resources for the child, including telephone numbers and addresses [Medium-Low]; and
 - (F) Aftercare plans and recommendations for the child, including medical, psychiatric, psychological, dental, educational, and social appointments [Medium-Low];
- (2) The child's background information, including progress notes for the past 60 days, if applicable [Medium-Low];
- (3) Any unresolved incidents or investigations involving the child, if applicable [Medium-Low]; and
- (4) Assessments and/or evaluations that you have performed for the child, including the child's admission assessment, diagnostic assessment, educational assessment, neurological assessment, and psychiatric or psychological evaluation. [Medium-Low]

§748.1443. What constitutes an emergency discharge or transfer?

Subchapter I, Admission, Service Planning, and Discharge

Division 6, Discharge and Transfer Planning

January 2007

An emergency discharge or transfer occurs when:

- (1) The parent withdraws a child unexpectedly from care;
- (2) There is a medical emergency requiring inpatient care;
- (3) The child is absent from your operation and cannot be located; or
- (4) There is an immediate danger to the child or others and you determine that you cannot serve the child.

Division 7, Release of Child

§748.1481. To whom may I release a child?

Subchapter I, Admission, Service Planning, and Discharge

Division 7, Release of Child

January 2007

- (a) Except in an emergency, you must only release a child to the child’s parent, a person designated by the parent, law enforcement authorities, or a person authorized by law to take possession of the child. [Medium-High]
- (b) You must instruct all employees and service providers to follow your policies for:
 - (1) Releasing a child [Medium-High];
 - (2) Verifying the identity of a person authorized to pick up a child but whom the caregiver does not know [Medium-High];
 - (3) Recording the identity of the person in a log or other designated location [Medium-High]; and
 - (4) Retaining the identifying information at the operation until the child returns. [Medium-High]

Helpful Information
If you suspect the person picking up a child is under the influence of drugs or alcohol, you have the option of contacting local law enforcement to request their assistance. You may not legally prevent the child from being picked up by a parent or person designated by the parent; however, you have the option of addressing this issue at admission by asking parents what they would like for you to do if you do not feel comfortable releasing the child to one of the parents or their designee and signing an agreement to this effect. Law enforcement officers and DFPS Child Protective Services staff have the authority by law to remove a child without a parent’s permission. You may want to ask to see identification of persons you do not know.

Subchapter J, Child Care

Division 1, Dental Care

§748.1501. What general dental requirements must my operation meet?

Subchapter J, Child Care

Division 1, Dental Care

January 2017

- (a) A child in your care must receive dental care:
 - (1) Initially, according to the requirements in §748.1225 of this title (relating to What are the dental requirements when I admit a child into care?) [Medium];
 - (2) At as early an age as necessary [Medium];
 - (3) As needed for relief of pain and infections [Medium-High]; and
 - (4) As needed for ongoing maintenance of dental health. [Medium-High]
- (b) The child's record must include a written record of each dental examination that consists of [Medium-Low]:
 - (1) A copy of the results of the dental examination [Medium-Low];
 - (2) Follow-up treatment recommended and any appointments scheduled [Medium-Low]; and
 - (3) A notation of the child's refusal to accept dental treatment, if applicable. [Medium-Low]
- (c) For a child in the conservatorship of the department, you must supplement any information already documented in the child's health passport in order to comply with subsection (b) of this section. In your written record for the child, you are not required to repeat information that is already in the child's health passport. [Medium-Low]
- (d) You must obtain follow-up dental work recommended by the dentist, such as treatment of cavities and cleaning. [Medium-High]

§748.1503. Who must determine the need and frequency of ongoing maintenance of dental health for a child?

Subchapter J, Child Care

Division 1, Dental Care

January 2007

A licensed dentist must determine the need and frequency of ongoing maintenance of dental health. You must comply with dentist recommendations for examinations and treatment for each child. [Medium]

§748.1505. Who must perform dental examinations and provide dental treatment?

Subchapter J, Child Care

Division 1, Dental Care

January 2007

A health-care professional licensed in the United States to practice dentistry must provide dental care. [Medium]

Division 2, Medical Care

§748.1531. What general medical requirements must my operation meet?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

(a) A child in your care must receive medical care:

- (1) Initially, according to the requirements in §748.1223 of this title (relating to What are the medical requirements when I admit a child into care?) [Medium-High];
- (2) As needed for injury, illness, and pain [High]; and
- (3) As needed for ongoing maintenance of medical health. [Medium-High]

(b) The child's record must include a written record of each medical examination that consists of [Medium]:

- (1) A copy of the results of the medical examination [Medium];
- (2) Follow-up treatment recommended and any appointments scheduled [Medium];
- (3) A notation of the child's refusal to accept medical treatment, if applicable [Medium];
- (4) If the medical examination is a result of an injury or illness, the documentation of the date, time, and circumstances surrounding the injury or illness [Medium]; and
- (5) Any other documentation provided by the health-care professional who performed the examination. [Medium]

(c) For a child in the conservatorship of the department, you must supplement any information already documented in the child's health passport in order to comply with subsection (b) of this section. In your written record for the child, you are not required to repeat information that is already in the child's health passport. [Medium]

(d) You must obtain follow-up medical treatment as recommended by the health-care professional. [Medium-High]

Helpful Information

If there is no date by which to obtain follow-up treatment, then if necessary the follow-up should be done as soon as practical and integrated into the next service plan review.

§748.1533. Who determines the need and frequency for ongoing maintenance of medical care and treatment for a child?

Subchapter J, Child Care

Division 2, Medical Care

January 2007

A health-care professional determines the need and frequency for ongoing maintenance of medical care and treatment for a child. [Medium-High]

§748.1535. Who must perform medical examinations and provide medical treatment for a child?

Subchapter J, Child Care

Division 2, Medical Care

January 2007

A health-care professional licensed in the United States to practice in an appropriate medical or health-care discipline must perform medical examinations and provide medical treatment for a child. [Medium-High]

§748.1539. What immunizations must a child in my care have?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

- (a) Each child that you admit must meet and continue to meet the applicable immunization requirements as specified by the Department of State Health Services. [Medium-High]
- (b) You must maintain current immunizations records for each child in your care, including any immunization exemptions or exceptions. [Medium-Low]
- (c) Unless the child is exempt from immunization requirements, all immunizations required for the child's age must [Medium-High]:
 - (1) Be completed by the date of admission; or
 - (2) A child that is homeless or a child in foster care shall be admitted temporarily for 30 days if acceptable evidence of immunization is not available. You should immediately refer the child to an appropriate health care professional to obtain the required immunizations

Helpful Information

The current immunization requirements can be found at <http://www.immunizetexas.com> and:

- For children 0 through 43 months click on "School Requirements", click on "Main Page", to the right of the page click on "Child-Care Facilities", and click on "2015-2016 Texas Minimum State Vaccine Requirements for Child-Care Facilities";
- For children 44 months through 18 years click on "School Requirements", click on "Main Page", to the right of the page click on "Schools", and click on "2015-2016 Texas Minimum State Vaccine Requirements for Students Grades K-12".

§748.1541. What exemptions or exceptions are there concerning immunization requirements?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

- (a) A child may be exempt from immunization requirements for a medical reason or reason of conscience, including a religious belief. To claim an exemption, the person applying for the child's admission must meet criteria specified by [Medium]:
 - (1) §42.043(d) and (d-1) of the Human Resources Code; or
 - (2) The Department of State Health Services rule in 25 TAC §97.62 (relating to Exclusions from Compliance).

- (b) For some diseases, a child who previously had a disease and is accordingly naturally immune from it may qualify for an exception to immunization requirements for the disease. To claim this exception, the person applying for the child's admission must meet the criteria specified by the Department of State Health Services rule in 25 TAC §97.65 (relating to Exceptions to Immunization Requirements). [Medium]

Helpful Information

- You can find more information regarding the Department of State Health Services' exemptions at <http://www.dshs.state.tx.us/immunize/default.shtm>, click on "School Requirements", click on "Main Page", and to the right of the page click on "Exclusions from Immunization Requirements".
- While exemptions that comply with HRC §42.043(d) and (d-1) may be used by the person applying for the child's admission into an operation, these exemptions may not comply with the school exemption requirements.

§748.1543. What documentation is acceptable for an immunization record?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

Acceptable documentation includes:

- (1) An official immunization record generated from a state or local health authority, including a record from another state. Examples include a registry, a copy of the current immunization record that is on file at the pre-kindergarten program or school, or the health passport for a child in the conservatorship of DFPS, so long as the record includes [Medium]:
 - (A) The child's name and date of birth [Medium-Low];
 - (B) The type of vaccine and number of doses [Medium-Low]; and
 - (C) The month, day, and year the child received each vaccination [Medium-Low]; or
- (2) An official immunization record or photocopy, such as from a doctor's office, that includes [Medium]:
 - (A) The child's name and date of birth [Medium-Low];
 - (B) The type of vaccine and number of doses [Medium-Low];

- (C)The month, day, and year the child received each vaccination [Medium-Low];
- (D) The signature (including a rubber stamp or electronic signature) of the health-care professional who administered the vaccine, or another health-care professional's documentation of the immunization as long as the name of the health-care professional that administered the vaccine is documented [Medium-Low]; and
- (E)Clinic contact information, if the immunization record is generated from an electronic health record system. [Medium-Low]

§748.1545. Must children in my care have a vision and hearing screening?

Subchapter J, Child Care

Division 2, Medical Care

September 2010

- (a)You must ensure that each child you admit is screened for possible vision and hearing problems that meet the requirements of the Special Senses and Communication Disorders Act, Health and Safety Code, Chapter 36. If problems are detected, the child must have a professional vision and hearing examination. [Medium-High]
- (b)For each child required to be screened, you must keep one of the following in each child's record [Medium-Low]:
 - (1)The individual vision and hearing screening results; however, results found in the child's health passport if the child is in DFPS conservatorship are sufficient to meet this requirement;
 - (2)A signed statement from the child's parent that the child's screening records are current and on file at the program or school the child attends away from the operation. The statement must be dated and include the name, address, and telephone number of the program or school; or
 - (3)An affidavit from the child's parent stating that the vision or hearing screening and/or examination conflicts with the tenets or practices of a church or religious denomination of the parents.

Helpful Information

You can refer to the Health and Safety Code, §36.011, for specific information on vision and hearing screening, including determining which children must be screened and the timeframes for screening. This information may be accessed on the Department of State Health Services' website at: www.dshs.state.tx.us/vhs/.

§748.1547. What must I do if a child in my care is identified as needing a diagnostic vision or hearing examination?

Subchapter J, Child Care

Division 2, Medical Care

January 2007

You must:

- (1) Schedule the child for a professional examination and needed health services [Medium-High];
- (2) Ensure the professional and medical recommendations are carried out [Medium]; and
- (3) Convey the information concerning the child's visual and/or hearing difficulty to the educational and operation caregivers, so the recommended adjustments can be made in programs. [Medium]

§748.1549. What special equipment must I provide for a child with a physical disability?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

When recommended by a health-care professional, you must ensure that a child with a physical disability has any special equipment that can be reasonably obtained. [Medium-High]

§748.1551. How often must the physician review a child with primary medical needs?

Subchapter J, Child Care

Division 2, Medical Care

January 2017

- (a) A licensed physician must review a child's primary medical needs:
 - (1) At least every 90 days or on a schedule recommended by the child's physician [Medium-High]; and
 - (2) Whenever a medical or related problem occurs. [Medium-High]
- (b) The review must address:
 - (1) Whether the child can continue to be cared for appropriately in the operation [Medium-High]; and
 - (2) Any new or changed orders regarding the items outlined in §748.1219(3)(B) of this title (relating to What are the additional admission assessment requirements when I admit a child for treatment services?). [Medium-High]
- (c) Documentation of each physician review must be filed in the child's record. [Medium]

Division 3, Communicable Diseases

§748.1581. What health precautions must I take if someone in my operation has a communicable disease?

Subchapter J, Child Care

Division 3, Communicable Diseases

January 2017

- (a) You must notify the Department of State Health Services (DSHS) after you become aware that a person in your care, a person who resides at your operation, an employee, a contract service provider, or a volunteer has contracted a communicable disease that the law requires you to report to the DSHS as specified in 25 TAC 97, Subchapter A (relating to Control of Communicable Diseases). [Medium-High]
- (b) If a person in your care or a person who resides at your operation has symptoms of a communicable disease that is reportable to the Department of State Health Services, you must:
 - (1) Consult a health-care professional about the person's treatment [Medium-High];
 - (2) Follow the treating physician's orders, which may include separating the person from others [Medium-High];
 - (3) Notify the person's parent, if applicable [Medium]; and
 - (4) Sanitize all items used by the sick person before another person uses one of them. [Medium-High]
- (c) If a health-care professional diagnoses a person in your care or a person who resides at your operation with a communicable disease that is reportable to DSHS, a health-care professional must authorize the person's participation in any routine activities at your operation. The authorization must [Medium-High]:
 - (1) Be in the person's record, if the person is in care at your operation [Medium-Low];
 - (2) Include a written statement that the person will not pose a serious threat to the health of the others [Medium]; and
 - (3) Include any specific instructions and precautions to be taken for the protection of others, if necessary. [Medium]

- (d) If an employee, contract service provider, or volunteer has a communicable disease that is reportable to DSHS, you must obtain written authorization from a health-care professional for the person to be present at the operation. The written authorization must include a statement that the person will not pose a serious threat to the health of the others. [Medium]
- (e) You must follow any written instructions and precautions specified by a health-care professional. [Medium-High]

Helpful Information

Communicable diseases that exclude a child from routine activity are defined by the Department of State Health Services (DSHS) in 25 TAC §97.7 (relating to Diseases Requiring Exclusion from Child-Care Facilities and Schools). You can obtain this information from the Department of State Health Services.

§748.1583. Who must have a tuberculosis (TB) examination?

Subchapter J, Child Care

Division 3, Communicable Diseases

September 2010

- (a) All persons over the age of one year old must have a documented tuberculosis screening that was conducted as recommended by the Center for Disease Control, within 30 days before or after beginning to live, work, or volunteer at your operation unless the person [Medium]:
 - (1) Has lived, worked, or volunteered at a regulated residential child-care operation within the previous 12 months. For example, an employee beginning employment in a regulated residential child-care operation for the first time would need a baseline tuberculosis screening. Employment in a different residential child-care operation would not require a new screening, as long as documentation in paragraph (2) of this subsection is also provided. If the employee left employment in regulated residential child-care for more than 12 months and then returned, a new screening would be required; and
 - (2) Provides documentation of a tuberculosis screening.
- (b) Documentation must consist of a copy of the results of the baseline tuberculosis screening or chest radiograph, which must be in the person's record at your operation within 40 days of the person beginning to live, work, or volunteer at your operation. Documentation of a copy of the results of treatment (if treatment is required) must also be maintained in the person's record. For a child in DFPS conservatorship, documentation in the child's health passport is sufficient. [Medium-Low]

- (c) Except on the advice of a physician, no additional screening is required for a person who continues to live, work, and/or volunteer in a regulated residential child-care setting.

Helpful Information

Current CDC recommendations are as follows:

- Conduct a baseline tuberculosis screening. This screening includes a two-step tuberculosis skin test or a single blood assay for mycobacterium tuberculosis to test for infection with mycobacterium tuberculosis.
- After the initial baseline screening is conducted and shows negative for tuberculosis, no other testing is required as long as the person continues to live, work, or volunteer in a regulated residential child-care operation.
- In any of the following circumstances, use a chest radiograph to exclude TB disease:
 - The person's baseline screening shows positive,
 - The result shows a mycobacterium tuberculosis infection, or
 - There is documentation of treatment for latent tuberculosis infection or tuberculosis disease.

Obtain the chest radiograph within a six-month period from the initial baseline screening. Repeat radiographs are not needed unless symptoms or signs of TB disease develop, unless recommended by a physician, or unless the person ceases to live, work, or volunteer in a regulated residential child-care operation for more than 12 months.

Division 4, Protective Devices

§748.1611. What is a protective device?

Subchapter J, Child Care

Division 4, Protective Devices

September 2010

(a) A protective device:

- (1) Protects a person from involuntary self-injurious behavior or permits wounds to heal; and
- (2) Does not prohibit a person's mobility.

(b) Examples of a protective device are helmets, elbow guards, mittens, and wheelchair seat belts.

(c) If used appropriately, devices intended to encourage mobility or minimally restrain a young child for safety purposes, such as wheelchairs, car seats, high chairs, strollers, bed rails, and child leashes manufactured and sold specifically to harness a young child for safety purposes, are not protective devices.

§748.1613. What does “involuntary self-injurious behavior” mean when used in this division?

Subchapter J, Child Care

Division 4, Protective Devices

January 2007

Involuntary self-injurious behavior means a person’s physical movements that are automatic and not subject to control of the person’s will that may inflict injury to the person.

§748.1615. May I use protective devices?

Subchapter J, Child Care

Division 4, Protective Devices

January 2007

- (a) You may use protective devices if a licensed physician orders their use for a specific child. The orders must indicate the circumstances under which the protective device is permitted. [Medium-High]
- (b) You may not use protective devices as:
 - (1) Punishment [Medium-High];
 - (2) Retribution or retaliation [Medium-High];
 - (3) A means to get a child to comply [Medium-High];
 - (4) A convenience for caregivers or other persons [Medium-High]; or
 - (5) A substitute for effective treatment or habilitation. [Medium-High]
- (c) You must document the use of protective devices in the child's record, service plan, and service plan reviews. The service planning team must discuss and document in the child's service plan reviews [Medium]:
 - (1) Clinical justification for continued use of protective devices [Medium]; and
 - (2) Ways to reduce the need for protective devices. [Medium]

§748.1617. Who may use PRN orders with respect to protective devices?

Subchapter J, Child Care

Division 4, Protective Devices

January 2007

A licensed physician ordering protective devices may use PRN orders. The physician must review PRN orders for protective devices at least every 90 days. [Medium-High]

Division 5, Supportive Devices

§748.1631. What is a supportive device?

Subchapter J, Child Care

Division 5, Supportive Devices

January 2007

- (a) A supportive device is used:
 - (1) To support a person's posture;
 - (2) To assist a person who cannot obtain and/or maintain normal physical functioning to improve his mobility and independent functioning; or
 - (3) As an adjunct to proper care and treatment, for example physical therapy.
- (b) The purpose of a supportive device is not to restrict movement.

§748.1633. May I use supportive devices?

Subchapter J, Child Care

Division 5, Supportive Devices

January 2007

- (a) You may use supportive devices if a licensed physician orders their use for a specific child. The orders must indicate the circumstances under which the supportive device is permitted. [Medium-High]
- (b) You may not use a supportive device as a substitute for appropriate nursing care. [Medium-High]
- (c) You may not use supportive devices that include tying or depriving or limiting the use of a child's hands or feet. [Medium-High]
- (d) You may not use supportive devices as:
 - (1) Punishment [Medium-High];
 - (2) Retribution or retaliation [Medium-High];
 - (3) Means to get a child to comply [Medium-High];
 - (4) A convenience for caregivers or other persons [Medium-High]; or
 - (5) A substitute for effective treatment or habilitation. [Medium-High]
- (e) If a device is not specifically for assisting with sleep or safety during sleep, you must remove the device during rest periods. [Medium-High]

(f) You must document the use of supportive devices in the child's record, service plan, and service plan reviews. The service planning team must discuss and document in the child's service plan review [Medium]:

(1) Clinical justification for continued use of supportive devices [Medium];
and

(2) Ways to reduce the need for supportive devices. [Medium]

§748.1635. Who may use PRN orders with respect to supportive devices?

Subchapter J, Child Care

Division 5, Supportive Devices

January 2007

A licensed physician ordering supportive devices may use PRN orders. The physician must review PRN orders for supportive devices at least every 90 days. [Medium-High]

Division 6, Tobacco and E-Cigarette Use

§748.1661. What policies must I enforce regarding tobacco products and e- cigarettes?

Subchapter J, Child Care

Division 6, Tobacco and E-Cigarette Use

January 2017

- (a) A child may not use or possess tobacco products, e-cigarettes, or any type of vaporizers. [High]
- (b) An adult may not smoke tobacco products, e-cigarettes, or vaporizers in the children's living quarters or inside any building on your premises where children are present. [Medium-High]
- (c) An adult may only smoke tobacco products, e-cigarettes, or vaporizers on your premises at a safe distance from the children's living quarters. [Medium-High]
- (d) No one may smoke tobacco products, e-cigarettes, or vaporizers in motor vehicles when transporting children in care. [Medium-High]

Division 7, Nutrition and Hydration

§748.1691. How often must I feed children in care?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) You must feed an infant whenever the infant is hungry. [Medium-High]
- (b) For a toddler or school-age child:
 - (1) You must provide the child with three meals and at least one snack a day [Medium-High]; and
 - (2) No more than 14 hours may pass between the last meal or snack of the day and the serving of the first meal of the following day. [Medium-High]

Best Practice Suggestion
Best practice suggests that toddlers and pre-school children should not go more than three hours without a meal or snack being offered, unless the child is sleeping or unless otherwise justified in writing by the child's health-care professional. Likewise, school-age children should not go more than six hours without a meal or snack being offered, unless the child is sleeping or unless otherwise justified in writing by the child's health-care professional.

§748.1693. What type of food and water must I provide children?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) You must provide a child with food that is:
- (1) Of adequate variety, quality, and in sufficient quantity to supply the nutrients needed for proper growth and development according to the United States Department of Agriculture guidelines [High]; and
 - (2) Appropriate for the child's age and activity level. [High]
- (b) You must not serve a child nutrient concentrates and supplements, such as protein powders, liquid protein, vitamins, minerals, and other nonfood substances, in lieu of food to meet the child's daily nutritional needs, except with written instructions from a licensed health-care professional. [Medium-High]
- (c) You must ensure drinking water is always available to each child and is served in a safe and sanitary manner. Children must be well hydrated and must be encouraged to drink water during physical activity and in warm weather. [Medium-High]

Best Practice Suggestion
<i>Children's Nutrition</i> Research suggests the following: Milk and milk products served to children 12 months old or older should be Grade A pasteurized or from sources approved by the Department of State Health Services. The following milks do not contain the right amounts of all the nutrients infants need and can harm an infant's health. Iron-fortified infant formula is the best substitute for breast milk.

Best Practice Suggestion

Infants should not be given the following unless recommended by the infant's health-care professional:

- Cow's milk;
- Evaporated cow's milk or home-prepared evaporated cow's milk formula;
- Sweetened condensed milk;
- Goat's milk;
- Soy milk; or
- Imitation milks, including those made from rice or nuts (such as almonds) or nondairy creamer.

(http://www.fns.usda.gov/tn/Resources/feeding_infants.html)

Feeding Infants: A Guide for Use in the Child Nutrition Programs p.24)

- Milk should be fluid milk.
- Breads and grains should be made from whole-grain or enriched meal or flour.
- Cereal should be whole grain or enriched or fortified.
- Vegetable or fruit juices should be 100% vegetable or fruit juice when used to meet a serving from the vegetable or fruit group.
- Children under one year old should not be offered unpasteurized or raw honey because it may contain spores that pose a health risk.

Food Allergies

A food allergy is caused by the body's immune system reacting inappropriately to a food or food additive. Symptoms may include wheezing, difficulty breathing, diarrhea, rashes, itching, hives, and headaches. Food allergies are most common in infants, due to their immature digestive systems. Food allergies are usually outgrown during the preschool years. Although any food may cause an allergic reaction, six foods are responsible for most of these reactions in children. These foods are:

- Peanuts;
- Eggs;
- Milk;
- Tree nuts;

Best Practice Suggestion

- Soy; and
- Wheat.

A child who is pregnant or breastfeeding should avoid consuming peanuts and peanut products due to its association with the development of peanut allergies in infants. It is best not to offer children under two to three years old peanuts or peanut products, such as peanut butter and foods containing or cooked in peanut oil, because of the potential of developing this life-threatening and often life-long allergy. Foods that cause allergic reactions should be eliminated from the diet. However, it is important that the diet still contain a variety of foods for healthy growth and development. A child should receive a medical evaluation if food allergies are suspected. If the child's licensed physician determines that the child has a food allergy, a determination should be made of whether the child's allergic condition meets USDA's definition of disability.

Food Intolerance

A food intolerance is an adverse food-induced reaction that does not involve the body's immune system. Lactose intolerance is one example of food intolerance. A person with lactose intolerance lacks an enzyme needed to digest milk sugar. When that person eats milk products, gas, bloating, and abdominal pain may occur. It is best to provide food substitutions for children with food intolerances who cannot consume the regular meal.

(<http://www.fns.usda.gov/tn/Resources/blocks1.pdf> - pg. 18) Choking

Research has shown that 90% of fatal choking occurs in children younger than four years old. Examples of foods that present a risk of choking include hot dogs sliced into rounds, whole grapes, hard candy, nuts, seeds, raw peas, dried fruit, pretzels, chips, peanuts, popcorn, marshmallows, spoonful of peanut butter, and chunks of meat larger than can be swallowed whole.

§748.1695. What are the specific requirements for feeding an infant?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2017

(a) You must feed the infant:

- (1) On demand following the infant's lead on when to feed, how long to feed, and how much to feed [Medium-High]; and
 - (2) Based on the recommendation of the infant's health-care professional, who must approve you giving the infant any milk other than fortified formula. [Medium-High]
- (b) You must hold the infant while feeding an infant that is:
- (1) Birth through six months old [Medium-High]; or
 - (2) Unable to sit unassisted in a high chair or other seating equipment during feeding. [Medium-High]
- (c) You must never prop a bottle by supporting it with something other than the infant's or adult's hand. [Medium-High]
- (d) If you care for more than one infant, you must:
- (1) Label each bottle and training cup with the child's first name and initial of last name [Medium-High];
 - (2) Not permit the infant to share bottles or training cups [Medium-High]; and
 - (3) Sanitize high chair trays before each use. [Medium-High]

Best Practice Suggestion
Best practice suggests: • Feeding infants while infants are awake; • Providing regular snack and meal times for infants who eat table food; and • Ensuring children no longer being held for feeding are fed in a safe manner.

Suggested meals:

Infant's age	Breakfast	Lunch and Supper	Snack
Birth through three months: Serve liquids only	4 to 6 oz. of iron fortified infant formula	4 to 6 oz. of iron fortified infant formula	4 to 6 oz. of iron fortified infant formula

Infant's age	Breakfast	Lunch and Supper	Snack
Four months through seven months: Add semisolid foods	• 4 to 8 oz. of iron fortified infant formula • 0 to 3 tablespoons of iron fortified infant cereal	• 4 to 8 oz. of iron fortified infant formula • 0 to 3 tablespoons of iron fortified infant cereal • 0 to 3 tablespoons of strained fruit and/or strained vegetables * May be started later in the age range	4 to 6 oz. of iron fortified infant formula
Eight months through eleven months: Add modified table foods	• 6 to 8 oz. of iron fortified infant formula • 2 to 4 tablespoons of iron fortified infant cereal • 1 to 4 tablespoons of strained fruit and/or strained vegetables	• 6 to 8 oz. of iron fortified infant formula • 2 to 4 tablespoons of iron fortified infant cereal, and/or • 1 to 4 tablespoons strained meat, fish, or poultry, mashed egg yolk, or mashed cooked dry beans or peas, or • 1/2 to 2 oz. of Cottage cheese, yogurt, or cheese, or • 1 to 4 tablespoons mashed or diced soft fruit or mashed or soft cooked vegetables	• 2 to 4 oz. of iron fortified infant formula or 100% fruit juice • 0 to 1/2 slice of soft bread, or 0 to 2 crackers

(<http://www.fns.usda.gov/tn/Resources/blocks1.pdf> - pg. 24)

Best Practice Suggestion (continued)
An infant who is hungry may wake and toss, suck on his or her fist, cry or fuss, or look like he or she is going to cry. It is best to respond to early signs of hunger rather than waiting until the infant is upset and crying hard from hunger. (Feeding Infants: A Guide for Use in the Child Nutrition Programs p.33) Signs of fullness include the infant sealing his or her lips together, decreased sucking, spitting out the nipple, turning away from the bottle, or pushing the bottle away.

§748.1697. What are the specific requirements for feeding toddlers and older children?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2017

- (a) A toddler or older child must eat meals in the dining areas unless the service planning team's recommendations are to the contrary. [Medium]
- (b) Food service practices for children receiving treatment services for primary medical needs or an intellectual disability, including non-mobile children, must encourage self- help and development. [Medium]

Best Practice Suggestion
The daily food needs for children 12 months through 23 months are included in the following chart:

Food Groups	Number of Servings to Meet 1/3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Milk, Yogurt, and Cheese	1 and 1/3	4	• 4 oz. Milk or • 1/2 oz. Cheese or • 4 oz. Yogurt
Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts	1	3	• 1/2 to 1 oz. Cooked meat or • 1/2 to 1 Egg or • 1/2 c. Cooked beans

Food Groups	Number of Servings to Meet 1 / 3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Vegetables and Fruit	1 and 1/3 +	5 Another vegetable should be offered to a child when dried peas or beans are counted as a meat alternative.	• 2 to 3 Tb. Cooked vegetables of • 2 to 3 Tb. Canned fruit or • 1/4 to 1/2 Small fresh fruit or • 1/4 to 1/2 c. Juice
Bread, Cereal, Rice, and Pasta	1 and 1/3 +	5	• 1/2 Slice Bread or • 1/4 to 1/2 c. Cooked Cereal or • 4 oz. To 1/3 c. Pasta or Rice or • 1 or 2 Crackers

Best Practice Suggestion (continued)
The daily food needs for children two years through five years old are included in the following chart:

Food Groups	Number of Servings to Meet 1 / 3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Milk, Yogurt, and Cheese	2/3 of one serving	2	• 1 c. Milk or • 2 oz. Cheese or • 1 c. Yogurt
Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts	2/3 of one serving	2	• 2 & 1/2 oz. Cooked meat or • 1 Egg or • 1/2 c. Cooked beans

Food Groups	Number of Servings to Meet 1 / 3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Vegetable	1	3 Another vegetable should be offered to a child when dried peas or beans are counted as a meat alternative.	• 1/2 c. Raw or cooked vegetables of • 1 c. Raw leafy vegetable.
Fruit	2/3 of one serving	2	• 1/2 c. Canned or chopped fruit or • 1 Piece fruit or melon wedge or • 1/4 c. Dried fruit or • 3/4 c. Juice
Bread, Cereal, Rice, and Pasta	2	6	• 1 Slice Bread or • 1/2 c. Cooked Cereal or • 1 oz. Ready to eat cereal or • 1/2 c. Cooked pasta or Rice or • 3 to 5 Crackers

Best Practice Suggestion (continued)

The daily food needs for children six years old and older are included in the following chart:

Food Groups	Number of Servings to Meet 1 / 3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Milk, Yogurt, and Cheese	2/3 to 1	2 to 3 A child who is pregnant or breast feeding should have at least 3 servings of milk or dairy products. * Teenagers and young adults should have at least 3 servings of milk or dairy products.	• 1 c. Milk, or • 1 c. Yogurt, or • 1 & 1/2 oz. Natural cheese, or • 2 oz. Processed cheese
Meat, Poultry, Fish, Dry Beans, Eggs, and Nuts	2/3 to 1	2	• 3 oz. Cooked meat, poultry, or fish, or • 1 egg or • 1/2 c. Cooked dry beans, or • 1/2 c. Tofu, or • 2 Tb. Peanut butter
Vegetable	1 to 1 and 2/3	4 Another vegetable should be offered to a child when dried peas or beans are counted as a meat alternative.	• 1/2 c. Raw or cooked vegetables, of • 1 c. Raw leafy vegetable, or • 3/4 c. vegetable juice

Food Groups	Number of Servings to Meet 1 / 3 of Daily Needs	Number of Servings to Meet Daily Needs	Serving Size
Fruit	2/3 to 1 and 1/3	2 to 4	• 1 medium piece of fruit, or • 1/2 c. Canned, chopped, or cooked fruit, or • 1/4 c. Dried fruit or • 3/4 c. Fruit juice
Bread, Cereal, Rice, and Pasta	2 to 3 and 2/3	6 to 11	• 1 slice bread, or • 1 oz. Ready-to-eat cereal or • 1/2 c. Cooked Cereal or • 1/2 c. Cooked pasta or Rice or • 4 to 6 Crackers

Best Practice Suggestion (continued)
Most teenage boys will need to eat the higher number of servings from each food group, and teenage girls who participate in vigorous sports may need to eat a higher number of servings. It is best to serve enough food to allow these children second servings from the vegetable, fruit, grain, and milk groups and have snacks available if the child becomes hungry. Best practice suggests that snacks be nutritious and include at least one of the following, which can be included in the child's daily food needs: • One serving from the fruit or vegetable group; • One serving from the milk group; • One serving from the grain group; or • One serving from the meat or meat alternative group.

§748.1699. What must I do if a child refuses to or cannot eat a meal or snack that I offer?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) You must offer a child a meal or snack according to this division, but you may not force the child to eat. You are not required to offer other food to a child who [Medium-High]:
 - (1) Refuses a meal or snack; or
 - (2) Chooses not to be present when a meal or snack is scheduled.
- (b) You must discuss recurring eating problems with the child's parent. [Medium-Low]
- (c) If a meal or snack is not appropriate to meet a child's individual needs, for example food allergies or religious reasons, then you must offer the child an appropriate nutritional substitute. [Medium]

§748.1701. What must I do if a child requires a therapeutic or special diet?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) To serve a therapeutic or special diet to a child, you must have written approval in the child's record from a licensed physician or a registered or licensed dietitian. [Medium-High]
- (b) If a child requires a therapeutic or special diet, you must give the following people information regarding the diet:
 - (1) All employees who prepare and serve food [Medium]; and
 - (2) The child's caregivers. [Medium]
- (c) You must make dietary alternatives available to a child who has special health needs. [Medium]

§748.1703. What are the requirements for daily menus?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

September 2010

- (a) You must maintain daily menus showing all meals and snacks that you prepare and serve. [Low]
- (b) You must document food substitutions on the menu. Food substitutions must be of comparable food value. [Low]
- (c) You must date menus and keep copies for 90 days. [Low]
- (d) This rule does not apply to meals prepared and served in cottage homes.

§748.1705. What are the nutrition requirements for a child with primary medical needs?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

September 1, 2008

- (a) You must feed a child with primary medical needs according to his medical and developmental needs. [Medium-High]
- (b) A licensed physician must prescribe tube feeding. A dietitian or physician must plan the diet that the physician prescribes. [Medium-High]
- (c) Children must eat in an upright position unless the service planning team recommendations are to the contrary. [Medium-High]

§748.1707. What are the requirements for tube-feeding formula?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) A registered or licensed dietitian, physician, or a registered nurse must ensure the caregiver that prepares the formula is adequately trained and has demonstrated competency in preparing the formula. [Medium-High]
- (b) Tube feeding formulas must supply the recommended dietary allowance for each child. [Medium-High]
- (c) You must prepare and store the formula [Medium-High]:
 - (1) According to directions; or
 - (2) As prescribed by a health-care professional.

§748.1709. What are the requirements for using a nasogastric tube to feed a child?

Subchapter J, Child Care

Division 7, Nutrition and Hydration

January 2007

- (a) Only the following may insert a nasogastric tube [High]:
 - (1) A physician; or
 - (2) A registered nurse according to a physician's written orders.
- (b) You must document each insertion in the child's record. The documentation for each insertion must include the [Medium]:
 - (1) Signature of the nurse who inserted the tube [Medium]; and
 - (2) Date of the insertion. [Medium]
- (c) You must follow the physician's written orders concerning the tube. [High]

Division 8, Additional Requirements for Infant Care

§748.1741. What do certain words mean in this division?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

These terms have the following meaning in this division:

- (1) Baby doorway jumper – A bucket seat that is suspended from a doorway by an elastic bungee cord that allows an infant to bounce while sitting in the seat.
- (2) Baby walker – A baby walker allows an infant to sit inside the walker equipped with rollers or wheels and move across the floor.
- (3) Bouncer seat – A stationary seat designed to provide gentle rocking or bouncing motion by an infant's movement, or by battery-operated movement. This type of equipment is designed for an infant's use from birth until the child can sit up unassisted.
- (4) Restrictive device – Equipment that places the body of an infant in a position that may restrict airflow or cause strangulation; usually, the infant is placed in a semi-seated position. Examples of restrictive devices are car seats, swings, bouncy seats, and high chairs.

§748.1743. What are the basic care requirements for an infant?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

- (a) Each infant must receive individual attention, including playing, talking, cuddling, and holding. [Medium-High]
- (b) When an infant is upset, a caregiver must hold and comfort the infant. [Medium-High]
- (c) A caregiver must provide prompt attention to an infant's physical needs, such as feeding and diapering. [Medium-High]
- (d) An infant's caregiver must ensure that the environment is safe. For example, the caregiver must free the area of objects that may choke or harm the infant, take measures to prevent electric shock, free the area of furniture that is in disrepair or unstable, and allow no unsupervised access to water to prevent the risk of drowning. [Medium-High]
- (e) Items necessary for diaper changing must be kept out of the reach of children, but do not need to be in locked storage. [Medium]

- (f) An infant's caregiver must never leave the infant unsupervised. A sleeping infant is considered supervised if the caregiver is within eyesight or hearing range of the infant and can intervene as needed, or if the caregiver uses a video camera or audio monitoring device to monitor the infant and is close enough to the infant to intervene as needed.

[Medium-High]

§748.1745. What steps must a caregiver follow when changing a child's diaper?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2007

A caregiver must:

- (1) Promptly change soiled or wet diapers or clothing [Medium];
- (2) Thoroughly cleanse children with individual cloths or disposable towels [Medium];
- (3) Use a clean, individual cloth or disposable towel to dry the child [Medium];
- (4) Ensure that the child is dry before placing a new diaper on the child [Medium]; and
- (5) Keep all diaper-changing supplies out of children's reach. [Medium]

§748.1747. What must I do to prevent the spread of germs when diapering children?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2007

To prevent the spread of germs when diapering a child, you must:

- (1) Wash your hands with soap and running water before and after diapering a child [Medium];
- (2) Cover a container used for soiled diapers or keep it in a sanitary manner, such as placing soiled diapers in individual sealed bags [Medium];
- (3) Discard a disposable towel after use [Medium]; and
- (4) Launder any cloth before reusing it. [Medium]

§748.1749. What furnishings and equipment must I have in my infant care area?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2007

Your infant care area must at a minimum include the following furnishings and equipment:

- (1) An individual crib for each infant [Medium]; and
- (2) A sufficient number of toys to keep each child engaged in activities. [Medium-Low]

§748.1751. What specific safety requirements must my cribs meet?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

(a) All cribs must have:

- (1) A firm, flat mattress that snugly fits the sides of the crib. The mattress must not be supplemented with additional foam material or pads [Medium-High];
- (2) Sheets that fit snugly and do not present an entanglement hazard [Medium-High];
- (3) A mattress that is waterproof or washable [Medium-High];
- (4) Secure mattress support hangers, and no loose hardware or improperly installed or damaged parts [Medium-High];
- (5) A maximum of 2 3/8 inches between crib slats or poles [Medium-High];
- (6) No corner posts over 1/16 inch above the end panels [Medium-High];
- (7) No cutout areas in the headboard or footboard that would entrap a child's head or body [Medium-High];
- (8) Drop gates, if present, which fasten securely and cannot be opened by a child [Medium-High]; and
- (9) Documentation that each crib meets the applicable federal rules at Title 16, Code of Federal Regulations, Parts 1219 or 1220, concerning "Safety Standards for Full-Size Baby Cribs" and "Safety Standards for Non-Full-Size Baby Cribs," respectively, or documentation that each crib is a medical device listed and registered with the U.S. Food and Drug Administration. [High]

- (b) You must sanitize each crib when soiled and before reassigning the crib to a different child. [Medium-High]
- (c) You must never leave a child in the crib with the drop gate down. [High]
- (d) You may not have stackable cribs. [Medium-High]

Helpful Information

- Research shows more babies die in incidents involving cribs than with any other piece of nursery equipment.
- Non-full-size cribs may be either smaller or larger than a full size crib, or shaped differently than the usual rectangular crib. The category of non-full-size cribs includes oversized, specialty, undersized, and portable cribs, but does not include any product with mesh/net/screen siding, non-rigidly constructed cribs, cradles, car beds, baby baskets, or bassinets. For requirements for play yards, which are mesh or fabric sided products, see §748.1753 of this title (relating to Are play yards allowed?).
- Regarding paragraph (1), a mattress is too loose if there are more than two finger widths between the edge of the mattress and the crib side.
- Regarding paragraph (5), if a soda can fits easily between the slats on a crib, the slats are too wide.

Regarding paragraph (9):

- Cribs manufactured before 06/28/2011 may not meet the safety standards established by the Consumer Product Safety Commission (CPSC).
- Documentation that you may use to verify your crib is in compliance with CPSC regulations includes the certificate of compliance, registration card, or tracking label. You may request this documentation from the manufacturer or retailer.
 - The certificate of compliance is a document that describes the crib and whether the crib complies with 16 CFR 1219 or 16 CFR 1220. The certificate includes the contact information for the importer or domestic manufacturer and the testing lab. It also lists the date and location of manufacture and testing.
 - The registration card is a postage-paid form provided by the crib manufacturer. The card includes the manufacturer's name and contact information, model name, model number, and the date of manufacture.
 - The tracking label is attached to the crib and contains basic information such as the date of manufacture and the source of the crib.
 - You may find additional guidance on obtaining supporting documentation for your cribs on the CPSC website at <http://www.cpsc.gov>.
- In order to maintain the required documentation for each crib consider developing a system to easily tie the required documentation to the appropriate crib. Examples may include photographs of each crib attached to the documentation or a tracking sheet that includes information such as the date of purchase, manufacturer and model number, date of manufacture, and what documentation is on file (certificate of compliance, tracking label, or registration card).
- A crib that meets the definition of "device" in the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 201(h)) is subject to regulation by the Food and Drug Administration (FDA), not CPSC. A crib that is not a "device" is subject to CPSC's crib standards. If your crib is a medical device, the manufacturer must be registered with the FDA. For additional information, visit the FDA website at <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/RegistrationandListing/default.htm>

§748.1753. Are play yards allowed?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

(a) Play yards, which are mesh or fabric sided cribs, are allowed if they meet the following safety requirements:

(1) The play yards must be used according to the manufacturer's instructions, including the cleaning of the cribs [Medium-High];

(2) Play yards must have:

(A) A firm, flat mattress that snugly fits the sides of the crib and that is designed for the crib. The mattress must not be supplemented with additional foam material or pads [Medium-High];

(B) Sheets that fit snugly and do not present an entanglement hazard [Medium-High];

(C) A mattress that is waterproof or washable [Medium-High];

(D) Secure mattress support hangers, and no loose hardware or improperly installed or damaged parts [Medium-High];

(E) A minimum height of 22 inches from the top of the railing to the mattress support at its lowest level [Medium-High];

(F) Folded sides that securely latch in place when raised [Medium-High];

(G) For mesh cribs, mesh openings that are 1/4 inch or less [Medium-High]; and

(H) Mesh or fabric that is securely attached to the top rail, side rail, and floor plate [Medium-High]; and

(3) You must never leave an infant in a play yard with a side folded down. [High]

(b) If you become aware of a recall for a non-full-size crib or a mesh crib that you are using, you must discontinue its use immediately. [High]

§748.1755. What equipment must have safety straps before I can use it with an infant?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2007

If you use a high chair, swing, stroller, infant carrier, rocker, bouncer seat, or a similar type of equipment for an infant:

- (1) It must be equipped with safety straps [High]; and
- (2) The safety straps must be fastened whenever the infant is using the equipment. [High]

§748.1757. What types of equipment are not allowed for use with infants?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

- (a) You may not use any of the following types of equipment with infants:
 - (1) Baby walkers [Medium-High];
 - (2) Baby doorway jumpers [Medium-High];
 - (3) Accordion safety gates [Medium-High];
 - (4) Toys that are not large enough to prevent swallowing or choking [High]; and
 - (5) Bean bags, waterbeds, and foam pads for use as sleeping equipment. [High]
- (b) Except for a tight fitting sheet and as provided in subsection (c), the crib must be bare for an infant younger than twelve months of age. [High]
- (c) A crib mattress cover may be used to protect against wetness, but the cover must:
 - (1) Be designed specifically for the size and type of crib and crib mattress that it is being used with [Medium-High];
 - (2) Be tight fitting and thin [Medium-High]; and
 - (3) Not be designed to make the sleep surface softer. [Medium-High]
- (d) An infant receiving treatment services for primary medical needs may have special items that assist with safe sleep at the written recommendation of a health-care professional. You must keep the recommendation in the child's record. [Medium-High]

Helpful Information

The prohibited equipment is not safe or beneficial to an infant's development and is not recommended by either the American Academy of Pediatrics or the Consumer Product Safety Commission.

- Regarding paragraph (1), baby walkers present a hazard due to risk of falling down stairs or steps and tipping over thresholds or carpet edges. They provide infants accessibility to potentially hot surfaces, containers of hot liquids such as coffee, dangling appliance cords, poisonous plants or hazardous substances and buckets, toilets or other containers of water.
- Regarding paragraph (2), baby doorway jumpers present a hazard due to increased risk of injury to the child as a result of spinning, swinging, or bumping into walls while placed in the jumper.
- Regarding paragraph (3) accordion gates with large V-shaped openings along the top edge and diamond shaped openings between the slats present entrapment and entanglement hazards resulting in strangulation, choking or pinching to children who try to crawl through or over the gate.
- Regarding paragraph (4), examples of items that present a choking hazard for infants and toddlers include coins, balloons, safety pins, marbles, Styrofoam[®] and similar products, and anything that can fit into the inside tube of a toilet-paper roll.
- Regarding paragraph (6), studies on SIDS support eliminating soft bedding materials, sleep positioning devices, and stuffed toys used for infants under twelve months. Examples of items that can be used as alternatives to blankets and sheets are a one-piece footed sleeper, a body shirt or undershirt underneath a sleeper, sleep sack or wearable blanket that zips up the front and can be worn over a sleeper. Wearable blankets are sleeveless, so a baby can still move his arms around while the rest of his body stays covered.

§748.1759. What activities must I provide for infants?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

You must provide the following activities for an infant:

- (1) Multiple opportunities each day to explore in a safe and clean area that is outside of the crib or restrictive device [Medium-High];
- (2) Opportunities for visual, auditory, and sensory stimulation [Medium-High];
- (3) Opportunities for small- and large-muscle development [Medium-High]; and
- (4) A supervised nap period that allows the infant to maintain the child's own pattern of sleeping and waking. [Medium-High]

§748.1761. How long may an infant remain in a crib after awakening?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

An infant may remain in the crib for up to 30 minutes after awakening, as long as the infant is content and responsive. [Medium-High]

§748.1763. What are the specific sleeping requirements for infants?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

- (a) You must place an infant not yet able to turn over on his own in a face-up sleeping position unless a health-care professional orders otherwise. You must keep any orders from a health-care professional in the child's record. [High]
- (b) An infant's head, face, or crib must not be covered at any time by an item such as a blanket, linen, or clothing. [High]
- (c) An infant may not sleep in a prone position with a sleeping adult at any time, including in the adult's bed, on a couch, etc. [High]

§748.1765. May I allow infants to sleep in a restrictive device?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

January 2017

No. You may not allow an infant to sleep in a restrictive device. If an infant falls asleep in a restrictive device, the infant must be removed from the device and placed in a crib as soon as possible. [High]

Helpful Information
- Infants sleeping in restrictive devices are at risk for strangulation, injury, and positional asphyxiation. - You must not place a car seat in a crib with a sleeping infant.

§748.1767. May I swaddle an infant to help the infant sleep?

Subchapter J, Child Care

Division 8, Additional Requirements for Infant Care

April 2021

You may not lay a swaddled infant down to sleep or to rest on any surface at any time, unless you have an order signed by a health-care professional. You must keep the order in the child's record. [High]

Helpful Information

There is evidence that swaddling can increase the risk of serious health outcomes, including SIDS and hip disease, and research does not provide definitive data to support the use of swaddling. Even with newborns, research does not provide conclusive data about whether swaddling should be used. Swaddling blankets that become loose during sleep pose an additional risk for infants. For concerns with maintaining an infant's temperature, appropriate clothing and/or a sleeveless infant sleep sack that does not restrict the infant's movement can be utilized. For more information on safe sleep, see the [American Academy of Pediatrics Health Initiatives for Safe Sleep](#) and the [National Institutes of Health Safe to Sleep Campaign](#).

Division 9, Additional Requirements for Toddler Care

§748.1791. What are the basic care requirements for a toddler?

Subchapter J, Child Care

Division 9, Additional Requirements for Toddler Care

January 2017

- (a) Each toddler must receive individual attention, including playing, talking, and cuddling.
[Medium-High]
- (b) A toddler's caregiver must ensure that the environment is safe. For example, the caregiver must free the area of objects that may choke or harm the toddler, take measures to prevent electric shock, free the area of furniture that is in disrepair or unstable, and allow no unsupervised access to water to prevent the risk of drowning.
[High]
- (c) A toddler's caregiver must never leave the toddler unsupervised. A sleeping toddler is considered supervised if the caregiver is within eyesight or hearing range of the toddler and can intervene as needed, or if the caregiver uses a video camera or audio monitoring device to monitor the toddler and is close enough to the toddler to intervene as needed.
[High]

§748.1793. What furnishings and equipment must I provide for toddlers?

Subchapter J, Child Care

Division 9, Additional Requirements for Toddler Care

January 2017

Furnishings and equipment for toddlers must at a minimum include the following:

- (1) Age-appropriate seating, tables, and nap and sleep equipment. Toddlers may use cribs or beds, as appropriate [Medium];
- (2) Enough popular items available, so a toddler is not forced to compete for them [Medium]; and
- (3) Containers or low shelving that are accessible to toddlers, so toddlers can safely obtain the items without adult intervention. [Medium]

§748.1795. What activities must I provide for toddlers?

Subchapter J, Child Care

Division 9, Additional Requirements for Toddler Care

January 2007

You must provide the following activities for a toddler:

- (1) Daily opportunities for outdoor play, when weather permits; [Medium]
- (2) Opportunities for thinking skills and sensory development; [Medium]
- (3) Opportunities for small and large-muscle development; [Medium]
- (4) Opportunities for language development [Medium];
- (5) Opportunities for social/emotional development [Medium];
- (6) Opportunities to develop self-help skills such as toileting, hand washing, and feeding [Medium]; and
- (7) Supervised naptimes. You must provide a supervised sleep or rest period after the noon meal for all toddlers. [Medium]

Best Practice Suggestion

Best practices for nap or rest time include the following:

- Schedule a supervised sleep or rest period after the noon meal for children 12 months of age or older or according to the child's individual physical needs;
- Lighting should allow for visual supervision of the children;
- Limit the sleep or rest period to no more than three hours;
- Do not force children to sleep and do not put anything in or on a child's head or body to force the child to rest or sleep;
- Allow each child who is awake after resting or sleeping for one hour to participate in an alternative, quiet activity until the nap/rest time is over for other children who may be resting; and
- Take a toddler who sleeps or rests in a crib out of the crib for other activities when the child awakens.

Division 10, Additional Requirements for Pregnant and Parenting Children

Best Practice Suggestion

If you have a pregnant child in care in the final trimester of pregnancy, it is best to have a complete and sterile emergency obstetrical kit available in a designated location at your operation and when transporting the child.

A sterile emergency obstetrical kit should contain the following supplies:

- Pair of sterile exam gloves such as latex gloves;
- One disposable plastic apron;
- One plastic lined underpad;
- Three disposable towels;
- Two O.B. towelettes to wipe and clean the birth opening prior to delivery;
- Four sterile gauze sponges;
- Two sterile umbilical cord clamps to clamp the umbilical cord before cutting;
- One sterile disposable pair of scissors to cut the umbilical cord;
- One disposable bulb syringe for fluid removal from the infant's mouth and throat;
- Receiving blanket;
- One plastic bag to hold the placenta for the hospital placenta examination;
- Two twist ties for use with the plastic bag; and
- One sterile O.B. pad for post delivery.

It is also advisable for your operation to have the following items easily accessible:

- An instruction manual for caregivers on emergency childbirth delivery;
- A clean sheet and/or blanket for the mother who is about to give birth to prevent hypothermia; and
- A clean knit infant cap to prevent hypothermia in a newborn infant.

§748.1821. What information must I provide a pregnant child regarding her pregnancy?

Subchapter J, Child Care

Division 10, Additional Requirements for Pregnant and Parenting Children

September 2010

You must:

- (1) Ensure information, training, and counseling is available regarding health aspects of pregnancy, preparation for child birth, and recovery from child birth [Medium];
- (2) Ensure the pregnant child receives nutritional counseling and guidance that meets generally accepted standards, including nutrition during pregnancy, lactation, and foods to avoid [Medium]; and
- (3) Inform the child, within seven days of admission or upon learning of the pregnancy, of her right to be free from pressure to get an abortion, relinquish her child for adoption, or to parent her child. [Medium]

§748.1823. Is the use of emergency behavior intervention of a pregnant child permitted in my operation?

Subchapter J, Child Care

Division 10, Additional Requirements for Pregnant and Parenting Children

January 2007

If your policies allow for the use of personal restraints on a pregnant child:

- (1) The health-care professional attending to the child's pregnancy must document whether any type of emergency behavior intervention that your policies allow is inadvisable [Medium-High]; and
- (2) You may not use any emergency behavior intervention that the child's health-care professional attending to her pregnancy finds inadvisable. [High]

§748.1825. If my policies permit the admission of adolescent parents with their child(ren), who is responsible for the care of the **adolescent's child(ren)?**

Subchapter J, Child Care

Division 10, Additional Requirements for Pregnant and Parenting Children

January 2007

If your policies permit the admission of adolescent parents with their child(ren):

- (1)An adolescent parent must provide most of the care for her child [Medium];
- (2)Caregivers must be available to the adolescent parent as a resource and support [Medium-High]; and
- (3)When you care for an adolescent's child in the adolescent parent's absence, you are responsible for that child as if the child is in your care. [Medium-High]

Subchapter K, Operations That Provide Care for Children and Adults

Division 1, Scope

§748.1901. What operations do the rules in this subchapter apply to?

Subchapter K, Operations That Provide Care for Children and Adults

Division 1, Scope

January 2007

The rules in this subchapter apply to operations that provide care for both children and adults.

Division 2, General Requirements

§748.1931. After a child in my care turns 18 years old, may the person remain in my care?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

September 2010

(a) A young adult may remain in your care until his 23rd birthday in order to [Low]:

- (1) Transition to independence, including attending college or vocational or technical training;
- (2) Attend high school, a program leading to a high school diploma, or GED classes;
- (3) Complete your program; or
- (4) Stay with a minor sibling.

(b) A young adult who turns 18 in your care may remain in your care indefinitely if the person [Low]:

- (1) Continues to need the same level of care; and
- (2) Is unlikely to physically and/or intellectually progress over time.

§748.1933. May I admit a young adult into care?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

September 2010

- (a) You may admit a young adult into your transitional living program.
- (b) For other programs or services, the young adult must [Low]:
 - (1) Come immediately from another residential child-care operation if the reason for admittance is consistent with a condition listed in §748.1931 of this title (relating to After a child in my care turns 18 years old, may the person remain in my care?); or
 - (2) Be in the care of the Texas Department of Family and Protective Services.
- (c) A young adult may remain in your care until his 23rd birthday. [Low]

§748.1935. How does the child/caregiver ratio apply if I provide care to both children and adults?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

January 2007

- (a) If you provide care to both children and adults, you may maintain the required child/caregiver ratio by [Medium-High]:
 - (1) Counting all residents in your care as children and maintaining the appropriate ratio; or
 - (2) Assigning caregivers to work exclusively with the children in care.
- (b) The child/caregiver ratio for minor and adult residents applies to operation-sponsored activities or appointments, regardless of where they occur. [Medium-High]
- (c) You may not count adult residents as caregivers in the child/caregiver ratio. [Medium-High]

§748.1937. May an adult in care share a bedroom with a child in care?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

September 2010

An adult in care may share a bedroom with a child in care if:

- (1) A professional level service provider determines there are no risks to either of them after assessing the following [Medium-Low]:
 - (A) Their behaviors [Medium-Low];
 - (B) Their compatibility with each other [Medium-Low];
 - (C) Their respective relationships [Medium-Low];
 - (D) Any past history of sexual trauma or sexually inappropriate behavior [Medium-Low]; and
 - (E) Appropriateness [Medium-Low]; and
- (2) The assessment and approval by the professional level service provider is documented and dated in the child's record [Medium-Low]; and
- (3) Their age difference is less than two years. [Medium-Low]

§748.1939. How much general living space and floor space in a bedroom must I provide for children and young adults who are in my care?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

January 2007

For adult residents, you must meet the space requirements listed in §748.3351 of this title (relating to What are the requirements for general living space?) and §748.3357 of this title (relating to What are the requirements for floor space in a bedroom used by a child?). [Medium-Low]

§748.1941. What must I do if an adult resident is responsible for his own medication?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

January 2007

If an adult resident is responsible for his own medication, you must:

- (1) Establish written safeguards to prevent children in care from having access to the medications [Medium]; and
- (2) Implement the safeguards. [Medium]

§748.1943. Must adult residents have a tuberculosis (TB) examination?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

January 2007

Yes. You must meet applicable requirements listed in §748.1583 of this title (relating to Who must have a tuberculosis (TB) examination?). [Medium]

§748.1945. What must I do if an adult resident has a positive tuberculosis test result?

Subchapter K, Operations That Provide Care for Children and Adults

Division 2, General Requirements

January 2007

You must meet applicable requirements listed in §748.1581 of this title (relating to What health precautions must I take if someone in my operation has a communicable disease?). [Medium]

Subchapter L, Medication

Division 1, Administration of Medication

§748.2001. What consent must I obtain to administer medications?

Subchapter L, Medication

Division 1, Administration of Medication

January 2007

- (a) You must obtain a general written consent to administer routine, preventive, and emergency medications. [High]
- (b) You must obtain a written, signed, and dated consent, specific to the psychotropic medication to be administered, from the person legally authorized to give medical consent before administering a new psychotropic medication to a child, per §748.2253 of this title (relating to If my operation employs or contracts with a health-care professional who prescribes psychotropic medications to a child in care, what information must I provide the person legally authorized to give consent before requesting his consent for the child to be placed on psychotropic medication?) or §748.2255 of this title (relating to If my operation does not employ or contract with a health-care professional who prescribes psychotropic medications to a child in care, what information must I provide the person legally authorized to give medical consent prior to the health-care professional prescribing psychotropic medications to a child in care?). [High]

Best Practice Suggestion

The following are recommended before a health-care professional prescribes a psychotropic medication for a child in care:

- Develop clearly defined target symptoms and treatment goals for the child's use of psychotropic medications.
- Ask the health-care professional to consider potential side effects for the child and evaluate the overall benefit-to-risk ratio of pharmacotherapy for the child.
- Consider the role of nonpharmacological interventions, except in urgent situations.
- Document appropriate monitoring of indices such as height, weight, blood pressure, or other medical/laboratory findings.

§748.2003. What are the requirements for administering prescription medication?

Subchapter L, Medication

Division 1, Administration of Medication

January 2017

- (a) To the best of your knowledge, you must inform the person legally authorized to give medical consent of the benefits, risks, and side effects of all prescription medication and treatment procedures used and the medical consequences of refusing them, and/or provide the name and telephone number of the prescribing health-care professional for more information. [High]
- (b) For prescription medications, you must:
 - (1) Be informed about possible side effects of medications administered to the child [Medium-High];
 - (2) Store all medication in the original container unless you have an additional container with the same label and instructions [Medium-High];
 - (3) Administer all medications according to the instructions on the label or according to a prescribing health-care professional's subsequent signed orders (See §748.2005 of this title (relating to May I accept verbal orders on the administration of medication?)) [Medium-High];
 - (4) Administer each child's medication within one hour of preparation [Medium];
 - (5) Ensure the child has taken the medication as prescribed [Medium-High];
 - (6) Ensure a person trained in and authorized to administer medication administers the medication to a child in care unless the child is on a self-medication program [Medium-High];
 - (7) Maintain any documentation provided by the health-care professional on the administration of current medication [Medium];
 - (8) Not physically force a child to take medication except as allowed by §748.2455(a)(2)(B) of this title (relating to What actions must a caregiver take before using a permitted type of emergency behavior intervention?) [Medium-High];
 - (9) Ensure that your employees do not provide any medication or treatment to a child except on written orders of a health-care professional [High];
 - (10) Not borrow or administer medication to a child that is prescribed to another person [Medium-High]; and

- (11) Not administer medication to more than one child from the same container. Only the child for whom the medication was prescribed may use the medication. [Medium-High]

§748.2005. May I accept verbal orders on the administration of medication?

Subchapter L, Medication

Division 1, Administration of Medication

January 2007

- (a) Assuming you have obtained written consent according to §748.2001 of this title (relating to What consent must I obtain to administer medications?), a licensed health-care professional may provide verbal orders. However, the health-care professional must write and sign orders within 72 hours of the verbal order. [Medium-High]
- (b) The verbal order must be documented in the child's record, including the health care professional's name and the date and time of the call. [Medium-High]

§748.2009. What are the requirements for administering nonprescription medication and supplements?

Subchapter L, Medication

Division 1, Administration of Medication

January 2017

- (a) For non-prescription medications and supplements, you must:
- (1) Follow the label instructions for dosage [High];
 - (2) Inform the child's prescribing health-care professional of the administration and dosage of any non-prescription medication or supplements to ensure the nonprescription medication and/or supplements are not contraindicated with any other medication prescribed to the child or the child's medical conditions. [Medium-High]
- (b) You may give nonprescription medication or supplements to more than one child from one container.

Division 2, Self-Administration of Medication

§748.2051. What are the requirements for a self-medication program?

Subchapter L, Medication

Division 2, Self-Administration of Medication

September 2010

For a child to be on a self-medication program:

- (1) The child's parent must give written authorization for the child to be on the program [Medium];
- (2) The child's service plan must include the self-medication program and any requirements for caregiver supervision [Medium]; and
- (3) The health-care professional who prescribed the medication must be consulted, and any concerns of the health-care professional documented in the child's record. [Medium-High]

§748.2053. Who must record the medication dosage if a child is on a self-medication program?

Subchapter L, Medication

Division 2, Self-Administration of Medication

January 2017

When a child who is on a self-medication program takes a dosage of the medication, you must ensure there is a system for reviewing the child's medication each day and that the child either [Medium]:

- (1) Records the daily dosage; or
- (2) Reports the medication to an appropriate employee or service provider, who must then do the actual daily recording.

Division 3, Medication Storage and Destruction

§748.2101. What medication storage requirements must my operation meet?

Subchapter L, Medication

Division 3, Medication Storage and Destruction

January 2017

You must:

- (1) Store medication in a locked container [High];
- (2) Keep medication inaccessible other than to employees responsible for stored medication [High];
- (3) Store medication covered by Schedule II of the Texas Controlled Substances Act under double lock in a separate container. For example, a double lock can include a lock on the cabinet or filing cabinet and the door to the closet where medications are stored [Medium-High];
- (4) Make provisions for storing medication that requires refrigeration [Medium-High];
- (5) Keep medication storage area(s) clean and orderly [Medium-High];
- (6) Remove discontinued medication immediately and destroy it in a way that ensures that children do not have access to it [Medium-High];
- (7) Remove medication on or before the expiration date and destroy it in a way that ensures that children do not have access to it [Medium-High];
- (8) Remove medication of a discharged or deceased child immediately and destroy it in a way that ensures that children do not have access to it [Medium]; and
- (9) Provide prescription medication to the person to whom a child is discharged or transferred if the child is taking the medication at that time. [Medium-High]

§748.2103. What are the requirements for discontinued or expired medication?

Subchapter L, Medication

Division 3, Medication Storage and Destruction

January 2007

- (a) Discontinued medication, expired medication, and medication left at your operation must be inventoried and stored separately from current medications as directed by the administrator. [Medium-High]
- (b) When you have an accumulation of this medication, you must destroy the medication in accordance with state and federal law and in a way that ensures children do not have access to it. The medication must be destroyed by [Medium]:
- (1) A health-care professional or pharmacist; or
 - (2) The licensed child-care administrator and another adult who is not a resident.

Best Practice Suggestion

When medication is destroyed, it is a good idea to have the person(s) involved in the medication destruction sign a record that lists the following information:

- Name of the child to whom the medication was prescribed;
- Another form of identification for the child, such as a child's file number;
- The prescription number and the name of the pharmacy;
- The name of the medication, strength, and quantity destroyed; and
- The date of destruction.

It is best to retain the record of destroyed medication at least one year from the date of destruction.

Division 4, Medication Records

§748.2151. What records must you maintain for each child receiving medication?

Subchapter L, Medication

Division 4, Medication Records

January 2017

- (a) You must maintain a cumulative medication record of all [Medium-High]:
 - (1) Prescription medication dispensed to each child; and
 - (2) Nonprescription medications and supplements that are dispensed to a child under five years old.
- (b) The cumulative medication record must be updated:
 - (1) Within 2 hours of administering medication, unless you operate a cottage home model [Medium-High]; or
 - (2) Within 24 hours of administering medication if you operate a cottage home model. [Medium-High]
- (c) You must maintain the medication record, which must include:
 - (1) Child's full name [Medium-High];
 - (2) Prescribing health-care professional's name, if applicable; [Medium]
 - (3) Reason medication was prescribed, for prescription medication [Medium];
 - (4) Medication name, strength, and dosage [Medium-High];
 - (5) Date (day, month, and year) and time the medication was administered [Medium-High];
 - (6) Name and signature of the person who administered the medication [Medium];
 - (7) Child's refusal to accept medication, if applicable [Medium]; and
 - (8) Reasons for administering the medication, including the specific symptoms, condition, and/or injuries of the child that you are treating, only for [Medium-High]:
 - (A) PRN psychotropic medications; and
 - (B) Nonprescription medications and supplements for children under five years old.
- (d) Unless you operate on a cottage home model, you must count each medication prescribed to a child at least daily and document the count. The medication count must match the medication documentation. [Medium-High]

- (e) You must document in the medication record any non-prescription medication or supplement that is given to the child and how often the child receives the medication or supplement. [Medium]
- (f) You must document any prohibited prescription medications (for example, medication allergies or contraindications) or prohibited nonprescription medications and supplements in the medication record. [High]
- (g) You must incorporate the medication record into the child's record. [Medium-Low]

Helpful Information

Documenting the time a medication is given:

For medications with regularly scheduled doses, you may use the regularly scheduled time to document giving the medication as long as it is given within thirty minutes of the scheduled time. Otherwise, you must document the actual time the medication is given.

Example: For a regularly scheduled 9:00 a.m. medication given at 9:20, you may document 9:00 a.m.; if the medication is given at 9:45, then you must document 9:45 a.m.

If you document the time by initialing the regularly scheduled time (pre-printed on the form), there must be space on the form to document the time given when it is outside the 30-minute window.

For medications that are PRN or one-time only, you must document the exact time the medication is given.

Documenting the name and signature of the person who administered a medication:

The purpose of the signature is to be able to identify the person who administered a specific medication to a child, if a concern arises later about that medication. Licensing requires one full signature for each person who administers medication, but there is no need for the person to record a full signature for each dose of medication that he/she administers. Most medication records provide space for a signature and matching initials (usually at the bottom of the page or on the back), then only require a person to use his/her initials to record each time he/she actually gives a dose of medication. Using this system, the initials can be matched to the signature as needed. This complies with minimum standards.

Division 5, Medication and Label Errors

§748.2201. What is a medication error?

Subchapter L, Medication

Division 5, Medication and Label Errors

January 2007

A medication error includes, but is not limited to, the following:

- (1) A child receives the wrong medication;
- (2) A child receives medication prescribed for someone else;
- (3) A child receives the wrong dosage of medication;
- (4) A child receives medication at the wrong time;
- (5) A medication dose is skipped or missed;
- (6) A child receives expired medication;
- (7) Not following the medication administration instructions, such as giving a child medication on an empty stomach when the medication should be given with food; and
- (8) A child receives medication that was not stored as required to maintain the effectiveness of the medication, such as refrigerating or not refrigerating the medication or exposing the medication to heat or sunlight.

§748.2203. What must I do if I find a medication error?

Subchapter L, Medication

Division 5, Medication and Label Errors

January 2007

- (a) If you find a medication error regarding a prescribed medication, you must contact a health-care professional immediately, unless the error is the type described in paragraph (4) or (5) of §748.2201 of this title (relating to What is a medication error?), and follow the health-care professional's recommendations. [Medium-High]
- (b) If you find a medication error regarding a nonprescription medication, you must take the appropriate and necessary actions as required by the circumstances. [Medium-High]

(c) For all medication errors, you must document the following within 24 hours [Medium-High]:

- (1) The time and date of the error [Medium-High];
- (2) The medication error [Medium-High];
- (3) The time and date of the call(s) to the licensed health-care professional, if applicable [Medium-High];
- (4) The name and title of the health-care professional contacted, if applicable [Medium-High]; and
- (5) The health-care professional's medical recommendations for ensuring the child's safety, if applicable. [Medium-High]

§748.2205. What must I do if I find a medication label error?

Subchapter L, Medication

Division 5, Medication and Label Errors

January 2007

If you find a medication label error, you must:

- (1) Report the error to the pharmacist [Medium]; and
- (2) Have the label on the medication container corrected as soon as possible, but no later than the next business day. [Medium]

Division 6, Side Effects and Adverse Reactions to Medication

§748.2231. What must I do if a child has an adverse reaction to a medication?

Subchapter L, Medication

Division 6, Side Effects and Adverse Reactions to Medication

January 2017

If a child has an adverse reaction (unexpected or dangerous reaction) to a medication, you must:

- (1) Immediately report the reaction to a health-care professional and the child's parent [High];
- (2) Follow the health-care professional's recommendations [High];
- (3) Seek further medical care for the child if the child's condition appears to worsen [High]; and
- (4) Document in the child's medical record the:
 - (A) Adverse reactions that the child had to the medication; [Medium-High]
 - (B) Time and date of call(s) to the health-care professional; [Medium-High]
 - (C) Name and title of the health-care professional contacted [Medium-High]; and
 - (D) Health-care professional's medical recommendations for ensuring the child's safety. [Medium-High]

§748.2233. What must I do if a child experiences side effects from any medications?

Subchapter L, Medication

Division 6, Side Effects and Adverse Reactions to Medication

January 2017

- (a) A side effect from any medication is an effect of medication in addition to the medication's intended effect, often an undesirable effect.
- (b) If a child experiences side effects from any medication, you must:
 - (1) Document the observed and reported side effects [Medium-High];
 - (2) Immediately report any serious side effects to the child's prescribing health-care professional and the child's parent [Medium-High]; and
 - (3) Report any other side effect to the prescribing health-care professional within 72 hours. [Medium-High]

Division 7, Use of Psychotropic Medication

§748.2253. If my operation employs or contracts with a health-care professional who prescribes psychotropic medications to a child in care, what information must I provide the person legally authorized to give consent before requesting his consent for the child to be placed on psychotropic medication?

Subchapter L, Medication

Division 7, Use of Psychotropic Medication

January 2007

- (a) Before requesting the person's written consent to give the child psychotropic medication, the prescribing health-care professional must give the following in writing or document a discussion with the person or a combination of both [Medium-High]:
- (1) The child's diagnosis [Medium-High];
 - (2) The nature of the child's mental illness or condition [Medium-High];
 - (3) An explanation of the purpose of the medication [Medium-High];
 - (4) A description of the benefits expected Medium;
 - (5) A description of any accompanying discomforts and risks, including those which could result from long-term use of the medication, and possible side effects, including side effects that are known to frequently occur in persons, side effects to which the child may be predisposed, and the nature and possible occurrence of irreversible symptoms [Medium-High];
 - (6) A statement of whether the medication is habituating in nature [Medium-High];
 - (7) Alternative interventions to the use of psychotropic medication that have been attempted and that have been unsuccessful [Medium-High];
 - (8) Other alternative treatments or procedures to the use of the psychotropic medication [Medium-High];
 - (9) Risks and benefits of the alternative treatments or procedures [Medium-High];
 - (10) Risks and benefits of not receiving or undergoing a treatment or procedure [Medium-High];
 - (11) An explanation that the person legally authorized to give medical consent may ask questions about the child's response to the medication, and may review your daily records on request [Medium-High]; and

(12) An explanation that the person legally authorized to give medical consent may withdraw consent and request the medication be discontinued at any time. [Medium-High]

(b) The health-care professional must offer to answer any questions the person legally authorized to give consent has about the medication. [Medium-High]

(c) The person must sign a consent form that acknowledges that you have provided all of the information set forth in subsection (a) of this section. A copy of this signed consent form must be filed in the child's record. [Medium-High]

§748.2255. If my operation does not employ or contract with a health-care professional who prescribes psychotropic medications to a child in care, what information must I provide the person legally authorized to give medical consent prior to the health-care professional prescribing psychotropic medications to a child in care?

Subchapter L, Medication

Division 7, Use of Psychotropic Medication

January 2007

If you are requesting consent and the person legally authorized to give consent is not privy to this information, you must:

(1) Before requesting the person's written consent to give the child psychotropic medication, provide information in writing or document a discussion with the person regarding [Medium-High]:

(A) The nature of the child's mental illness or condition [Medium-High];

(B) A general explanation of the purpose of the medication [Medium-High];

(C) A general description of the benefits expected Medium;

(D) An explanation that the person may ask questions about the child's response to the medication [Medium-High]; and

(E) An explanation that the person may withdraw medical consent and request the medication be discontinued at any time. [Medium-High]

(2) Offer to answer any questions the person legally authorized to give medical consent has about the medication and/or provide the name and telephone number of the prescribing health-care professional for further information. [Medium-High]

- (3) Obtain a signed consent form from the person legally authorized to give medical consent that acknowledges that you have provided all of the information set forth in paragraph (1) of this section. A copy of this signed consent form must be filed in the child's record. [Medium-High]

§748.2257. What are the requirements if a physician orders administration of a psychotropic medication to a child in an emergency?

Subchapter L, Medication

Division 7, Use of Psychotropic Medication

January 2007

- (a) If a physician has made a determination that there is an emergency according to §266.009 of the Family Code and the emergency requires the administration of a psychotropic medication, then you must follow the physician's orders and do not have to obtain consent prior to the administration of the medication. [Medium-High]
- (b) Within 72 hours after you have administered the medication, you must notify the parent and the person legally authorized to give medical consent. [Medium-High]
- (c) The physician's statement regarding the emergency and the prescription must be documented in the child's record. [Medium]

§748.2259. What information must I document about a child's use of psychotropic medication?

Subchapter L, Medication

Division 7, Use of Psychotropic Medication

January 2007

- (a) You must maintain a daily record of the child's use of such medication according to the requirements in §748.2151 of this title (relating to What records must I maintain for each child receiving medication?). [Medium-High]
- (b) You must document in the child's record a description of any noticeable change in the child's behavior in response to the medication. [Medium]
- (c) You must provide the information in subsection (b) of this section to the prescribing health-care professional or the child's current health-care professional to use in evaluating the appropriateness of continuing the medication. You must document the health-care professional's evaluation and review in the child's record. [Medium]

§748.2261. If my operation employs or contracts with a health-care professional who prescribes psychotropic medications to a child in care, what are the requirements for evaluating whether a child should continue taking a psychotropic medication?

Subchapter L, Medication

Division 7, Use of Psychotropic Medication

January 2007

- (a) If a child takes psychotropic medications, the prescribing health-care professional must evaluate and document in the child's medication record a description of the child's response to the medication and an assessment of its effectiveness and the appropriateness of continuing the medication at least quarterly. The written evaluation must include any reasons for discontinuing the medication. [Medium-High]
- (b) If the health-care professional decides that he can evaluate the appropriateness of continuing the medication without seeing the child, you do not have to schedule an appointment for the evaluation.
- (c) The health-care professional must consider the target symptoms and treatment goals in evaluating the child's use of psychotropic medications. [Medium]
- (d) The health-care professional must document whether the child needs to continue taking the medication. You must document the health-care professional's decision in the child's record. [Medium-High]
- (e) If the health-care professional does not substantiate the effectiveness of a specific psychotropic medication within 90 days, the health-care professional must provide a written rationale for continuing the medication for an additional period. The continuation of the medication may not exceed an additional 90 days (for a total of 180 days) if effectiveness is not substantiated by the health-care professional. A copy of the written rationale must be documented in the child's record. [Medium-High]

Division 8, Unassigned Epinephrine Auto-Injectors

§748.2271. What are the requirements if my operation chooses to maintain and administer unassigned epinephrine auto-injectors?

Subchapter L, Medication

Division 8, Unassigned Epinephrine Auto-Injectors

October 2021

If your operation maintains and administers unassigned epinephrine auto-injectors to use when a child in care has an emergency anaphylaxis reaction, you must:

- (1) Adopt and implement a written policy that complies with the unassigned epinephrine auto-injector requirements set by the Texas Department of State Health Services, as specified in 25 TAC Chapter 40, Subchapter C (relating to Epinephrine Auto-Injector Policies in Youth Facilities) and Texas Health and Safety Code §773.0145 [High];
- (2) Notify the child’s parent, immediately after ensuring the safety of the child, if the child has had an emergency anaphylaxis reaction that required administration of an unassigned epinephrine auto-injector [High]; and
- (3) Maintain and make available for review, upon our request, proof that you have notified the child’s parent of an incident where the child in care had an emergency anaphylaxis reaction that required administration of an unassigned epinephrine auto-injector. [Medium]

Helpful Information
DSHS requirements for the maintenance and administration of unassigned epinephrine auto-injectors include requirements for: • Training; • Storage; • Administration; • Disposal; • Reporting; and • Parental notification of policies. You can find more information about these requirements, as well as definitions pertaining to anaphylaxis, at Allergies and Anaphylaxis, Epinephrine Auto-Injector Policies in Youth Facilities, and in the CCR TA Library.

Subchapter M, Discipline and Punishment

§748.2301. What are the requirements for disciplinary measures?

Subchapter M, Discipline and Punishment

January 2007

- (a) Only a caregiver known to and knowledgeable of a child may discipline the child. [Medium]
- (b) Each disciplinary measure must:
 - (1) Be consistent with your policies and procedures [Medium];
 - (2) Not be physically or emotionally damaging to the child [High];
 - (3) Be individualized to meet each child's needs [Medium];
 - (4) Be appropriate to the child's level of understanding, age, and developmental level [Medium]; and
 - (5) Be appropriate to the incident and severity of the behavior demonstrated. [Medium]
- (c) The goal of each disciplinary measure must be to teach the child acceptable behavior and self-control. The caregiver must explain the reason for the disciplinary measure when the caregiver imposes the measure. [Medium]

Best Practice Suggestion

It is a good idea for disciplinary measures to be consistent among caregivers. Using positive methods of discipline and guidance encourage self-esteem, self-control, and self-direction. Positive methods of discipline include the following:

- Using praise, positive reinforcement, and encouragement of good behavior instead of focusing only on unacceptable behavior;
- Reminding a child of behavior expectations daily by using clear, positive statements;
- Talking with the child about the situation;
- Focusing on the rule to learn and the reason for the rule;
- Focusing on solutions that are respectful, reasonable, and related to the problem behavior, rather than blaming or focusing on consequences;
- Redirecting the child's attention or behavior using positive statements;
- Providing prior notice of possible consequences for inappropriate behaviors;
- Giving the child acceptable choices or alternatives;
- Using brief supervised separation or time away from the group or situation, when appropriate for the child's understanding, age, and development. Best practice suggests that quiet time or time out from the group be limited to no more than one minute per year of the child's chronological or developmental age. However, this time frame may need to be adjusted for some children, such as a child who has attention-deficit disorder. Time out is not appropriate for infants and is not recommended for toddlers, since they are too young to understand this intervention;
- Arranging the environment to allow safe testing of limits;
- Using kind but firm action;
- Giving logical consequences that are appropriate to the situation and severity of the behavior; and
- Withholding privileges.

§748.2303. May I use corporal punishment for children in care?

Subchapter M, Discipline and Punishment

January 2007

- (a) You may not use or threaten to use corporal punishment with any child in care. [High]
- (b) Corporal punishment is the infliction of physical pain on any part of a child's body as a means of controlling or managing the child's behavior. It includes:
- (1) Hitting or spanking a child with a hand or instrument; or
 - (2) Forcing or requiring the child to do any of the following as a method of managing or controlling behavior:
 - (A) Perform any form of physical exercise, such as running laps or doing sit ups or push ups;
 - (B) Hold a physical position, such as kneeling or squatting; or
 - (C) Do any form of "unproductive work."

§748.2305. What is “unproductive work”?

Subchapter M, Discipline and Punishment

January 2007

- (a) “Unproductive work” is work that serves no purpose except to demean the child. Examples include moving rocks or logs from one pile to another or digging a hole and then filling it in. Unproductive work is never an appropriate behavior management tool.
- (b) “Unproductive work” does not include work that corrects damage that the child’s behavior caused. For example, you may require a child who defaces a fence or wall to repaint it. This example includes a logical consequence and is an acceptable behavior management tool.

§748.2307. What other methods of punishment are prohibited?

Subchapter M, Discipline and Punishment

January 2007

In addition to corporal punishment, prohibited discipline techniques include:

- (1) Any harsh, cruel, unusual, unnecessary, demeaning, or humiliating discipline or punishment [High];
- (2) Denial of mail or visits with their families as discipline or punishment [Medium];
- (3) Threatening with the loss of placement as discipline or punishment [Medium-Low];
- (4) Using sarcastic or cruel humor, and verbal abuse [Medium-High];
- (5) Maintaining an uncomfortable physical position, such as kneeling, or holding his arms out [Medium-High];
- (6) Pinching, pulling hair, biting, or shaking a child [High];
- (7) Putting anything in or on a child’s mouth, such as soap or tape [High];
- (8) Humiliating, shaming, ridiculing, rejecting, or yelling at a child [Medium-High];
- (9) Subjecting a child to abusive or profane language [Medium-High];
- (10) Placing a child in a dark room, bathroom, or closet [High];
- (11) Requiring a child to remain silent or inactive for inappropriately long periods of time for the child’s age [Medium-High];
- (12) Confining a child to a highchair, box, or other similar furniture or equipment as discipline or punishment [Medium-High];
- (13) Denying basic child rights as discipline or punishment [High];
- (14) Withholding food that meets the child’s nutritional requirements [High]; and

- (15) Using or threatening to use emergency behavior intervention as discipline or punishment [High].

§748.2309. To what extent may I restrict a child's activities as a behavior management tool?

Subchapter M, Discipline and Punishment

January 2017

- (a) Within limits, a caregiver may restrict a child's activities as a behavior management tool.
- (b) Restrictions of activities that will be imposed on a child for more than fourteen days, must have prior approval by the treatment director, service planning team, or professional level service provider. [Medium-Low]
- (c) Restrictions to a particular room or building that will be imposed on a child for more than 24 hours must have prior approval by the treatment director, service planning team, or professional level service provider. [Medium-Low]
- (d) You must inform the child and parent about any restrictions that you place on the child. [Low]
- (e) Documentation of all approvals, justification for the restriction, and informing the child and parents must be in the child's record. [Low]

§748.2311. May a child or adult in care discipline or punish another person in care?

Subchapter M, Discipline and Punishment

January 2007

No. A person in care must not discipline or punish another person in care. [Medium-High]

Subchapter N, Emergency Behavior Intervention

Division 1, Definitions

§748.2401. What do certain words mean in this subchapter?

Subchapter N, Emergency Behavior Intervention

Division 1, Definitions

January 2017

These terms have the following meaning in this subchapter:

- (1) Transitional hold – The use of a temporary restraint technique that lasts no longer than one minute as part of the continuation of a longer personal or mechanical restraint.
- (2) Triggered review – A review of a specific child’s placement, treatment plan, and orders or recommendations for intervention, because a certain number of interventions have been made within a specified period of time (e.g. three seclusions within a seven-day period).

Division 2, Types of Emergency Behavior Intervention That May Be Administered

§748.2451. What types of emergency behavior intervention may I administer?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

February 2017

- (a) If permitted in your policies and you meet the requirements of this subchapter, you may administer the following types of emergency behavior intervention to a child in your care:
 - (1) Short personal restraint [Medium-High];
 - (2) Personal restraint [Medium-High];
 - (3) Emergency medication [Medium-High];
 - (4) Seclusion:

- (A) Only for a child with an emotional disorder or an Autism Spectrum Disorder; and only if you provide treatment services to 25 or more children with emotional disorders or Autism Spectrum Disorder, or if more than 30% of the children in your care receive treatment services for emotional disorders or Autism Spectrum Disorder. Seclusion is not permitted for children receiving therapeutic camp services [Medium-High]; or
- (B) Only if you provide emergency care services to the child and only while waiting for the arrival of law enforcement or emergency medical services [Medium-High]; and
- (5) Mechanical restraint, only if you are a Residential Treatment Center. [Medium-High]
- (b) You may never administer chemical restraints. [High]
- (c) Protective and supportive devices, used appropriately, are not considered emergency behavior interventions. For information on protective and supportive devices, see Divisions 4 and 5 of Subchapter J of this chapter (relating to Child Care).

§748.2453. Who may administer emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

January 2007

Only a caregiver qualified in emergency behavior intervention may administer any form of emergency behavior intervention, except for the short personal restraint of a child. [High]

§748.2455. What actions must a caregiver take before using a permitted type of emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

September 2010

- (a) Before using a permitted type of emergency behavior intervention, the caregiver must:
 - (1) Attempt less restrictive behavior interventions that prove to be ineffective at defusing the situation [Medium-High]; and

(2) Determine that the basis for the emergency behavior intervention is [Medium-High]:

- (A) An emergency situation; or
- (B) A need for a personal restraint to administer intra-muscular medication or other medical treatments prescribed by a licensed physician, such as administering insulin to a child with diabetes.

(b) A child's active attempt to run away may be considered an emergency situation when the following is a factor:

- (1) The child is developmentally or chronologically under six years old;
- (2) The child is suicidal;
- (3) The operation is located near a high traffic area;
- (4) Adverse weather conditions pose a clear safety risk to the child; or
- (5) Other clear safety risks are present.

§748.2459. What is the appropriate use for a short personal restraint?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

September 2010

Generally, a short personal restraint is used in urgent situations, such as:

- (1) To protect the child from external danger that causes imminent significant risk to the child, such as preventing the child from running into the street or coming into contact with a hot stove. The restraint must end immediately after the danger is averted;
- (2) To intervene when a child under five years old (chronological or developmental age) demonstrates disruptive behavior, if other efforts to de-escalate the child's behavior have failed;
- (3) When a child over five years old demonstrates behavior disruptive to the environment or milieu, such as disrobing in public, provoking others that creates a safety risk, or to intervene to prevent a child from physically fighting; or
- (4) When a child is significantly damaging property, such as breaking car windows or putting holes into walls.

§748.2461. What precautions must a caregiver take when implementing a short personal restraint?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

January 2007

- (a) When a caregiver implements a short personal restraint, the caregiver must:
 - (1) Minimize the risk of physical discomfort, harm, or pain to the child [High]; and
 - (2) Use the minimal amount of reasonable and necessary physical force. [High]
- (b) A caregiver may not use any of the following techniques as a short personal restraint:
 - (1) A prone or supine restraint [High];
 - (2) Restraints that impair the child's breathing by putting pressure on the child's torso, including leaning a child forward during a seated restraint [High];
 - (3) Restraints that obstruct the airways of the child or impair the breathing of the child, including procedures that place anything in, on, or over the child's mouth, nose, or neck, or impede the child's lungs from expanding [High];
 - (4) Restraints that obstruct the caregiver's view of the child's face [High];
 - (5) Restraints that interfere with the child's ability to communicate or vocalize distress [High]; or
 - (6) Restraints that twist or place the child's limb(s) behind the child's back. [High]

§748.2463. Are there any purposes for which emergency behavior intervention cannot be used?

Subchapter N, Emergency Behavior Intervention

Division 2, Types of Emergency Behavior Intervention That May Be Administered

January 2007

Emergency behavior intervention may never be used as:

- (1) Punishment [Medium-High];
- (2) Retribution or retaliation [Medium-High];
- (3) A means to get a child to comply [Medium-High];
- (4) A convenience for caregivers or other persons [Medium-High]; or
- (5) A substitute for effective treatment or habilitation. [Medium-High]

Division 3, Orders

§748.2501. Are written orders required to administer emergency behavior intervention, and if so, who can write them?

Subchapter N, Emergency Behavior Intervention

Division 3, Orders

January 2007

According to the following chart, written orders by certain professionals are required to administer certain emergency behavior intervention:

Weight	Type of Emergency Behavior Intervention	(A) Are written orders required to administer the intervention for a specific child?	(B) Who can write orders for the use of the intervention for a specific child?
No Weight	(1) Short personal restraint	(A) NO.	(B) Not applicable.
No Weight	(2) Personal restraint	(A) NO. However, successive restraints, a restraint simultaneous with emergency medication, and/or a restraint that exceeds the maximum time limit all require orders as specified in this subchapter. PRN orders are also permitted under §748.2507 of this title (relating to Under what conditions are PRN orders permitted for a specific child?).	(B) Not Applicable.
(A) High (B) High	(3) Emergency medication	(A) YES.	(B) A licensed physician.
(A) Medium-High (B) Medium-High	(4) Seclusion	(A) YES, except written orders are not required when you provide emergency care services to the child placed in seclusion.	(B) A licensed psychiatrist, psychologist, or physician.
(A) High (B) High	(5) Mechanical restraint	(A) YES.	(B) A licensed psychiatrist.

§748.2503. Must the written order be in a child’s record before a caregiver can use an emergency behavior intervention on a child?

Subchapter N, Emergency Behavior Intervention

Division 3, Orders

January 2007

Yes, any type of written order that is required, must be in the child’s record before a caregiver can use emergency behavior intervention on that child, except for seclusion when it is necessary to prevent the child from endangering himself or others. In this seclusion situation, a licensed psychiatrist, psychologist, or physician must provide a verbal order within one hour after a caregiver initiates the seclusion. The caregiver must document this order, and the professional who provides the verbal order must provide a written version of the order within 72 hours after issuing the order. The written copy must include the time, date, and the professional’s signature.

[Medium-High]

§748.2505. What information must a written order include?

Subchapter N, Emergency Behavior Intervention

Division 3, Orders

January 2007

(a) All written orders must include the following:

- (1) A statement that the particular type of emergency behavior intervention may only be used in an emergency situation [Medium-High];
- (2) Designation of the specific intervention and procedure or technique that is authorized [Medium-High];
- (3) Any specific measures for ensuring the child’s health, safety, and well being, and the privacy of the setting that safeguards the child’s personal dignity [Medium-High];
- (4) A complete description of the behaviors and circumstances under which the intervention may be used [Medium-High];
- (5) Instructions for observation or heightened observation of the child during the intervention [Medium-High];
- (6) The behaviors that indicate the child is ready to be released from the intervention [Medium-High];
- (7) The maximum length of time the child may be restrained or secluded regardless of behaviors exhibited [Medium-High];

(8) The prescribing professional's consideration of any potential medical and/or psychiatric contraindications for the specific child, such as a history of physical or sexual abuse or victimization involving the type of intervention [Medium-High]; and

(9) Clinical justification for the intervention. [Medium-High]

(b) For emergency medication, the written order must also include instructions on how to administer the medication. [Medium-High]

(c) For mechanical restraint, the written order must also include the specific device or devices authorized. [Medium-High]

§748.2507. Under what conditions are PRN orders permitted for a specific child?

Subchapter N, Emergency Behavior Intervention

Division 3, Orders

January 2007

PRN orders for certain emergency behavior interventions are permitted under the following conditions:

Type of Emergency Behavior Intervention	Conditions:
(1) Short personal restraint	Not applicable, because short personal restraints do not require orders.

Type of Emergency Behavior Intervention	Conditions:
(2)Personal restraint	Note: Continuation orders are required for extending the maximum amount of time for a personal restraint; and an order or recommendation from the service planning team is needed to forestall some triggered reviews. (A)Orders must include the number of times a child may be restrained in a seven-day period. [Medium-High] (B)If the orders allow more than three restraints within a seven-day period, the order must include a plan for reducing the need for emergency behavior intervention. [Medium-High] (C)The licensed psychiatrist or psychologist must review PRN orders for personal restraint at least every 30 days. The review must include written clinical justification for the continuation of PRN orders and be documented in the child’s record. [Medium-High] (D) PRN orders may not be used to restrain a child beyond the maximum length of time for personal restraint. See §748.2801 of this title (relating to What is the maximum length of time that an emergency behavior intervention can be administered to a child?). [Medium-High]
(3)Emergency medication	The licensed physician must review PRN orders for emergency medication at least every 30 days. The review must include written clinical justification for the continuation of PRN orders and be documented in the child’s record. ([Medium-High])
(4)Seclusion	(A)A licensed psychiatrist ordering seclusion is permitted to use PRN orders; however, a licensed psychologist is not. ([Medium-High]) (B)PRN orders may not be used to seclude a child beyond the maximum length of time for seclusion. See §748.2801 of this title. ([Medium-High]) (C)The psychiatrist must review PRN orders for seclusion at least every 30 days. The review must include written clinical justification for the continuation of PRN orders and be documented in the child’s record. ([Medium-High])
(5)Mechanical restraint	PRN orders are not permitted. (High)

Division 4, Responsibilities During Administration of Any Type of Emergency Behavior Intervention

§748.2551. What responsibilities does a caregiver have when implementing a type of emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 4, Responsibilities During Administration of Any Type of Emergency Behavior Intervention

February 2017

- (a) The use of emergency behavior intervention must be an appropriate response to the behavior demonstrated, and de-escalation must have failed. [Medium-High]
- (b) The caregiver must act to protect the child's safety and consider [High]:
 - (1) The characteristics of the immediate physical environment [High];
 - (2) The permitted types of emergency behavior intervention [Medium-High]; and
 - (3) The potential risk of harm in using emergency behavior intervention versus the risk of not using emergency behavior intervention. [High]
- (c) The caregiver must:
 - (1) Initiate an emergency behavior intervention in a way that minimizes the risk of physical discomfort, harm, or pain to the child [High]; and
 - (2) Use the minimal amount of reasonable and necessary physical force to implement the intervention. [High]
- (d) The caregiver must make every effort to protect the child's:
 - (1) Privacy, including shielding the child from onlookers [Medium]; and
 - (2) Personal dignity and well-being, including ensuring that the child's body is appropriately covered. [Medium]
- (e) As soon as possible after starting any type of emergency behavior intervention, the caregiver must:
 - (1) Explain to the child the behaviors the child must exhibit to be released or have the intervention reduced, if applicable [Medium-High]; and
 - (2) Permit the child to suggest actions the caregivers can take to help the child de-escalate. [Medium-High]

- (f) If the child does not appear to understand what the child must do to be released from the emergency behavior intervention, the caregiver must attempt to re-explain it every 15 minutes until the child understands or is released from the intervention. [Medium-High]

§748.2553. When must a caregiver release a child from an emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 4, Responsibilities During Administration of Any Type of Emergency Behavior Intervention

September 2010

A child must be released as follows:

Type of Emergency Behavior Intervention	The caregiver must release the child:
(1) Short personal restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately [High]; or (B) Within one minute, or sooner if the danger is over or the disruptive behavior is de-escalated. [Medium-High]
(2) Personal restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately [High]; (B) Within one minute of the implementation of a prone or supine hold [High]; (C) As soon as the child's behavior is no longer a danger to himself or others [Medium-High]; (D) As soon as the medication is administered [Medium-High]; or (E) When the maximum time allowed for personal restraint is reached. [Medium-High]
(3) Emergency medication	Not applicable.

Type of Emergency Behavior Intervention	The caregiver must release the child:
(4) Seclusion	(A) Immediately when an emergency health situation occurs during the seclusion. The caregiver must obtain treatment immediately [High]; (B) As soon as the child's behavior is no longer a danger to himself or others [Medium-High]; (C) No later than five minutes after the child begins exhibiting the required behaviors [Medium-High]; (D) When the maximum time allowed for seclusion is reached [Medium-High]; (E) If the child falls asleep in seclusion. In this situation, the caregiver must: (i) Unlock the door [Medium]; (ii) Continuously observe the child until he awakens [Medium]; and (iii) Evaluate his overall well-being [Medium-High]; or (F) If the child is receiving emergency care services: (i) As soon as the child is no longer a danger to himself or others [Medium-High]; (ii) Upon the arrival of a medical professional [Medium-High]; or (iii) Upon assistance from law enforcement or the fire department. [Medium-High]
(5) Mechanical restraint	(A) Immediately when an emergency health situation occurs during the restraint. The caregiver must obtain treatment immediately [High]; (B) As soon as the child's behavior is no longer a danger to himself or others [Medium-High]; (C) No later than five minutes after the child begins exhibiting the required behaviors [Medium-High]; (D) When the maximum time allowed for mechanical restraint is reached [Medium-High]; or (E) If the child falls asleep in the mechanical restraint. In this situation, the caregiver must release the child from the restraint and continuously observe the child until he awakens and evaluate him. [Medium-High]

Division 5, Additional Responsibilities During Administration of a Personal Restraint

§748.2601. Who must monitor a personal restraint?

Subchapter N, Emergency Behavior Intervention

Division 5, Additional Responsibilities During Administration of a Personal Restraint

February 2017

- (a) During any personal restraint, a caregiver qualified in emergency behavior intervention must:
 - (1) Monitor the:
 - (A) Personal restraint to make sure it is being performed appropriately [High]; and
 - (B) Child's breathing and other signs of physical distress [High]; and
 - (2) Take appropriate action to ensure adequate respiration, circulation, and overall well-being. [High]
- (b) If available, a caregiver who is not restraining the child should monitor the child. However, general residential operations with a capacity of more than 16 children must monitor prone and supine restraints as required in §748.2605(b) of this title (relating to What personal restraint techniques are prohibited?).

§748.2603. What is the appropriate action for a caregiver to take to ensure the **child's** adequate respiration, circulation, and overall well-being?

Subchapter N, Emergency Behavior Intervention

Division 5, Additional Responsibilities During Administration of a Personal Restraint

February 2017

Appropriate action includes responding prudently to a potentially life-threatening situation, for example, releasing a child when a child is unresponsive or indicates the child cannot breathe and immediately seeking medical assistance from a health-care professional.

Helpful Information

Signs of distress:

- Circulation – Are the child's extremities cold to the touch? Are the child's extremities turning blue or is the child turning blue around the mouth?
- Respiration – Is the child's breathing rapid and shallow? Is there an absence of breathing? Is the child saying he or she cannot breathe?
- Neurological – Is the child disoriented? Is he or she having a seizure?
- Gastrointestinal – Is the child vomiting or losing control of his or her bowels?
- Muscular-Skeletal – Is there apparent bruising, swelling, and/or complaints of pain?

§748.2605. What personal restraint techniques are prohibited?

Subchapter N, Emergency Behavior Intervention

Division 5, Additional Responsibilities During Administration of a Personal Restraint

September 2010

(a) The following personal restraint techniques are prohibited:

- (1) Restraints that impair the child's breathing by putting pressure on the child's torso, including restraints that obstruct the child's lungs from expanding such as leaning a child forward during a seated restraint [High];
- (2) Restraints that obstruct the child's airway, including procedures that place anything in, on, or over the child's mouth, nose, or neck [High];
- (3) Restraints that obstruct a caregiver's ability to view the child's face [High];
- (4) Restraints that interfere with the child's ability to communicate or vocalize distress [High]; or
- (5) Restraints that twist or place the child's limb(s) behind the child's back. [High]

(b) Prone and supine restraints are prohibited except:

- (1) As a transitional hold that lasts no longer than one minute [High];
- (2) As a last resort when other less restrictive interventions have proven to be ineffective [High]; and
- (3) When an observer meeting the following qualifications ensures the child's breathing is not impaired [High]:
 - (A) Trained to identify risks associated with positional, compression, or restraint asphyxia [High];
 - (B) Trained to identify risks associated with prone and supine holds [High]; and

(C)Not involved in the restraint. General residential operations and residential treatment centers with a capacity of 16 or fewer children are exempt from meeting this requirement. [High]

Division 6, Additional Responsibilities During Administration of Seclusion

§748.2651. What are the additional responsibilities for implementing seclusion?

Subchapter N, Emergency Behavior Intervention

Division 6, Additional Responsibilities During Administration of Seclusion

January 2007

- (a) Caregivers must continuously observe the child placed in seclusion. This observation can take place through a window or a one-way mirror. The use of a video camera to continuously observe a child in seclusion is not permitted. [Medium-High]
- (b) There must be a protected, private, and observable environment or room that safeguards the child's personal dignity and well-being that must [Medium]:
 - (1) Have 40 square-feet of floor space and a ceiling height of at least eight feet [Medium];
 - (2) Be free of safety hazards [Medium-High];
 - (3) Be adequately ventilated during warm weather and adequately heated during cold weather [Medium-High];
 - (4) Be appropriately lighted [Medium-High]; and
 - (5) Have a mat and bedding, unless the prescribing professional writes orders to the contrary. [Medium]

§748.2653. What must occur for a caregiver to remove the mat or bedding without a written order?

Subchapter N, Emergency Behavior Intervention

Division 6, Additional Responsibilities During Administration of Seclusion

January 2007

- (a) If a caregiver cannot obtain a written order to remove the mat or bedding, the caregiver must obtain and document a licensed psychiatrist's, psychologist's, or

physician's verbal order with the rationale for the removal no later than one hour following the intervention. [Medium-Low]

(b) The verbal order must include an evaluation by the psychiatrist, psychologist, or physician assessing whether seclusion is the most appropriate intervention for the child given the situation. [Medium]

(c) The professional who provides the verbal order must provide a written version of the order within 72 hours of issuing the order. The written copy must include the time, date, and the professional's signature. [Medium-Low]

Division 7, Additional Responsibilities During Administration of a Mechanical Restraint

§748.2701. What are the additional responsibilities for implementing a mechanical restraint?

Subchapter N, Emergency Behavior Intervention

Division 7, Additional Responsibilities During Administration of a Mechanical Restraint

February 2017

(a) Only commercially available devices specifically designed for the safe and comfortable restraint of humans may be used as mechanical restraints. [High]

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

(c) There must be a protected, private, and observable environment or room that safeguards the child's personal dignity and well-being. [Medium]

(d) Caregivers must continuously observe the child placed in mechanical restraint ensuring the child has adequate respiration, circulation, and overall well-being. This observation can take place through a window or a one-way mirror. The use of a video camera to continuously observe a child in mechanical restraint is not permitted. In addition to continual observation, a caregiver must check for circulation, skin color, and respiration at least every 15 minutes. [High]

(e) You must notify a child's parent that mechanical restraint was used on the child within 72 hours after the restraint is concluded. [Medium]

§748.2703. May my residential treatment center use altered mechanical restraint devices when restraining a child?

Subchapter N, Emergency Behavior Intervention

Division 7, Additional Responsibilities During Administration of a Mechanical Restraint
January 2007

Yes; however, any alteration of commercially available mechanical restraint devices must be reviewed and approved by a licensed psychiatrist who must [Medium-High]:

- (1) Base his approval on the individual child's special physical needs [Medium-High]; and
- (2) Take into consideration any potential medical contraindications, including psychiatric contraindications, such as the child's history of sexual abuse or previous use of mechanical restraints. [Medium-High]

§748.2705. What mechanical and other restraint devices are prohibited?

Subchapter N, Emergency Behavior Intervention

Division 7, Additional Responsibilities During Administration of a Mechanical Restraint
September 2010

The following must not be used as restraint devices:

- (1) Devices with metal wrist or ankle cuffs, such as handcuffs or shackles [Medium-High];
- (2) Devices with rubber bands, rope, or cord [Medium-High];
- (3) Devices with padlocks, key locks, or fastening devices [Medium-High];
- (4) Long ties, such as leashes [Medium-High];
- (5) Bed sheets or blankets [Medium-High]; and
- (6) Veil beds. [Medium-High]

Division 8, Successive Use and Combinations of Emergency Behavior Intervention

§748.2751. May a caregiver successively use emergency behavior interventions on a child?

Subchapter N, Emergency Behavior Intervention

Division 8, Successive Use and Combinations of Emergency Behavior Intervention

February 2017

- (a) A caregiver may successively use emergency behavior interventions on a child only if:
- (1) Allowed by your policies [Medium-High];
 - (2) Permitted by rules of this subchapter for both types of emergency behavior intervention [Medium-High]; and
 - (3) The following written orders are met:
 - (A) If the successive intervention is seclusion immediately following a personal restraint or mechanical restraint: the written order for the seclusion meets the requirements in Division 3 of this subchapter (relating to Orders) and provides clinical justification for the use of the seclusion successive to a personal restraint or a mechanical restraint [Medium-High];
 - (B) If the successive intervention is a mechanical restraint immediately following a personal restraint or seclusion: the written order for the mechanical restraint meets the requirements in Division 3 of this subchapter and permits and provides clinical justification for the use of the mechanical restraint successive to a personal restraint or a seclusion [Medium]; and
 - (C) If the successive intervention is a personal restraint immediately following a seclusion or a mechanical restraint: The professional ordering the seclusion or mechanical restraint must approve of and provide clinical justification for the successive use of the personal restraint in a written order. [Medium]
- (b) If the successive intervention is personal restraint immediately following another personal restraint, the time spent in the personal restraints is cumulative and may not exceed the maximum length of time permitted. [Medium-High]
- (c) A caregiver must allow the child:
- (1) Bathroom privileges as needed and at least once every two hours [Medium-High];

- (2)An opportunity to drink water at least once every two hours [High];
- (3)Regularly prescribed medications unless otherwise ordered by the licensed physician [Medium-High];
- (4)Regularly scheduled meals and snacks served in a safe and appropriate manner [Medium-High]; and
- (5)An environment that is adequately ventilated during warm weather, adequately heated during cold weather, appropriately lighted, and free of safety hazards. [Medium-High]

§748.2753. May a caregiver simultaneously use emergency medication in combination with another emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 8, Successive Use and Combinations of Emergency Behavior Intervention

January 2007

- (a)A caregiver may simultaneously use emergency medication in combination with personal restraint or seclusion only if:
 - (1)Allowed by your policies [Medium-High];
 - (2)Permitted by the rules of this subchapter for both types of emergency behavior intervention [Medium-High]; and
 - (3)Written orders specifically allow the combination. [Medium-High]
- (b)The written orders must include clinical justification for the combination of emergency medication with personal restraint or seclusion that goes beyond the justification for the use of a single emergency behavior intervention. Clinical justification for the combination must be provided by [Medium-High]:
 - (1)The licensed physician ordering the emergency medication for the combination of emergency medication and seclusion; or
 - (2)Both the licensed physician ordering the emergency medication and the professional ordering the personal restraint, if they are different people.

§748.2755. May a caregiver simultaneously implement mechanical restraint in combination with emergency medication?

Subchapter N, Emergency Behavior Intervention

Division 8, Successive Use and Combinations of Emergency Behavior Intervention

September 2010

- (a) A caregiver may simultaneously implement mechanical restraint in combination with emergency medication only if:
- (1) Allowed by your policies [Medium-High];
 - (2) Permitted by the rules of this subchapter for both types of emergency behavior intervention [Medium-High]; and
 - (3) Written orders specifically allow the combination. [Medium-High]
- (b) The written orders must include clinical justification for the combination of mechanical restraint with emergency medication that goes beyond the justification for the use of a single emergency behavior intervention. Clinical justification for the combination of mechanical restraint and emergency medication must be coordinated and provided by the licensed psychiatrist ordering the mechanical restraint and the licensed physician ordering the emergency medication, if they are different people. [Medium-High]

§748.2757. May a caregiver simultaneously implement mechanical restraint in combination with seclusion?

Subchapter N, Emergency Behavior Intervention

Division 8, Successive Use and Combinations of Emergency Behavior Intervention

January 2007

No, mechanical restraint and seclusion may not be simultaneously implemented. [Medium-High]

Division 9, Time Restrictions for Emergency Behavior Intervention

§748.2801. What is the maximum length of time that an emergency behavior intervention can be administered to a child?

Subchapter N, Emergency Behavior Intervention

Division 9, Time Restrictions for Emergency Behavior Intervention

February 2017

The maximum length of time that certain emergency behavior interventions can be administered to a child is as follows:

Types of Emergency Behavior Intervention	The maximum length of time is:
(1) Short personal restraint	One minute. [Medium-High]
(2) Personal restraint	(A) For a child of any age, 30 minutes. [High] (B) A prone or supine personal restraint hold may not exceed one minute. [High]
(3) Emergency medication	Not applicable.
(4) Seclusion	(A) For a child under nine years old, one hour. [Medium-High] (B) For a child nine years old or older, two hours. [Medium-High]
(5) Mechanical restraint	(A) For a child under nine years old, 30 minutes. [High] (B) For a child nine years old or older, one hour. [High]

§748.2803. How long may a caregiver seclude or mechanically restrain a child who has been released within the same 12-hour time period?

Subchapter N, Emergency Behavior Intervention
Division 9, Time Restrictions for Emergency Behavior Intervention
January 2007

If a child is released from seclusion or a mechanical restraint and then secluded or mechanically restrained again within the same 12-hour period, the time spent in seclusion or mechanical restraint is cumulative and may not exceed the maximum length of time permitted. [High]

§748.2805. Can a caregiver exceed the maximum length of time that an emergency behavior intervention can be administered to a child?

Subchapter N, Emergency Behavior Intervention
Division 9, Time Restrictions for Emergency Behavior Intervention
February 2017

A caregiver may exceed the maximum length of time for certain emergency behavior interventions as follows:

Types of Emergency Behavior Intervention	The maximum length of time is:
(1)Short personal restraint	May not be exceeded. [Medium-High]
(2)Personal restraint	May be not be exceeded. [Medium-High]
(3)Emergency medication	Not applicable.

Types of Emergency Behavior Intervention	The maximum length of time is:
(4) Seclusion	May be exceeded if the caregiver obtains a written continuation order before the end of the time period from the licensed psychiatrist, psychologist, or physician with written clinical justification [Medium]: (A) Indicating that the emergency situation continues to exist [Medium]; and (B) For the length of time the psychiatrist, psychologist, or physician permits the child to be secluded, which must not exceed four hours. [Medium]
(5) Mechanical restraint	May be exceeded if the caregiver obtains a written continuation order before the end of the time period from the licensed psychiatrist with written clinical justification [Medium-High]: (A) Indicating that the emergency situation continues to exist [Medium-High]; and (B) For the length of time the psychiatrist permits the child to be restrained, which must not exceed four hours. [Medium-High]

§748.2807. May continuation orders be obtained verbally to exceed the maximum length of time that seclusion or mechanical restraint can be administered to a child?

Subchapter N, Emergency Behavior Intervention

Division 9, Time Restrictions for Emergency Behavior Intervention

February 2017

(a) Yes, if:

- (1) The caregiver does a face-to-face evaluation of the child [Medium-High];
- (2) Verbal authorization is obtained before the end of the maximum length of time [Medium-High];
- (3) The caregiver documents the verbal continuation orders [Medium]; and
- (4) The professional who provides the verbal order provides a written version of the order within 72 hours of issuing the order. The written copy must include the time, date, and the professional's signature. [Medium]

(b) If the seclusion and mechanical restraint continues beyond the maximum length of time, then the caregiver must allow the child:

- (1) Bathroom privileges as needed and at least once every two hours [Medium];

- (2) An opportunity to drink water at least once every two hours [Medium-High];
 - (3) Regularly prescribed medications, unless otherwise ordered by the licensed physician [Medium-High];
 - (4) Regularly scheduled meals and snacks served in a safe and appropriate manner [Medium-High]; and
 - (5) An environment that is adequately ventilated during warm weather, adequately heated during cold weather, appropriately lighted, and free of safety hazards. [Medium-High]
- (c) If the mechanical restraint continues beyond the maximum length of time, then the caregiver must also allow the child an opportunity for range-of-motion exercises for at least five minutes of each hour a child is in restraint. [Medium-High]
- (d) In no event may the order permit the seclusion or mechanical restraint to exceed four hours. [Medium-High]

Division 10, General Caregiver Responsibilities, Including Documentation, After the Administration of Emergency Behavior Intervention

§748.2851. What follow-up actions must caregivers take after the **child's behavior no longer** constitutes an emergency situation?

Subchapter N, Emergency Behavior Intervention

Division 10, General Caregiver Responsibilities, Including Documentation, After the Administration of Emergency Behavior Intervention

January 2007

- (a) The caregivers must take appropriate actions to help the child return to routine activities. [Medium] The follow-up actions of the caregivers must include:
 - (1) Providing the child with an appropriate transition and offering the child an opportunity to return to regular activities [Medium];
 - (2) Observing the child for at least 15 minutes [Medium-High]; and
 - (3) Providing the child with an opportunity to discuss the situation that led to the need for emergency behavior intervention and the caregiver's reaction to that situation. The discussion must be held in private as soon as possible and no later than 48 hours after the child's use of an emergency medication or release from any emergency behavior intervention. [Medium]
- (b) Caregivers involved in the emergency behavior intervention must conduct a post-emergency behavior intervention discussion with the child. The goal of the discussion is to allow the child and caregiver to discuss [Medium]:
 - (1) The child's behavior and the circumstances that constituted the need for an emergency behavior intervention [Medium];
 - (2) The strategies attempted before the use of the emergency behavior intervention and the child's reaction to those strategies [Medium];
 - (3) The emergency behavior intervention itself and the child's reaction to the emergency behavior intervention [Medium];
 - (4) How caregivers can assist the child in regaining self-control in the future to avoid the administration of an emergency behavior intervention [Medium]; and
 - (5) What the child can do to regain self-control in the future to avoid the administration of an emergency behavior intervention. [Medium]

- (c) Caregivers involved in the emergency behavior intervention must:
- (1) Debrief with each other concerning the incident as soon as possible after the situation has stabilized [Medium]; and
 - (2) Make reasonable efforts to debrief with children in care who witness the incident. [Medium-Low]
- (d) The supervisor(s) of the caregivers involved in the emergency behavior intervention must review the use of the emergency behavior intervention within 72 hours of the intervention. [Medium-High]
- (e) The caregivers do not have to return the child to previous activities or place the child in current activities that the group is participating in if the caregivers deem the child's participation is not in the best interests of the child or the other children in the group. However, caregivers must engage the child in an alternative routine activity.
- (f) This rule does not apply to the following types of emergency behavior intervention:
- (1) Short personal restraint; and
 - (2) Seclusion, if the child is receiving emergency care services.

§748.2853. What must the caregiver document after discussing with the child the use of the emergency behavior intervention?

Subchapter N, Emergency Behavior Intervention

Division 10, General Caregiver Responsibilities, Including Documentation, After the Administration of Emergency Behavior Intervention

September 2010

The caregiver must document the following after discussing with the child the use of the emergency behavior intervention:

- (1) The date and time the caregiver offered the discussion [Medium-Low];
- (2) The child's reaction to the opportunity for discussion [Medium-Low];
- (3) The date and time the discussion took place, if applicable [Medium-Low]; and
- (4) The content of the discussion, if applicable. [Medium-Low]

§748.2855. When must a caregiver document the use of an emergency behavior intervention, and what must the documentation include?

Subchapter N, Emergency Behavior Intervention

Division 10, General Caregiver Responsibilities, Including Documentation, After the Administration of Emergency Behavior Intervention

February 2017

(a) As soon as possible, but no later than 24 hours after the initiation of the emergency behavior intervention, the caregiver involved in the intervention must document in the child's record the following information [Medium]:

- (1) The child's name [Medium];
- (2) A description and assessment of the circumstances and specific behaviors that caused the basis for the emergency behavior intervention [Medium];
- (3) The de-escalation attempted before and during the use of the emergency behavior intervention and the child's reaction to those strategies [Medium];
- (4) The specific emergency behavior intervention administered [Medium];
- (5) The date and time the intervention was administered [Medium];
- (6) The length of time the child was restrained or secluded [Medium];
- (7) The name of the caregiver(s) that participated in the incident that led to the intervention, and who administered the intervention [Medium];
- (8) The name of the person(s) who observed the child [Medium];
- (9) The names of any witnesses to the emergency behavior intervention, including any child who witnessed the intervention [Medium];
- (10) All attempts to explain to the child what behaviors were necessary for release from the intervention [Medium];
- (11) The child's condition following the use of the medication or release from the intervention, including any injury the child sustained as a result of the intervention or any adverse effects caused by the use of the intervention. If the child received medical assistance or treatment, the caregiver must document the name of the person(s) who provided the medical assistance or treatment [Medium]; and

- (12) The actions the caregiver(s) took to facilitate the child's return to normal activities following the end of the intervention. [Medium]
- (b) Supervisors of caregivers involved in emergency behavior intervention of a child must document their review of the use of the intervention within 72 hours of the incident. [Medium-High]
- (c) If personal restraint is used, documentation must also include the specific restraint techniques used, including a prone or supine restraint used as a transitional hold. [Medium]
- (d) If emergency medication is used, documentation must also include the specific medication used and the dosage administered to the child. [Medium]
- (e) If mechanical restraint is used, documentation must also include:
- (1) The specific restraint device used [Medium]; and
 - (2) Continuous observation and regular respiration and circulation checks and times the checks were conducted. [Medium]
- (f) This rule does not apply to short personal restraints.

Division 11, Triggered Reviews

§748.2901. What circumstances trigger a review of the use of emergency behavior intervention for a specific child?

Subchapter N, Emergency Behavior Intervention

Division 11, Triggered Reviews

February 2017

- (a) The following circumstances trigger a review for certain emergency behavior interventions:

Types of Emergency Behavior Intervention	Circumstances that trigger a review:
(1) Short personal restraint	Not applicable, because short personal restraints are not monitored.
(2) Personal restraint	Except as provided by subsection (b) of this section: (A) The same child is personally restrained: (i) four times within a seven-day period. [Medium-High] (ii) more than 12 times in a single 30-day period [Medium-High]; or (B) The same child is personally restrained more often than the written order or service planning team recommendation allows. [Medium-High]
(3) Emergency medication	Emergency medication is used on the same child three times in a 30-day period. [Medium-High]
(4) Seclusion	(A) The seclusion of the same child continues for more than 12 hours [Medium-High]; or (B) The same child is secluded three times in a seven-day period. [Medium-High]
(5) Mechanical restraint	(A) The mechanical restraint of the same child continues for more than three hours [Medium-High]; or (B) The same child is mechanically restrained three times in a seven-day period. [Medium-High]

- (b) You may exceed the number of restraints otherwise allowed in (2) Personal restraint of Figure: 40 TAC §748.2901(a) for a child if a licensed psychiatrist or psychologist issues a written order or if a service planning team makes a recommendation allowing you to do so and you ensure the following:

- (1) If applicable, the recommendation from the service planning team includes the same written information as an order, as specified in §748.2505 of this title (relating to What information must a written order include?); and
- (2) At least one triggered review is conducted in accordance with §748.2907 of this title (relating to What must the triggered review include and what must be documented in the child's record?) every 30 days that personal restraints in excess of the threshold are authorized.

§748.2903. When must a triggered review occur?

Subchapter N, Emergency Behavior Intervention

Division 11, Triggered Reviews

January 2007

- (a) A triggered review must occur as soon as possible, but no later than 30 days after the review is triggered. [Medium-High]
- (b) The regularly scheduled review of the child's service plan can serve as the triggered review if it meets the requirements in §748.2907 of this title (relating to What must the triggered review include and what must be documented in the child's record?) and takes place no later than 30 days after the review is triggered. [Medium-High]

§748.2905. Who must participate in the triggered review?

Subchapter N, Emergency Behavior Intervention

Division 11, Triggered Reviews

February 2017

- (a) A full service planning team must participate in the triggered review. You must invite the child, as appropriate, and the parents to the review, so they may have the opportunity to participate and provide input into the content of the review. However, you are not required to delay the review because a parent or child is unable to participate in the review at its scheduled time [Medium-High].
- (b) Even if the child is not receiving treatment services, the two additional professions required in §748.1339(b) of this title (relating to Who must be involved in developing an initial service plan?) must be involved in the triggered review. [Medium-High]

§748.2907. What must the triggered review include and what must be documented in the child's record?

Subchapter N, Emergency Behavior Intervention

Division 11, Triggered Reviews

February 2017

- (a) Except in cases in which the regularly scheduled review of the child's service plan also addresses the requirements of a triggered review in accordance with §748.2903(b) of this title (relating to When must a triggered review occur?), a triggered review is not a full review of the child's service plan and is focused on the requirements identified in subsection (c) of this section.
- (b) Other than the requirements in this section and in §748.2905 of this title (relating to Who must participate in the triggered review?), the notification, participation, implementation, and documentation requirements in Division 4 of Subchapter I (relating to Admission, Service Planning, And Discharge) do not otherwise apply to a triggered review.
- (c) The following must be included in a triggered review and documented in the child's record:
 - (1) A review of the records and orders of the emergency behavior interventions [Medium-High];
 - (2) A review and documentation of any potential medical or psychiatric reason for not using emergency behavior interventions on the child, including the prescribing professional's consideration of any potential medical and/or psychiatric contraindications for the specific child, such as a history of physical or sexual abuse or victimization involving the type of intervention [Medium-High];
 - (3) An examination of identified behaviors and patterns, any significant events leading up to the use of emergency behavior intervention, and all attempted de-escalation methods, whether successful or unsuccessful [Medium-High];
 - (4) Identification of alternatives to manage the child's behavior and more effectively prevent the use of emergency behavior intervention in the future [Medium-High]; and
 - (5) A written plan for reducing the need for emergency behavior intervention. [Medium-High]

§748.2909. What if there are four triggered reviews within a 90-day period?

Subchapter N, Emergency Behavior Intervention

Division 11, Triggered Reviews

January 2007

If there are four triggered reviews within a 90-day period:

- (1) A licensed psychiatrist, psychologist, clinical social worker, professional counselor, or marriage and family therapist must examine the child [Medium-High]; and
- (2) The licensed professional must make service plan recommendations regarding the use of emergency behavior interventions. You must document these recommendations in the child's record. [Medium-High]

Division 12, Overall Operation Evaluation

§748.2951. What is an overall operation evaluation?

Subchapter N, Emergency Behavior Intervention

Division 12, Overall Operation Evaluation

January 2007

- (a) The overall operation evaluation is an annual review regarding:
 - (1) The use and effectiveness of emergency behavior interventions at your operation [Medium]; and
 - (2) Your emergency behavior intervention policies and procedures, including the training policy and curriculum. [Medium]
- (b) The objectives of the evaluation are to:
 - (1) Develop and maintain an environment or milieu that supports positive and constructive behaviors of children in care [Medium];
 - (2) Use any type of emergency behavior intervention safely, appropriately, and effectively [Medium]; and
 - (3) Eliminate or reduce physical injuries and any other negative side effects on the child's behavior or emotional development resulting from the emergency behavior interventions. [Medium]
- (c) One focus of the evaluation must be on:
 - (1) The frequency, patterns, and effectiveness of the types of emergency behavior intervention techniques that are used for all children in your operation [Medium];
 - (2) Strategies to reduce the need for emergency behavior interventions for all children in your operation [Medium]; and
 - (3) Specific strategies to reduce the need for use of specific types of emergency behavior intervention techniques for all children in your operation. [Medium]
- (d) The results of each overall operation evaluation must be made available to us for review. [Medium]

§748.2953. What data must be collected?

Subchapter N, Emergency Behavior Intervention

Division 12, Overall Operation Evaluation

January 2007

- (a) Quarterly, you must collect, document, and review aggregate numbers of emergency behavior interventions by type of intervention, with the exception of short personal restraints. [Medium]
- (b) This information must be reported to us quarterly. [Medium]
- (c) You must maintain the data for five years. [Medium]

Helpful Information

You must use the provider login section of the DFPS Child Care Licensing web site to report quarterly emergency behavior intervention statistics to Licensing. Please note that you are expected to submit a report even if no emergency behavior interventions were used within your operation during the quarter.

The quarterly data on emergency behavior interventions is due to Licensing at the end of each quarter. Since the current minimum standards went into effect on January 2007, this is when the data collection was expected to begin. The quarterly reports are based on this start date. Therefore, quarterly reports should represent the following time frames each calendar year:

Quarter 1 – January through March

Quarter 2 – April through June

Quarter 3 – July through September

Quarter 4 – October through December

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

§748.3001. When must I have an annual sanitation inspection?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

June 2014

- (a) A local sanitation official must conduct a sanitation inspection of your operation [Medium-High]:
 - (1) Before we issue you an initial permit [Medium-High]; and
 - (2) At least once every 12 months from the date of the last sanitation inspection. [Medium-High]
- (b) Each inspection must meet regulations set by the local health department ordinances. [Medium]
- (c) If an inspection is not available from a local sanitation official, you must [Medium]:
 - (1) Obtain documentation from a state or local sanitation official or a county judge stating that an inspection is not available; and
 - (2) Maintain this documentation at the operation and make it available to us upon request.

§748.3003. How must I document that a sanitation inspection has been completed?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2007

You must keep the most recent sanitation inspection report, letter, or checklist at your operation to verify the inspection date and findings. The report must include the name and telephone number of the inspector. [Medium-Low]

§748.3005. Must I make all corrections specified in the sanitation inspection report?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2007

You must correct deficiencies and comply with corrections, restrictions, or conditions that the inspector specifies in the sanitation report, letter, or checklist. [Medium-High]

§748.3007. What must I sanitize?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2007

You must sanitize any item or surface that comes into contact with bodily fluids and has the possibility for cross contamination. [Medium-High]

§748.3009. How should items be sanitized?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

September 2010

Items may be sanitized by [Medium-High]:

- (1) Completing the four-step process outlined in the definition in §748.43(41) of this title (relating to What do certain words and terms mean in this chapter?);
- (2) Washing the items for five or more minutes in a dishwasher or washing machine that uses hot water of a temperature of at least 160 degrees Fahrenheit;
- (3) Washing in a three-compartment sink or three containers. The sinks and/or containers must be large enough to completely immerse the items for soaking, rinsing, and disinfecting; or
- (4) Following the requirements of any alternative methods that have been approved by the Department of State Health Services for your operation.

§748.3013. What are the parameters for sinks used for food service or food preparation?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2007

All sinks that you use for food service or food preparation must be supplied with hot and cold running water under pressure. [Medium]

§748.3015. How must caregivers handle bodily fluids that require universal precautions?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2017

Caregivers must follow universal precautions outlined by the Centers for Disease Control (CDC) when handling blood, vomit, or other bodily fluids that may contain blood, including.

- (1) Using disposable, nonporous gloves [Medium-High];
- (2) Placing gloves contaminated with blood in a tied, sealed, or otherwise closed plastic bag and discarding them immediately [Medium-High];
- (3) Discarding all other gloves in a sanitary manner immediately after one use [Medium-High];
- (4) Washing hands with soap and running water after using and disposing of the gloves [Medium-High];
- (5) Disposing the bodily fluids in accordance with local regulations. Where local disposal regulations do not exist, the Department of State Health Services must be consulted regarding the appropriate disposal procedures and their recommendations must be followed [Medium-High]; and
- (6) Disposing disposable syringes, needles, and other sharp items used by persons for injections or for medical or other procedures in a hard plastic, leak and puncture-resistant container immediately after use, and keep them inaccessible to children. [Medium-High]

§748.3017. Are animals allowed at my operation?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2017

(a) Yes; if:

(1) You have documentation at your operation showing dogs and cats have been vaccinated for rabies as required by Texas Health and Safety Code, Chapter 826 [Medium]; and

(2) All animals on the premises, including pets and livestock, are treated according to a licensed veterinarian's recommendations to protect the health and safety of children. If you choose to have animals on the premises, you must ensure that the animals do not create health problems or a health risk for children. [Medium]

(b) For therapeutic camp services, you must house horses and other animals that you maintain at a camp at a reasonable distance from any sleeping, living, eating, or food preparation area. [Medium]

Best Practice Suggestion
If a child is pregnant, the following health precautions are recommended: • Keep litter boxes out of the child's bedroom or bathroom, kitchen, or dining area; • Clean litter boxes daily; and • Do not allow the pregnant child to clean litter boxes.

§748.3019. Must I use a licensed exterminator to treat my operation for insects, rodents, and other pests?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

March 2008

(a) You may treat your operation for pests only if the Structural Pest Control Board or Department of Agriculture has certified you as a noncommercial applicator. [Medium]

(b) Otherwise, you must use a pest control operator licensed by the Texas Structural Pest Control Board or Department of Agriculture to prevent, control, or eliminate pest infestations at your operation. [Medium]

- (c) For therapeutic camp services, you must maintain a vector control program to ensure effective control of all insects and rodents in the buildings and on the premises of your permanent camp. If chemical control is needed, then you must comply with subsections (a) and (b) of this section. [Medium]

§748.3021. How must I protect children from dangerous tools and equipment?

Subchapter O, Safety and Emergency Practices

Division 1, Sanitation and Health Practices

January 2007

Dangerous tools and equipment, such as hatchets, saws, and axes must be stored, so they are inaccessible to children. Children may use these tools and equipment with caregiver supervision, as appropriate based on the child's age, maturity, and treatment issues. [Medium-High]

Division 2, Natural Gas and Liquefied Petroleum

§748.3061. When must my operation be inspected for gas leaks?

Subchapter O, Safety and Emergency Practices

Division 2, Natural Gas and Liquefied Petroleum

January 2007

Your operation must be inspected for gas leaks:

- (1) Before we issue your initial permit [Medium-High]; and
- (2) At least once every 24 months from the date of the last inspection for gas leaks. [Medium-High]

§748.3063. Who must conduct a gas leak inspection at my operation?

Subchapter O, Safety and Emergency Practices

Division 2, Natural Gas and Liquefied Petroleum

January 2007

- (a) If your operation uses natural gas, a licensed plumber or a gas company official must conduct the gas leak inspection. [Medium]
- (b) If your operation uses liquefied propane (LP) gas, you must have your LP-gas system inspected for proper installation and leaks by:
 - (1) A licensed LP-gas servicing company [Medium]; or
 - (2) A licensed plumber who is also licensed with the LP-gas section of the Texas Railroad Commission. [Medium]

§748.3065. What documentation must I maintain regarding gas leak inspections?

Subchapter O, Safety and Emergency Practices

Division 2, Natural Gas and Liquefied Petroleum

January 2007

- (a) A written gas inspection report must show your gas system is free of leaks and must indicate the date of the inspection, as well as the name and telephone number of the inspector. [Medium-Low]
- (b) You must keep the most recent inspection report at your operation to verify the inspection date and findings. [Medium-Low]
- (c) You must comply with all corrections, conditions, or restrictions specified in the gas inspection report within the timeframes specified by the inspector. [Medium-High]

Division 3, Fire Safety Practices

§748.3101. When must I have a fire inspection?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

You must have a fire inspection:

- (1) Before we issue your initial permit [Medium-High]; and
- (2) At least once every 12 months from the date of the last fire inspection. [Medium-High]

§748.3103. Who must conduct a fire inspection?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) A state or local fire inspector must conduct the inspection. [Medium]
- (b) If an inspector cannot conduct an inspection, you must provide documentation of this from a state or local fire inspector or county judge. [Medium]

§748.3105. What documentation must I maintain regarding a fire inspection?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) You must keep the most recent fire inspection report, letter, or checklist at the operation to verify the inspection date and findings. The report must include the inspector's name and telephone number. [Medium-Low]
- (b) You must comply with the local code and all corrections, restrictions, or conditions specified by the inspector in the fire inspection report, letter, or checklist. [Medium-High]

§748.3107. What type of smoke-detection system must I have?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) Your operation must have an operable smoke-detection system that is audible throughout the building. This may be [Medium-High]:
 - (1) An electronic fire alarm and smoke-detection system; or
 - (2) Individual electric or battery-operated smoke detectors located according to the state or local fire inspector's recommendations. If no fire inspector is available or able to give recommendations, smoke detectors must be located in the following areas [Medium-High]:
 - (A) In hallways or open areas outside sleeping rooms [Medium-High]; and
 - (B) On each level of a building with multiple levels. [Medium-High]
- (b) Depending on the size and layout of the operation, additional smoke detectors may be required based on manufacturer's or fire inspector's instructions. [Medium-High]
- (c) New operations granted a permit by us on or after January 2007, must have smoke detectors that get their power from building wiring from a commercial source. Wiring must be permanent. Smoke detectors must [Medium-High]:
 - (1) Be equipped with a battery back-up [Medium-High]; and
 - (2) Emit a signal when the batteries are low. [Medium-High]

§748.3109. How must smoke detectors be installed at my operation?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) Smoke detectors must be installed and maintained according to the manufacturer's instructions or in compliance with the state or local fire inspector's instructions. [Medium-High]
- (b) Batteries must be changed annually or sooner, as required to maintain operable smoke detector units. [Medium-High]

§748.3111. How often must the smoke detectors at my operation be tested?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) The administrator or designee must test all battery-operated smoke detectors monthly by pressing the test button or switch on the unit. The date of the test and the name of the employee who does the testing must be documented and kept at the operation for review. [Medium]
- (b) A company licensed by the State Fire Marshal, or the state or local fire inspector, must test an electronic smoke alarm system at least annually. You must keep documentation of the inspection at the operation for review. The documentation must indicate the date of the inspection and the inspector's name and telephone number. [Medium]

§748.3113. Must my operation have a fire-extinguishing system?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) Your operation must have a fire-extinguishing system, which may be a sprinkler system and/or fire extinguishers. [Medium-High]
- (b) The state or local fire inspector must approve the sprinkler system and/or fire extinguishers in your operation. If an inspector cannot conduct an inspection, you must have at least one fire extinguisher in the operation rated not less than 3A:40BC. [Medium-High]
- (c) Any fire extinguisher that has been used or has lost operating pressure must be serviced or replaced immediately with an equivalent unit. [Medium-High]

§748.3115. How often must I inspect and service the fire extinguisher(s)?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

You must inspect the fire extinguisher(s) monthly and ensure [Medium]:

- (1) There will be no interference with access to the extinguisher in an emergency, for example, there are no objects blocking access [Medium];
- (2) Fire extinguishers are accessible for immediate use by employees, caregivers, and volunteers [Medium]; and
- (3) Fire extinguishers are serviced as required by manufacturer's instructions, or as required by the state or local fire inspector. [Medium-High]

Best Practice Suggestion

It is a good idea to mount fire extinguishers on the wall by a hanger or bracket, with the top of the extinguisher no higher than five feet above the floor and the bottom at least four inches above the floor or any other surface. If a state or local fire inspector has different mounting instructions, follow those instructions.

When inspecting a fire extinguisher, best practice suggests ensuring that:

- The fire extinguisher pressure is at the recommended level. On extinguishers with a gauge, the needle must be in the green zone;
- The pin and tamper seal are intact, if applicable;
- There are no leaks, dents, rust, chemical deposits or other signs of abuse or wear; and
- The date of the inspection and the name of the employee is recorded and maintained at the operation for one year.

§748.3117. How often must the state or local fire inspector inspect fire extinguisher(s)?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

September 2010

- (a) A company licensed by the State Fire Marshal must inspect each fire extinguisher at least annually and conduct any required service or testing. Newly purchased fire extinguishers do not require inspection during the first 12 months of service unless indicated by the monthly inspection. [Medium]

- (b) You must keep documentation of the inspection and/or the purchase of new fire extinguishers at the operation for review. The documentation must indicate the date of the inspection and the inspector's name and telephone number. [Medium-Low]

§748.3119. How often must a fire sprinkler system be inspected?

Subchapter O, Safety and Emergency Practices

Division 3, Fire Safety Practices

January 2007

- (a) If your operation has a fire sprinkler system, a company licensed by the State Fire Marshal must inspect the fire sprinkler system at least annually and conduct any required service or testing. [Medium]
- (b) You must keep the most recent inspection report at the operation for review. The documentation must indicate the date of the inspection and the inspector's name and telephone number. [Medium-Low]

Division 4, Heating Devices

§748.3161. What steps must I take to ensure that heating devices do not present hazards to children?

Subchapter O, Safety and Emergency Practices

Division 4, Heating Devices

September 2010

- (a) Gas appliances must be safe and in good repair. [Medium-High]
- (b) Space heaters must be enclosed and have a screen or guard. [Medium-High]
- (c) You must ensure that children do not have access to floor and wall furnace grates, steam and hot water pipes, and electric space heaters. [Medium-High]
- (d) If you use a fireplace or wood-burning stove, it must be kept clean and have a screen or guard. [Medium-High]
- (e) You may not use a stove to heat any part of the operation, including portable camp stoves. [Medium-High]
- (f) You may not use open flame or liquid fuel heaters. [Medium-High]

Division 5, Carbon Monoxide Safety Practices

§748.3191. Must I have a carbon monoxide detector-system?

Subchapter O, Safety and Emergency Practices

Division 5, Carbon Monoxide Safety Practices

January 2007

You must have an operable carbon monoxide detector-system if your operation has gas appliances. This may be [Medium-High]:

- (1) An electronic carbon monoxide detector-system; or
- (2) Individual electric or battery-operated carbon monoxide detectors.

Best Practice Suggestion

Some sources of carbon monoxide include: appliances fueled with natural gas, liquefied petroleum (LP gas), oil, kerosene, coal, or wood may produce carbon monoxide, such as unvented kerosene and gas space heaters; leaking chimneys and furnaces; back-draft from furnaces, gas water heaters, wood stoves, and fireplaces; gas stoves; gas air conditioners and refrigerators. Burning charcoal and automobile exhaust also produce carbon monoxide. Avoid conditions that place people in closed spaces where exhaust can accumulate and cause carbon monoxide poisoning.

It is best to:

- Not turn on a gasoline or kerosene-operated engine or tools, charcoal grill or a barbecue grill inside buildings or living quarters;
- Not burn charcoal indoors;
- Not use portable fuel-burning camping equipment inside a home, building, garage, vehicle, cabin, camper or tent;
- Open the garage door and garage windows fully for ventilation before starting a gasoline or kerosene operated engine, such as a generator, lawn mower or vehicle.
- Drive out as soon as possible if you turn on a vehicle in a garage, or keep the door connecting the garage to the building closed when the vehicle is running in the garage. Carbon monoxide can easily go from the garage through the door that opens into the building, even if your garage door is open to let in fresh air;
- Ensure appliances are installed according to manufacturer's instructions and local building codes;
- Buy equipment carrying the seal of a national testing agency, such as the American Gas Association or the Underwriters' Laboratory;
- Have the heating system (including chimneys and vents) inspected and serviced annually. The inspector should also check chimneys and flues for blockages, corrosion, partial and complete disconnections, and loose connections; and

Keep your vehicle windows open while driving in heavy traffic or when the vehicle is idling, even when you run the air conditioner. Even with an air conditioner, carbon monoxide can be pulled into your car or truck while you drive slowly in heavy traffic.

§748.3193. How must carbon monoxide detectors be installed?

Subchapter O, Safety and Emergency Practices

Division 5, Carbon Monoxide Safety Practices

January 2007

- (a) You must install carbon monoxide detectors that meet Underwriters Laboratories Inc. requirements (UL-Listed). [Medium-High]
 - (1) You must install carbon monoxide detectors according to manufacturer's specifications for proper location and installation [Medium-High]; and
 - (2) Furniture, draperies, or other items must not cover up detectors. [Medium-High]
- (b) If you use an electronic carbon monoxide detection-system connected to an alarm/smoke detection system, the system must be installed according to the state or local fire inspector's requirements. [Medium-High]

§748.3195. How must I maintain carbon monoxide detectors?

Subchapter O, Safety and Emergency Practices

Division 5, Carbon Monoxide Safety Practices

January 2007

You must maintain electric or battery-operated carbon monoxide detectors in compliance with the manufacturer's instructions. [Medium-High]

Division 6, Emergency Evacuation and Relocation

§748.3231. What is an emergency evacuation and relocation plan?

Subchapter O, Safety and Emergency Practices

Division 6, Emergency Evacuation and Relocation

January 2007

- (a) An emergency evacuation and relocation plan is a plan designed to ensure the safety of children during a fire, severe weather conditions, or another type of emergency requiring evacuation or relocation of children in care.
- (b) In an emergency, your first responsibility is to move all the children to a designated safe area known to all employees, caregivers, and volunteers. Your plan must also require the person in charge of your operation during the emergency to [High]:

- (1) Designate an employee to call the fire department in case of fire or danger of fire, explosion, toxic fumes, or other chemical release. If the danger requires immediate evacuation of the operation, this person must first evacuate the operation and then make the necessary call from another location [Medium-High];
- (2) Designate an employee responsible for securing children's emergency numbers, emergency medical authorizations, and medications during the emergency [Medium];
- (3) Once the person in charge is at the designated safe area, account for all children who were in attendance at the time of the emergency [Medium-High]; and
- (4) Ensure that no one uses elevators during a fire. [Medium-High]

§748.3233. Must I have an emergency evacuation and relocation diagram?

Subchapter O, Safety and Emergency Practices

Division 6, Emergency Evacuation and Relocation

January 2007

- (a) You must have a written emergency evacuation and relocation diagram specifying directions for egress on file at your operation. [Medium-High]
- (b) The emergency evacuation and relocation diagram must show the following:
 - (1) A floor plan of your operation [Medium-High];
 - (2) The designated location outside of the operation where all caregivers and children meet to ensure everyone has exited the operation safely [Medium-High];
 - (3) The designated location inside the operation where all caregivers and children take shelter from threatening weather [Medium-High]; and
 - (4) At least two exit routes that [Medium-High]:
 - (A) Are located in distant parts of the building and lead to the outside [Medium-High];
 - (B) Are not blocked in any way, including with furniture or equipment [Medium-High];
 - (C) Are not through a kitchen or other hazardous area, unless specifically approved in writing by the state or local fire inspector. The written approval must be signed and dated by the state or local fire inspector and maintained at your operation for our review [Medium-High];

- (D)Are not a window, unless children and caregivers are physically able to exit through the window to the ground outside safely and quickly [Medium-High];
- (E)Are not doors or windows that are locked and require a key to open from the inside, unless specifically approved in writing by the state or local fire inspector. The written approval must be signed and dated by the state or local fire inspector and maintained at your operation for our review [Medium-High];
- (F)Do not lead into a pool area [Medium-High]; and
- (G)If above the ground level, are served by standard stairs and do not require ladders, folding stairs, or trap doors to gain access to the ground floor. [Medium-High]

§748.3235. Where must I post the emergency evacuation and relocation diagram?

Subchapter O, Safety and Emergency Practices

Division 6, Emergency Evacuation and Relocation

January 2007

You must post the emergency evacuation and relocation diagram in a prominent and visible location in all buildings used by an employee, volunteer, or child. [Medium-High]

§748.3237. What other safety provisions must I make?

Subchapter O, Safety and Emergency Practices

Division 6, Emergency Evacuation and Relocation

January 2007

- (a) Closet door latches must allow children to open the door from the inside of the closet. [Medium-High]
- (b) In case of electrical failure, you must have an operable source of emergency lighting that is approved by the state or local fire inspector, or operable battery-powered lighting. [Medium-High]
- (c) Children must be able to open emergency exit doors easily from the inside, unless specifically approved in writing by the state or local fire inspector. The written approval must be signed and dated by the state or local fire inspector and maintained at your operation for our review. [Medium-High]

§748.3239. How often must I practice my emergency evacuation and relocation plans?

Subchapter O, Safety and Emergency Practices

Division 6, Emergency Evacuation and Relocation

January 2007

- (a) You must practice an unannounced fire drill at least once every six months from the date of the last fire drill. During each drill [Medium]:
 - (1) You must set off a fire alarm or smoke detector [Medium-Low];
 - (2) The participants must use alternate exit routes [Medium];
 - (3) The children must be able to safely exit the building to the designated meeting place within three minutes [Medium]; and
 - (4) The participants must not use elevators. [Medium]
- (b) You must practice a severe weather drill at least once every six months from the date of the last severe weather drill. [Medium]
- (c) Emergency evacuation and relocation plans must be routinely practiced at different times during hours of operation. [Medium]
- (d) You must document these drills, including the date of the drill, time of the drill, type of drill, and length of time for the evacuation or relocation to take place. [Medium-Low]

Division 7, First-Aid Kits

§748.3271. Must I have a first-aid kit at my operation?

Subchapter O, Safety and Emergency Practices

Division 7, First-Aid Kits

January 2007

Yes. All separate living areas and buildings must have a complete first-aid kit available. A first-aid kit must also be available for all field trips. Each first-aid kit must be [Medium]:

- (1) Clearly labeled [Medium-Low];
- (2) Kept in a clean and sanitary condition [Medium];
- (3) In good condition and not have expired medications or supplies [Medium-High];
- (4) Easily accessible to all employees [Medium];
- (5) Stored in a designated location known to all employees [Medium]; and

(6)Kept out of the reach of children. [Medium]

§748.3273. What must each first-aid kit contain?

Subchapter O, Safety and Emergency Practices

Division 7, First-Aid Kits

January 2007

Each first-aid kit must contain at least the following supplies:

- (1)A current guide to first aid and emergency care [Medium];
- (2)Adhesive tape [Medium];
- (3)Antiseptic solution or wipes [Medium];
- (4)Cotton balls [Medium-Low];
- (5)Multi-size adhesive bandages [Medium];
- (6)Scissors [Medium-Low];
- (7)Sterile gauze pads [Medium];
- (8)Thermometer [Medium-Low];
- (9)Tweezers [Medium-Low]; and
- (10) Waterproof, disposable gloves. [Medium-Low]

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

§748.3301. What general physical site requirements must my operation meet?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

- (a) Buildings, including exterior and interior surfaces (such as walls, floors, and ceilings), must be structurally sound, clean, and in good repair. Paints used at the operation after January 1, 2007, must be lead-free. [High]
- (b) Buildings must comply with applicable building, plumbing, electrical, fire, and similar codes. [High]
- (c) Windows and doors must be in good repair and free of broken glass or hazards. Windows used for ventilation, including windows in doors, must be provided with properly fitted and secure screens in good repair for protection from insects when windows are open. [Medium-High]
- (d) Walkways must be free of ice, snow, and obstruction. [Medium]
- (e) Outdoor areas must be well drained. [Medium]
- (f) The grounds of the operation must be well maintained and free of hazards. [Medium-High]
- (g) The grounds of the operation must be free of accumulation of garbage and debris and maintained in a sanitary manner. All garbage must be disposed of in a sanitary manner in accordance with the Texas Commission on Environmental Quality (see 30 TAC Chapter 330, Municipal Solid Waste). Outdoor garbage cans must have lids. [Medium]
- (h) The building must be free of rodents and insects.
- (i) Equipment and furniture must be safe for children and must be kept clean and in good repair. [Medium-High]

Helpful Information

- Repair work that is scheduled or in progress may be considered as compliance with the requirements in this rule, as long as any risk to children has been adequately addressed.
- Related to subsection (d), this includes reasonable and timely efforts to shovel the snow from the walkways and/or deicing the ice and/or snow.
- Related to subsection (h), this includes reasonable and timely efforts to control insects, such as regularly scheduled exterminator visits.

§748.3303. What parts of my operation must be ventilated?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

Living quarters, recreation areas, dining areas, bathrooms, bedrooms, and kitchens must be adequately ventilated by at least one operable window or mechanical ventilation system.

[Medium-High]

§748.3305. What are the requirements for handrails, railings, and stairway and stairwell landings?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

- (a) Each ramp, stairway, and steps exceeding two steps must have a well-secured handrail. Stairs must have a minimum width of 36 inches. [Medium]
- (b) Each porch or deck that has over an 18-inch drop must have a well-secured railing. [Medium-High]
- (c) If a door opens directly to a stairway, the door must be a minimum of 34 inches wide. There must be a landing between the door and the stairs. The landing must be wide enough to allow the door to open and a person to safely step on to the landing while closing the door. [Medium]

§748.3307. What are the requirements for lighting?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

- (a) All living quarters must be provided with electric services. [Medium-High]
- (b) The following must be lighted in order to avoid accidents:
 - (1) Habitable rooms [Medium-High];
 - (2) Common use rooms, such as dining rooms, living rooms, laundry rooms, and gymnasiums [Medium-High];
 - (3) Bathrooms [Medium-High];
 - (4) Hallways [Medium-High];
 - (5) Interior stairs; [Medium-High]
 - (6) Outside steps and doorways [Medium];
 - (7) Porches [Medium];
 - (8) Ramps [Medium]; and
 - (9) Fire escapes. [Medium-High]
- (c) You may not use propane, kerosene, or other flammable fuel as a light source. [High]

§748.3309. What are the requirements for a communication system?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

Your operation must have:

- (1) An operable telephone with an outside line that is accessible to employees in emergencies. This telephone must have a listed telephone number and not be coin-operated [Medium]; and
- (2) A communication system to allow employees to contact other employees in the operation for assistance in an emergency or as needed. [Medium]

§748.3311. What are the requirements for using a tractor?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

You must never permit a child:

- (1) Under 16 years old to operate a tractor [Medium]; or
- (2) To ride as a passenger on a tractor. [Medium]

Helpful Information

A riding lawn mower is not considered a tractor. Riding lawn mowers are used only for mowing. A tractor is a multi-purpose vehicle used for towing or pulling something which cannot propel itself and, often, powering it too. A riding lawn mower is lawn equipment, while a tractor is farm equipment.

§748.3313. May I use water from a private water system?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

You may use water from a private water system if you maintain:

- (1) The water supply in a safe and sanitary manner [Medium-High]; and
- (2) Written records indicating the private water supply meets the requirements of the Texas Commission on Environmental Quality. [Medium-Low]

§748.3315. What are the requirements for running hot water?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

A thermostat must control the temperature of hot water accessible to children, so the water temperature is no higher than 120 degrees Fahrenheit. [High]

§748.3317. May I use a septic system for sewage disposal?

Subchapter P, Physical Site

Division 1, Grounds and General Requirements

January 2007

You may use a septic system for sewage disposal if the septic system [Medium-High]:

- (1) Is sanitary; and
- (2) Meets the standards of the Texas Commission on Environmental Quality, including any routine inspections required by law.

Division 2, Interior Space

§748.3351. What are the requirements for general living space?

Subchapter P, Physical Site

Division 2, Interior Space

January 2017

You must provide:

- (1) Living space, appropriate furnishings, and bathroom facilities that are safe, clean, and maintained in good repair [Medium-High];
- (2) Provisions for personal storage space in the child's bedroom for each child's clothing and belongings [Medium-Low];
- (3) At least 40 square feet per child, including adult residents and children of caregivers residing at the operation, of indoor activity space, excluding bedrooms, halls, kitchens, bathrooms, and any other space not regularly available to a child [Medium-Low];
- (4) Each bedroom with at least one window with outside exposure as a source of natural light, unless you were granted a permit by us prior to January 1, 2007, and your permit is still valid [Low]; and
- (5) Every bedroom window with curtains, blinds, shades, or other provisions for rest and privacy. [Medium-Low]

§748.3353. May I use a video camera to supervise a child in the **child's bedroom?**

Subchapter P, Physical Site

Division 2, Interior Space

January 2017

- (a) Video cameras may be used to supervise infants and toddlers.
- (b) Video cameras may not be used to supervise children, other than infants and toddlers unless the:
 - (1) Parent, or other person legally authorized to consent, consents to the use of the video camera [Medium-Low]; and
 - (2) Child [Medium-Low]:
 - (A) Is younger than five years old;
 - (B) Has primary medical needs; or
 - (C) Requires heightened supervision, such as a child who sleepwalks, experiences night terrors, engages in physically aggressive or sexual behavior problems, or resides in a bedroom with such a child. You must document the justification for the video camera in each child's service plan, and each child must have other accessible and reasonable locations where the child may change clothing in private.
- (c) Video cameras may not be used to tape the child, and images may not be accessible except to operation employees and caregivers. [Medium-Low]

§748.3355. May I use an audio monitoring device to supervise a **child in the child's bedroom?**

Subchapter P, Physical Site

Division 2, Interior Space

January 2007

- (a) Audio monitoring devices may be used to supervise infants and toddlers.
- (b) Audio monitoring devices may not be used to supervise other children, except infants and toddlers, unless the:
 - (1) Parent, or other person legally authorized to consent, consents to the use of the audio monitoring device [Medium-Low]; and

(2) Child [Medium]:

(A) Is younger than five years old;

(B) Has primary medical needs; or

(C) Requires heightened supervision, such as a child who sleepwalks, experiences night terrors, engages in physically aggressive or sexual behavior problems, or resides in a bedroom with such a child. You must document the justification for the audio monitoring device in each child's service plan.

§748.3357. What are the requirements for floor space in a bedroom used by a child?

Subchapter P, Physical Site

Division 2, Interior Space

January 2017

(a) Floor space [Medium]:

(1) Is space that a child can use for daily activities;

(2) Does not include closets or other alcoves; and

(3) May not be averaged.

(b) You must provide comfortable sleeping arrangements that meet one of the following [Medium-Low]:

(1) A single occupancy bedroom with at least 80 square feet of floor space [Medium];
or

(2) A bedroom with at least 60 square feet of space for each occupant and no more than four occupants per bedroom are permitted even if the square footage of the room would accommodate more than four occupants. The four-occupant restriction does not apply to children receiving treatment services for primary medical needs.
[Medium]

(c) If we granted you a permit prior to January 1, 2007, then you are exempt from the maximum bedroom occupancy requirement until:

(1) You move your operation to a new building;

(2) You structurally alter the current building by adding a new room; or

(3) Your permit is no longer valid.

(d) If we granted you a permit to provide emergency care services to a child prior to January 1, 2007, then you are also exempt from the 60 square feet of bedroom space for each occupant until:

- (1) You move your operation to a new building;
- (2) You structurally alter the current building by adding a new room; or
- (3) Your permit is no longer valid.

§748.3359. What rooms may I not use as bedrooms?

Subchapter P, Physical Site

Division 2, Interior Space

January 2007

You may not use the following as bedrooms:

- (1) Rooms commonly used for other purposes, such as dining rooms, living rooms, hallways, porches or dens, except for a child temporarily requiring close supervision or a child who is admitted to your operation during sleeping hours (for the first night only). These exceptions are permitted only if the child is provided with comfortable sleeping arrangements and if supervision of the child is not compromised [Medium-Low];
- (2) Rooms that are passageways to other rooms [Medium-Low]; or
- (3) Basements; however, if prior to January 2007, we granted you a permit, then basements may be used as bedrooms as long as other relevant requirements are met, and until:
 - (A) You move your operation to a new building [Medium-Low];
 - (B) You structurally alter the current building by adding a new room [Medium-Low]; or
 - (C) Your permit is no longer valid. [Medium-Low]

§748.3361. May a child in care share a bedroom with an adult?

Subchapter P, Physical Site

Division 2, Interior Space

September 2010

- (a) Generally, each child should have his own designated bedroom or share a bedroom with other children. [Medium-Low]
- (b) A child may share a bedroom with an adult if:
 - (1) It is in the best interest of the child [Medium];
 - (2) The child is under three years old and sleeps in the bedroom of the caregiver [Medium]; and

(3) Approval is documented and dated in the child's service plan by the service planning team. [Medium]

(c) To determine whether a child should share a bedroom with an adult resident, see §748.1937 of this title (relating to May an adult in care share a bedroom with a child in care?).

(d) Children may not sleep in the same bed with an adult caregiver at any time. [High]

(e) Subsections (a) – (c) of this section do not apply to travel and camping situations.

§748.3363. May children of opposite genders share a bedroom?

Subchapter P, Physical Site

Division 2, Interior Space

September 2010

(a) A child six years old or older must not share a bedroom with a child of the opposite gender. Prior to permitting a child under six years old to share a bedroom with a child of the opposite gender, the service planning team must assess [Medium]:

(1) What is in the best interest of each child [Medium];

(2) The history of these children for possible sexual abuse and/or sexual behavior problems [Medium]; and

(3) The appropriateness. [Medium]

(b) The assessment and approval by the service planning team must be documented and dated in each child's record. [Medium-Low]

§748.3365. What are the requirements for beds and bedding?

Subchapter P, Physical Site

Division 2, Interior Space

January 2017

(a) You must provide each child with an individual bed or bunk bed in the child's bedroom that elevates the mattress off of the floor. For infants and toddlers, a crib is allowable. For crib requirements, see §748.1751 of this title (relating to What specific safety requirements must my cribs meet?). [Medium]

(b) Each bed being used by a child must have:

(1) A clean and comfortable mattress [Medium]; and

(2) A mattress cover or protector if the child is not provided with a mattress that is waterproof. [Medium]

(c) You must also provide the child with:

- (1) A pillow and linens appropriate for the temperature, including a pillowcase, top sheet, and fitted or bottom sheet [Medium];
- (2) Extra linens as needed for the child's warmth and comfort, such as a blanket or bedspread [Medium]; and
- (3) Clean linens that are changed or laundered if used by a different child and as often as needed for cleanliness and sanitation, but not less than once a week. [Medium]

(d) If laundry service is not provided, laundry facilities supplied with hot and cold water under pressure must be provided for all children in care to use. [Medium-Low]

Helpful Information

Mattress covers are not required to be plastic. Mattress covers are intended to provide an additional layer of protection between the child and the mattress, which may help prevent contamination of the mattress by a child's bodily fluids or spread of germs from the mattress to the child (since multiple children may use the same mattress over the course of time).

Regular washing of mattress covers may also be helpful to children who are allergic to dust mites.

§748.3367. What types of beds are not allowed for a child?

Subchapter P, Physical Site

Division 2, Interior Space

January 2007

The following types of beds are not allowed:

- (1) Triple-deck beds [Medium-High];
- (2) Veil beds designed to prohibit a child from leaving the bed, not including beds that have mosquito netting to protect the child from mosquitoes or other insects [Medium-High];
- (3) Beds that have bedrails that can entrap a child [Medium-High]; or
- (4) Any cribs, except for infants and toddlers. [Medium-High]

§748.3369. What are the requirements for bunk beds?

Subchapter P, Physical Site

Division 2, Interior Space

January 2007

- (a) A bunk bed must only consist of double-deck beds. [Medium-High]
- (b) A child who is under six years old, non-ambulatory, or subject to seizures or other medical or physical problems who may require greater caregiver supervision and caregiver access must not use a top bunk bed. [Medium-High]
- (c) A bunk bed must allow enough space in between beds and the ceiling to allow a child to sit up in bed. [Medium-High]
- (d) A bunk bed must be equipped with a securely attached ladder capable of supporting the child using the bed and an employee. [Medium-High]
- (e) A bunk bed that is more than 30 inches above the floor must be equipped with securely attached safety bedrails along the lengths of the bed on each side with a means to allow a child to get in and out of bed. Bunk beds securely attached to a wall may use the wall as one of the required guardrails. The top of safety guardrails must be at least five inches above the top of the mattress. The bed rails and the mattress supports under the mattress must not be an entrapment hazard. [High]
- (f) Openings in guardrails or between ladder rungs must not have openings that can entrap a child's body or body part that has penetrated the opening. Openings must measure less than 3 1/2 inches or more than nine inches to prevent a child's body or body part from being entrapped. [Medium-High]
- (g) A bunk bed must be spaced to provide a walk space on at least one side and one end of each bed. [Medium]

Division 3, Toilet and Bath Facilities

§748.3391. What are the general requirements for bathroom facilities?

Subchapter P, Physical Site

Division 3, Toilet and Bath Facilities

January 2007

- (a) All bathrooms must be maintained in good repair and kept clean at all times [Medium-High].
- (b) You must provide bathrooms located on the same floor as the child's bedroom. The child must not have to exit the building to access the bathroom. [Medium]
- (c) To provide privacy, you must ensure a child does not have to cross an activity room, dining room, living room, or similar type room to access a bathroom from the child's bedroom. If prior to January 1, 2007, we granted you a permit, you are exempt from this requirement until [Low]:
 - (1) You move your operation to a new location;
 - (2) You structurally alter the current building by adding a new room; or
 - (3) Your permit is no longer valid.
- (d) Each bathroom or room with a lock must be able to be unlocked from the outside during an emergency. [Medium-High]

§748.3393. What are the requirements for a toilet that a child uses?

Subchapter P, Physical Site

Division 3, Toilet and Bath Facilities

September 2010

- (a) Your operation must dispose of wastewater into a sanitary sewage system, or an approved septic system in accordance with the Texas Commission on Environmental Quality, and submit to any routine inspections required by law. [Medium-High]
- (b) You must provide:
 - (1) At least one toilet for every eight children. All toilets must provide individual privacy, including doors to individual toilet stalls [Medium-Low]; and
 - (2) Separate toilet facilities for males and females. [Medium]

- (c) When toilet facilities for each gender are located in the same building, the toilet facilities must be:
- (1) Distinctly marked for each gender [Medium-Low]; and
 - (2) Separated by a solid wall from floor to ceiling. [Medium-Low]
- (d) Toilets must be equipped with toilet paper at all times. [Medium-Low]
- (e) Toilet facilities must meet the handicap accessibility standards according to the American with Disabilities Act, if applicable. [Medium-Low]
- (f) Urinals may be substituted for the toilets for the males on a ratio of one urinal or 24 inches of trough-type urinal for one toilet, not to exceed one-third of the required toilets. Urinals must have privacy walls on three sides that must be constructed of nonabsorbent materials. [Low]

§748.3395. What are the requirements for hand-washing sinks that a child uses?

Subchapter P, Physical Site

Division 3, Toilet and Bath Facilities

January 2007

- (a) You must maintain all hand-washing sinks in good repair and keep them clean at all times. [Medium]
- (b) You must provide:
- (1) At least one hand-washing sink for every eight children [Medium];
 - (2) A hand-washing sink that is adjacent to toilet facilities [Medium];
 - (3) Hand-washing sinks with hot and cold running water under sufficient pressure to meet the demands of the children [Medium-Low]; and
 - (4) Hand-washing sinks equipped with soap and a personal towel, single-use disposable towels, or hot air hand dryers. [Medium]

§748.3397. What are the requirements for bathing facilities?

Subchapter P, Physical Site

Division 3, Toilet and Bath Facilities

January 2007

- (a) All bath and shower areas must provide for individual privacy. This includes doors or nonabsorbent shower curtains to individual bathtubs and showers stalls. [Medium]
- (b) You must provide:
 - (1) At least one bathtub or shower for every eight females and one for every eight males [Medium-Low]; and
 - (2) Separate shower and bath facilities for each gender, where applicable. [Medium]
- (c) When common-use shower facilities for each gender are located in the same building, the facilities must be:
 - (1) Distinctly marked for each gender [Low]; and
 - (2) Separated by a solid wall from the floor to ceiling. [Low]
- (d) Each shower and bathtub must be equipped with [Low]:
 - (1) Hot and cold running water under sufficient pressure to meet the demands of the children [Low]; and
 - (2) Sufficient hot water to meet the demands of the children. [Medium-Low]
- (e) If prior to January 1, 2007, we granted you a permit, then you do not have to comply with these requirements until:
 - (1) You move your operation to a new location;
 - (2) You structurally alter the current bathroom facilities; or
 - (3) Your permit is no longer valid.

§748.3399. May I use a video camera or audio monitoring device to supervise a child while the child is in a bathroom?

Subchapter P, Physical Site

Division 3, Toilet and Bath Facilities

January 2007

No. You may not use a video camera or audio monitoring device to supervise a child while the child is in a bathroom. [Medium-High]

Division 4, Poisons

§748.3421. What are the requirements for protecting children from poisonous or flammable material?

Subchapter P, Physical Site

Division 4, Poisons

January 2007

You must ensure that poisonous or flammable materials are:

- (1) Stored in their original, labeled containers [High];
- (2) Kept separate from medication, food, food preparation surfaces, and dining surfaces [High];
- (3) Inaccessible to children, unless caregivers have evaluated a child as capable and likely to use such items responsibly [Medium-High]; and
- (4) Cleaned up immediately when spilled. [High]

Division 5, Food Preparation, Storage, and Equipment

§748.3441. What general requirements apply to food service and preparation?

Subchapter P, Physical Site

Division 5, Food Preparation, Storage, and Equipment

September 2010

- (a) All food and drinks must be of safe quality and must be stored, prepared, distributed, and served under sanitary and safe conditions. [Medium-High]
- (b) You must sanitize food service equipment, dishware, and utensils after each use. All eating and cookware must be properly stored. [Medium]
- (c) You must keep furniture, equipment, food contact surfaces, and other areas where food is prepared, eaten, or stored clean and in good repair. [Medium-High]
- (d) If your operation lacks adequate facilities for sanitizing dishes and utensils, you must only use disposable, single-use items. [Medium]
- (e) You must discard single-service napkins, bibs, dishware, containers, and utensils after each use. [Medium]

- (f) You must wash re-useable napkins and bibs after each use. [Medium]
- (g) You must wash re-useable tablecloths when soiled. [Medium]
- (h) Persons who handle food and/or eating utensils for the group must:
 - (1) Maintain personal cleanliness [Medium-High];
 - (2) Keep hands clean at all times [Medium-High];
 - (3) Wash his hands with soap and water thoroughly after each visit to the toilet [Medium-High];
 - (4) Be free of infections commonly transmitted through the handling of food or drink and free of communicable diseases [Medium-High]; and
 - (5) Minimize food contamination through the use of utensils. [Medium-High]
- (i) Food packages must be in good condition and protect the integrity of the contents, so food is not exposed to adulteration or potential contaminants. You must discard cans that are leaking, bulging, or rusted. [Medium]
- (j) When you serve an infant or toddler:
 - (1) If the child is capable of sitting up, you must serve food on plates, napkins, or other sanitary holders, such as a high chair tray [Medium]; and
 - (2) You must not serve foods that present a risk of choking. [High]
- (k) When you prepare a meal at the operation, the food preparation area must be in a separate space from the eating, play, and bathroom areas. [Medium]
- (l) Fruits and vegetables must be properly washed before use. [Medium-High]
- (m) Food must be thawed in the refrigerator, in cold water in a leak-proof bag, or in the microwave. [Medium-High]
- (n) Food must be protected from contamination. [Medium-High]
- (o) You must keep raw meat, poultry, fish, and their juices away from other food. After cutting raw meat, you must wash your hands, the cutting board, the knife, and the countertops with hot, soapy water. You must sanitize cutting boards by using a solution of one- teaspoon chlorine bleach in one quart of water. [Medium-High]
- (p) You must maintain hot food at 140 degrees Fahrenheit or above. [Medium-High]

- (q) You must refrigerate perishable food at proper temperatures:
 - (1) Within one hour after use when the temperature is above 90 degrees Fahrenheit [Medium-High]; or
 - (2) Otherwise, within two hours. [Medium-High]
- (r) Uneaten food from a person's plate must not be served again or used in the preparation of other dishes. [Medium-High]
- (s) You must not permit animals to be in the area of food storage, food preparation, and dining. [Medium-High]
- (t) This rule does not apply to cottage homes.

§748.3443. What are the requirements for storing food?

Subchapter P, Physical Site

Division 5, Food Preparation, Storage, and Equipment

September 2010

- (a) All food items must be:
 - (1) Covered and stored off the floor [Medium];
 - (2) Stored on clean surfaces [Medium];
 - (3) Protected from contamination [Medium-High];
 - (4) Stored in a container that is protected from insects and rodents [Medium-High];
 - (5) Refrigerated immediately after use and after meals, if the food requires refrigeration [Medium]; and
 - (6) Covered when stored in the refrigerator. [Medium]
- (b) You must have a thermometer in refrigerators and freezers and store:
 - (1) Refrigerated food at 40 degrees Fahrenheit or below [Medium]; and
 - (2) Frozen food at 0 degrees Fahrenheit or below. [Medium]
- (c) Subsection (b) of this section does not apply to cottage homes.

§748.3445. How must kitchen, dining areas, supplies, and equipment be maintained in a cottage home?

Subchapter P, Physical Site

Division 5, Food Preparation, Storage, and Equipment

September 2010

- (a) All food and drinks must be of safe quality and must be stored, prepared, and served under sanitary and safe conditions. [Medium-High]
- (b) You must keep furniture, equipment, food contact surfaces, and other areas where food is prepared, eaten, or stored clean and in good repair. [Medium-High]
- (c) Persons who handle food and/or eating utensils for the group must:
 - (1) Maintain personal cleanliness [Medium-High];
 - (2) Keep hands clean at all times [Medium-High];
 - (3) Be free of infections commonly transmitted through the handling of food or drink and free of communicable diseases [Medium-High]; and
 - (4) Minimize food contamination through the use of utensils. [Medium-High]
- (d) Food must be protected from contamination. [Medium-High]
- (e) When you serve an infant or toddler:
 - (1) If the child is capable of sitting up, you must serve food on plates, napkins, or other sanitary holders, such as a high chair tray [Medium]; and
 - (2) You must not serve food that presents a risk of choking. [High]
- (f) Utensils and containers intended for one-time use, such as paper and plastic dishes, must not be used more than once. [Medium]

Division 6, Play Equipment and Safety Requirements

§748.3471. What are the minimum safety requirements for outdoor equipment?

Subchapter P, Physical Site

Division 6, Play Equipment and Safety Requirements

September 2010

You must ensure that outdoor equipment and supplies at the operation are safe for the children as follows [High]:

- (1) The outdoor activity space must be arranged, so caregivers can adequately supervise children at all times [High];
- (2) The design, scale, and location of the equipment must be appropriate for the body size and ability of the children using the equipment [Medium-High];
- (3) Equipment must not have openings that can entrap a child's body or body part that has penetrated the opening [High];
- (4) Equipment must not have protrusions or openings that can entangle something around a child's neck or a child's clothing [High];
- (5) Equipment must be securely anchored according to manufacturer's specifications to prevent collapsing, tipping, sliding, moving, or overturning [High];
- (6) All anchoring devices must be placed below the level of the playing surface to prevent tripping or injury resulting from a fall [Medium-High];
- (7) Equipment must not have exposed pinch, crush, or shear points on or underneath it [High];
- (8) You must not install climbing equipment, swings, or slides over asphalt or concrete, unless the asphalt or concrete is covered with properly installed unitary surfacing materials as specified in this subchapter [High];
- (9) Outdoor platforms more than 20 inches in height for children five years old and younger, and more than 30 inches in height for school-age children, must be equipped with guardrails that surround the elevated surface, except for entrances and exits, and that prevent children from crawling over or through the guardrail [High];

- (10) The height of the highest play surface or platform cannot be more than eight feet [High]; and
- (11) Stairs and steps on outdoor climbing equipment, regardless of height, must have well-secured handrails on both sides of stairs and steps that the children can reach. Rung ladders do not require handrails. [Medium-High]

§748.3473. How high must platform guardrails be?

Subchapter P, Physical Site

Division 6, Play Equipment and Safety Requirements

January 2007

Guardrails and protective barriers must be at least:

- (1) 29 inches high for pre-kindergarten or younger children [Medium-High]; and
- (2) 38 inches high for school-age children. [Medium-High]

§748.3475. What special maintenance procedures must I follow for my playground?

Subchapter P, Physical Site

Division 6, Play Equipment and Safety Requirements

September 2010

- (a) Your administrator or designee must inspect the playground weekly to ensure no hazards are present. Your administrator or designee must inspect the equipment and surfacing material for [Medium-High]:
 - (1) Normal wear and tear [Medium-High];
 - (2) Broken or missing parts [Medium-High];
 - (3) Debris or foreign objects [Medium-High];
 - (4) Drainage problems [Medium]; or
 - (5) Other hazards, such as tripping hazards, like exposed concrete footings, tree stumps, and rocks. [Medium-High]
- (b) Your administrator or designee must:
 - (1) Ensure that hazards or defects identified during the inspection are removed or repaired promptly [Medium-High]; and
 - (2) Arrange for protection of the children or prohibit use of the equipment until the hazards or defects can be removed or repaired. [Medium-High]

§748.3477. What are the specific safety requirements for swings?

Subchapter P, Physical Site

Division 6, Play Equipment and Safety Requirements

January 2007

- (a) All swing seats must be constructed of durable, lightweight, rubber or plastic material. [Medium]
- (b) Edges of all swing seats must be smooth or rounded and have no protrusions. [Medium-High]
- (c) Swings must not be attached to a composite play structure (a playscape or structure containing equipment for a variety of activities). [Medium-High]
- (d) Only children under four years old may use a bucket swing, and only if an adult is present to lift and secure the child into the swing. The distance between the protective surfacing and the bottom of a bucket swing must be at least 24 inches to minimize the likelihood of unsupervised young children climbing into the swing. [Medium-High]
- (e) Tire swings must:
 - (1) Not be made from heavy truck tires, or tires with exposed steel-belted radials [Medium-High];
 - (2) Not be suspended from a composite play structure (a playscape or structure containing equipment for a variety of activities) or with other swings in the same swing bay [Medium];
 - (3) Have drainage holes drilled in the underside of the tire and maintained to facilitate water drainage [Medium]; and
 - (4) Have a minimum clearance between the seating surface of a tire swing and the uprights of the supporting structure of 30 inches or more when the tire is in a position closest to the support structure. [Medium-High]

§748.3479. May I have indoor equipment such as climbing equipment or platforms?

Subchapter P, Physical Site

Division 6, Play Equipment and Safety Requirements

January 2007

You may have indoor climbing equipment if you comply with the following safety standards:

- (1) Floor surfaces under indoor climbing equipment and platforms over 20 inches in height must have a unitary surface that will effectively cushion the fall of a child. The surface must be installed in the use zone and maintained according to the manufacturer's directions. Carpeting alone, even if it is installed over thick padding, is not an acceptable surface under indoor climbing equipment. [Medium-High]
- (2) Stairs and steps on indoor climbing equipment, regardless of height, must have well-secured handrails on both sides of stairs and steps that the children can reach. Rung ladders do not require handrails. [Medium-High]
- (3) Platforms, including stairs and steps, over 20 inches in height must be equipped with protective barriers that prevent young children from crawling over or falling through the barrier, or becoming entrapped. [Medium-High]

Division 7, Playground Use Zones

§748.3521. What does the term “use zone” mean?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone is the surface area under and around a piece of playground equipment and platforms onto which a child falling from or exiting from the equipment would be expected to land.
- (b) Other than the equipment itself, the use zone must be free of obstacles that a child could run into or fall on top of and be injured. [Medium-High]

§748.3523. How do I measure the use zone for stationary equipment?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone for stationary equipment, excluding slides, must extend a minimum of six feet in all directions from the perimeter of the equipment. [Medium-High]
- (b) Use zones for stationary equipment must not overlap the use zones of any other equipment. [Medium-High]

§748.3525. How do I measure the use zone for slides?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone in front of the access and to the sides of a slide must extend a minimum of six feet from the perimeter of the equipment. [Medium-High]
- (b) The use zone in front of the exit of a slide must extend a minimum of six feet. [Medium-High]
- (c) The use zone in front of the slide exit must not overlap the use zone of any other equipment. [Medium-High]

§748.3527. How do I measure the use zone for to-fro swings?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone to the front and back of to-fro swings (single-axis swings) must extend twice the height of the suspending bar to the protective surfacing below. [Medium-High]
- (b) The use zone to the front and back of the to-fro swing must not overlap the use zone of any other equipment. [Medium-High]
- (c) The use zone around the sides of the to-fro swing structure (frame which supports the swings) must be at least six feet and may overlap the use zone of an adjacent swing structure. [Medium-High]

§748.3529. How do I measure the use zone for tire swings?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone for tire swings or other multi-axis swings must extend in all directions for a distance equal to the height of the suspending bar to the top of the sitting surface of the tire, plus six feet. [Medium-High]
- (b) The use zone on the sides of the tire swing support structure must be at least six feet and may overlap the use zone on the sides of an adjacent swing support structure. [Medium-High]

§748.3531. How do I measure the use zone for bucket swings?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone to the front and rear of the bucket swing must extend twice the height from the swing beam to the top of the swing-sitting surface. [Medium-High]
- (b) The use zone specified in subsection (a) of this section must not overlap any other use zone. [Medium-High]
- (c) The use zone on the sides of the bucket swing structure must be at least six feet and may overlap the use zone on the sides of an adjacent swing support structure. [Medium-High]

§748.3533. How do I measure the use zone for rotating or rocking equipment or for track rides?

Subchapter P, Physical Site

Division 7, Playground Use Zones

January 2007

- (a) The use zone for rotating or rocking equipment on which the child sits must be at least six feet from the perimeter when not in use. [Medium-High]
- (b) The use zone for rotating or rocking equipment or track rides on which the child stands or rides must be at least seven feet from the perimeter of the equipment when not in use. [Medium-High]
- (c) The use zone for rocking and rotating equipment must not overlap any other use zone. [Medium-High]

Division 8, Protective Surfacing

§748.3561. Where must I install protective surfacing?

Subchapter P, Physical Site

Division 8, Protective Surfacing

January 2007

You must install protective surfacing in use zones identified in Division 7 of this subchapter (relating to Playground Use Zones). [Medium-High]

§748.3563. What are the requirements of protective surfacing for use zones?

Subchapter P, Physical Site

Division 8, Protective Surfacing

January 2007

- (a) There must be loose-fill surfacing material or unitary surfacing material in the use zones for all climbing, rocking, rotating, bouncing, or moving equipment, slides, and swings. Loose-fill surfacing materials include loose particles such as sand, pea gravel, shredded wood products, and shredded rubber. [Medium-High]
- (b) You must not install loose-fill surfacing materials over concrete or asphalt. [Medium-High]
- (c) If you use loose-fill surfacing materials, you must install nine inches or more of uncompressed loose-fill material in the use zones. [Medium-High]
- (d) You must ensure nine inches of the loose-fill materials are maintained at all times. [Medium-High]
- (e) You must mark all equipment support posts to indicate the depth at which the loose-fill surfacing material must be maintained. [Medium]
- (f) If you use unitary materials, they must be installed and maintained according to manufacturer's specifications. Unitary surfacing materials are manufactured materials including rubber tiles, mats, or poured-in-place materials cured to form a unitary shock- absorbing surface. [Medium-High]
- (g) Unitary materials may be installed over concrete or asphalt only if recommended by the manufacturer. [Medium-High]

§748.3565. What documentation must I keep at the operation if I use unitary surfacing materials?

Subchapter P, Physical Site

Division 8, Protective Surfacing

January 2007

- (a) If you use unitary surfacing materials, you must have test data from the manufacturer showing [Medium-High]:
 - (1) The impact rating of the material (the maximum height of equipment that may be installed over the surfacing material); and
 - (2) Installation and maintenance requirements.
- (b) This documentation must be at the operation and available for review by Licensing staff upon request. [Medium]

Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs

§748.3601. What are the requirements for swimming pools that a child uses?

Subchapter P, Physical Site

Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs

January 2017

If a swimming pool with more than two feet of water is used in an activity sponsored by you, then the swimming pool, either at or away from your operation, must meet the following criteria:

- (1) At least two life-saving devices must be available, such as a reach pole, backboard, buoy, or a safety throw bag with a brightly colored buoyant rope or throw line [High];
- (2) One additional life-saving device must be available for each 2,000 square feet of water surface, so a pool of 2,000 square feet would require three life saving devices [High];
- (3) Drain grates, vacuum outlets, and skimmer covers must be in place [High];
- (4) Pool chemicals and pumps must be inaccessible to all children [High];
- (5) Machinery rooms must be locked when any child is present [High];
- (6) All parts of the swimming pool must be clearly visible during the use of the pool [High];
- (7) The bottom of the pool must be visible during the use of the pool [High];
- (8) Pool covers must be completely removed prior to pool use and must not present an entrapment hazard [High]; and
- (9) Swimming area rules and emergency procedures must be posted at the swimming area and explained to the children. [High]

§748.3603. What are the additional requirements for a swimming pool located at my operation?

Subchapter P, Physical Site

Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs

January 2017

- (a) The swimming pool must be built and maintained according to the standards of the Department of State Health Services and any other applicable state or local regulations. [High]
- (b) An adult must be present who is able to immediately turn off the pump and filtering system when any child is in a pool. [High]
- (c) If the pool is aboveground, it must meet all pool safety requirements specified in this subchapter and have a barrier that prevents a child's unauthorized access to the pool. [High]
- (d) Outdoor swimming pools must be enclosed with a six-foot fence or wall that prevents children's access to the pool. It must be constructed, so the fence or wall does not obscure the pool from view. [High]
- (e) Doors, operable windows, or gates of living quarters must not be part of the pool enclosure for outdoor swimming pools. [High]
- (f) Fence gates leading to the outdoor pool area must have self-closing and self-latching hardware located at least 60 inches from the ground and must be locked when the pool is not in use. An indoor swimming pool must be secured at all times to prevent children's access to the pool when a lifeguard is not on duty. [High]
- (g) Fence gates must open outward away from the pool and must not be propped open. [High]
- (h) The space between the ground and the bottom of the fence must not exceed four inches. [High]
- (i) When a fence is made of horizontal and vertical slats, the horizontal slats must be located on the swimming pool side of the fence. [Medium-High]
- (j) Doors from the operation leading to the pool area must have a lock that can only be opened by an adult. [High]
- (k) The doors and fence gates leading to or through the pool area must not be designated as fire and emergency evacuation exits. [Medium-High]
- (l) The drain grates, vacuum outlets, and skimmer covers that must be in place, must also be in good repair, and not be able to be removed without using tools. [High]

- (m) All indoor/outdoor areas within 50 feet outside of the fence around the pool must be free of furniture and equipment that a child could use to enter the pool area by scaling a fence or barrier or releasing a lock. [High]

§748.3605. What are the safety requirements for wading/splashing pools at my operation?

Subchapter P, Physical Site

Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs

January 2007

- (a) Wading/splashing pools (two feet of water or less) at your operation must be:
- (1) Stored out of children's reach, when not in use [Medium-High];
 - (2) Drained at least daily and sanitized [Medium-High]; and
 - (3) Stored, so they do not hold water. [Medium-High]
- (b) A portable wading pool must not be placed on concrete or asphalt. [Medium-High]

§748.3607. What are the requirements for a hot tub?

Subchapter P, Physical Site

Division 9, Swimming Pools, Wading/Splashing Pools, and Hot Tubs

September 2010

A hot tub must be:

- (1) Enclosed per the requirements in §748.3603 of this title (relating to What are the additional requirements for a swimming pool located at my operation?) [Medium-High]; or
- (2) Covered with a locking cover when not in use. [Medium-High]

Subchapter Q, Recreation Activities

Division 1, General Requirements

§748.3701. What are my responsibilities for providing opportunities for recreational activities and physical fitness?

Subchapter Q, Recreation Activities

Division 1, General Requirements

January 2017

- (a) You must provide daily indoor and outdoor recreational and other activities appropriate to the needs, interests, and abilities of the children, so every child may participate. [Medium-Low]
- (b) You must have a written plan for ensuring that a range of indoor and outdoor recreational and leisure opportunities are provided for children in care. [Low]
- (c) Except for a child who has written medical orders to the contrary, your programs for non- ambulatory children must include:
 - (1) Physical fitness development that prescribes a variety of body positions [Medium-Low]; and
 - (2) Changes in environment. [Medium-Low]
- (d) Each child must have individual free time as appropriate to the child's age and abilities. [Medium-Low]
- (e) You must provide the follow types of recreational activities based on each individual child's needs:

Type of Service	The caregivers must:
(1) Child-care services	(A) [Medium-Low] Ensure that opportunities to participate in community activities, such as school sports or other extracurricular school activities, religious activities, or local social events, are available to the child; and (B) [Medium-Low] Organize community activities, religious activities, or local social events that are available to the child.

Type of Service	The caregivers must:
(2) Treatment services	(A) [Medium-Low] Meet the requirements in paragraph (1)(A) of this chart; (B) [Medium-Low] Ensure that each child receiving treatment services has an individualized recreation plan designed by the service planning team or professionals who are qualified to address the child's individual needs, that the plan is implemented, and that the plan is revised by the service planning team or qualified professionals, as needed; and (C) [Medium-Low] Ensure that medical and physical support are given if the recreational and leisure-time activities require it for a child who is receiving treatment services for primary medical needs, autism spectrum disorder, or intellectual disability.

§748.3703. What are the requirements for recreational areas and equipment?

Subchapter Q, Recreation Activities

Division 1, General Requirements

January 2007

You must provide indoor and outdoor recreational areas and equipment for stimulating children in appropriate recreational activities. The activities must be in sufficient variety and quantity, so every child may participate and have some choice of activities. [Medium]

§748.3705. What are higher risk recreational activities?

Subchapter Q, Recreation Activities

Division 1, General Requirements

January 2017

Higher risk recreational activities are activities that present a greater potential of injury to the child and involve special technical skill, equipment, or safety regulations for participation, including using all-terrain vehicles, swimming activities, watercraft activities, riding horses, wilderness hiking and camping excursions, trampoline use, and using weapons, firearms, explosive materials, and projectiles.

§748.3707. Does Licensing regulate higher risk recreational activities?

Subchapter Q, Recreation Activities
Division 1, General Requirements
January 2007

Licensing only regulates activities that are sponsored or conducted by the operation, including higher risk recreational activities.

§748.3709. What are the requirements when children participate in a higher risk recreational activity?

Subchapter Q, Recreation Activities
Division 1, General Requirements
January 2007

You must meet the following requirements when children participate in a higher risk recreational activity:

- (1) There must be a person that is responsible for and supervises the higher risk recreational activity [Medium-High];
- (2) When the person supervising the higher risk recreational activity is an employee of the operation, the supervising employee must:
 - (A) Determine each participant's experience and skill level [Medium]; and
 - (B) Take this information into account in supervising and assigning equipment or animals to children [Medium];
- (3) Continue to meet the child/caregiver ratios and appropriately supervise the children at all times. If the person supervising the higher risk recreational activity is not a caregiver with the operation, then that person cannot be counted in the child/caregiver ratio. For additional requirements for child/adult ratios for swimming activities, see Division 2 of this subchapter (relating to Swimming Activities) [Medium-High]; and
- (4) You must provide children with equipment that is appropriate to the activity, properly sized and adjusted where applicable, and in good condition. [Medium-Low]

Best Practice Suggestion

It is recommended that children wear a properly fitted helmet appropriate for the activity when participating in the following higher risk activities: bicycling, horseback riding, outdoor in-line skating and skateboarding, white-water kayaking, snow skiing or snow boarding, tackle football, riding on an all-terrain vehicle, or baseball, softball, and tee-ball when batting. In addition to wearing a helmet for in-line skating, it is suggested that children wear wrist and elbow guards, and kneepads. In addition to wearing a helmet for horseback riding, it is suggested that children be appropriately dressed, including shoes or boots, snug clothing, and long pants. It is recommended that barns, stables, corrals or other structures used to house horses or other animals be at least 100 feet away from any sleeping, eating or food preparation area, or body of water to prevent contamination.

Chapter 768 of the Texas Health and Safety Code outlines specific requirements for children who participate in rodeos, including wearing protective gear. Operations need to be aware of the requirements of this law if children in their care participate in rodeos.

§748.3711. Who must supervise a higher risk recreational activity?

Subchapter Q, Recreation Activities

Division 1, General Requirements

January 2007

(a) The higher risk recreational activity must be supervised by a person:

- (1) Knowledgeable about safety precautions for the type of higher risk recreational activity being performed [Medium]; and
- (2) Who has the appropriate experience, training, and/or certification in the activity. [Medium]

(b) If the person supervising a higher risk recreational activity is an employee of the operation, you must document these qualifications in the employee's personnel record. [Medium-Low]

§748.3713. What duties are required for a person supervising higher risk recreational activities?

Subchapter Q, Recreation Activities

Division 1, General Requirements

September 2010

A person supervising higher risk recreational activities must:

- (1) Be present at the site of the activity whenever the activity is being carried out [Medium];
- (2) Facilitate training or experience for other persons working in the activity to prepare them for foreseeable risks [Medium];
- (3) Assign duties to other persons working in the activity [Medium-Low];
- (4) Ensure there is a person at the site of the activity that has a current first-aid and CPR certificate when the activity is in progress [Medium-High];
- (5) Ensure that all necessary equipment is complete, in good repair, and safe to use [Medium-High];
- (6) Ensure there is a first-aid kit located at the site of the activity that contains appropriate and sufficient equipment for the type of activity and number of participants [Medium-High];
- (7) Obtain information on weather and travel conditions before a trip or activity that is outdoors [Medium-Low];
- (8) Develop a plan for action in case of emergencies relevant to the terrain and activity, including lost participants, injuries, and illnesses and communicate the plan to other persons working on the activity [Medium];
- (9) Consider each participant's age, physical condition, and experience, as well as the season and weather trends [Medium];
- (10) Ensure that risk factors are explained to the child prior to the activity, and that the child has an opportunity to decline participation [Medium-Low]; and
- (11) Instruct children on the safety precautions and proper use of relevant items or animals. This must be done before access to the item or animal is allowed. [Medium]

§748.3719. May children in care use all-terrain vehicles?

Subchapter Q, Recreation Activities

Division 1, General Requirements

January 2007

(a) A child in care may not ride on or operate a three-wheel all-terrain vehicle. [Medium]

(b) Only a child 16 years or older may ride on or operate a four-wheel all-terrain vehicle.
[Medium]

Helpful Information
The intent of this rule is to limit children's use of all-terrain vehicles for sport or recreation, due to safety concerns. This rule is not intended to limit the safe and appropriate use of utility vehicles, golf carts, riding lawn mowers, etc.

Division 2, Swimming Activities

Helpful Information

The rules in this Division apply to swimming activities that are sponsored by the operation, whether the swimming activities are at the operation or away from the operation.

§748.3751. Must a certified lifeguard be on duty during a swimming activity?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2017

- (a) A certified lifeguard must supervise children at all times during a swimming activity involving a body of water two feet deep or more which occurs at your operation. [Medium-High]
- (b) At all times during a swimming activity sponsored by the operation involving a body of water two feet deep or more which occurs away from your operation:
 - (1) If there are six or fewer children participating in the swimming activity, at least one adult counted in the swimming child/adult ratio must be able to swim or must be trained to carry out a water rescue [Medium-High]; and
 - (2) If more than six children are participating in the swimming activity, a certified lifeguard must also be on duty. [Medium-High]
- (c) A child in your care who is a certified lifeguard may act as the lifeguard if he is:
 - (1) At least 16 years old [Medium-High]; and
 - (2) Not counted as an adult or caregiver in the required child/adult swimming ratio. [Medium-High]

§748.3753. Who must provide a certified lifeguard's training?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2017

A certified lifeguard's training must be provided through a recognized organization. [Medium]

§748.3755. Where must a certified lifeguard be positioned when supervising children who are swimming?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2007

The lifeguard must be located in a position to observe all swimmers and to respond to emergencies. [High]

§748.3757. What are the child/adult ratios for swimming activities?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2017

- (a) The maximum number of children one adult can supervise during swimming activities is based on the age of the youngest child in the group and is specified in the following chart [High]:

If the age of the youngest child is...	Then the Swimming Child / Adult Ratio is
0 to 23 months old	1:1
2 years old	2:1
3 years old	3:1
4 years old	4:1
5 years old or older	You must meet the applicable child/caregiver ratios as provided in §748.1003 of this title (relating to For purposes of the child/caregiver ratio, how many children can a single caregiver care for during the children's waking hours?).

- (b) When all of the children in the group are four years old or older, in addition to meeting the required swimming child/adult ratio listed in subsection (a) of this section, at least two adults must supervise four or more children who are actually in the water. [High]

(c) When a child who is non-ambulatory or who is subject to seizures is engaged in swimming activities, you must assign one adult to that one child. This adult must be in addition to the lifeguard on duty in the swimming area. You do not have to meet this requirement if a licensed physician writes orders in which the physician determines that the child [High]:

(1) Is at low risk of seizures and that special precautions are not needed; or

(2) Only needs to wear an approved life jacket while swimming and additional special precautions are not needed.

Helpful Information
Regarding subsection (b), if you take four 4-year olds swimming, subsection (a) only requires one person to supervise the four children. However, if all four 4-year olds are actually in the water at the same time, then subsection (b) requires there to be at least two adults to supervise the children.

§748.3759. May I count the certified lifeguard in the swimming child/adult ratio?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

September 2010

A lifeguard who is supervising the area where the children are swimming may be counted in the child/adult ratio except as specified in §748.3751(c) of this title (relating to Must a certified lifeguard be on duty during a swimming activity?). The lifeguard must never be left alone with any of the children unless the lifeguard is also a qualified caregiver for your operation. [Medium]

§748.3763. May I include volunteers or employees who do not meet minimum qualifications for caregivers in the swimming child/adult ratio?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

September 2010

To meet the swimming child/adult ratio, you may include adult volunteers and employees of the operation who do not meet the minimum qualifications for caregivers, providing you:

- (1) Maintain enough caregivers to meet the ratios required in Subchapter G of this chapter (relating to Child/Caregiver Ratios) [High]; and
- (2) Ensure compliance with all other rules of this chapter, including rules relating to supervision and discipline. [High]

§748.3765. What are the requirements for a child's access to a body of water?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2017

- (a) Prior to any activity regarding a body of water, you must explain the dangers of the body of water and the rules governing the activity to the children in a manner that each child can understand. [High]
- (b) If your operation sponsors a swimming activity and you allow a child to swim in a body of water:
 - (1) The supervising adult must clearly designate the swimming areas [High];
 - (2) You must meet the swimming child/adult ratios [Medium-High]; and
 - (3) If more than six children are participating in the activity, you must have life-saving equipment present at all times that is sufficient to reach and rescue the child, such as a safety throw bag with a brightly colored 50-foot buoyant rope or a rescue boat equipped with a reach pole and a buoy. [Medium-High]

§748.3767. May I use a stock tank as a pool for a swimming activity?

Subchapter Q, Recreation Activities

Division 2, Swimming Activities

January 2007

No. You may not use a stock tank used by livestock for a swimming activity. [High]

Division 3, Watercraft Activities

Helpful Information

The rules in this Division apply to watercraft activities that are sponsored by the operation, whether the water activities are at the operation or away from the operation.

§748.3801. What watercraft activities do the rules of this division apply to?

Subchapter Q, Recreation Activities

Division 3, Watercraft Activities

January 2017

The rules of this division apply to activities involving bodies of water:

- (1) In which more than six children participate; and
- (2) That involve boats, canoes, kayaks, sailboats, rafts, jet skis, or inflatable tubes.

§748.3803. What are the requirements for watercraft activities?

Subchapter Q, Recreation Activities

Division 3, Watercraft Activities

September 2010

- (a) A non-swimmer must wear a life vest. [High]
- (b) At least two adults able to swim and carry out a water rescue must be at the shoreline and/or on the water to respond to emergencies any time children are on the water during watercraft activities. [Medium-High]

Best Practice Suggestion

The following are best practice recommendations regarding watercraft activities:

- The activity supervisor should run or scout a river prior to taking children on the water, ensure that caregivers have experience on the class of waters to be traveled, ensure that caregivers hold a current Standard First Aid Certificate or equivalent, and ensure that caregivers have training in hypothermia;
- There should be a warning device that can be readily heard by persons in the boats that must indicate the need for them to return to the shore. There should be a rescue boat available at the river or lake where boating activities take place. This rescue boat should be in good repair and contain a buoy or a safety throw bag with brightly colored 50-foot buoyant rope or throw line and a reach pole. When canoeing or rafting, the rescue boat should have an extra paddle or oar; and
- Watercraft should not enter a swimming area when swimmers are in the water or use the swimming area as a watercraft docking area unless it is an emergency and the watercraft is man-powered. Water skiers should not launch or stop in the swimming area.

§748.3805. What considerations must the watercraft activity supervisor take into account prior to the implementation of the activity?

Subchapter Q, Recreation Activities

Division 3, Watercraft Activities

January 2007

The supervisor of the watercraft activity must:

- (1) Assess the skill and swimming ability of each child prior to the activity [Medium-High];
- (2) Accompany children on any trip [Medium-High];
- (3) Determine if an adult must be in the boat with the child or children [Medium-High]; and

(4) Take into account hazards, such as the size of the body of water, the skill and swimming ability of the children, the air temperature, the conditions of the water, and the temperature of the water when determining:

- (A) Whether to permit children to participate in a watercraft activity [Medium-High];
- (B) The experience and number of adults necessary [Medium-High]; and
- (C) Whether or not each child must wear a life vest. [Medium-High]

§748.3807. What are the requirements for watercraft equipment?

Subchapter Q, Recreation Activities

Division 3, Watercraft Activities

January 2007

- (a) The watercraft and all equipment must be kept in good repair at all times.
- (b) You must meet the watercraft requirements of Texas Parks and Wildlife, if applicable.
[Medium-High]

Division 4, Wilderness Hiking and Camping Excursions

§748.3841. What are the requirements for hiking or camping excursions?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

September 2010

When you participate in a hiking or camping activity in an area unfamiliar to the participating adults, and the hiking activity lasts more than two hours:

- (1) The person qualified to supervise the hiking or camping excursion must consider the following when selecting the area for hiking or camping:
 - (A) Evacuation [Medium];
 - (B) Communication [Medium]; and
 - (C) Water quality and quantity [Medium];
- (2) The person qualified to supervise the hiking or camping excursion must have experience leading a group in hiking or camping at the elevation, terrain, and climate where the activity is to take place [Medium];
- (3) Before participation, the caregivers and children must receive instruction on:

- (A)The fundamental safety procedures for the area where the hiking or camping will occur [Medium];
- (B)Procedures to follow if the participant gets lost [Medium];
- (C)Proper health and sanitation procedures [Medium];
- (D) Potential high-risk areas where the hiking or camping will occur [Medium]; and
- (E) Fire risks [Medium];

(4)The emergency medical care consent forms must be readily accessible to the caregivers accompanying them [Medium];

(5)Caregivers participating in the hiking or camping activity must regularly monitor and care for the health and safety of children [Medium-High]; and

(6)If the excursion will be on private land, you must have an agreement with the person responsible for that land. [Medium-Low]

Best Practice Suggestion

The following are suggestions for when a child is in or around a grassy, wooded area while camping, hiking or participating in any other outdoor activity, especially in the months between April and October:

- Cover arms and legs. Have the child wear a long-sleeved shirt, and tuck his pants into his socks.
- Wear a hat to help keep ticks away from the scalp. Keep long hair pulled back.
- Wear light-colored clothing to make it easier to spot ticks.
- Wear enclosed shoes or boots. Avoid wearing sandals in an area where ticks may live.
- Use insect repellent. Products with DEET are effective against ticks and can be used on the skin. However, large amounts of DEET can be harmful to the child if it is absorbed through the skin. Look for products that contain no more than 30 percent DEET. Wash the DEET off with soap and water when your child returns indoors. Products with permethrin can be used on clothing, but cannot be applied to the skin.
- Stay on cleared trails whenever possible. Avoid wandering from a trail or brushing against overhanging branches or shrubs.
- After coming indoors, check for ticks. This will only take a few minutes. Ticks often hide behind the ears or along the hairline. It may take up to 48 hours for a person to become infected, so removing any ticks soon after they have attached themselves can help reduce the chances of becoming infected.

Removing leaves and keeping your yard clear of brush and tall grass may reduce the number of ticks. You may wish to talk to a licensed professional pest control expert about other steps you can take to reduce ticks in your yard.

§748.3843. What are the requirements for monitoring **children's** safety and health during hiking or camping excursions?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

Caregivers participating in the hiking or camping activity must ensure that:

- (1) Each child participating in the hiking or camping activity has the clothing, equipment, and provisions necessary to protect the child from the environment, including insect repellent and sunscreen [Medium];
- (2) A child does not carry a load of more than 30% of the child's body weight [Medium];
- (3) Hiking does not exceed the physical capabilities of the weakest member of the group. If a participating child cannot or will not hike, the group must not continue unless other provisions have been made to care for the child [Medium];
- (4) In temperatures above 80 degrees Fahrenheit:
 - (A) Children are offered a minimum of three quarts of drinking water per day [Medium-High];
 - (B) Electrolyte replacement is available to children at all times [Medium-High]; and
 - (C) Other techniques are available to cool a participant, such as water to coat a child's body or cold packs [Medium-High]; and
- (5) Potable water is available at each campsite. Caregivers must verify water cache location information before the group leaves camp each day, if applicable. [Medium]

§748.3845. What type of itinerary must I have for hiking or camping excursions?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

September 2010

- (a) For hiking or camping excursions that last for over five hours, you must have an itinerary prepared prior to departure, including the [Medium-Low]:
 - (1) Time of departure and anticipated time of return [Medium-Low];
 - (2) Destination [Medium-Low]; and

(3) Travel route. [Medium-Low]

(b) For hiking or camping excursions that last overnight, each point of the itinerary must also identify:

(1) Sources of emergency care, such as hospitals, police, and forest service offices [Medium-Low];

(2) Methods of communicating with sources of emergency care [Medium]; and

(3) Date and time of departure and anticipated date and time of return.
[Medium-Low]

(c) The caregivers on the excursion must:

(1) Follow the itinerary as closely as possible [Medium-Low]; and

(2) Notify the operation of any change, when possible. [Medium]

§748.3847. Where must the itinerary be kept?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

(a) You must keep a copy of the itinerary on file at the operation. [Medium]

(b) If the excursion is on land governed by the national or state forest service, then you must also provide the service's office with a copy of the itinerary. [Medium-Low]

§748.3849. What are the requirements for shelter during an overnight excursion?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

(a) During an overnight excursion, you must provide each child with:

(1) Adequate shelter, such as a tent, tarp, or cabin [Medium]; and

(2) Reasonable insulation from cold and dampness by such things as a rain fly, ground cloth, and an insulated pad under bedrolls or sleeping bags. [Medium]

(b) Open air sleeping is allowable if:

- (1) The weather permits [Medium-Low];
- (2) The child consents [Medium-Low]; and
- (3) You provide a ground cloth and an insulated pad under bedrolls or sleeping bags. [Medium-Low]

§748.3851. What are the requirements for bed equipment used during an overnight excursion?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

You must provide each child with:

- (1) An individual bed, bedroll, or sleeping bag [Medium-Low];
- (2) Extra linens as needed for the child's warmth and comfort, such as a blanket [Medium-Low];
- (3) Clean bed linens that are changed as often as needed for cleanliness and sanitation, but not less than once a week, if applicable [Low]; and
- (4) Provisions for proper laundering of bedrolls and sleeping bags between trips or between uses by different individuals. [Low]

§748.3853. What are the specific requirements for storing food during a hiking or camping excursion?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

- (a) You may only use foods capable of being maintained in a wholesome condition with the available equipment. [Medium-Low]
- (b) You must refrigerate perishable food when possible. [Medium]
- (c) If you use an ice chest to refrigerate food during the excursion, you must provide adequate ice at all times. [Medium]
- (d) You must drain ice chests to prevent accumulation of water from melted ice. [Medium-Low]
- (e) You may not store meat and other highly perishable foods for more than 24 hours. [Medium]
- (f) You must discard any contaminated foods. [Medium-High]

Best Practice Suggestion

The following are health and safety recommendations related to cooking and food storage on hiking and camping trips.

Keeping Food Cold:

It is best to:

- Fill the cooler with cold or frozen foods.
- Pack foods in reverse order. The first foods packed should be the last foods used, except that raw meat or poultry should be packed below ready-to-eat foods to prevent raw meat or poultry juices from dripping on the other foods.
- Take foods in the smallest quantity needed (e.g., a small jar of mayonnaise).
- In the car, put the ice chest in the air-conditioned passenger section, rather than in the trunk.

Best Practice Suggestion

- At the campsite, insulate the cooler with a blanket, tarp, or poncho. When the camping trip is over, discard all perishable foods if there is no longer ice in the cooler or if the gel- pack is no longer frozen.

If you are planning to fish, check with the fish and game agency or state health department to see where you can fish safely, then follow these guidelines:

Finfish:

- Scale, gut, and clean fish as soon as they are caught.
- Live fish can be kept on stringers or in live wells, as long as they have enough water and enough room to move and breathe.
- Wrap fish, both whole and cleaned, in water-tight plastic and store on ice.
- Keep 3 to 4 inches of ice on the bottom of the cooler. Alternate layers of fish and ice.
- Store the cooler out of the sun and cover with a blanket.
- Once home, eat fresh fish within 1 to 2 days or freeze them. For top quality, use frozen fish within 3 to 6 months.

Shellfish:

- Crabs, lobsters, and other shellfish must be kept alive until cooked.
- Store in live wells or out of water in a bushel or laundry basket under wet burlap or seaweed.
- Crabs and lobsters are best eaten the day they are caught.
- Live oysters should be cooked within 7 to 10 days.
- Live mussels and clams should be cooked within 4 to 5 days.
- Eating raw shellfish is extremely dangerous. People with liver disorders or weakened immune systems are especially at risk.

Using a Food Thermometer:

If you are cooking meat or poultry on a portable stove or over a fire, you will need a way to determine when it is done and safe to eat. Color is not a reliable

Best Practice Suggestion

indicator of doneness, and it can be especially tricky to tell the color of a food if you are cooking in a wooded area in the evening.

When cooking hamburger patties on a grill or portable stove, use a digital thermometer to measure the temperature. Digital thermometers register the temperature in the very tip of the probe, so the safety of thin foods, such as hamburger patties and boneless chicken breasts, can be determined. A dial thermometer determines the temperature of a food by averaging the temperature along the stem and, therefore, should be inserted 2 to 2 ½ inches into food. If the food is thin, the probe must be inserted sideways into the food. It is critical to use a food thermometer when cooking hamburgers. Ground beef may be contaminated with *E. coli* O157:H7, a particularly dangerous strain of bacteria. Illnesses have occurred even when ground beef patties were cooked until there was no visible pink. The only way to insure that ground beef patties are safely cooked is to use a food thermometer, and cook the patty until it reaches 160 °F. For chicken, cook breasts or cutlets to 170 °F and legs and thighs to 180 °F. Pork should be cooked to 160 °F. Heat hot dogs and any leftover food to 165 °F. Be sure to clean the thermometer between uses.

§748.3855. What requirements must I meet for food utensils and equipment when camping?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

- (a) A common use drinking cup, container, or utensil must be washed with uncontaminated hot water and detergent before another person uses it.
[Medium-Low]
- (b) You must not use a dish, container, or utensil that is chipped, cracked, broken, damaged, or constructed so as to prevent proper cleaning and sanitizing.
[Medium-Low]
- (c) You must discard disposable or single-use dishes, containers, or utensils used in handling food after one use. [Medium-Low]
- (d) You must store eating utensils:

- (1) Separately from foods or other materials or substances [Medium-Low];
and
- (2) In clean, dry containers. [Medium-Low]

Best Practice Suggestion

The following are best practices for food utensils and equipment when camping:

- Food utensils and equipment should be rinsed in hot water and sanitized in disinfected water. Prepare each solution daily and place it in a closed and labeled container; or
- Where group dishwashing is practiced, all food utensils should be immersed for at least two minutes in a lukewarm chlorine bath containing at least 50 ppm of available chlorine. Where chlorine is used, a three-compartment vat or three containers should be used for washing, rinsing, and immersing.

§748.3857. What parameters must I follow for drinking water during a hiking or camping excursion?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

- (a) Drinking water used during a hiking or camping excursion must come from a source known to be safe or must be rendered safe. [Medium-High]
- (b) An adequate supply of water, under pressure where possible, must be provided at the cooking area for hand washing, dishwashing, food preparation, and drinking. [Medium-Low]

Best Practice Suggestion

It is recommended that drinking water be disinfected by one of the following methods:

- Boil water for at least 1 to 15 minutes after it reaches a full boil;
- A water purifier;
- A water filter;
- Iodine tablets or crystals – add five drops of iodine per quart of clear water or ten drops per quart of cloudy water, thoroughly mix the solution, and wait 30 minutes before using;

Best Practice Suggestion

- Chlorine dioxide tablets, or halazone tablets used according to the manufacturer's directions; or
- Liquid iodine or household chlorine bleach – add two drops of household chlorine bleach per quart of water. You must ensure the chlorine does not have an active ingredient other than 4% to 6% sodium hypochlorite. Thoroughly mix the solution and wait 30 minutes before using. If the water does not have a slight chlorine odor and taste, add two more drops of chlorine bleach and wait 15 more minutes before using.

Safe Drinking Water:

It is not a good idea to depend on fresh water from a lake or stream for drinking, no matter how clean it appears. Some pathogens thrive in remote mountain lakes or streams and there is no way to know what might have fallen into the water upstream. It is best to bring bottled or tap water for drinking, starting out with a full water bottle, and replenishing your supply from tested public systems when possible. On long trips, you should consider purifying any water taken from the wild, no matter how clean it appears.

The surest way to make water safe is to boil it. Boiling will kill microorganisms. First, bring water to a rolling boil, and then continue boiling for 1 minute. Before heating, muddy water should be allowed to stand for a while to allow the silt to settle to the bottom. Dip the clear water off the top and boil. At higher elevations, where the boiling point of water is lower, boil for several minutes.

As an alternative to boiling water, you may also wish to use water purification tablets and water filters. The purification tablets – which contain iodine, halazone, or chlorine – kill most waterborne bacteria, viruses, and some (but not all) parasites. Because some parasites are not killed by purification tablets, you should also use a water filter. These water filtering devices should be 1 micron absolute or smaller. Over time, purification tablets lose their potency, so it is important to keep your supply fresh. Water sanitizing tablets for washing dishes can also be purchased (just do not confuse the two). Water purification tablets, filters, and sanitizing tablets can be purchased at camping supply stores.

§748.3861. What are the requirements for toilet facilities during overnight camping excursions?

Subchapter Q, Recreation Activities

Division 4, Wilderness Hiking and Camping Excursions

January 2007

- (a) If the campsite is not provided with toilet facilities, pit privies or other portable toilets, there must be separate designated areas for each gender for toilet use.

[Low]

- (b) Toilet paper must be available at all times, as needed. [Low]

- (c) Privies must be located at least:

- (1) 20 feet from any stream, lake, well, spring, or other water supply

[Low]; and

- (2) 75 feet from the camp, tent, sleeping, or housing arrangement.

[Medium]

- (d) Soap and water for hand washing must be located within 20 feet of the toilet areas. [Low]

Division 5, Trampoline Use

§748.3891. May I use a trampoline?

Subchapter Q, Recreation Activities

Division 5, Trampoline Use

January 2017

(a) You may use a trampoline if:

- (1) The use of the trampoline and the number of children allowed on the trampoline at one time meets the manufacturer's instructions [Medium-High];
- (2) Shock-absorbing pads cover the springs, hooks, and frame [Medium-High];
- (3) Ladders are removed from the trampoline when the trampoline is not in use [Medium-High]; and
- (4) A caregiver provides supervision as follows:
 - (A) For children under 12 years old, the caregiver must be immediately present, watching the child/ren at all times, enforcing safety rules and manufacturer's instructions, and able to respond to an emergency [Medium-High]; and
 - (B) For children 12 years old and older, the caregiver must be on the premises, visually check on the child/ren at frequent intervals, and able to respond in an emergency [Medium-High]

(b) You may use a trampoline as gym equipment as provided in §748.3893 of this title (relating to What are the requirements for using a trampoline as gym equipment?).

§748.3893. What are the requirements for using a trampoline as gym equipment?

Subchapter Q, Recreation Activities

Division 5, Trampoline Use

January 2007

You may use a trampoline for supervised training programs, such as gymnastics, diving, and other competitive sports if you meet the following requirements:

- (1) You must prohibit the use of the trampoline when there is no trampoline supervisor present **[High]**;
- (2) The trampoline supervisor must have formal training and experience in the use of the trampoline and knowledge of trampoline safety and spotting techniques **[Medium-High]**;
- (3) When the trampoline is in use, personal spotters must be present, ready to intervene, and posted on four sides of each trampoline **[Medium-High]**;
- (4) You must prohibit any child younger than six years old from using the trampoline, even in supervised training programs **[Medium-High]**;
- (5) A safety pad must cover all portions of the steel frame and springs **[High]**;
- (6) The surface around the trampoline must have an impact absorbing surface material **[High]**;
- (7) Only one child at a time may use a trampoline, regardless of the size of the trampoline **[Medium-High]**;
- (8) Children must not be allowed to jump off the trampoline. If the trampoline is above ground, children must dismount the trampoline by sitting on the edge and sliding off **[Medium-High]**;
- (9) The trampoline must be secured and inaccessible when not in use **[Medium]**;
- (10) The condition of the trampoline must be checked for tears, rust, and detachments at least monthly and repaired prior to its next use **[Medium]**; and
- (11) The child using a trampoline must be at the center of the mat and must not attempt to do maneuvers beyond the child's capability or training. **[Medium]**

Best Practice Suggestion

Consider setting the trampoline in a pit so that the mat is at ground level. Safety harnesses and spotting belts, when appropriately used, may offer added protection for athletes learning or practicing more challenging skills on the trampoline.

Division 6, Weapons, Firearms, Explosive Materials, and Projectiles

§748.3931. Are weapons, firearms, explosive materials, and projectiles permitted at my operation?

Subchapter Q, Recreation Activities

Division 6, Weapons, Firearms, Explosive Materials, and Projectiles

January 2017

Generally, weapons, firearms, explosive materials, and projectiles (such as darts or arrows), are permitted, however, there are some specific restrictions:

- (1) Handguns are not permitted at an operation or during any type of activity [High];
- (2) A child receiving treatment services or emergency care services is not permitted to use weapons, firearms, explosive materials, or projectiles, or toys that explode or shoot (such as fireworks or BB guns) [High];
- (3) If you allow weapons, firearms, explosive materials, projectiles, or toys that explode or shoot, you must ensure children do not have unsupervised access to them by implementing specific precautions outlined in your policies, including locked storage and separate locked storage for the weapons and ammunition [High];
- (4) You must determine it is appropriate for a child receiving only child-care services to use the weapons, firearms, explosive materials, projectiles, or toys that explode or shoot [High]; and
- (5) No child may use a weapon, firearm, explosive material, projectile, or toy that explodes or shoots, unless the child is directly supervised by a qualified adult. A qualified adult must hold a generally recognized credential or possess documented knowledge and/or experience in the type of the weapon, firearm, explosive material, projectile, or toy that explodes or shoots that is to be used by the child. [High]

§748.3933. What factors must I consider when determining whether weapons, firearms, explosive materials, or projectiles are stored adequately?

Subchapter Q, Recreation Activities

Division 6, Weapons, Firearms, Explosive Materials, and Projectiles

January 2007

When determining if these items are stored adequately, you must consider the age, history, emotional maturity, and background of the children in your care. [High]

§748.3935. May a caregiver transport a child in a vehicle where weapons, firearms, explosive materials, or projectiles are present?

Subchapter Q, Recreation Activities

Division 6, Weapons, Firearms, Explosive Materials, and Projectiles

January 2007

A caregiver may not transport a child in a vehicle where a handgun is present. Otherwise, a caregiver may transport a child in a vehicle where weapons, firearms, explosive materials, or projectiles are present if:

- (1)The child is only receiving child-care services [High];
- (2)All firearms are not loaded [High]; and
- (3)The weapons, firearms, explosive materials, or projectiles are inaccessible to the child. [High]

Subchapter R, Transportation

Division 1, General Requirements

§748.4001. What types of transportation does Licensing regulate?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

(a) We regulate any transportation that you provide for trips away from and to your operation.

(b) You must ensure the safety of all children during any transportation that you provide.

[High]

§748.4003. What requirements must I meet when transporting a child away from the operation?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

Anytime you transport a child away from the operation, you must comply with each of the following requirements:

(1) Each driver must:

(A) Be at least 21 years old. For an exception for children in care, see §748.4005 of this title (relating to May a child in care transport other children in care?) [High];

(B) Be covered by automobile insurance [Medium-Low]; and

(C) Have a current driver's license allowing the driver to operate the type of vehicle that is used to transport children. [Medium-High]

(2) You must not transport more people than the capacity of the vehicle. [Medium-High]

(3) The vehicle must travel at a safe speed consistent with the speed limit, terrain, and weather conditions. [Medium-High]

(4) For requirements regarding firearms and transportation, see §748.3935 of this title (relating to May a caregiver transport a child in a vehicle where weapons, firearms, explosive materials, or projectiles are present?).

§748.4005. May a child in care transport other children in care?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

Yes, a child in care may transport other children in care if the child:

- (1) Has a valid driver's license [Medium-High];
- (2) Is covered by automobile insurance [Medium-Low]; and
- (3) Is given permission by the service planning team to drive and transport other children in care. [Medium]

§748.4007. What specific information and equipment must be in a vehicle I use to transport children during overnight trips away from the operation?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

The following information and items must be accessible and in each vehicle you use to transport children during overnight trips:

- (1) A list of the children being transported, which you must check in order to account for the presence of all participating children [High];
- (2) Emergency medical transport and treatment authorization forms for each child being transported [High];
- (3) A list of medications each child is currently taking, the dosage, and the frequency [High];
- (4) Your operation's name and telephone number, and the administrator's or permit holder's name [Medium-High];
- (5) Parent's names and telephone numbers and emergency telephone numbers for each child being transported [Medium-Low];

- (6) A fire extinguisher approved by the local or state fire marshal, secured in the passenger compartment and accessible to the adult occupants [High];
- (7) A first-aid kit [High]; and
- (8) An operable flashlight. [Medium-High]

§748.4009. What plan must I have for handling transportation emergencies?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

- (a) You must ensure the driver and caregivers have clear instructions in handling emergency breakdowns and accidents, including vehicle evacuation procedures, supervision of the children, and contacting emergency help. [Medium-High]
- (b) The administrator or designee in charge of the operation must know what action to take in responding to a transportation emergency call. [Medium-High]
- (c) Emergency transportation must be available at all times. It may be provided by the operation or pre-arranged with community services. [Medium]

§748.4011. What safety precautions must I take when loading and unloading a child from the vehicle?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

You must take the following precautions when loading and unloading a child from any vehicle used for transportation, including a bus with a gross vehicular weight rating (GVWR) of 10,000 pounds or more:

- (1) You must account for all children exiting the vehicle before leaving the vehicle unattended. [High]
- (2) You must not allow a child under eight years old to cross a street to enter a vehicle or after exiting a vehicle, unless an adult accompanies the child. [High]
- (3) You must never leave a child under eight years old unattended in a vehicle. [High]

§748.4013. What is required when my operation takes children on out-of-state overnight trips?

Subchapter R, Transportation

Division 1, General Requirements

January 2007

- (a) If your operation takes children on out-of-state overnight trips, you must:
 - (1) Develop a written itinerary and safety plan for each trip [Medium];
 - (2) Provide necessary equipment and make provisions to meet participants' needs on the trip [Medium]; and
 - (3) Inform parents before the planned departure date, and document in the child's record the discussion and date when this contact occurred. [Medium-Low]
- (b) You must obtain the written permission from each child's parent for each out-of-state trip or must obtain a general written permission from each child's parent for any out-of-state trip in which the child will participate. [Medium-Low]

Division 2, Safety Restraints

§748.4041. What are the requirements for transporting children?

Subchapter R, Transportation

Division 2, Safety Restraints

January 2017

The driver and all passengers must follow all federal, state, and local laws when driving, including laws on the use of a child passenger safety seat system, seat belts, and liability insurance. [High]

Helpful Information
The Transportation Code prohibits a child under five years old to ride on a motorcycle, unless seated in a sidecar.

Below is a chart from the web site of the Texas Department of Public Safety regarding child passenger safety seat system:

2013 Child Passenger Safety National Best Practice Recommendations

Phase	Type of Restrictive Device	Best Practice Recommendation
Phase 1	Rear-Facing Seats	Infants: Birth – 35+ pounds, 2+ years old. Rear-facing infant or rear-facing convertible safety seat as long as possible, up to the rear-facing height or weight limit of the seat. Properly install according to instructions in owner's manual, rear-facing in the back seat.
Phase 2	Forward-facing Seats	When children outgrow the rear-facing safety seat (2+ years), they should ride in a forward-facing safety seat as long as possible, up to the upper height or weight limit (40 – 80+ pounds) of the harnesses. Usually 4+ years old. Properly installed forward-facing in the back seat. NEVER turn forward-facing before child meets all: AGE/HEIGHT/WEIGHT requirements set by safety seat manufacturer for forward-facing.
Phase 3	Booster Seats	After age 4 and 40+ pounds, children can ride in a booster seat with the adult lap and shoulder belt until the adult safety belt will fit them properly (usually when the child is 4'9" tall, 10 – 12 years old). MUST have a lap/shoulder belt to use a booster seat.

Phase	Type of Restrictive Device	Best Practice Recommendation
Phase 4	Adult Safety Belt	Once children outgrow their booster seat (usually at 4'9", 10 – 12 years) they can use the adult lap/shoulder safety belt if it fits them properly. Lap portion low over the hips/tops of thighs and shoulder belt crosses the center of the shoulder and center of the chest.

Children are better protected the longer they can stay in each phase. Keep children in each seat up to the MAXIMUM age/weight/height limits before moving to the next phase. ALL children younger than age 13 years should ride properly restrained in the back seat.

§748.4043. Do the seat belt requirements prohibit transporting children in the bed of a pick-up truck?

Subchapter R, Transportation

Division 2, Safety Restraints

January 2017

- (a) Children may be transported in the bed of a pick-up truck on the facility grounds if the following conditions are met:
- (1) If children are being transported in the bed of a pick-up truck, children must be at least 13 years old [Medium-High];
 - (2) Children must be seated [Medium-High];
 - (3) No children may sit on the side of the vehicle, the tire wells, or on the tailgate [Medium-High];
 - (4) No children may lean against the tailgate [Medium-High];
 - (5) The tailgate must be securely closed while the vehicle is in motion [Medium-High];
 - (6) The vehicle must travel at a safe speed consistent with the terrain and weather conditions [Medium-High];
 - (7) The driver of the vehicle must be knowledgeable about the dangers associated with issues, such as but not limited to, sudden braking and travel over uneven terrain [Medium-High]; and
 - (8) Open bed pick-up trucks or trailers must not be used to transport children on public roads. [High]

- (b) Subsection (a) of this section does not apply to hay-rides on trailer beds for special occasions as long as there is adequate adult supervision to prevent children from falling off of the trailer. [High]
- (c) At all other times transportation is provided by the operation, employees, or volunteers, each child must be in a child passenger safety seat system when the vehicle is in motion. [High]

§748.4045. May I place more than one person in each child passenger safety seat system or seat belt?

Subchapter R, Transportation

Division 2, Safety Restraints

January 2017

No. Only one person may use each child passenger safety seat system or seat belt. [High]

Division 3, Vehicle and Vehicle Maintenance

§748.4081. What type of vehicle may I use to transport children?

Subchapter R, Transportation

Division 3, Vehicle and Vehicle Maintenance

January 2007

- (a) We do not regulate the type of vehicle you may use to transport children.
- (b) You must make special provisions if you transport non-ambulatory children. When necessary, this may include locks for wheel chairs and hydraulic lifts. [Medium]

§748.4083. What vehicle maintenance requirements must I maintain for a vehicle used for transporting children?

Subchapter R, Transportation

Division 3, Vehicle and Vehicle Maintenance

January 2007

- (a) You must maintain a vehicle in a safe operating condition at all times. [Medium-High]
- (b) Each vehicle you use must be registered and have a current inspection sticker for the state in which it is registered. [Medium-Low]

Division 4, Transportation Records

§748.4111. What transportation records must I maintain?

Subchapter R, Transportation

Division 4, Transportation Records

January 2007

- (a) You must maintain on file at your operation the name of each driver who transports children and a copy of a valid driver's license for that person. [Low]
- (b) You must also maintain the following:
 - (1) Insurance verification in the vehicle; or
 - (2) If your transportation services are provided by a private person, a firm under contract, or by another arrangement, you must maintain on file a copy of the person's or firm's insurance coverage. [Low]

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Helpful Information

Only an emergency care services program that plans to admit a specific child population requiring treatment services is required to meet treatment service requirements. Emergency care service programs which do not limit their admissions with regard to treatment service needs are not required to meet minimum standards related to treatment services.

For example, an emergency care services program specifically for children with primary medical needs is required to meet all minimum standards related to primary medical needs.

However, an emergency care services program with a broader admissions policy, able to admit children with a variety of needs, is not required to meet treatment services requirements.

In the first example, the emergency care services program knows that most or all of the children admitted will require a certain type of care. Therefore, the operation is able to plan appropriately for the required professional staff and services needed for the care of these children. In the second example, with a broader admissions policy, the emergency care services program is not able to predict the needs of children being admitted. Therefore, the operation does not have the opportunity to plan in advance to have professional staff, staff training, or services available for the specific, specialized needs of children in care.

Division 1, Service Management

§748.4201. What must I do when I admit a child who cannot consent to emergency care services?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services
Division 1, Service Management
January 2007

- (a) If you admit a child for emergency care services who does not meet the requirements to consent to emergency care services, you must try to contact the child's parent(s) within 24 hours, if you know their identity and how to contact them. [Medium-Low]
- (b) If you cannot contact the parent(s), you must notify the appropriate public agency (Child Protective Services, Juvenile Probation, or police department) of the child's presence. [Medium-Low]
- (c) Your operation must document in the child's record efforts to contact the child's parent(s) and contacts with public agencies. [Low]

§748.4203. What are the additional medical requirements when I admit a child to receive emergency care services?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services
Division 1, Service Management
January 2007

Each child receiving emergency care services must receive a health screening or EPSDT examination within 72 hours after admission [High]:

- (1) A health-care professional must provide the screening examination. The health-care professional does not have to be your employee. [Medium-High]
- (2) With the exception of EPSDT examinations, the person who does the examination must sign and date the results of the screening examination. You must document the results of the examination in the child's record. [Medium-Low]
- (3) If a child has been in a residential child-care operation and has had a health screening in the last 12 months, the child does not have to have another health screening unless there is reason to believe the child is ill or has been abused. [High]
- (4) If the child is coming from a medical setting, you may accept a statement from a licensed health-care professional in place of the examination.

§748.4205. What is the maximum amount of time a child receiving emergency care services may stay in care without a placement extension?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 1, Service Management

January 2007

A child receiving emergency care services may stay in care without a placement extension for a maximum of 15 days. [Low]

§748.4207. What is the maximum amount of time a child receiving emergency care services may stay in care with a placement extension?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 1, Service Management

January 2007

- (a) If there is an appropriate reason for continuing the care, a child:
 - (1) Younger than five years old may continue the placement for emergency care services for up to a total of 30 days in care [Low]; and
 - (2) Five years old or older may continue the placement for emergency care services for up to a total of 90 days in care. [Low]
- (b) If a child of any age has a parent under 18 years old admitted in the operation or has a sibling five years old or older admitted in the operation, the child may continue placement for emergency care services for the length of time the parent or sibling is receiving emergency care services if:
 - (1) Deemed in the best interests of the child by the service planning team [Low]; and
 - (2) Only for a maximum of 90 days. [Low]

§748.4209. What are the documentation requirements for a placement extension?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 1, Service Management

January 2007

- (a) The child's service planning team must document the reason for the extension in the child's record. [Low]
- (b) If the parent responsible for the child has begun presenting the child's information to different operations, agencies, or foster homes based on what the parent believes the child's needs are and where the child's needs can best be met, you must document in the child's record the following verbal information that you receive from the parent:
 - (1) The reason(s) why a placement cannot be completed timely [Low]; and
 - (2) The date a placement is expected to be completed. [Low]
- (c) In other situations, you must document the following information for the placement extension, as appropriate:
 - (1) The child has qualified for financial assistance under Chapter 31, Human Resources Code, and is on the waiting list for housing assistance [Low]; or
 - (2) The child meets the requirements to consent to emergency care and consents to the continuation of services to the child or the child's offspring. [Low]
- (d) You must document your efforts to contact the parent and obtain the rationale for the continuation of care, including the dates you made those efforts. [Low]

§748.4211. When must I document the appropriate reason for continuing emergency care services?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 1, Service Management

January 2007

- (a) You must document the reason for continuing emergency care services in the child's record by the 16th day that the child is in care. [Low]
- (b) You must include documentation of additional continuations in the child's record every 30 days thereafter, if applicable. [Low]
- (c) This documentation must be available for our review. [Low]

§748.4213. What are the requirements for a preliminary discharge plan?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 1, Service Management

January 2017

- (a) If the child receives emergency care services for more than 15 days, you must have a written preliminary discharge plan for the child from the person responsible for the child. [Low]
- (b) You must place the preliminary discharge plan in the child's record on or before the child's 16th day in care at your operation. [Low]
- (c) You must obtain written documentation from the person responsible for the child that the preliminary discharge plan is reviewed and updated at least weekly. [Low]
- (d) The preliminary discharge plan and weekly reviews must be available for our review. [Low]

Division 2, Admission Assessment

§748.4231. What information must an admission assessment include for a child needing emergency care services, including respite child-care services?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 2, Admission Assessment

September 2010

- (a) An admission assessment must provide an initial evaluation of the appropriate placement of the child and must include [Medium]:
 - (1) The child's immediate needs [Medium];
 - (2) The name of the referral source [Low];
 - (3) The date and time of placement [Low];
 - (4) A description of the child's condition as observed by the intake worker [Medium-Low]; and
 - (5) Only for emergency care services:
 - (A) The reason for emergency placement [Low];
 - (B) The child's understanding of the need for emergency care services [Low]; and

(C)The child's feelings about the crisis situation and operation care.
[Low]

(b)You must also obtain the following information as soon as possible after admission:

(1)The child's identity, date of birth, and as applicable any additional information needed to determine the child's ability to consent to emergency care services for the child or the child's offspring. To consent to services, the child must be [Low]:

(A)The parent of a child;

(B)Pregnant; or

(C)16 years old or older; and

(i) Residing separate and apart from the child's parent, regardless of whether the parent consents to the admission and duration; and

(ii) Managing his own financial affairs, regardless of the source of income;

(2)Name, address, and telephone number of the child's parents, if available. This information is not required if the child meets the requirements to consent to emergency care services [Low];

(3)Medications the child is taking [High];

(4)Chronic health conditions, such as asthma or diabetes [High]; and

(5)Allergies to medication or food. [High]

(c) If you cannot obtain the required information for an assessment:

(1)You must make reasonable efforts to obtain all required information.
[Medium]

(2) If attempting to get information at the time of placement would not be in the child's best interests, you may postpone attempting to acquire the information.

(3)In the child's admission assessment, you must document why a:

(A)Particular piece of information is unavailable [Low]; or

(B)Delay in obtaining a piece of information is necessary, including efforts made to obtain the information. [Low]

Division 3, Respite Child-Care Services

§748.4261. May I provide respite child-care services?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 3, Respite Child-Care Services

January 2017

- (a) Respite child-care services are not subject to regulation under this subchapter, if the:
 - (1) Respite child-care services are completely separate from the emergency care services. You must provide the respite child-care services in a completely separate physical space using different caregivers from the caregivers for the emergency care services; and
 - (2) Care meets the short-term program's criteria for exemption as specified §745.117(2) of this title (relating to Which programs of limited duration are exempt from Licensing regulation?).
- (b) An operation that only provides emergency care services to children may provide respite child-care services, if you:
 - (1) Meet all applicable requirements for all services, including children admitted only for respite child-care. This includes compliance with capacity limits, child/caregiver ratios, and supervision rules [Medium]; and
 - (2) Ensure that your respite child-care services do not present a conflict of care for any child receiving emergency care services. [Medium]

§748.4263. Whom must I notify when I accept a child for respite child-care?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 3, Respite Child-Care Services

January 2007

You must notify the child's parent before accepting the child for respite child-care. [Low]

§748.4265. What information regarding a child must I receive prior to providing respite child-care services to that child?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 3, Respite Child-Care Services

January 2017

To ensure continuity of care, you must obtain the following information:

- (1) Specific needs of a child, including [Medium]:
 - (A) All psychological, psychiatric, or medical treatment currently being provided [Medium-High] ;
 - (B) Medication regimen and medication instructions [Medium-High];
 - (C) Authorization for medical treatment [Medium-High]; and
 - (D) Safety plans, including any special supervision precautions [Medium-High];
 - (E) Sleeping information [Medium];
 - (F) Discipline instructions [Medium-High];
 - (G) Any expectations that the current caregiver may have of the operation [Medium]; and
 - (H) Any other needs of a child that should be addressed by the operation [Medium-High];
- (2) Non-routine events taking place in the life of the child, including any scheduled appointments such as family and sibling visits [Medium];
- (3) Emergency contact information, including the [Medium-High]:
 - (A) Child's physician(s) [Medium-High];
 - (B) Child's parent [Medium]; and
 - (C) Telephone number of the agency or operation that placed the child [Medium-Low]; and
- (4) The child's history that may affect the operation's ability to provide care for the child, including [Medium-High]:
 - (A) Background of abuse and/or neglect [Medium-High];
 - (B) Physical aggression or sexual behavior problems [Medium-High];
 - (C) Fire setting [Medium-High];
 - (D) Maiming or killing animals [Medium-High];
 - (E) Suicidal ideations and attempts [Medium-High] ; and

(F) Run-away behaviors. [Medium-High]

§748.4267. How long may a child be in respite child-care?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 3, Respite Child-Care Services

January 2007

- (a) With the exception of subsection (b) of this section, a child may be in respite child-care for 14 consecutive days or 40 days each year. [Medium-Low]
- (b) A respite child-care services placement that is made because a child's foster home is under investigation for abuse or neglect does not count toward nor is it limited by the time frames noted in subsection (a) of this section. However, these placements are limited to a maximum of 60 days. [Medium-Low]
- (c) If a child needs respite child-care for more than 14 consecutive days or more than 60 days for an abuse or neglect investigation, this is considered a new placement and will not be respite child-care. [Medium-Low]
- (d) When a child finishes a respite child-care placement, he may not return to respite child-care for at least 10 days. [Medium-Low]
- (e) Respite child-care must not be used if it could be detrimental to the child. [Medium-High]

Helpful Information

The time limit of 40 days per year of respite care for each child is intended to serve the best interests of the child by minimizing disruptions in care. To that end, and in an effort to comply with these minimum standard rules, you are expected to seek out information about a child's time spent in respite child-care at any previous placement(s) earlier in the year. You are responsible for limiting the child's placement(s) in respite child-care accordingly for the remainder of the year.

§748.4269. May I update an admission assessment when I provide respite child-care services to a child to whom I have already provided respite child-care?

Subchapter S, Additional Requirements for Operations That Provide Emergency Care Services

Division 3, Respite Child-Care Services

January 2007

When you admit into your respite child-care services program a child to whom you have already provided respite child-care, you may update the existing admission assessment information rather than completing a new assessment.

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 1, Regulation

§748.4301. Does Licensing regulate all assessment services?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 1, Regulation

January 2017

- (a) No. This subchapter only regulates general residential operations that also provide an assessment services program.
- (b) Services provided by other individuals, agencies, and organizations are not subject to regulation under this subchapter.

Division 2, Admission

§748.4331. What are the requirements for approving a child's admission into my assessment services program?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 2, Admission

January 2007

- (a) The person responsible for the assessment services program must review and approve in writing the determination that your program will be able to provide or obtain all assessment services the child appears to need at intake. [Medium]
- (b) The review, determination, and approval must be:
 - (1) In writing, signed, and dated from the person responsible for the assessment services program [Medium]; and
 - (2) Completed prior to the admission of the child into your assessment services program. [Medium]

- (c) The determination on the appropriateness of the program to meet the child's assessment needs must be filed in the child's record if the child is admitted into your assessment services program. [Medium]
- (d) You must document in the child's record whether you are [Medium]:
 - (1) Only providing assessment services to the child; or
 - (2) Also providing other services, such as emergency care services.
- (e) You must document in the child's record the date of the child's admission into your assessment services program. [Medium]

Division 3, Assessment Plan

§748.4361. When must I complete the child's individual plan for the assessment?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 3, Assessment Plan

January 2007

- (a) You must complete the child's individual plan for the assessment within 10 days from the date of the child's admission into the program. [Medium]
- (b) You must document the plan in the child's record. [Medium]

§748.4363. When does admission into the assessment services program begin?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 3, Assessment Plan

January 2007

Admission into the assessment services program begins when [Medium]:

- (1) The parent makes the decision to place the child into the assessment services program; and
- (2) You decide to accept the child for these services.

§748.4365. What must an individual plan for the assessment include?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 3, Assessment Plan

January 2007

- (a) An individual plan for the assessment must include:
 - (1) Time frames for providing all assessment services [Medium-Low];
 - (2) Recommendations for the child's care during the assessment process [Medium];
 - (3) Any treatment to be provided during the assessment period [Medium-High]; and
 - (4) Current data from the caregiver's evaluation of the child's behavior and level of functioning. [Medium]
- (b) The common application is not and must not serve as the individual plan for the assessment. [Medium]

§748.4369. How must my assessment services program collect information from a child's caregivers?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 3, Assessment Plan

January 2007

- (a) Your assessment services program must systematically collect information from caregivers throughout the child's participation in the assessment services program. This information includes the caregivers' observations and opinions of the child. [Medium]
- (b) You must document this information in the child's record. Your documentation must include your consideration of the caregivers' observations and opinions. [Medium]

§748.4371. When is the plan for the assessment complete?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 3, Assessment Plan

January 2007

- (a) The plan for the assessment is complete when it contains the necessary information and the signed approval of the person responsible for the assessment services program or a designated employee who meets the qualifications of a person responsible for the assessment program. [Medium]
- (b) The parent must review and be provided a copy of the plan for the assessment. [Medium]

Division 4, Assessment Report

§748.4391. What is an assessment report?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 4, Assessment Report

January 2007

- (a) The assessment report that is the result of the assessment services is a narrative report that pulls together data from:
 - (1) Professional evaluation reports on the child [Medium]; and
 - (2) The program's assessment on how the child is managing in the program. [Medium]
- (b) The report includes:
 - (1) Recommendations made in other professional evaluations [Medium]; and
 - (2) Recommendations based on the program's experiences with and assessment of the child. [Medium-High]
- (c) The common application is not and must not serve as the assessment report. [Medium]

§748.4393. When must I complete the assessment report?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 4, Assessment Report

September 2010

- (a) The assessment report must be completed rapidly, consistent with good practice, in order to allow for a permanent placement as soon as possible. [Medium]
- (b) You must complete the assessment report within:
 - (1) 30 days after you admit the child, if the child is younger than five years old [Medium]; or
 - (2) 45 days after you admit the child, if the child is five years old or older. [Medium]
- (c) With the approval of the child's parent, you may extend the time frame for completing the report for an additional 15 days. You must document the need for the extension of time in the child's record. [Low]
- (d) You must complete the assessment report before a planned discharge of the child from the assessment services program. However, additional assessment services may be conducted subsequent to placement if a quick placement is in the best interest of the child. [Medium]
- (e) You must provide a copy of the assessment report to the child's parent as soon as the report is complete. [Medium-Low]

§748.4395. What must be included in the written assessment report?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 4, Assessment Report

January 2007

In addition to the requirements set forth in §748.1217 of this title (relating to What information must an admission assessment include?), a written assessment report must include [Medium]:

- (1) Copies and results of the determination of the child's basic health and social and developmental assessment, including [Medium]:
 - (A) The child's basic health status, as determined under the supervision of a licensed physician [Medium-High];

(B)The child’s basic social and developmental needs, as determined under the supervision of the person responsible for the assessment services program or a designated employee who meets the qualifications for a person responsible for the assessment program [Medium];

(C)Recommendations for any further assessment services and testing [Medium]; and

(D) An assessment of the child’s immediate and extended family in terms of an ongoing relationship with the child [Medium-Low];

(2)Copies and results of all evaluations and testing [Medium-High];

(3)A summary of the primary caregivers’ evaluations of the child’s behavior and level of functioning [Medium-High];

(4)An assessment of the results and summary in terms of appropriate short- and long-term planning for the child [Medium];

(5)Recommendations for placement [Medium-High]; and

(6)A recommended behavior management plan based on the assessment results and the primary caregivers’ evaluations of the child’s behavior and level of functioning. [Medium-High]

§748.4397. Who must review and approve an assessment report?

Subchapter T, Additional Requirements for Operations That Provide an Assessment Services Program

Division 4, Assessment Report

January 2007

(a)The following people must review the assessment report:

(1)The person responsible for the assessment program or a designated employee who meets the qualifications of a person responsible for the assessment program [Medium-High];

(2)The child’s primary caregiver [Medium-High]; and

(3)The child’s parent. [Medium]

- (b) The person responsible for the assessment program, or the designated qualified employee, must approve and sign the report. [Medium]
- (c) You must file the original, approved and signed assessment report, including any addendums to the report, in the child's record. [Medium]

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 1, Definitions

§748.4401. What do certain words mean in this subchapter?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 1, Definitions

January 2007

These words have the following meanings in this subchapter:

- (1) Permanent camp – The permanent structure at which the basic needs for camp operation, such as resident housing, water supply and septic systems, and permanent toilet and/or cooking facilities, are provided.
- (2) Permanent structure – Man-made permanent or semi-permanent structures in which groups of people live, eat, sleep, or assemble, such as dining halls, dormitories, cabins, or other structures which are not constructed to be readily movable.
- (3) Primitive camp – A portion of the permanent campsite premises or another site at which the basic needs for camp operation, such as water supply systems, and permanent toilet and/or cooking facilities or other permanent structures, are not provided and in which a child stays no longer than 14 days before returning to the permanent camp.

§748.4403. What children are eligible to participate in a therapeutic camp program?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 1, Definitions

January 2017

- (a) For a child to be eligible to participate in a therapeutic camp program, the child must:
 - (1) Be 13 years old or older [Medium];
 - (2) Be in need of treatment services for an emotional disorder [Medium]; and
 - (3) Have difficulty functioning in his home, school, or community. [Medium]
- (b) Individuals that are not eligible to participate in a therapeutic camp program include:

- (1)An adult [Medium];
- (2)A child under 13 years old [Medium];
- (3)A child who receives child-care services only, including a child in a transitional living services program [Medium];
- (4)A child who is pregnant. If a child becomes pregnant while in care, you must arrange for the child's immediate discharge or transfer from your therapeutic camp program [Medium];
- (5)An adolescent parent with his or her child [Medium-High];
- (6)A child with primary medical needs or other medical conditions that cannot be easily provided to the child at the permanent campsite or during primitive camping excursions [High];
- (7)A child diagnosed with Autism Spectrum Disorder [Medium-High];
- (8)A child diagnosed with an intellectual disability [Medium-High];
- (9)A child for an emergency admission [Medium]; and
- (10) A child for child day care services. [Medium-High]

Division 2, Activities Requiring Spotting or Belaying

§748.4431. What are the requirements for an adventure / challenge program that requires spotting or belaying?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 2, Activities Requiring Spotting or Belaying

January 2007

You must ensure that:

- (1) An employee with at least six weeks experience in supervising a similar type of activity supervises an adventure/challenge program that requires spotting or belaying [Medium-High];
- (2) Prior to assuming duty as a spotter and belayer, a person receives instruction in the proper procedures [High];
- (3) A spotter or belayer is directly supervised until the person demonstrates competency [High];
- (4) There is a method for controlling access to the equipment and the activity area in order to prevent unauthorized or unsupervised use by a child [High];
- (5) Safety checks are performed on all equipment and ropes prior to each use [High];
- (6) Each child has a safety orientation before engaging in the activity [High]; and
- (7) Each child wears appropriate personal protective equipment during an activity. [High]

Division 3, Primitive Camping Excursions

§748.4461. What is considered a primitive camping excursion?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2007

A primitive camping excursion lasts no more than 14 days, after which children on the camping excursion must return to the permanent camp. [Medium-Low]

§748.4463. How long must children **remain at the operation's permanent camp between primitive camping excursions?**

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2007

- (a) If your therapeutic camp program only allows children to stay at the camp for less than 90 days, then children must remain at the permanent camp at least two days between primitive camping excursions and activities. [Medium-Low]
- (b) If your therapeutic camp program allows children to stay at the camp for 90 days or more, then children must remain at the permanent camp at least 21 days between primitive camping excursions and activities. [Medium-Low]

§748.4465. What child /caregiver ratios apply to a primitive camping excursion?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2007

- (a) In addition to meeting the child/caregiver ratio requirements in Subchapter G of this chapter (relating to Child/Caregiver Ratios), you must have at least two caregivers during any primitive camping excursion. [High]
- (b) In a mixed gender group, there must be a caregiver of each gender at all times. [Medium-High]

§748.4467. What are the requirements for toilet facilities for a primitive camping excursion?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2007

- (a) You may use pit privies and portable toilets in remote camping areas. You must ensure that the pit privies and portable toilets are:
 - (1) Maintained in good repair and kept clean at all times [Medium-Low];
 - (2) Constructed and maintained according to manufacturer designs and standards set forth by the Department of State Health Services, General Sanitation Division [Medium-Low];
 - (3) Maintained to prevent access by flies and animals to the contents contained within, to prevent fly breeding, and to prevent contamination of any water supply [Medium-Low];
 - (4) Equipped with toilet paper at all times [Low]; and
 - (5) Serviced for the disposal of human excreta that meet regulations set forth by the Texas Commission on Environmental Quality. [Medium-Low]

- (b) If the camp site is not provided with pit privies or other portable toilets, you must:
- (1) Comply with the requirements of §748.3861 of this title (relating to What are the requirements for toilet facilities during overnight camping excursions?) [Medium-Low]; and
 - (2) Have a readily available supply of clean earth backfill or other disposal methods that meet regulations set forth by the Texas Commission on Environmental Quality for the disposal of human excreta in these areas. [Medium-Low]

§748.4469. What are the requirements for sanitizing hands at a primitive campsite?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2007

- (a) Children and employees must sanitize their hands. [Medium]
- (b) At least one of the following methods for sanitizing hands must be available at the campsite [Medium]:
 - (1) Bathrooms equipped with running water must always have soap available for use within 20 feet of the toilet areas;
 - (2) A hand-washing sink using a portable water supply must have a sanitary catch system approved by your local health department and must always have antibacterial liquid soap or an alcohol-based hand sanitizer available for use:
 - (A) You must follow label directions when using alcohol-based hand sanitizers; and
 - (B) Children must not have access to soiled water; or
 - (3) Privies and portable toilet facilities not equipped with running water must always have at least a waterless alcohol-based hand sanitizer available for use adjacent to toilet facilities. You must follow label directions when using alcohol-based hand sanitizers.

§748.4471. What personal hygiene provisions must I provide to a child who participates in a primitive camping excursion?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2017

You must provide the following to a child who participates in a primitive camping excursion with:

- (1) Personal hygiene supplies that are biodegradable [Medium];
- (2) A means for a child to bathe or clean the child's body at least twice weekly [Medium]; and
- (3) Females with body or hand sanitizing wipes or similar products for feminine hygiene purposes. [Medium]

§748.4473. What are the requirements for laundry provisions on a primitive camping excursion?

Subchapter U, Additional Requirements for Operations That Provide Therapeutic Camp Services

Division 3, Primitive Camping Excursions

January 2017

You must provide the following to a child who participates in a primitive camping excursion [Medium-Low]:

- (1) A way to launder clothes at least weekly; or
- (2) Clean clothes at least weekly.

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 1, Definitions and Scope

§748.4501. What does “trafficking victim services” mean when used in this subchapter?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services
Division 1, Definitions and Scope
December 2014

In this subchapter, trafficking victim services means a specialized type of child-care services designed to treat and support trafficking victims, in addition to basic child care services.

§748.4503. When am I required to meet the additional rules of this subchapter?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services
Division 1, Definitions and Scope
December 2014

You must meet the additional rules of this subchapter if you provide trafficking victim services to [High]:

- (1) 25 or more children; or
- (2) More than 30% of the children in your care.

§748.4505. In addition to the rules in this subchapter, what other rules in this chapter apply to an operation?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services
Division 1, Definitions and Scope
December 2014

An operation that is required to comply with this subchapter must comply with all other rules in this chapter that apply to all operations, as well as the rules that apply to an operation that provides treatment services to children with an emotional disorder, unless any such rule is replaced by a rule in this subchapter, as noted in §748.4507 of this title (relating to What rules in this subchapter replace other rules in this chapter?).

§748.4507. What rules in this subchapter replace other rules in this chapter?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 1, Definitions and Scope

December 2014

An operation that is required to comply with the rules in this subchapter is not required to comply with other rules in this chapter if the rule has been replaced, as specified in the following chart:

Topic	An operation must comply with this rule:	Instead of this rule:
Treatment Director Qualifications	§748.4601 of this title (relating to What qualifications must a treatment director have?)	§748.605 of this title (relating to What qualifications must a treatment director have?)
Pre-service Experience Requirements for a Caregiver	§748.4651 of this title (relating to What are the pre-service experience requirements for a caregiver?)	§748.861 of this title (relating to What are the pre-service experience requirements for a caregiver?)
Pre-service Hourly Training Requirements for Caregivers and Employees	§748.4653 of this title (relating to What are the pre-service hourly training requirements for caregivers and employees?)	§748.863 of this title (relating to What are the pre-service hourly training requirements for caregivers and employees?)
Annual Training Requirements for Caregivers and Employees	§748.4657 of this title (relating to What are the annual training requirements for caregivers and employees?)	§748.931 of this title (relating to What are the annual training requirements for caregivers and employees?)
Child/Caregiver Ratio During Children's Waking Hours	§748.4701 of this title (relating to For purposes of the child/caregiver ratio, how many children can a single caregiver care for during the children's waking hours?)	§748.1003 of this title (relating to For purposes of the child/caregiver ratio, how many children can a single caregiver care for during the children's waking hours?)

Topic	An operation must comply with this rule:	Instead of this rule:
Child/Caregiver Ratio During Children's Sleeping Hours	§748.4703 of this title (relating to For purposes of the child/caregiver ratio, how many children can a single caregiver care for when children are asleep at night?)	§748.1007 of this title (relating to For purposes of the child/caregiver ratio, how many children can a single caregiver care for when children are asleep at night?)
Admission of Young Adults	§748.4765 of this title (relating to May I admit a young adult into care?)	§748.1933 of this title (relating to May I admit a young adult into care?)

Division 2, Policies and Procedures

§748.4551. What additional child-care policies must I develop?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 2, Policies and Procedures

June 2016

You must develop written policies that address how your operation will:

- (1) Provide a variety of engaging activities to help trafficking victims develop their skills and independence and gain a sense of personal identity, including providing life skills training for children 14 years of age or older [Medium-Low];
- (2) Tailor education to the child's needs [Medium-Low];
- (3) Provide mentoring services [Medium-Low]; and
- (4) Prevent and discourage trafficking victims from running away from your operation. [Medium]

§748.4553. What safety and security policies must I develop?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 2, Policies and Procedures

December 2014

You must develop written policies that address:

- (1) The measures you will implement to ensure the safety and security of trafficking victims and employees, including measures that address both interior and exterior security while promoting a comfortable and nurturing environment [Medium];
- (2) Employee protocols and procedures for ensuring a safe environment, including [Medium]:
 - (A) An internal and external communication system that addresses emergency situations [Medium]; and
 - (B) How to handle visitors not allowed on the premises of the operation [Medium]; and
- (3) Appropriate safeguards with respect to a trafficking victim's access to forms of communication, including telephones, cell phones, computer, internet, mail, and visitors, which may pose a risk of further victimization of the child. [Medium]

§748.4555. What confidentiality policies must I develop?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 2, Policies and Procedures

December 2014

You must develop written policies that address confidentiality, including policies that:

- (1) Restrict the disclosure of information, both written and oral, that would identify a child as a trafficking victim, or describe the nature of the victim's trafficking history, other than as needed to serve the victim or comply with other laws [Medium];
- (2) Specify to whom and under what circumstances an employee or volunteer may disclose the location of the operation [Medium]; and
- (3) Specify the circumstances under which a visitor may or may not be allowed on the premises of the operation. [Medium]

Division 3, Personnel

§748.4601. What qualifications must a treatment director have?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 3, Personnel

December 2014

A treatment director that provides or oversees treatment services for trafficking victims must [Medium]:

- (1) Be a psychiatrist or psychologist;
- (2) Have a master's degree in a human services field from an accredited college or university and three years of experience providing treatment services for trafficking victims or children with an emotional disorder, including one year in a residential setting; or
- (3) Be a licensed master social worker, a licensed clinical social worker, a licensed professional counselor, or a licensed marriage and family therapist, and have three years of experience providing treatment services for trafficking victims or children with an emotional disorder, including one year in a residential setting.

§748.4603. Are there additional training requirements for volunteers who have contact with children receiving trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 3, Personnel

December 2014

Each volunteer whose responsibilities include working with trafficking victims must have one hour of training prior to working with the children. The training must include the following components that explain [Medium]:

- (1) The operation's confidentiality policies [Medium]; and
- (2) How the effects of trauma impact working with trafficking victims. [Medium]

Division 4, Training

§748.4651. What are the pre-service experience requirements for a caregiver?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 4, Training

December 2014

- (a) Before you may assign a caregiver to be the only caregiver responsible for a child in care, the caregiver must have a minimum of 40 hours of supervised child-care experience in [Medium]:
 - (1) Your operation;
 - (2) Another general residential operation, in which treatment services for children with an emotional disorder or trafficking victim services are provided to 25 or more children or 30% or more of the operation's children; or
 - (3) A child-placing agency, in which treatment services for children with an emotional disorder or trafficking victim services are provided to 30 or more children or 50% or more of the agency's children;
- (b) Until a caregiver has the minimum amount of supervised child-care experience as specified in subsection (a) of this section, the caregiver must be supervised at all times by another caregiver who has already satisfied the minimum caregiver qualifications described in subsection (a) of this section. [Medium]
- (c) The supervised child-care experience must be documented in the appropriate personnel record. [Medium-Low]

§748.4653. What are the pre-service hourly training requirements for caregivers and employees?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 4, Training

December 2014

- (a) Caregivers and certain employees must complete the following training hours before the noted time frame:

Weight	Who is required to receive the training?	What type of pre-service training is required?	How many hours of training are required?	When the training must be completed by?
[Medium]	(1) All caregivers	General pre-service training	8 hours	Before the person can be the only caregiver responsible for a child in care.
[Medium-High]	(2) All caregivers	Pre-service training regarding emergency behavior intervention	16 hours; however, if your operation prohibits the use of emergency behavior intervention, then only 8 hours of training are needed	At least half of the required hours of training before the person can be the only caregiver responsible for a child in care, and all of the required hours of training within 90 days of being responsible for a child in care.
[Medium-High]	(3) All caregivers	Pre-service training regarding complex trauma experienced by trafficking victims	5 hours	At least two of the required hours of training before the person can be the only caregiver responsible for a child in care, and all of the required hours of training within 90 days of being responsible for a child in care.

Weight	Who is required to receive the training?	What type of pre-service training is required?	How many hours of training are required?	When the training must be completed by?
[Medium]	(4) Child-care administrators, treatment directors, professional level service providers, and case managers	Pre-service training regarding emergency behavior intervention	8 hours	All 8 hours of training within 90 days of beginning job duties.
[Medium]	(5) Child-care administrators, treatment directors, professional level service providers, and case managers	Pre-service training regarding complex trauma experienced by trafficking victims	5 hours	All 5 hours of training within 90 days of beginning job duties.

(b) You must document the completion of each training requirement in the appropriate personnel record. [Medium-Low]

§748.4655. Must I provide pre-service training to a caregiver or employee who has previously worked in another operation?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 4, Training

December 2014

(a) An operation does not have to provide additional general pre-service training or pre-service training regarding emergency behavior intervention to any caregiver or employee who is exempt from this training by §748.867 of this title (relating to Must I provide pre-service training to a caregiver or an employee who has previously worked in an operation?). In addition, a caregiver or employee (child-care administrator, treatment director, professional level service provider, or case manager) does not have to complete the five hours of pre-service training regarding complex trauma experienced by trafficking victims if the caregiver or employee:

(1) During the last 12 months:

(A) Worked in a general residential operation that provides trafficking victim services to 25 or more children, or 30% or more of the operation's children in care; or

(B) Was a caregiver or employee for a child-placing agency that provides trafficking victim services to 30 or more children, or 50% or more of the child-placing agency's children in care; and

(2) Has documentation that the caregiver or employee has previously received the five hours of pre-service training.

(b) You must document the exemption factors in the appropriate personnel record.

[Medium-Low]

§748.4657. What are the annual training requirements for caregivers and employees?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 4, Training

December 2014

Caregivers and certain employees must complete the following training hours:

Who is required to receive the annual training?	How many hours of annual training and what types of annual training are needed?
(1) All caregivers	[Medium] 50 hours. Of the 50 hours: (A) [Medium-High] Four hours must be completed every six months on training specific to the emergency behavior intervention techniques that you allow, and this training must be completed within 180 days from the date that the caregiver last received such training; (B) [Medium-High] Four hours must be on training specific to trafficking victims, as further described in §748.4659 of this title (relating to What areas or topics must the four hours of annual training regarding trafficking victims include?); and (C) [Medium-High] Two hours must be on training specific to transportation safety if the caregiver transports a child in care whose chronological or developmental age is younger than nine years old.

Who is required to receive the annual training?	How many hours of annual training and what types of annual training are needed?
(2) Child-care administrators, professional level service providers, treatment directors, and case managers who hold a relevant professional license	(A) [Medium] 15 hours. (B) [Medium-High] Of the 15 hours, two hours must be on training specific to transportation safety if the person transports a child in care whose chronological or developmental age is younger than nine years old. (C) [Medium-High] There are no annual training requirements for emergency behavior intervention. However, if there is a substantial change in techniques, types of intervention, or operation policies regarding emergency behavior intervention, then the staff must be re-trained in emergency behavior intervention. (D) Annual training hours completed to maintain a person's relevant professional license may be used to satisfy all or part of the 15 hours of annual training required by this section.
(3) Child-care administrators, professional level service providers, treatment directors, and case managers who do not hold a relevant professional license	(A) [Medium] 20 hours. (B) [Medium-High] Of the 20 hours, two hours must be on training specific to transportation safety if the person transports a child in care whose chronological or developmental age is younger than nine years old. (C) There are no annual training requirements for emergency behavior intervention. However, if there is a substantial change in techniques, types of intervention, or operation policies regarding emergency behavior intervention, then the staff must be re-trained in emergency behavior intervention.

§748.4659. What areas or topics must the four hours of training regarding trafficking victims include?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 4, Training

December 2014

The four hours of annual training must include:

- (1) One hour of training in preventing compassion fatigue and secondary traumatic stress [Medium]; and
- (2) Three hours of training in areas appropriate to the needs of children for whom the operation or caregiver will be providing care, which may include [Medium]:
 - (A) Typology of trafficking victims;
 - (B) Manifestations of trauma and practice in trauma informed care;
 - (C) How trafficking victims are manipulated and controlled;
 - (D) Making informed decisions and setting boundaries for trafficking victims;
 - (E) Understanding and avoiding the triggers of trafficking victims;
 - (F) Creating and maintaining nurturing environments for trafficking victims; and
 - (G) Identifying and responding to internal safety and security risks (e.g. high flight risk, potential self-harm, harm to others, and internal recruitment).

Division 5, Child/Caregiver Ratios

§748.4701. For purposes of the child/caregiver ratio, how many children can a single caregiver care for during the children's waking hours?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 5, Child/Caregiver Ratios

January 2017

(a) A single caregiver may care for a maximum of four children during waking hours.

[Medium-High]

(b) A child does not count in the child/caregiver ratio while the child is away from the operation participating in an approved unsupervised childhood activity.

§748.4703. For purposes of the child/caregiver ratio, how many children can a single caregiver care for when children are asleep at night?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 5, Child/Caregiver Ratios

December 2014

(a) A single caregiver may care for a maximum of eight children during night-time sleeping hours. [Medium-High]

(b) Caregivers must remain awake during night-time sleeping hours. [Medium-High]

Division 6, Admission and Service Planning

§748.4751. Are there additional medical requirements when I admit a child for trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

December 2014

In addition to meeting the requirements under §748.1223 of this title (relating to What are the medical requirements when I admit a child into care?):

- (1) You must ensure that a child receiving trafficking victim services is screened within 72 hours of admission to determine whether there is an immediate need for any of the following types of medical services [Medium]:
 - (A) A medical examination by a health-care professional [Medium]; and
 - (B) Medical tests for pregnancy and the following infectious diseases [Medium]:
 - (i) Hepatitis B [Medium];
 - (ii) Hepatitis C [Medium];
 - (iii) HIV [Medium];
 - (iv) Sexually transmitted diseases (STDs) [Medium]; and
 - (v) Tuberculosis. [Medium]
- (2) Each individual screening is not required if:
 - (A) The child was previously placed in a residential child-care operation regulated by DFPS or a facility operated by the Texas Juvenile Justice Department;
 - (B) There was a previous screening completed within the last 12 months;
 - (C) You have documentation of the outcome of the screening;
 - (D) The child did not run away from the operation or get discharged from the program since the previous screening; and
 - (E) There is no clear indication that the child has been injured, victimized, or re-victimized since the previous screening.
- (3) If the results of the required screening indicate that there is an immediate need for a medical examination or medical tests, you must obtain the medical examination and/or medical tests within five days. [Medium-High]

§748.4753. Must a child I admit for trafficking victim services have an alcohol and substance abuse screening?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services
Division 6, Admission and Service Planning
December 2014

Yes, you must ensure that a child receiving trafficking victim services is screened for alcohol and substance abuse within 72 hours of admission. The screening is not required if [Medium]:

- (1) You have documentation of:
 - (A) A child's alcohol and substance abuse screening that was conducted within the previous 12 months during the child's placement at a residential child-care operation regulated by DFPS or a facility operated by the Texas Juvenile Justice Department; or
 - (B) A professional assessment that was conducted within the previous 12 months that determined whether alcohol and substance abuse services were needed for the child; and
- (2) There is no clear indication that the child has developed an alcohol or substance abuse dependency since the date of the previous screening or assessment.

§748.4755. What must I do if an alcohol and substance abuse screening determines that a child receiving trafficking victim services may need alcohol or substance abuse treatment?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services
Division 6, Admission and Service Planning
December 2014

If an alcohol and substance abuse screening determines a child receiving trafficking victim services may need alcohol or substance abuse treatment, you must:

- (1) Within 14 days, coordinate and schedule the child for an alcohol and substance abuse professional assessment [Medium-High];
- (2) Ensure the professional recommendations are carried out [Medium-High]; and
- (3) File documentation of the professional assessment, recommendations, and follow-up in the child's record. [Medium-High]

§748.4757. What behavioral health assessments are required when I admit a child for trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

December 2014

- (a) Within 30 days of admission, you must ensure that a child receiving trafficking victim services is assessed for the following [Medium]:
 - (1) Post-Traumatic Stress Disorder (PTSD) [Medium];
 - (2) Depression [Medium]; and
 - (3) Anxiety. [Medium]
- (b) The results of all assessments must be documented in the child's record. [Medium-Low]
- (c) Each individual behavioral health assessment is not required if:
 - (1) The child was previously placed at a residential child-care operation regulated by DFPS or a facility operated by the Texas Juvenile Justice Department;
 - (2) There was a previous assessment completed within the last 12 months;
 - (3) You have documentation of the outcome of the child's assessment; and
 - (4) There is no clear indication that the child has developed one of these disorders since the previous assessment.

§748.4759. What mental health services are required for a child receiving trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

June 2016

- (a) A professional service provider must [Medium]:
 - (1) Provide individual counseling to each child receiving trafficking victim services. The counseling must address any issues noted in the behavioral health assessment and whether intervention and additional treatment is needed for sexual assault [Medium];
 - (2) Provide family counseling, as appropriate [Medium]; and
 - (3) Assess the frequency and duration of the counseling. [Medium]
- (b) You must document the assessment in the child's record. [Medium-Low]

(c) If a child refuses counseling, you must document this refusal in the child's record.

[Medium-Low]

(d) For purposes of this rule, a professional service provider means:

- (1) A psychiatrist licensed by the Texas State Board of Medical Examiners;
- (2) A psychologist licensed by the Texas State Board of Examiners of Psychologists;
- (3) A master's level social worker or higher licensed by the Texas State Board of Social Work Examiners;
- (4) A professional counselor licensed by the Texas State Board of Examiners and Professional Counselors;
- (5) A marriage and family therapist licensed by the Texas State Board of Examiners of Marriage and Family Therapists; or
- (6) A master's level or higher nurse licensed as an Advanced Practice Registered Nurse by the Texas Board of Nursing and board certified in Psychiatric/Mental Health.

§748.4761. Are there additional requirements for a preliminary service plan when I admit a child for trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

December 2014

In addition to the requirements listed in §748.1331 of this title (relating to What are the requirements for a preliminary service plan?), the preliminary service plan for a child receiving trafficking victim services must include a description of the child's immediate:

- (1) Safety needs [Medium]; and
- (2) Behavioral health and treatment care needs. [Medium]

§748.4763. What additional items must be included in a child's initial service plan?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

June 2016

- (a) In addition to the requirements and items noted in §748.1337 of this title (relating to What must a child's initial service plan include?), the initial service plan for a child receiving trafficking victim services must include:

- (1) The plans to obtain alcohol treatment, substance abuse treatment, or both, for children who require it [Medium]; and
 - (2) Updated plans for behavioral health treatment, including intervention and treatment services for sexual assault, for children who require it [Medium]; and
 - (3) A description of any legal services required for the child and how you will assist the child in meeting those needs. [Medium]
- (b) You must document all professional consultations, examinations, recommendations, and treatment in the child's record. [Medium-Low]

§748.4765. May I admit a young adult into care?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

December 2014

- (a) You may admit a young adult into your transitional living program.
- (b) For other programs and services for trafficking victims, you may admit a young adult into your care if the young adult is determined to be a trafficking victim as stated in §748.61(2)(E) of this title (relating to What types of services does Licensing regulate?) and [Low]:
 - (1) Is placed at your operation directly after being discharged from another residential child-care operation regulated by DFPS or a facility operated by the Texas Juvenile Justice Department; or
 - (2) Is placed at your operation within 12 months after being discharged from another residential child-care operation regulated by DFPS or a facility operated by the Texas Juvenile Justice Department.
- (c) A young adult may remain in your care until the young adult's 23rd birthday. [Low]

§748.4767. May a young adult in care share a bedroom with a child in care receiving trafficking victim services?

Subchapter V, Additional Requirements for Operations that Provide Trafficking Victim Services

Division 6, Admission and Service Planning

December 2014

- (a) In addition to the requirements listed in §748.1937 of this title (relating to May an adult in care share a bedroom with a child in care?), a professional level service provider for operations must complete a re-assessment anytime a child or young adult:
 - (1) Runs away from the operation and returns to care [Medium-Low]; or
 - (2) Is discharged from your program and returns to care. [Medium-Low]
- (b) The re-assessment and approval by the professional level service provider must be documented and dated in the child's record. [Medium-Low]

Appendix A: Definitions

Texas Administrative Code, Title 26 Health and Human Services

Part 1, Health and Human Services Commission

Chapter 745, Licensing Subchapter A. Precedence and Definitions Division 2. Definitions for Licensing

§745.21. What words must I know to understand this subchapter?

The following words and terms, when used in this chapter, have the following meanings unless the context clearly indicates otherwise:

- (1) Abuse--As defined in the Texas Family Code, §261.001(1) (relating to Definitions) and Texas Administrative Code, Title 40, Chapter 707, Subchapter C, Division 5 (relating to Abuse, Neglect, and Exploitation).
- (2) Affinity--Related by marriage as set forth in Texas Government Code, §573.024 (relating to Determination of Affinity).
- (3) Business entity--May be an association, corporation, nonprofit association, nonprofit corporation, nonprofit association with religious affiliation, nonprofit corporation with religious affiliation, or limited liability company.
- (4) Capacity--The maximum number of children that a permit holder may care for at one time.
- (5) Caregiver--A person who is counted in the child to caregiver ratio, whose duties include the supervision, guidance, and protection of a child.
- (6) Child--A person under 18 years old.

- (7) Child-care facility--An establishment subject to regulation by Licensing that provides assessment, care, training, education, custody, treatment, or supervision for a child who is not related by blood, marriage, or adoption to the owner or operator of the facility, for all or part of the 24-hour day, whether or not the establishment operates for profit or charges for its services. A child-care facility includes the people, administration, governing body, activities on or off the premises, operations, buildings, grounds, equipment, furnishings, and materials. A child-care facility does not include child-placing agencies, listed family homes, employer-based child care operations, or shelter care operations.
- (8) Child day care--As defined in §745.33 of this chapter (relating to What is child day care?).
- (9) Child-placing agency (CPA)--A person, including a sole proprietor, partnership, or business or governmental entity, other than the parents of a child, who plans for the placement of or places a child in a child care operation or adoptive home.
- (10) Children related to the caregiver--Children who are the children, grandchildren, siblings, great-grandchildren, first cousins, nieces, or nephews of the caregiver, whether by affinity or consanguinity or as the result of a relationship created by court decree.
- (11) Consanguinity--Two individuals are related to each other by consanguinity if one is a descendant of the other; or they share a common ancestor. An adopted child is related by consanguinity for this purpose. Consanguinity is defined in Texas Government Code, §573.022 (relating to Determination of Consanguinity).
- (12) Contiguous operations--Two or more operations that touch at a point on a common border or located in the same building.
- (13) Controlling person--As defined in §745.901 of this chapter (relating to Who is a controlling person at a child-care operation?).
- (14) Deficiency--Any failure to comply with a minimum standard, rule, statute, specific term of your permit, or condition of your probation.
- (15) Designated perpetrator--As defined in §745.731 of this chapter (relating to What are designated perpetrators and sustained perpetrators of child abuse or neglect?).
- (16) Designee--The person named on the application as the designated representative of the operation who is officially authorized by the owner to speak for and act on the operations' behalf.

- (17) Employee--Any person employed by or that contracts with the permit holder, including caregivers, drivers, kitchen personnel, maintenance and administrative personnel, and the center or program director.
- (18) Endanger--To expose a child to a situation where physical or mental injury to a child is likely to occur.
- (19) Exploitation--As defined in Texas Family Code, §261.001(3) and Texas Administrative Code, Title 40, Chapter 707, Subchapter C, Division 5.
- (20) Finding--The conclusion of a Licensing investigation or inspection indicating compliance or deficiency with one or more minimum standards, rules, or statutes.
- (21) Full license--The type of full permit that is issued to an operation that requires a license. See also §745.341 of this chapter (relating to What type of permit does Licensing issue?) and §745.343 of this chapter (relating to What is the difference between an initial license and a full license?).
- (22) Full permit--A full permit includes a listing, registration, compliance certificate, or a full license. See also §745.341 and §745.343 of this chapter.
- (23) Governing body--A group of persons or officers of a business or governmental entity that has ultimate control over the entity.
- (24) Governmental entity--A political subdivision or state agency of Texas.
- (25) Household member--An individual, other than the caregivers, who resides in an operation.
- (26) Initial license--A time-limited license that we issue to certain applicants for a full license in situations described in §745.345 of this chapter (relating to When does Licensing issue an initial license?).
- (27) Licensed administrator--As defined in §745.8905 of this chapter (relating to What is a licensed administrator?).
- (28) Minimum standards-- Minimum requirements for permit holders that are enforced by Licensing to protect the health, safety, and well-being of children. The minimum standards consist of the rules contained in:
 - (A)Chapter 742 of this title (relating to Minimum Standards for Listed Family Homes;
 - (B)Chapter 743 of this title (relating to Minimum Standards for Shelter Care);
 - (C)Chapter 744 of this title (relating to Minimum Standards for School-Age and Before or After-School Programs);
 - (D) Chapter 746 of this title (relating to Minimum Standards for Child-Care Centers);
 - (E) Chapter 747 of this title (relating to Minimum Standards for Child-Care Homes);

- (F) Chapter 748 of this title (relating to Minimum Standards for General Residential Operations);
 - (G) Chapter 749 of this title (relating to Minimum Standards for Child-Placing Agencies);
 - (H) Chapter 750 of this title (relating to Minimum Standards for Independent Foster Homes); and
 - (I) Subchapter D, Division 11 of this chapter (relating to Employer-Based Child Care).
- (29) Neglect--As defined in the Texas Family Code, §261.001(4) and Texas Administrative Code, Title 40, Chapter 707, Subchapter C, Division 5.
 - (30) Operation (also known as a child care operation)--A sole proprietor, partnership, or business or governmental entity offering a program that is subject to Licensing's regulation, including day-care operations and residential child care operations. An operation includes the building and grounds where the program is offered, any person involved in providing the program, and any equipment used in providing the program. An operation includes a child-care facility, child-placing agency, listed family home, employer-based child care operation, shelter care operation, or any operation that requires a permit under Chapter 42, Texas Human Resources Code.
 - (31) Owner—The sole proprietor, partnership, or business or governmental entity that owns an operation that is subject to regulation by Licensing.
 - (32) Parent--A person who has legal responsibility for or legal custody of a child, including the managing conservator or legal guardian.
 - (33) Permit--A license, certification, registration, listing, compliance certificate, or any other written authorization granted by Licensing to operate a child care operation. This also includes an administrator's license.
 - (34) Permit holder--The owner of the operation that is granted the permit.
 - (35) Pre-kindergarten age child--A child who is three or four years of age before the beginning of the current school year.
 - (36) Program--Activities and services provided by an operation.

- (37) Regulation--Includes the following:
 - (A)The development of rules, including minimum standards, as provided by statutory authority; and
 - (B)The enforcement of requirements that are minimum standards, rules, statutes, or any condition or restriction we have placed on a permit. Anyone providing or seeking to provide care or a service that is subject to regulation must comply with the applicable requirements. This includes a permit holder, an applicant for a permit, and anyone providing care or a service without the appropriate permit.
- (38) Report--A communication to Licensing or the Department of Family and Protective Services (DFPS), including the Statewide Intake division of DFPS, of:
 - (A)An allegation of a deficiency in a minimum standard, rule, or statute; or
 - (B)Any other possible risk to a child in the care of an operation that is subject to regulation by Licensing.
- (39) Residential child care--As defined in §745.35 of this chapter (relating to What is residential child care?).
- (40) School-age child--A child who is five years of age or older and is enrolled in or has completed kindergarten.
- (41) State Office of Administrative Hearings (SOAH)--See §745.8831 of this chapter (relating to What is a due process hearing?).
- (42) Sustained perpetrator--See §745.731 of this chapter (relating to Who are designated perpetrators and sustained perpetrators of child abuse or neglect?).

Appendix B, Vaccine-Preventable Diseases

This guide is intended to provide you with more information to assist in the development and implementation of a vaccine-preventable disease policy for your program.

What must the policy for protecting children from vaccine-preventable diseases include?

Your operation is responsible for developing a policy that includes all areas addressed in §748.241.

How will Licensing evaluate for compliance?

Licensing will review your program's policy to ensure that it covers each of the eight required areas. Licensing staff will ensure that your operation outlines how you will maintain either written or electronic records for each employee's compliance with your policy as well as any exemptions. We will not evaluate based on the content of each policy item.

What would be an example of how licensing will evaluate my operation's compliance with the new rule?

The new rule requires you to specify any vaccines that you have determined an employee must have based on the level of risk the employee presents. Licensing staff will review your policy to ensure you have specified any vaccines an employee must have. For example, if your policy outlines that all employees must only obtain a flu vaccine once every 12 months then we would only review compliance with the employee's requirement to obtain a flu vaccine.

What immunizations are recommended for adults?

The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) develops the recommendations and they are listed on the CDC website at <http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf>

Do I have to require employees to obtain all immunizations recommended by the CDC?

No, employees at your program will only need to obtain immunizations that are required in your policy. It is up to you to determine what immunizations will be required and which employees are required to obtain them based on their level of risk as determined by their routine and direct exposure with children.

How do I determine an employee's level of risk?

An employee's level of risk is determined by the policy you develop. The basis for determining an employee's level of risk must be outlined in your policy and must be based on the employee's routine and direct exposure to children. Items to consider when you develop policy include:

- What are the employee's primary duties?
- How closely does the employee work with children? (For example, does the employee change diapers, assist with toileting, prepare or serve food)
- How often does the employee work with children? (Regular contact vs. substitute basis)
- What are the ages of children the employee works with?

Can an employee be exempt from immunizations that my program's policy requires?

Yes, an employee may be exempt from one or more of your program's required immunizations for:

- Medical conditions identified as contraindications or precautions by the CDC; or
- Reasons of conscience, including a religious belief.

What procedures must an employee follow to be exempt from having a required vaccine?

Your policy must address exemption procedures an employee must follow in order for you to determine the employee's qualification of an exemption.

What are some examples of acceptable documentation for exemptions?

- For medical conditions, acceptable documentation may include a note from the employee's health care professional providing a statement that the required vaccine is medically contraindicated or poses a significant risk to the health and well-being of the individual.
- For reasons of conscience, acceptable documentation may include a signed and dated statement from the employee that states the employee is exempt for reasons of conscience, including the person's religious beliefs.

What are some examples of procedures that an exempt employee must follow to protect children in care from exposure to disease?

It is up to your operation to determine what and when protective procedures will be required.

Examples of protective procedures include:

- Wearing gloves when handling or cleaning body fluids, such as after wiping noses, mouths, or bottoms, and tending sores;
- Specifying that an employee with open wounds and/or any injury that inhibits hand washing, such as casts, bandages, or braces, must not prepare food or have close contact with children in care;
- Wearing masks when the employee has respiratory symptoms to reduce the spread of droplets to surrounding areas;
- Wearing masks when taking care of children with respiratory symptoms;
- Removing gloves and washing hands immediately after each task to prevent cross-contamination to other children;
- Excluding the employee from direct care when the employee has signs of illness.

How can I determine that an employee has complied with my operation's policy?

You must specify in your policy how you will verify that an employee has complied with your policy. This must include what written and/or electronic documentation you will accept.

Examples of documentation may include:

- Copy of the employee's current immunization record;
- Receipt that includes date a required immunization was received;
- Letter signed by a health care professional that lists the date an immunization was received;
- Documentation of exemption for medical reasons from a health care professional;
- Signed and dated statement from the employee for exemption based on a reason of conscience.

Where can my employees get the recommended immunizations?

Individuals should start with their health care provider. Other resources in your area include pharmacies, the health department, and public or community health clinics. For a list of local health departments in Texas visit the Texas Department of State Health Services (DSHS) website at: <http://www.dshs.state.tx.us/regions/lhds.shtm>

Are there any other resources available for employees to receive the recommended immunizations?

Yes, the Adult Safety Net program created by The Texas Department of State Health Services (DSHS) to increase access to vaccination services in Texas for uninsured adults.

What is the Adult Safety Net program?

The Adult Safety Net (ASN) program provides vaccine purchased with public funds to participating clinics to be used for immunizing uninsured adults.

How do I find an Adult Safety Net provider in my area?

Visit the ASN website at www.dshs.state.tx.us/ASN and click on the search page to locate an ASN clinic near you. (Please check with the clinic before visiting to make sure they can see you.)

Who is eligible to receive vaccinations from the ASN program?

Adults ages 19 years and older that do not have health insurance are eligible to receive ASN vaccines.

Who is not eligible to receive ASN vaccines?

Individuals who do not qualify for ASN vaccines include:

- Adults who have Medicare, Medicaid, or any other insurance, including private insurance.
- Adults who are underinsured for adult vaccines (e.g., those who have healthcare insurance that does not cover adult vaccines).
- Individuals younger than 19 years of age.

What vaccines are offered through the ASN program?

The following is a list of vaccines currently offered through the ASN program and a description of the diseases they prevent.

- Hepatitis B Vaccine — prevents infection of the liver by the hepatitis B virus, which can lead to liver cancer, cirrhosis of the liver, liver failure, and death.
- Hepatitis A Vaccine — prevents infection of the liver by the hepatitis A virus. Symptoms of hepatitis A include lack of energy, diarrhea, fever, nausea and jaundice (yellow color to the whites of the eyes or skin).
- Hepatitis A and Hepatitis B Combination Vaccine—see above.
- Human Papillomavirus (HPV) Vaccine — prevents infection from several strains of HPV, including those that cause genital warts and several types of cancer, such as cervical, anal, penile, and throat cancer.

- Measles/Mumps/Rubella (MMR) Vaccine — prevents infection from the measles virus, which can lead to rash, ear infection, brain damage, and death. Prevents infection from the mumps virus, which can cause fever, swollen glands, headache, and can lead to deafness and meningitis. Prevents infection from rubella virus, which can cause rash, arthritis, and miscarriage in pregnant women.
- Pneumococcal Polysaccharide (PPSV23) Vaccine — prevents infection by the *Streptococcus pneumoniae* bacterium, which is one of the most common causes of severe pneumonia and can lead to other types of infections, such as ear infections, sinus infections, meningitis (infection of the lining of the brain and spinal cord), and blood stream infections (bacteremia).
- Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine — prevents tetanus, which can cause muscle spasms, lockjaw, paralysis, and death. Prevents diphtheria, which can cause suffocation and heart failure. Prevents pertussis (known as “whooping cough”), which can cause severe coughing that can lead to rib fractures, pneumonia, and death. The CDC recommends* one dose for all pregnant women during every pregnancy and all other adults who have not yet received Tdap vaccination, especially those who come in contact with infants.
- Tetanus and Diphtheria (Td) Vaccine — similar to Tdap vaccine (see above), but protects against tetanus and diphtheria only, without the pertussis component.

If I qualify for ASN vaccine, do I have to pay anything?

ASN vaccines are supplied to participating medical providers at no cost. This means that ASN providers cannot charge a fee for the vaccine itself. However, providers are allowed to charge an administration fee of up to \$25 for each vaccine that is administered. Although ASN providers may charge this administration fee, they cannot deny the vaccine because of an inability to pay it.



GSMYC EMPLOYEE MANUAL FOR **RESIDENTIAL CHILDCARE**

GSMYC is licensed by the Texas Department of Family and Protective Services (DFPS) and required to adhere to Minimum Standards for General Residential Operations set forth by the licensing division of DFPS.

https://www.dfps.state.tx.us/Child_Care/documents/Standards_and_Regulations/748_GRO.pdf

GSMYC also contracts with the Texas Department of Family and Protective Services to provide residential childcare to children in the custody of the state and we are required to follow the mandates set forth in the contract.

https://www.dfps.state.tx.us/handbooks/RCC_Guide/default.asp

****Updates to these documents occur periodically through legislative mandates and GSMYC procedures are reviewed annually. In the event a discrepancy occurs, the highest standard of care applies.****

Employee Manual for Residential Childcare

The Greater San Marcos Youth Council, Inc. (GSMYC)

TABLE OF CONTENTS

Who We Are	4
Purpose of this Manual.....	4
DIRECT CARE STAFF MEMBER.....	5
Role of Staff member	5
Basic Requirements	5
Scheduling.....	6
Staff Member Training.....	6
SHELTER POLICIES AND PROCEDURES	8
Guidelines and Minimum Standards	12
Phone Procedures for Residents	13
Phone Procedures for Staff member	14
On-Call / Emergency Notification Procedure	14
Visitation Procedures.....	15
Resident File Procedures	16
Reports and Records.....	17
Incident Reports.....	18
Runaway Procedures	19
Medical and Dental Care for Residents	19
Medication Procedures	20
Dispensing Medications	21
Illness or Injury Procedures	21
Bloodborne Pathogens and Other Fluid Disease Control	22
Clean Up	22
Waste Handling.....	23
Economics	23
Nutrition.....	23

Food Preparation, Storage, and Equipment.....	24
Meal Procedure	24
Chore Procedures.....	25
Recreation.....	25
Off Grounds with Staff member or Volunteers	25
Overnight Trips Away from the GSMYC Facility	26
Group Meeting Procedures.....	26
Guidelines for Presentation of Group Meetings	27
Education, Work, and Training for Residents.....	27
INTAKE AND ADMISSION PROCEDURES	28
Admission Policy for Residents.....	28
Fees for Services	29
Waiting List	29
Orientation of Youth.....	30
Policy, Procedure, and Orientation for Residents	31
Service Plan	32
After Care Services	34
RESIDENTS' RIGHTS	34
Discipline Guidelines	36
Residents' Money	37
Residents' Mail, Phones, and Gifts.....	37
Resident Night Check Procedure	37
Searches	38
Grievance and Complaint Procedure for Residents	38
Resident's Weekday Schedule	39
Residents' Weekend Schedule	39
Hygiene.....	40
Environment.....	40
Building Grounds.....	40
Facilities Maintenance / Inspections.....	41
Facilities Equipment	42

Building and Grounds Damage Procedures	42
Vehicle and Equipment Usage	42
Safety	43
Security / Alarm System.....	43
Disaster Plans	43
Miscellaneous Disaster Plan Information.....	45
Summary Statement	46

Summary Statement

These policies and procedures are to be utilized in conjunction with the state mandated guidelines and requirements of all contracts entered into by GSMYC, including adherence to the Minimum Standards set forth by the licensing division of DFPS. In the event these documents do not coincide, GSMYC personnel will abide by the policy with the highest standard.

As an employee of GSMYC it is your responsibility to become familiar with these policies and procedures and to follow the guidelines as set forth by this agency and all contractual entities. Please contact your immediate supervisor if you have questions, comments or need clarification about this manual.

Who We Are

GSMYC provides area youth with a safe, structured, and supportive environment, where education, intervention, and counseling, along with the utilization of community resources, assist them to live productive lives. GSMYC operates one home permitted to care for 16 children between the ages of 2-17. Formally known as "Casa de Maria" for one of the original founders, Maria Fedrick, residential care, and assessment services are provided to boys and girls who are abused and neglected, runaways, or who otherwise find themselves in need of a brief stay with our agency. Primarily the Department of Family and Protective Services (DFPS) and law enforcement agencies refer children to the shelter.

Casa de Maria, dba the Children's Shelter, provides 24-hour emergency care for children in time of crisis; family, group and individual counseling; psychological assessments, medical and dental screenings, as well as social and educational assessments. GSMYC's primary goal is to provide a safe, comfortable living environment until permanent living arrangements can be made, or until the child is able to return home. Programs are based on positive reinforcement and mutual respect.

Purpose of this Manual

This manual has been prepared to inform you about GSMYC's residential practices and policies, as well as staff member expectations and conduct. We hope this manual will help answer any questions you have about our agency and the operations of the house. Please do not hesitate to ask questions. We believe you will enjoy your meaningful work here.

We ask that you read this manual carefully and refer to it whenever questions arise. These guidelines are for informational purposes and are not intended to be a legal document or an employment contract. Questions regarding the guidelines should be directed to your immediate supervisor.

GSMYC reserves the right to change, modify, suspend, interpret, or cancel, in whole or in part, any employee policies, guidelines, or practices at any time without advance notice. If and when provisions are changed, we will update you by periodically by sending replacement pages for those sections that become outdated.

DIRECT CARE STAFF MEMBER

Role of Staff Member

Direct care staff members are the heart of any agency serving children/youth in a residential setting. They have the day-to-day contact with the children and are the ones who:

- Wake the children up in the morning and put them to sleep at night.
- Maintain rules, provide structure, prepare meals, play sports and/or board games, interact, lead groups, take children/youth on outings, etc.
- Help children/youth navigate the services that are available to them.
- Are often the first to know if children/youth are in crisis, feeling depressed or suicidal, have been victimized sexually or are engaging in dangerous sexual behavior, taking unnecessary risks, and/or abusing drugs or alcohol.
- Are the first to hear about a new partner, celebrate the youth achieving a goal, and congratulate a child/youth for safe choices and positive progress.
- Are often viewed as safe targets for displaced anger or fear.
- Sometimes become attachment figures.

Basic Requirements

- Employees involved in direct care of the children/youth will be responsible, mature, healthy adults capable of meeting the needs of residents.
- A professionally administered drug test, cleared criminal background checks, and a tuberculosis skin test are required prior to employment. An FBI fingerprint clearance is required prior to staff member having unsupervised access to children/youth in care.
- Three written and/or verbal references will be obtained for each employee involved in resident care. Information obtained from references will be written and filed whether the interview is done in person, by telephone or virtually.
- Each applicant of GSMYC will submit a written statement concerning any felony and/or misdemeanor convictions within the last 10 years and any pending criminal charges.
- Persons whose behavior or health status endangers residents will not be allowed in the facility.

- Direct Care Staff will be at least 19 years old, have a high school diploma or GED and be able to read and write.
- Direct care workers must complete 8 hours of pre-service general training, prior to having access to children/youth in care (unless exempt)
- Direct Care Staff must also complete a minimum of 20 hours of training related to children's services each year.
- Staff member openings may be advertised after an in-house announcement has been made. Applicants will be selected based on qualifications, education, experience and willingness to comply with GSMYC philosophy.

Scheduling

GSMYC will provide the staff members necessary to protect the health and safety of residents in its care.

The Executive Director of GSMYC will comply with applicable requirements of Chapter 43, Human Resources Code.

GSMYC facility will have 24-hour awake staff member coverage.

- Sufficient staff members will be available to maintain staff member-child ratios as outlined in the Department's Minimum Standards for Residential Child Care, 24 hours per day, 365 days per year. When residents are in school or at work, at least one adult will be available.
- During resident sleeping hours there will be at least one direct care worker in the facility who will remain alert and awake for the duration of his/her shift.

Staff Training

1. All staff member members who are responsible for the care and safety of the residents will receive at least the minimum hours of orientation and training, including 8 hours of pre-service general training if applicable, related to children's services upon hiring and annually, as outlined in the *Minimum Standards for General Residential Operations*, unless state contract mandates require additional hours. Records of staff member orientation and training will be kept.
2. GSMYC's discipline policy does not allow physical punishment of residents.

3. In-service training for staff members will include alternatives to physical punishment.
 - a. Non-judgmental listening.
 - b. Focus of attention is always on the positive attributes of each child/youth.
 - c. The ability to assist the child/youth with investigating, discovering, and putting to use his/her own assets in managing his/her own life effectively.
 - d. Encourage the resident to recognize that positive changes within his/her control have occurred.
4. Emergency behavior intervention when a resident's physical well-being is in immediate danger. Physical restraints are discouraged and to be used only when no other alternative exists to ensure a resident's safety. It is our philosophy that no one, especially frightened and traumatized children, wants to be restrained when feeling angry or out-of-control. We believe most excessive behaviors can be prevented with distraction, re-direction, humor, and other communicative techniques.

GSMYC works hard to ensure no resident is physically restrained and staff will receive training in behavior intervention techniques utilized by the agency to diffuse situations and help residents calm themselves. In the event physical restraint can not be avoided, only those staff members who are trained and certified in Handle with Care are allowed to perform restraints.
5. First aid, CPR and **suicide** training are required for direct care workers within 90 days of start date.
6. First aid training scheduled and/or received will be documented.
 - a. Training will be conducted by a Red Cross instructor or a licensed/certified health professional.
 - b. First aid training will be scheduled to meet renewal requirements.
 - c. First aid training manual will be available to direct care staff members as a reference.
7. Staff member meetings will be held for case presentation and supervision. Daily supervision will be available as needed.

Employees and volunteers of GSMYC are required to be trained in Reporting **Suspected** Child Abuse or Neglect and in Reporting Child Sexual Abuse. Both are available through on-line training by the Department of Family and Protective Services, at no charge.

In Texas, anyone who **suspects** that a child is being abused or neglected has a legal obligation

to report it. Professional reporters are required to report **suspicion** of abuse or neglect within 48 hours. No one is above suspicion This includes your colleagues, the management team, the Executive Director, *anyone* associated with the agency who has access to children/youth in the care of GSMYC who you suspect of abusing or neglecting a child/youth.

A Professional Reporter is anyone licensed or certified by the state or works for an agency or facility licensed or certified by the state and has contact with children as a result of their normal duties. By law, professionals may **not** delegate their duty to report to another person such as a coworker or family member.

Professional reporters include, but are not limited to:

Teachers	Employees of a clinic or health care facility that provides reproductive
Nurses	services
Doctors	Juvenile probation, detention or correctional officers
Daycare employees	

It is the responsibility of professionals to **report** and the responsibility of the Texas Department of Family and Protective Services to **investigate** allegations or suspicions of abuse or neglect.

AVOIDING FALSE ACCUSATIONS

Self-awareness is important to any direct care staff member role in residential childcare, meaning a staff member must be aware of the unconscious messages they send, as well as the intended ones.

Clothing

Male and female staff member members and volunteers are not to wear any clothes that could be determined as sexy. “Sexy” means revealing and/or provocative—too loose, clingy, too tight, see-through, or anything that could be construed as clothing inappropriate to wear in a professional setting with vulnerable children. GSMYC employees must be aware of the difference between comfortable and provocative clothing. Examples of inappropriate clothing include:

- Muscle shirts on males, thin T-shirts on females
- Short shorts (male as well as female)
- Pants that are tight enough to show underwear lines
- See through clothing
- Low cut or loose necklines on females (can you bend over without revealing?)
- Holes in clothing (be especially aware of where those holes are)

Always wear underclothes. Keep in mind that zipper locks do not always stay locked and females must be aware that residents can be turned on by the sight of nipples (even through clothes) as well as upper body floppiness.

Body Language

Direct Care Staff members must also be self-aware of their body language when interacting with residents, as it can send unintended messages such as flirtation and/or domination. Flirtatious body language includes the tilted head, giggling, tossing or playing with hair, or walking provocatively. Dominating includes standing over and/or close to a child/youth who is at a much smaller height than the staff member when standing, sitting on a chair, or on a bed; leaning with your hand on a wall, close to the child's head, while talking to the child; generally invading the child's personal space. Direct Care Staff members must also be aware of what they scratch, rub, or touch on their own bodies when in the company of others, especially children/youth.

Crushes

It is important to keep in mind that crushes are very real to children/youth and that their feelings can easily be hurt. A Direct Care Staff member-child relationship can often unintentionally become intimate for the child/youth (refer to conflict of interest). The very instant a Direct Care Staff member has a presumption a child/youth has a crush them; staff member must tell a supervisor and ask him/her to document it. Staff members can decide with the supervisor how to handle the crush; document a plan, and document how to implement the plan. If a supervisor is not immediately available, tell a co-worker, and document it in the child's file and the staff member log.

Sex Talk

Many of the children in our care have been sexually abused or victimized and often have incorrect beliefs regarding what is appropriate, what is normal sexual activity. When children ask questions about sexual activity and/or the facts of life, staff members should answer directly, factually, and without any embarrassment or obvious signs of discomfort. Answer only the questions they ask, briefly and to the point. Get comfortable with the correct words (i.e. penis/vagina). If a staff member does not feel comfortable answering sex related questions for a child, the staff member should refer the child to a staff member who is.

Self Disclosure

Sometimes professionals disclose personal information for the purpose of building rapport or

strengthening their therapeutic alliance and nonphysical connection with clients. However, it can be confusing to a child/youth if a staff member utilizes self-disclosure as an intervention to build rapport or make connections. Intimate information about a Direct Care Staff member's life can be burdensome for a child/youth and make it easier for boundaries to be blurred within the staff member-resident relationship. Direct Care Staff members who disclose personal information inappropriately can also expose themselves to the risk of ethical dilemmas and negligence lawsuits.

To protect the children/youth and themselves, Direct Care Staff members should NOT share personal information with residents. Most types of direct care services, and therefore staff member-resident relationships, are short-term. A child/youth may forget that the caretaker will not be in their lives for an extended period and be triggered to trauma or hurt in the end. This also applies to information that is not necessarily intimate yet is personal and is not necessary to develop a healthy relationship with the children/youth staff members are working with.

Children and adolescents tend to ask questions inquiring about a caretaker's personal life, such as, "How old are you?" "Do you have any children?" and "What did you do over the weekend?" If a staff member is unsure if disclosing personal information is appropriate or not, here are some questions a staff member should consider before disclosing personal information to a child:

- How will the child benefit from knowing this information?
- How will this information be interpreted?
- Is there a way that I can validate and empathize with the child without self-disclosing information?
- What would my supervisor say or think about this situation?
- Do I want to share this information? If so, why?

Secrecy

Under no circumstance should a Direct Care Staff member, or any adult connected to the agency create secrets with or ask a resident to keep a secret for them. ***Seemingly innocent secrets*** can scare or intimidate a child/youth, especially those who've experienced sexual trauma and abuse. Keeping secrets is commonly something an abuser will emphasize heavily to a child/youth during the "grooming" phase. This includes secrets regarding information that could get a staff member in trouble with a supervisor or cause conflict with other staff members.

Support for Colleagues

When a co-worker is in a one-on-one situation with a child, pop your head in from time to time, or stroll by the room. If you are in the one-on-one situation, don't close the door, and if no one has dropped by in a while, pop out yourself. Don't just hop up and run out of the room. Let the child/youth know you'll be right back. Make sure a co-worker sees you when you do. Going to get a drink of water is a good reason to give as you step out of the room for a minute.

Be alert to indicators that something is going amiss with your co-workers and be willing to act. You are legally responsible for reporting **suspected** abuse/neglect and this includes those individuals you work with, as well as those who supervise you or are part of the administration, including board members. You are not getting someone in trouble; you are protecting a child and following the law. You can discuss your concerns with a co-worker; pass it on to your supervisor or speak to the Executive Director. Whatever you do, you must act. Don't ignore it and hope things will get better. The penalties for not reporting suspected abuse and neglect were increased in the 83rd Legislative session.

Another way you can avoid the false accusation is to remember how important it is to never give your home address or phone number to residents. There was an actual case of false accusation where an employee had given a resident her address. He ran away and showed up on her doorstep. She refused to allow him to stay with her so in retaliation, he accused her of sexual abuse. The licensing branch of the Department of Family and Protective Services investigated her.

Those who work with children can be labeled as advocates, care givers, even big brothers or big sisters. It is not appropriate to be a friend. Children/youth have their peers to be their friends. The adults in their lives should always keep in mind that the most important task is to serve as a positive role model. Each interaction you have with the children/youth in our care must be supportive and coming from a place of kindness and concern for their well-being.

Language

This has to do with the less obvious language. Of course, do not use curse words or other derogatory language. Do use correct grammar; avoid using slang, etc. Use a firm, yet friendly tone and do not raise your voice in anger, even a raised voice can sound angry. Choose your words carefully. Never belittle or embarrass a child/youth in any form or fashion. Do not label children/youth or call them names. Avoid saying, "good boy/girl" as this implies that they are only "good" when someone says this to them or when they are engaging in the behavior that resulted in being called "good".

Do not volunteer information about your family. If your mother calls to check on you, do not announce “that was my mother”. Your family is not allowed in the shelter unless you have prior approval from your supervisor. When engaged in casual conversation with residents, refrain from mentioning your family members, unless specifically asked by a resident.

The point here is that these children/youth are in a residential setting. They do not get to go home at night to the place they choose to live. The last thing they need is a reminder from their caregivers that they are currently not part of a caring, supportive family.

RESIDENTIAL POLICIES AND PROCEDURES

Guidelines and Minimum Standards

1. GSMYC will ensure that residents in care are provided adequate protection from flammable and poisonous substances.
2. Flammable or hazardous materials such as gasoline, etc. will be stored out of residents’ reach. All hazardous materials will be locked in the storage shed.
3. Animals on the premises will be vaccinated and treated as recommended by a licensed veterinarian. Documentation of vaccination and treatment will be on file at GSMYC.
4. GSMYC will take measures to keep the facility free of rodents, insects and stray animals.
5. Residents will have indoor areas for their use; there will be at least 40 square feet per child. Bedrooms, halls, kitchen and any rooms not used by residents will not be included in the minimum space requirement.
6. A sleeping room will contain at least 50 square feet per person. Bedrooms for single occupants will have at least 80 square feet.
7. Sketches of floor plans giving measurements and purposes of rooms will be submitted to the Licensing Branch with the signed application.
8. Furniture in living areas will not block exit ways.
9. Each resident will have his or her own bed and mattress. Beds will be clean and comfortable. Mattresses will have covers and protectors.
10. There will be accessible storage space for each resident's clothing and personal

possessions.

11. Residents will not share a bedroom with a person of the opposite sex (unless child is under the age of five and sharing a room with a sibling).
12. There will be one lavatory, one tub or shower and one toilet for every eight (8) residents.
 - a. Lavatories, tubs and showers will have hot and cold running water.
 - b. Bathrooms will be near the sleeping area.
 - c. Bathrooms will be thoroughly cleaned each day.

Phone Procedures for Residents

1. Determine if phone calls are advisable for the resident and caller has been pre-approved by placing agent (as indicated in resident's file). If the caller is not listed in the resident's file, DO NOT DISCLOSE ANY INFORMATION ABOUT THE CHILD RESIDING IN THE HOUSE because this would violate confidentiality. Likewise, child cannot make outgoing calls unless the receiver is pre-approved and listed in the resident's file.
2. Note decision and reasons for denial, if appropriate, in resident's record.
3. Explain telephone use guidelines to resident:
 - a. Incoming calls will be authorized by primary staff member.
 - b. Outgoing calls must be made between 5:00 pm and 9:00 pm on Tuesdays, Thursdays, and Sundays.
 - c. Calls must be made only on designated phone.
 - d. Calls will only be made to or received from persons for whom permission has been given (documented in resident's file).
 - e. Calls must be no longer than 10 minutes each per resident.
 - f. Failure to respect guidelines will result in the denial of phone privileges.
 - g. Telephone calls will be documented in the resident's main file.
 - h. Denial of telephone privileges and the justification for the denial will be documented in the resident's file.
4. Attorneys-ad-litum and state placing agents may contact residents at any time.

Phone Procedures for Staff Members

1. For outgoing calls, the phone must be unlocked. It is very important the passcode for the phones is NOT seen or heard by the residents. The passcode is *490#. After unlocking the phone, select an open line and dial the outgoing number.
2. When going on an activity that requires leaving the shelter unattended, the agency's

phone calls must be forwarded to either the staff member's personal cell phone, or to the on-call staff member/supervisor on the shelter cell phone. If the staff member wishes to use a personal phone, the number must have the area code (512). To transfer to the phone lines over to a cell phone, *72 must be entered before entering the number. To transfer the phone lines back over to the shelter, simply enter *73 after unlocking the phone and selecting a line.

3. When someone calls with an abuse or neglect report, instruct them to call the Department of Family and Protective Services (DFPS) Crisis Hotline: (800) 252-5400 or online reporting <https://www.txabusehotline.org/>.
4. When someone calls with inquiry of available bed space for an emergency placement or intake, the on-call supervisor must be contacted for approval, if instructions were not stated beforehand. True emergency intakes are allowed from the San Marcos Police Department, Hays County Juvenile Probation, and the Hays County Sheriff's Department.
5. If a parent/client calls requesting an outreach counselor or counseling appointment inquiries after regular office hours (after 5:00pm), politely inform the client to call back during regular office hours. For emergencies, the counselors' contact numbers are listed in the brown medicine cabinet on the wall in the staff office.
6. If a parent calls to report their child as suicidal or physically aggressive, ask if they believe the situation warrants a call to 911. If not, take the contact information for an agency counselor to return their call as soon as possible. You may also give our crisis hotline to callers, (800) 457-0797.
7. If the power goes out after hours: (512) 393-8313.
8. If alarm goes off accidentally, the police or our alarm company will call and request a password. The password is **Protect 1**.

On-Call / Emergency Notification Procedure

It is the policy of GSMYC that a licensed childcare administrator or his/her designee will be available on a 24 hour on-call basis. This individual is responsible for the operations of the residential facility and for responding to emergency situations as needed. Notify the on-call person in the following situations:

- Any incident involving a resident that is physically or mentally damaging or life threatening, including suicide attempts, accidents, violent episodes or serious illness.
- Any condition in which evidence is viewed by staff member or suspicion of child abuse will be reported to staff member (*Child Abuse Hotline 1-800-252-5400*).
- Any legal emergency that a resident reports to a staff member or other adult connected to the agency or the child.
- Any contact with law enforcement agencies.
- Serious incidents must also be reported to the hotline within 24 hours (see Reports and

Records).

In order to be in compliance, you must also report to the on-call person when:

- A staff member calls in sick or does not show up for an assigned shift.
- Complaints from a resident, neighbor, or third party.
- A request for admission.
- Unplanned discharge approval.
- Notification of a runaway.
- Emergency medical needs.
- Needs that require expenditure of GMSYC funds, not previously approved.

The on-call person is available to answer questions that cannot wait until the next working day and to assist with reporting of serious incidents. The on-call person rotates regularly and carries the shelter cell phone. You may need to allow a few minutes for the on-call person to return your call. Personal telephone numbers are also posted in the staff office in the event, the situation warrants it. In the meantime, use your best judgment and follow GMSYC procedures.

There will also be a backup person on call in the event that the on-call person cannot be reached. The person on call will determine if it is necessary to contact the licensed child-care administrator prior to the next working day.

Visitation Procedures

Individuals approved by the placing agent to visit the resident are documented in his/her file. Determine if visitation by family, guardian or friends is in the best interests of the resident. Advise the resident of the decision and provide justification for the decision if it is a denial of visitation. Denial and the reason for must be documented in the resident's file.

1. Sunday 9:00 a.m. - 9:00 p.m. (exceptions can be made).
2. On facility grounds unless otherwise specified.
3. Document decision in file noting reasons for denial if appropriate.
4. No visitation by family, guardian or friends should take place unsupervised.

Exceptions must be approved by the Licensed Child Care Administrator or his/her designee.

Resident File Procedures

The following forms should be completed within 24 hours of admission:

Resident Record Summary (Full Intake Packet) as follows:

Main File:

1. Cover sheet
2. Initial intake information with assessment checklist
3. Contact list
4. Medical treatment release
6. Personal property agreement
7. Student clothing inventory
8. Resident policy and orientation checklist
9. Release of information.
10. Resident Contract
11. Application for admission
12. Goals while at GSMYC
13. Request to care for youth

Daily File:

1. Discharge Plan
2. Night check form
3. Medical information/ Screening examination
4. Medication Form (if applicable)
5. Daily progress notes
6. Immunization and school records (if available)

The following are to be completed, if applicable, and placed in the resident's file:

1. Phone log
2. Prescription medication form
3. Non-prescription medication form
4. Resident vehicle rules
5. Respite care report
6. Progress report (Daily summaries)
7. Special incident report
8. School enrollment
9. On/off campus visits documentation
10. Discharge procedure report
11. Extending the resident's placement beyond 30 days
12. Follow up record
13. Aftercare record

Reports and Records

https://www.dfps.state.tx.us/Child_Care/documents/Standards_and_Regulations/748_GRO.pdf

The link provided is Minimum Standards for General Residential Operations licensed by the Department of Family and Protective Services (DFPS). It outlines reportable serious incidents involving a resident and when such incidents must be reported and to whom. The standards are updated periodically making it critical you are referring to the most recent copy via DFPS.

GSMYC will complete written incident reports concerning serious occurrences involving staff members or residents. Each report will include the date and time of the occurrence, the staff member or resident involved, the nature of the incident, and the circumstances surrounding it. A copy of the report will be filed with the GSMYC licensed childcare administrator and will be available for review by the representative of the Licensing Branch and/or state contract managers.

The following types of serious occurrences are examples of what will be reported to the Licensing Branch (via the DFPS HOTLINE) and the DFPS contract manager or other administrative personnel within 24 hours or the next day: **suicide attempts, incidents of cruel or abusive treatment, incidents which critically injure or permanently disable a resident, hospitalization, or death of a resident.**

- Absences without permission will be reported to the parents and/or managing conservator when it is determined that the resident is a runaway or has been removed from GSMYC's facility by an unauthorized person.
- Disasters or emergency situations which require closure of the living unit, such as fires or severe weather, shall be reported to the proper authorities within 24 hours of the next working day.
- All clients' records/case files either residential or non-residential shall be kept confidential. Records/ case files will only be released to authorized personnel.
- GSMYC will submit reports to the proper authorities concerning:
 - Any change in administrator.
 - An impending change that would change the conditions of the license, (i.e. capacity, age range, sex, location, or name).
- GSMYC will allow the managing conservator of all contracts to visit and inspect the facility(s) at all reasonable times.
- GSMYC records will be available and open for review by the Licensing Branch of DFPS or the Administrative personnel.
- The license/permit will be displayed in a prominent place on the premises of GSMYC's facility.
- Progress reports, termination records, follow-up records, etc. will provide data for evaluation of individual placements.

- Variance/waiver requests are allowed when conditions warrant such changes.

Incident Reports

Reporting a serious incident involving a resident in care has specific requirements of agency staff. In the event there is a question about whether or not the incident is reportable, check Minimum Standards for General Residential Operations (link below). Again, standards are updated periodically making it critical to ensure the most updated copy is accessed for possible changes.

https://www.dfps.state.tx.us/Child_Care/documents/Standards_and_Regulations/748_GRO.pdf

Minimum Standards for General Residential Operations (GROs) outlines reportable serious incidents involving a resident and when such incidents must be reported and to whom. Documentation or notification of the resident's parents or managing conservator will be included in the resident's record.

A separate incident report should be filled out for each incident which occurs such as:

1. Death of a youth
2. A serious injury or significant damage to property caused by an escape from the facility
3. Any incident requiring a criminal investigation
4. Natural disaster
5. Apprehension specialist use of deadly force
6. Riots or the taking of hostages
7. Serious medical condition requiring hospitalization

The report should be filled out immediately after the incident occurs.

An incident report should be completely filled out with each injury or illness and should be filled out immediately after the situation has been properly addressed. The on-call person must be notified of any serious illness or injuries (i.e. fever over 102 degrees, blood in stool, vomiting, seizures, etc.)

Items to be included in the report:

- a. Time or cause of injury, illness or incident.
- b. Events leading up to injury, illness or incident.
- c. Description or explanation of injury, illness or incident.
- d. Name(s) of individual(s) notified (time and date) of illness/ injury or incident.
- e. Instructions/directions given to staff member at time doctor or caseworker were notified.

- f. Description of any First aid performed; first aid treatment should only be administered by a qualified staff member.
- g. Resident's reaction to situation and staff member.
- h. Person on call must be notified of any serious incidents.

Runaway Procedures

If a resident goes out the front door with the intent to run, lock the door and call the police to report a run-away.

If it appears a resident is missing, it is imperative that you make a complete search of the building and grounds to determine if it is the case. Upon determining that a resident has runaway, report it to the San Marcos Police Department immediately. Be prepared to give a full description of the resident(s).

Include findings, or lack thereof, in the incident report. Immediately notify placing agent, case worker, parent and/or guardian. If it is after 5:00 PM, call the hotline 1-800-252-5400 for DFPS residents.

Follow steps 1, 2 and 3 of the “general incident procedures” and complete an “incident report”.

All personal belongings should be bagged, labeled, dated and placed in the storage pod. All items not claimed within 90 days will be given away.

Residents will be allowed to return to the facility if brought back by local law enforcement or he/she returns on their own. However, under NO CIRCUMSTANCES will the resident(s) be allowed to return to the facility if he/she is intoxicated or under the influence of a controlled substance.

Medical and Dental Care for Residents

GSMYC will have written policies and procedures for obtaining diagnosis and treatment of emergency medical and dental problems. Copies of the policies and procedures will be available to the licensing branch of the Department of Family and Protective Services. Each new employee is required to read the agency policies and procedures. A copy of the policies and procedures is kept in each supervisor’s office, as well as in the staff member office of the shelter and the front office of 1402 IH 35 North for easy reference. Digital copies are also accessible on each of the agency’s computers.

Medication Procedures

GSMYC staff member will be responsible for administering medication, prescribed and over-the-counter, to residents.

All medication(s), including first aid, prescriptions and over-the-counter, are secured in the medicine cabinet located in the staff member office of the facility. This **MUST** be kept locked at all times and residents are not allowed in the office if it is unlocked or medications are being dispensed and/or counted.

Psychotropic medications (Schedule II) are kept in a designated locked box inside the locked medicine cabinet. Medications that require refrigeration will be kept in the refrigerator in the locked freezer room. All staff members are required to complete a psychotropic medication training through DFPS. As with all medications, residents are not allowed in the staff office when the medicine cabinet is unlocked or when any medication is being counted.

A separate medication log sheet will be kept on each resident and for each medication prescribed in the resident's daily folder.

For prescribed medication, the form must have resident's name, name of doctor, date, medication prescribed, prescription number, and the amount of medication upon intake of resident.

The medication board is located in the shelter staff office with the resident's name, prescription number and what time of day medication is to be given.

When medication is administered; medication board, medication container and medication form must coincide.

Before giving residents his/her prescribed medication, count medication(s), and ensure that the count is correct. Any and all discrepancies must be reported to the shelter supervisor or his/her designee. Include your name, (person dispensing the medications) date, time, amount given, and amount remaining.

Never use whiteout on an error. If an error occurs, draw one line through it and initial. Most prescriptive medication labels will give exact time medications are to be given. However, occasionally, a prescription label will state to administer medication three times daily.

EXAMPLE: 3 times daily is 8 am, 12 noon and 5 pm or with meals. When a label states **PRN**, it means **EVERY** 4 to 6 hours.

It is important to have a glass of liquid ready for residents when administering meds. Residents,

at times, will try and "cheek" the medications or spit them out. If either of these incidents occur document on the medication form and fill out an incident report. (See procedure on incident reports.)

When a resident leaves on a pass or pre-placement visit, medications will be released to the placing agent, parent(s) or legal guardian. Document in resident's medication log form that medications were given, date and time.

Dispensing Medications

1. Medication will be dispensed in the staff member office.
2. Medication will be taken under the supervision of a direct care worker.
3. To ensure ingestion of medication, resident may be asked to open mouth, lift tongue, and open hands.

Illness or Injury Procedures

I. General Illness or Injury

1. If a resident becomes sick or injured and needs immediate medical attention, follow these steps:
 - a. Don't panic. Panic can only worsen a situation, especially when other residents are around.
 - b. Calmly interpret the situation and, if possible, consult with other staff member members on duty as to a course of action.
 - c. Decide on a course of action. Making a hasty decision is better than making none at all

II. Emergency Medical Attention

1. If an injury or illness is serious and needs immediate professional attention, do not hesitate to call EMS.
2. While EMS is on the way, see to the needs of the resident. Apply First Aid when necessary.
3. When EMS arrives, explain the situation. If a resident is transported to the hospital, a direct care worker should follow with the resident's main file which must include Attachment A-Child Sexual History Report to share with temporary caregivers if resident is admitted, signed by hospital staff and stored in the resident's GSMYC file.
4. The staff member remaining at the shelter must contact all appropriate people involved. This would include the on-call person, placing agent, and parents or legal guardian. State mandated child/direct care worker ratio must always be maintained.

III. Non-emergency Medical Attention

1. Make sure the injury or illness is not serious.
2. Apply first aid if necessary (applied by trained personnel only).
3. If the resident requests non-aspirin or another over the counter drug, be sure to record this on the non-prescription medication sheet.
4. If the illness or injury does not require immediate attention by a doctor, wait until the next morning to make arrangements to see a physician. If you are unable to schedule an appointment, document in the staff member log explaining the situation, as well as completing the incident report.

Bloodborne Pathogens and Other Fluid Disease Control

GSMYC's policy is to eliminate or minimize employee exposure to blood borne pathogens in the course of providing first aid treatment to injured residents, clients or employees. The main concern is for the Hepatitis B Virus (HBV) and the Human Immunodeficiency Virus (HIV), although any body fluid should be considered as potentially infectious material.

This policy applies to all personnel. First aid will only be performed by authorized personnel. All other personnel are expressly forbidden to contact or treat open wounds, provide resuscitation, clean up spills, or otherwise contact body fluids.

All employees who are trained and authorized to provide first aid are required to use the protection provided. Protective equipment is stored under the kitchen sink in a locked cabinet.

A. Vinyl Medical Gloves: to be used when treating injuries that may involve contact with blood or other body fluids, and when cleaning up body fluids. Shelter personnel should also wear these gloves whenever changing soiled bed linen or handling soiled personal items used by residents.

B. Masks or Face shields, Protective Eyewear (with solid side shield), and Vinyl Aprons: to be used when stopping arterial bleeding any other time when there is a chance of blood or other body fluid contact from splashes, splatters, etc.

C. Plastic Mouth Pieces: These will be available for use in pulmonary resuscitation.

Clean Up

Any accident location of blood or bodily fluid contaminated areas will be off limits to all unauthorized personnel until areas are clean and decontaminated.

Only authorized persons will clean up pathogens. Two separate blood and bodily fluid clean up kits are provided and located in the same storage areas as the protective equipment.

Each kit contains disposable supplies consisting of three sponges, box of wipes, one gallon jug of germicide solution (one part chlorine bleach to six parts water) plastic bags, three pair of vinyl surgical gloves, three face masks, and a roll of paper towels. Other items, which should be available, include protective eyewear, medical grade soap and a pail.

Waste Handling

All used medical supplies and cleaning materials will be sterilized in a chlorine solution, placed in the white plastic bags, taped closed, labeled with the **RED BIOHAZARD SYMBOL** and stored in an approved container provided by an authorized disposal company.

Economics

Care should be taken by each employee to help maintain operations at the lowest cost possible. Lights, electronic games, radios and televisions, should be turned off when not in use.

Care should be taken by each employee driving agency vehicles to avoid heavy acceleration and/or braking.

Heating and air conditioning units are set by the administration and should not be changed.

Purchases and other expenses should be made carefully with tax exemption used each time funds are expended.

Nutrition

Children will be provided food of adequate quality and in sufficient quantity of nutrients needed for growth and development.

“Food for Fitness-- a Daily Food Guide”, developed by the United States Department of Agriculture will be used as a basis for meeting these nutritional standards.

Residents will have a minimum of three meals a day and two snacks; under no circumstances will a resident be denied food, regardless of the time of day.

Menus will be posted and retained on file for one month.

All milk and milk products will be Grade A pasteurized or from sources approved the Texas Department of Health.

Food Preparation, Storage, and Equipment

All food and drink will be stored, prepared and served in a sanitary manner.

1. Food preparations, dining, storage areas, equipment, and furniture will be cleaned and in good repair.
2. Disposable paper and plastic dishes, utensils, and containers will not be used more than once.
3. Store all food items at least four (4) inches off of the floor.
4. **ALL** food items, not stored in their original containers must be labeled and dated.

Meal Procedure

1. The case manager, with input from the residents, plans menus.
2. All staff members should follow the menu as closely as possible. Substitutions may be made, but care should be taken to not use food designated for other meals. (Note any changes on posted menu.)
3. Staff members, making sure the proper amount of food is prepared, will supervise preparation of all meals. The residents will be allowed to assist with food preparation and are encouraged to add their own ideas when possible.
4. Staff members will supervise residents during and after meals. Staff members will assist with all chores, interacting with the residents and providing instruction and assistance as necessary.
5. Leftovers must be stored in containers that are sealed, labeled, dated and placed in the appropriate place (i.e. refrigerator, pantry, etc.).
6. Residents will be provided with three planned meals a day and two snacks. They will also be allowed to eat when they are hungry. Staff members may not refuse food to the GSMYC residents. Alternative foods may be offered (i.e. peanut butter and jelly sandwiches, soup, cheese and crackers, fruit, etc.) in lieu of a meal and may be offered between meals. Leftovers from previous meals may also be offered.
7. Staff members are encouraged to eat meals with the children when there is enough prepared so that the children are able to eat until they are satisfied.

Chore Procedures

1. Chores will be completed three times daily at times designated by the supervisor or his/her designee.
2. Every morning, each resident will be assigned a chore which is listed on the chore list. Chores rotate on a daily basis.
3. Each resident is responsible for making his/her bed and cleaning his/her room.
4. Chores are assigned for the entire day.
5. Residents are expected to thoroughly clean their room weekly.
6. Residents will be led by the example set by staff members. Staff members will supervise and assist until chores are completed.

Recreation

Educational and recreational activities are scheduled at least once weekly and most importantly what is considered normal, for the residents of GSMYC. State mandated adult/child ratio for supervision is maintained at all times. Employees and residents will adhere to vehicle safety policies. A weekly activity schedule is posted in the staff member office and includes both on and off campus activities.

Residential petty cash will be kept in a locked cabinet in the shelter supervisor's office. These funds are to be utilized for residents' activities; recreation and entertainment and/or expenses related directly to residential facility operations. Employees that spend petty cash funds must turn in the receipts, before leaving for the day, to the administrative employee that distributed the funds. Both funds will be reconciled by the business office at the end of each month and approved by the Executive Director. The Executive Director must approve expenditures other than those listed.

Off Grounds with Staff Members and Volunteers

Employees of GSMYC who are trained as direct care staff members are permitted to transport and accompany residents' off-campus to appointments, activities, trips to the store and/or special events. Agency vehicle(s) will be used. Personal vehicles should not be used to transport the children in our care.

Under no circumstances will residents be allowed to accompany staff member or volunteers off-grounds for social purposes, without prior approval from the administrator charged with the responsibility of determining the reasonable prudent parent standard for each resident's participation in the activity or event.

Volunteers who transport residents or clients (non-residential) away from their homes must have prior approval from the supervisor and have on file at GSMYC a copy of their driver's license and current liability insurance. Only volunteers with employee level clearance are allowed to transport residents without a regular employee present.

GSMYC employees and volunteers may not socialize or have social contact with current or ex-residents outside GSMYC. To have such contact without prior written approval from supervisor and the youth's legal guardian is grounds for termination and the incident will be reported to the custodial agency.

Overnight Trips Away from the GSMYC Facility

GSMYC's staff member-resident ratio, in accordance with Minimum Standards for General Residential Operations, will be maintained for overnight trips. The Residential Program Director or his/her designee will ensure that individuals on trips are properly fed, lodged, supervised, and that safety precautions, medical care and structure are provided.

Temporary Placements

Overnight placements that are temporary such as hospitalization, detention, etc. require notifications of any special needs, known allergies, allowed phone calls or visitations and must also include Attachment A-Child Sexual History Report. The Program Director and/or his/her designee will submit the form to the temporary placement coordinator to ensure that the placement addresses the child's safety, any therapeutic needs and other children's safety. The form is to be signed and returned to GSMYC and stored in the resident's file.

Group Meeting Procedures

1. Group meetings can be called by staff members any time there is a need for one.
2. Residents can request to have a group meeting called, if they have a problem or subject to discuss with other residents.
3. Residents are required to attend each group meeting. Special group meetings may consist of only some of the residents. This depends upon the situation and is decided upon by the staff member on duty.
4. Residents are expected to sit up, pay attention and stay awake during group meetings.
5. Residents may be excused from the group meeting for appropriate reasons. This will be determined by the staff member in charge of the group meeting.

Guidelines for Presentation of Group Meetings

1. Pick a location that can be used regularly.
2. Arrange for comfortable seating (which could include sprawling on the floor in a loose circle).
3. Require attendance of all residents at the meeting and encourage active participation from everyone. Residents should feel that they have a right to voice their opinion without feeling forced.
4. Offer direction for the group. Focus your emphasis on facilitation of genuine sharing and closeness. Everyone's sharing is enhanced in that all have a personal, unique story.
5. Your own behavioral flexibility will be a model for the group. It is important to realize that feedback from the group can be constructive and utilized to the advantage of the group.
6. Your role as facilitator is to encourage conversation in which:
 - a. Everyone is listened to without interruption.
 - b. No one person may monopolize the floor time. (If you observe this occurring, an appropriate intervention might be; "I really appreciate your participation, I'd like to know what Joe thinks.").
 - c. Everyone builds on what others say; therefore, one person will have the floor for a reasonable amount of time without interruption.

Guide the meeting as much by example as possible. Try to hear what is being said between the lines and avoid setting yourself up as a lecturer or interpreter. The sharing of feelings/emotions is to be encouraged. Keep in mind; there is no right or wrong way to feel. Structured, informal and comfortable interaction is what you are after, so try to avoid either spontaneous chaos or rigid, mechanical pulling of strings.

Education, Work, and Training for Residents

1. Education: GSMYC residents are enrolled in the San Marcos Consolidated Independent School District (SMCISD) on the campus most appropriate for their grade level. Residents attending another Hays County school at time of intake will be allowed to remain enrolled where they are. Transportation is provided by each school district. GSMYC residents receive the same academic/physical education as other SMCISD students.
2. General Equivalent Diploma (GED): GSMYC residents who qualify to study for the GED are transported to and from the local testing site wherein they receive instruction to prepare them for testing.
3. Training: Residents of GSMYC who are unable to attend public school and who have

their GED are given life skills training, including but not limited to: filling out job applications, acquiring good interviewing skills, budgeting their money and proper social skills.

INTAKE AND ADMISSION PROCEDURES

Admission Policy for Residents

The Greater San Marcos Youth Council will admit children and youth after determining their eligibility under the following criteria:

- Child/youth is between the ages of 2-17 as stated on our permit from the state.
- Youth who turn 18 years of age after intake may remain if the program guidelines are met and the youth is not disruptive to the program.
- Child/youth does not pose imminent danger to self or others.
- Child/youth is not a known sex offender.
- Child/youth must be able to function in an open setting with supervision that meets the Minimum Standards for General Residential Operations.
- Youth must consent to contacting their parent or managing conservator.
- Youth must make a voluntary commitment to be in the facility and to follow the program's structure and rules.
- Child/youth with serious medical conditions that require constant supervision will be evaluated based on staff members' ability to meet medical needs.

The admission to the facility shall be made without regard to gender, ethnicity, religion, national origin or sexual orientation. All admissions to the facility will be approved by a licensed child care administrator or a designated representative.

The parent(s) or legal guardian of all children and youth admitted to the facility will be contacted to provide consent within 24 hours of placement (failure to make contact will be documented). During this contact, plans will be made for the parents or legal guardians to participate in counseling and the establishment of the service plan.

There will be arrangements made for face-to-face contact with the family within 24 hours of admission or on the first workday after admission if the family is willing to participate in planning and discharge for their child or youth.

Children/youth may be referred to GSMYC for residential and/or non-residential services through any legitimate source including self-referrals.

Fees for Services

It is the policy of GMSYC that fees for residential services will be charged to the parent or managing conservator of the resident. Fees for residential services will be billed to the placing agency that has established funds for such services. The rate for residential services shall be according to the contractual agreements made between the Executive Director of GMSYC and the referring agency.

A contract for services shall be developed as part of the admission process that establishes the fee for service. GMSYC scholarships are available to those who are in need of service but lack the ability to pay fees. No one will be refused services based on inability to pay.

Waiting List

In the event that there is no bed space, referrals will be made to other residential facilities and resources. Through networking with other providers and case management services, the goal is to return the youth to a safe environment. Priority will be given to Hays County children and youth and to those who are unable to access alternative living arrangements.

GMSYC reserves the right to deny admittance into the residential facility when there is not a program or procedure in place to care for a special needs child or youth.

Emergency Admission During Night Time Hours:

The staff member on duty will admit any youth who needs shelter or those referred by the Hays County Juvenile Probation Department or local law enforcement officers after calling the on-call person.

- Youth must fit the category of youth to be served.
- Check to determine if any emergency situations exist. If so, contact the on-call person.
- If not, admit the youth and settle him/her into sleeping area.
- Complete initial intake form with as much information as possible.
- Intake will be complete within 10 hours by designated staff member.
- Contact the parents/legal guardian of the resident if law enforcement has not already done so or document contact attempts.

Daytime Admissions / Following Emergency Night Time Admission:

- Complete intake process using appropriate forms.

- Notify parents and/or managing conservator.
- Explain the program and the responsibilities of each resident.
- Instruct the resident to read and sign resident's contract.
- Introduce new resident to staff member and other residents.
- Assign sleeping area.
- Assign primary staff member responsible for resident.
- Make certain that all paperwork is complete and establish both a daily and main file for resident.

Each child receiving **emergency care services** must receive an initial medical exam examination within 72 hours after admission (3 in 30). If a child has been in a residential child-care operation and has had a health screening in the last 12 months, the child does not have to have another medical exam unless there is reason to believe the child is ill or has been abused.

If the child is coming from a medical setting, you may accept a statement from a licensed health-care professional in place of the examination.

If a resident shows symptoms/signs of illness or abuse, he/she will be examined immediately by a licensed physician.

Cases of suspected child abuse will be reported immediately to the Department of Family and Protective Services via the State Hotline 1-800-252-5400. GSMYC staff will also contact the resident's placing agent. GMSYC staff will cooperate fully with the Department in the investigation of child abuse/neglect allegation.

Orientation of Youth

Children entering the facility for the first time may be physically ill, hungry, frightened, angry, anxious and/or confused. They have experienced a traumatic event(s) and it will take time for new residents to feel comfortable, assured of their safety and well-being in our care.

Be aware of the importance of being culturally sensitive and appreciate the differences in others. Do not assume that the child/youth has lived life like you or anyone you know. He/she may not know how to turn on the shower, sweep the floor, order food in a restaurant or other things you may take for granted everyone knows how to do.

Recognize that this time can be used to gather important information about the youth that will ensure their stay is positive, such as what they need, how they handle anger, where they want to live, etc.

Young women who are pregnant at the time of admission will receive treatment and/or referral appropriate to their needs. A safety plan will be developed regardless of how far along in the pregnancy she is. If physical problems are evident, immediate examination by a licensed physician will be arranged. If birth is expected within 30 days, referral to a more appropriate facility will be made as soon as possible. Prior to the move, agency staff will notify San Marcos-Hays County Emergency Medical Services and will secure the items required by Minimum Standards for General Residential Operations for teenagers who are close to delivery.

If drug or alcohol addiction is apparent at the time of admission, an appropriate referral will be sought. No resident will remain in the facility when the need for detoxification is evident or where the lack of detoxification indicates a life-threatening situation. Referral to an alternate treatment program will be made immediately.

When the use of alcohol/drugs is apparent, but addiction is not indicated, appropriate treatment will be scheduled in the treatment plan. A licensed physician will be consulted regarding medical concerns related to a particular drug in use.

GSMYC will not admit youth that are under the influence of alcohol or any type of controlled substance.

Policy, Procedure, and Orientation for Residents

1. No drugs, weapons or pornography.
2. No visiting in each other's rooms.
3. No physical violence or horseplay.
4. Residents may leave the shelter only with staff permission.
5. Personal phone calls are from 7:00pm to 9:00pm. (Sunday - Monday 10 minutes only.)
6. Visiting hours are Sundays 9:00am to 9:00pm (exceptions can be made).
7. Residents are expected to cooperate with household chores and follow staff member instructions.
8. Wake-up time is no later than 6:30 am for EVERYONE on school days and 8:00 am on weekends.
9. Bedtime is 9:45 P.M. Sunday-Thursday, Friday and Saturday night 11:00 P.M.
10. No physical contact of a sexual nature.
11. No gang related apparel, or destruction of GSMYC's property with gang tags.
12. Training in personal care, hygiene and grooming will be part of the program. No hygiene products will be kept in rooms or bathrooms. All hygiene products will be placed in laundry room when hygiene is completed.
13. Dress code will include no extremes and all residents will follow dress code as per

- placing agent, parent, legal guardian and school campus.
14. Windows are to remain closed at all times, due to alarm system.
 15. No graffiti anywhere on the facility/grounds.
 16. Residents may not lend, borrow, or trade personal property with others without permission from a staff member.
 17. Piercing and/or tattooing are not allowed.
 18. Residents are not allowed outside without staff permission.
 19. Consequences for infractions can be reprimand and/or suspension of on/off site privileges, restrictions of personal activities, facility work restitution, and/or loss of trust fund privileges. Personal illegal contraband will be confiscated.
 20. NO sexually explicit or drug-related books, magazines, clothing or music allowed.
 21. Residents are expected to be considerate of others' needs and rights.
 22. If at any time a resident feels the need to talk about their situation or a conflict with another resident, they are encouraged to let on duty staff member know and unless the problem requires immediate attention, staff member will schedule time to meet with you as soon as possible.

Service Plan

Following initial assessment, an individual treatment plan will be developed.

1. The following will be included depending upon need:
 - a. Crisis intervention and counseling
 - b. Individual counseling
 - c. Group counseling
 - d. Family counseling
 - e. Parent skills training
 - f. Life skills training
 - g. Community involvement
 - h. Psychological testing
 - i. Psychiatric evaluation
 - j. Home study
 - k. Referral to other service agencies
 - l. Medical evaluation
 - m. Nutritional study
 - n. Play therapy
2. Crisis intervention and counseling will be available 24 hours a day. Staff members providing crisis intervention and crisis counseling will be required to comply with state mandates

regarding education and experience.

3. Individual counseling will be available as needed with no less than one session per week of residency.
4. Group counseling will be scheduled for residents at least twice weekly.
5. Staff member providing group counseling will be required to have education and experience as required by the Department.
6. Parents or parental figure(s), potential residents, and non-residential clients will be encouraged to participate in the parenting program. Included in this program will be skills-based **training** in such areas as:
 - a. Parent-child communication
 - b. “Consequences appropriate for action”
 - c. Setting limits
 - d. Conflict resolution
 - e. Discussions on values
 - f. Mutual sharing and support

Parent skills-based training will be conducted by a designated staff member with appropriate training and/or other social services agencies with knowledge in these pertinent areas.

9. Life skills training will be offered to residents and voluntary high-risk youth in areas specific to their needs. **Examples** include:
 - a. Money management
 - b. Vocational training opportunities
 - c. Job seeking skills
 - d. Shopping and cooking
 - e. Nutrition
 - f. Physical health and emotional well being
 - g. Basic plumbing and home repairs

Residents and non-residential clients will be encouraged to develop involvement in community organizations and activities. **Examples** include:

- a. 4-H
 - b. Scouts
 - c. Community service projects
 - d. Baseball and soccer leagues
10. Staff members and volunteers will facilitate community involvement according to interest and needs.

1. Upon the request of the legal guardian, psychiatric evaluations will be scheduled for those who demonstrate the possibility of severe emotional problems or behavior disorders.
Evaluations will be performed by a licensed psychologist.
2. Referrals to appropriate social service agencies will be made when services needed are not provided by GSMYC.
3. All residents discharged from GSMYC's residential program will receive appropriate aftercare services according to individual needs.

After Care Services

- a. Referral to alternate services
- b. Follow-up when referred to alternate services
- c. Individual, group and/or family counseling
- d. Crisis intervention
- e. Advocacy
- f. Follow-up contact with schools, probation officials and other significant adults.

The length and extent of aftercare will be determined on an individual basis. Aftercare will be performed by Youth & Family Services staff member members and volunteers trained in this area.

Residents' Rights

Childcare facility Minimum Standards for General Residential Operations, and the contract for residential services, require provisions to protect children's privacy and child-placing agency standards require placement in the least restrictive environment capable of meeting the child's needs. Issues of privacy, individualization of discipline or behavior management and restrictiveness of the care environment must be balanced against the responsibility to protect children against the dangers of drugs, weapons, and other contraband and to determine the responsibility for thefts.

1. The staff members of GSMYC will allow privacy for each resident.
2. Each resident will have access to a quiet, private area where he/she can withdraw from the group as necessary.
3. Contacts between the resident and his/her family will be allowed while the resident is in care, unless the rights of the parents have been terminated by court or family contact is not in the resident's best interest. The frequency of contact will be based on the needs of

the resident and will be determined with the participation of his/her family or managing conservator and GSMYC staff member. Any limitations will be filed in the resident's case record.

- a. Residents will be allowed to send and receive mail and engage in telephone conversations with family members or managing conservator, unless the best interests of the resident or a court order necessitates restrictions.
 - b. When contact with the family is requested by either the resident or his/her family and GSMYC determines contact is not in the resident's best interest, restrictions from communication will be determined by a psychiatrist, licensed psychologist, social worker, or licensed administrator. Reasons for the restrictions will be documented in the resident's record.
 - c. If limits are put on communications or visits for practical reasons, such as expenses, the limits will be determined with resident and his/her family. These limitations will be documented in the resident's record.
4. Parents or guardians will be permitted to visit with their child on Sundays between 9:00 am and 9:00 P.M. Exceptions will be made according to individual need and will be recorded in the youth's file.
 - a. All visits will be recorded in the child's record.
 - b. All visits will be restricted to the facility or grounds of the facility, unless otherwise stated in the child's record.
 - c. No restriction in length of visits will be made unless necessary for the physical or emotional well-being of the child.
 - d. Visits will be restricted if the health of the child is threatened in any way.
5. Permission for visits from friends will be given on an individual basis. Permission will be authorized by primary staff member responsible for the child. Visits from friends will be limited to Sundays between 1:00pm and 4:00pm.
6. Mail or gifts from or to parents, guardians or friends will be permitted unless determined to be detrimental to the resident. Documentation of mail or gift denial will be kept in the resident's record.
7. Permission for telephone calls to be made by residents will be authorized by the primary staff member on an individual basis. If permission is granted, residents will be expected to respect the following guidelines stated previously in *Phone Procedures for Residents*.
8. Residents will be allowed to bring and acquire personal possessions while residing at GMSYC.

9. GSMYC will not place any resident in a position of having to acknowledge his/her dependency, destitution or neglect. GSMYC will not require the resident to make statements, regarding his/her background or dependence on GSMYC for care.
10. GSMYC will not require a resident to make public statements to acknowledge gratitude towards the agency.
11. Residents in care will not be required to perform at public gatherings.
12. Pictures, reports, or identifications that humiliate, exploit, or invade the privacy of a resident or his/her family will not be made public.
13. There will be no racial discrimination by GSMYC.
14. Resident's opinions and recommendations will be considered in the development and evaluation of the programs and activities of GSMYC. The procedure for this will be documented.
15. The discipline policy of GSMYC is based on positive reward rather than punishment. The philosophy of GSMYC encourages change from within, rather than restraint from the outside.

Children in our care can earn an allowance through their completion of chores, homework and/or reading, participation in activities and positive social interactions with other children. Chores are age appropriate as is the allowance offered (gift cards or an item from the treasure box). Each child has a morning chore chart and an evening chore chart, posted in the dining room with stickers to mark the completion of each section. Staff members also issue rewards for exceptional behavior or the completion of a chore outside of their assigned chore. For example, when a child shows exceptional kindness to another or completes an especially difficult homework assignment, an additional reward can be given.

Discipline Guidelines

As Minimum Standards require, residential childcare facilities must have discipline or behavior management policies. These policies must be followed. All sets of standards require that discipline or behavior management be individualized to meet the needs of each child.

1. Only adult staff members will set consequences for the residents.
2. Residents will not be subjected to cruel, harsh, unusual or unnecessary punishment.
3. Records will be kept of those residents restricted to the shelter premises for more than 24

hours.

4. Residents will not be subjected to verbal remarks that belittle or ridicule them or their families.
5. Consequences will match severity of the behavior.
6. Residents will not be punished by shaking, striking or spanking.
7. Emergency behavior intervention utilized by GSMYC is Handle with Care. It is to be used only in the event a resident is in imminent danger of physically harming himself or others. Only staff who are certified in Handle with Care are allowed to physically restrain a resident.

Residents' Money

It is the policy of GSMYC that monies earned by youth or received as a gift shall be the personal property of those youth and shall be held for them in the office and available to them for activities or any other need. Each youth will have an envelope that contains his/her money. Each time an addition or withdrawal is made; the staff member and youth shall sign the envelope and include the total amount.

Residents' Mail, Phones, and Gifts

Employees of GSMYC must allow contacts between the resident and his/her family while the resident is in care, unless the rights of parents have been terminated by court order, or family contact is not in the best interest of the child.

Youth in the care of GSMYC are allowed to send and receive mail and conduct telephone conversations with family member, friends, or managing conservators. The best interest of the child or a court order may necessitate restrictions on the communication.

GSMYC residents are allowed to receive gifts from family members or their managing conservator. Any gift received while a resident of GSMYC must be documented on his/her property inventory.

Resident Night Check Procedure

Residents rooms will be checked at least every 10 minutes by staff members on duty, alternating the order of rooms, to ensure that residents are in their beds asleep and not in danger, sick, or upset.

Staff members will routinely check to ensure that windows and doors are locked, surrounding

grounds are secure, and that the alarms are in working order.

Night staff members will keep a written record of the times each room is checked. If a resident is discovered missing after a thorough search, general runaway procedures must be followed.

Searches

Childcare facility staff members may search the room, possessions, or person of a specific child when there is reason to suspect the presence of any kind of contraband or responsibility for theft.

Routine searches may not be conducted in childcare facilities. Searches are only permitted when there is “just cause” to conduct a search.

A staff member of the same sex as the child must conduct searches that involve removing articles of a child’s clothing other than coats, jackets, hats, gloves, other “outerwear”, shoes, or socks. Searches must be conducted in the presence of an adult witness also the same sex as the child.

Person searches must be documented as a serious incident. Documentation of a person search must include the reasons for the search, the type of search, the name of the child or children involved, the name of the staff member conducting the search, the name of the witness, the article of clothing removed, the results of the search and the resolution of the issue with the child or children. Childcare facilities are encouraged, but not required, to document searches other than those that include the removal of a child's clothing.

Body cavity searches are prohibited in childcare facilities.

Grievance and Complaint Procedure for Residents

The policy of GSMYC is to provide residents with a safe, secure place to stay until permanent arrangements can be made. Should a resident have any complaints, GSMYC has a procedure in place to address their concerns using the following:

Step 1: The staff member can help residents state their complaint; Residents have a chance to tell the staff member whether they are satisfied or not satisfied. If they are not satisfied, residents should tell the staff member that they wish to appeal. Staff members cannot use this procedure to complain to the Supervisor about a resident’s behavior.

Step 2: Residents can file their complaint with the Program Director and within 10 working days, a staffmember will speak with the resident regarding the complaint and resolution. In most cases, the

Program Director's decision will solve the problem.

Step 3: If not, residents may appeal to the Executive Director to listen to all the facts and then render a fair decision. If residents are still not satisfied with the decision, they can contact their Case Worker or Managing Conservator for advice.

(A signed copy of this form will be filed in each resident's file.)

Resident's Weekday Schedule

(Monday through Friday during school year)

Wake up	6:00 am - 7:00 am
Breakfast	
Hygiene	
Chores	
School	7:15 am - 4:30 pm
Snack & break	4:30 pm - 5:30 pm
Dinner	5:30 pm - 6:30 pm
Chores	6:30 pm - 6:45 pm
Homework	6:45 pm - 7:30 pm
Activities/Free Time & Snack	7:30 pm - 9:30 pm
Hygiene/Shower Time	9:30 pm - 10:00 pm
Quiet Time and lights out	10:00 pm - 10:15 pm

Residents' Weekend Schedule

Wake up	8:30 am - 10:00 am
Hygiene	
Breakfast	
Chores	
Activities/free time/Snack	10:00 am - 12:00 pm
Lunch	12:00 pm - 12:30 pm
Chores	
Evening meal	5:30 pm - 6:00 pm
Chores	
Group Session	6:30 pm - 7:00 pm
Activities/free time/Snack	7:00 pm - 10:30 pm

Prepare for bed

(Bed time varies by age)

Quiet time/Lights Out

11:00 pm

Children under the age of nine (9) must be in bed with lights out by 9 pm.

Hygiene

Hygiene products are furnished to residents. Products are purchased by GSMYC for the residents. Products should be dispensed as economically as possible, but no one should go without necessary items. All hygiene products are to be kept locked up in the laundry room and given to the residents on request for their use.

Residents may not keep mouthwash, cologne, nail polish remover, or clippers with their hygiene products. These items must be locked in the medicine cabinet separately and marked with the resident's name. They may be used only under direct supervision. Residents will not use aerosol products while they are in the care of GSMYC.

Environment

The GSMYC facilities and grounds will be continuously maintained, repaired and cleaned so not to pose a danger to health and safety.

- a. Outdoor areas will be well drained.
- b. Windows and doors used for ventilation will be screened.

Building Grounds

1. GSMYC shall comply with all local, state, federal, fire, health and safety laws.
2. Buildings and grounds shall be maintained so that they are not hazardous to health and safety, and meet facility standards set by the local and state governments.
3. GSMYC shall meet the Texas Minimum Standards for General Residential Operations regarding health and safety.

The following standards apply:

Building and Grounds Maintenance: Building and grounds shall be maintained, repaired and cleaned so they are not hazardous to health and safety.

1. Outdoor areas shall be well drained.
2. Windows and doors used for ventilation shall be screened.
3. Equipment and furniture shall be safe and sturdy. Furniture must not block exit ways.
4. Anything flammable or poisonous shall be stored away from heat and out of the youth's reach; this includes paint containing lead and poisonous gas or fumes.
5. The Shelter Supervisor or his/her designee is responsible for the maintenance of the facility in conformity to these health and safety regulations and for directing required repairs and improvements.

Alcohol and Drugs: Alcoholic beverages, illicit or controlled drugs and substances, including marijuana, will not be allowed on the premises.

Hazardous Materials: All potentially hazardous items will be kept in a locked area. Kitchen knives will be locked in the pantry. Disposable razors will be kept in a container and locked in the Case Manager's office.) Sewing needles and scissors will be kept in a sewing kit, which will only be available upon request from staff member. When not in use they will be locked in the medicine cabinet. Staff members must supervise the use of these items.

Facilities Maintenance / Inspections

GSMYC has fire, health and safety inspections performed annually. Reports are kept on file, shared and reviewed by the Licensing Division of the Department of Protective and Regulatory Services (DFPS). Copies of each inspection are also shared with GSMYC's DFPS contract manager. The Licensing Branch may visit and inspect the premises at any time. They will make at least one unannounced visit annually and the contract manager will visit once annually, although scheduled.

GSMYC records and reports are available and open to review by the Licensing Division of DFPS. GSMYC shall display the current facility license/permit, as well as the Child Care Administrator's License, in the facility.

All Inspections will be on file at GSMYC's facility. Copies of the inspection reports will be submitted with the signed application to the Licensing Branch annually thereafter. Required annual inspections are:

- Fire inspections, which meet requirements, set by the local Fire Marshal.
- Health inspections, which meet regulations, set by local health ordinances and the Texas Department of Health.

Facilities Equipment

Direct Care/Childcare workers are held responsible for the daily care of the equipment and proper supervision of the use of the equipment is required to ensure that the equipment remains in good condition. Damaged equipment will be reported to the Program Director on a Damage Report Form completed by the staff member on duty. Reports shall be made promptly.

Inventory of equipment is compiled annually by the Supervisor.

Building and Grounds Damage Procedures

1. Each morning and each evening while chores are being checked, the building and grounds will also be checked for any signs of damage.
2. Things to be checked daily are windows, screens, doors, beds, closets, outside lights, walls, furniture, alarm system, etc.
3. When a damaged item has been noticed, immediately notify the Program Director. It will then be his/her responsibility to notify the Executive Director.
4. After the proper people have been notified, steps to correct the damage will be taken.

Vehicle and Equipment Usage

All employees are expected to make maximum use of all resources at their disposal. Employees are responsible for any hand tools, equipment and supplies that they use in their work. It is the employee's responsibility to make sure everything is kept in good condition and returned to its proper place. No employee will operate power tools or equipment unless they have been thoroughly instructed on the correct use of the tool.

Any employee operating a GSMYC vehicle, whether transporting residents or not, must have in his/her possession a valid, appropriate Texas operator's license, personal liability insurance and must take care to drive defensively and adhere to all traffic laws.

If an employee must use a personal vehicle for GSMYC business, he/she will be reimbursed at the state established rate of reimbursement. Careful records are to be kept of personal vehicle usage and prior approval must be obtained from the Executive Director. Residents are to be transported in agency vehicles.

Employees who misuse or abuse GSMYC equipment or supplies will be subject to disciplinary

action and will be responsible for repair or replacement costs.

Safety

Safety is extremely important within and on GSMYC facilities and grounds. It is essential that every precaution be taken to ensure the safety of the residents. Exterior and interior security cameras exist to increase their safety.

Any unsafe conditions must be reported immediately. Employees are expected to develop habits of caution and look for situations that might cause injury. On the job injuries should be immediately reported to his/her immediate supervisor who will then report the incident to the Executive Director. Any necessary safety placements should be implemented immediately.

Security / Alarm System

The security alarm for windows and doors is located in the shelter staff office by the wall phone. If alarm is activated, locate zone by the flashing light on the zone pad.

Security Zone 1: Front/Back doors

Security Zone 2: Side doors

Security Zone 3: Boys Bedrooms
Boys Bathroom

Security Zone 4: Girls Bedrooms
Girls Bathroom

To de-activate Alarm: Press **6815**. Close all doors and windows as indicated by the Zone pad.

To reset Alarm: Press ***1* 6815**

Detailed instructions for activating and disarming the alarm system for the shelter are posted in the medicine cabinet in the staff member office.

Disaster Emergency Plan (refer to DEP for specific details, hard copy stored in staff office, digital copy on agency's shared drive).

It is the policy of GSMYC to provide disaster plans in case of fire, tornado, other severe weather or any other catastrophic emergency. These plans are for protection of staff members and

residents, and it is the responsibility of all staff members to enforce the following procedures:

Fire:

1. All exits in the building are clearly marked with exit signs.
2. Individuals can exit by way of the boy's or girl's hallway or the front or the back doors.
3. Fire extinguishers are located strategically throughout the building.
4. In case of a fire or a fire drill, staff members will evacuate the building of all residents and any other persons present. The residents and staff members will be notified of the fire by the first person who spots the fire by shouting "FIRE!" and by giving the location of the fire. This notice shall be given at least three times.

Notify the fire department by calling 911.

5. Residents and staff members evacuating the building will meet in the parking lot.
6. Fire drills will be executed at least monthly by the shelter supervisor or his/her designee. A record of these practice drills will be kept in the activity log.
7. Practice drills should be carried out within one minute. Time is of the essence during an emergency.
8. Fire drills will begin by a staff member shouting "FIRE, FIRE, and FIRE!" or by sounding the emergency fire alarm. The fire department will not be notified when drills are conducted.

Wind:

1. If there is the impending threat of high winds/tornadoes, a staff member shall monitor a news source to keep informed of the storm's progress.
2. If a tornado warning is issued, staff members must begin safety protocol immediately, instructing residents to move to the nearest hallway. Everyone will face the wall and cover their heads and arms. This procedure will continue until the danger of the storm has passed.
3. Wind/tornado drills will be executed at least monthly by the shelter supervisor and his/her

designee. The same procedure outlined above also will be followed during a drill.

4. Wind/tornado drills will begin with a staff member shouting “TORNADO, TORNADO, TORNADO” The drill shall not end until a staff member says the drill is finished.
5. Practice drills shall be conducted within one minute. Time is of the essence during an emergency. Practice drills shall be recorded in the staff member log.

Miscellaneous Disaster Emergency Plan Information:

1. If safety permits, staff members shall check each room during a building evacuation to make sure everyone is out. As each room is checked, the door to that room shall be closed.
2. A head count shall be taken at the parking lot in front of the facility to make sure everyone is safely out of the building.
3. Staff members will use the shelter cell phone or their personal cell phone to notify each youth’s parents and/or managing conservator of the incident.
4. If the building cannot be reoccupied, staff members will stay with the residents until they are safely discharged to their parent/ managing conservator. GSMYC maintains a location separate from the general public for emergency evacuations (Grace Lutheran Church located at 1250 Belvin St., San Marcos, TX).
5. Disaster which forces the facility to close must be reported to DFPS and any other placing agency within 24 hours. The Executive Director and the licensed childcare administrator must be notified as soon as possible following the disaster.
6. A detailed incident report must be completed as soon as possible following the disaster.

Summary Statement

These policies and procedures are to be utilized in conjunction with the state mandated guidelines and requirements of all contracts entered into by GSMYC, including adherence to the Minimum Standards set forth by the licensing division of DFPS. In the event these documents do not coincide, GSMYC personnel will abide by the policy with the highest standard.

As an employee of GSMYC it is your responsibility to become familiar with these policies and procedures and to follow the guidelines as set forth by this agency and all contractual entities. Please contact your immediate supervisor if you have questions, comments or need clarification about this manual.



July 10, 2024
Greater San Marcos Youth Council
RE: Letter of Support

Dear Board Chair and Members:

On behalf of Community Action, Inc. of Central Texas and the Core Four Partnership, I am writing this letter of support for our community partner, the Greater San Marcos Youth Council, and their organization described below:

GSYMC is currently working closely with the Core Four Partnership- Youth Services Department. Through this partnership they participate in the SMTX Mental Health Coalition and play an active role in the steering committee for the CFP Youth Coalition. With their support they are helping to lead efforts in creating youth-centered coalition to help address the needs of local area youth in the Greater San Marcos Area. In Year 1 the youth coalition was able to create and distribute a Youth and Young Adult Community Needs Assessment in Fall 2023. We were able to finalize our findings in Spring 2024 which highlighted the needs of youth and young adults. Through this CNA and it's findings the coalition aims to provide community activities, trainings and support for youth/young adults, their families and the professionals who work closely with them. This is only a small portion of the work that GSYMC is actively doing in the community. Their collaborative spirit allows us to leverage our resources to provide services for youth and their families in our community.

The staff at GSMYC provide the needed service in the community, not available from any other organization in our community. Their expertise in working with this specific demographic is vital for the health and well-being of our community. The agency's ability to house children following emergency removal from their families as a vital resource in the community and one that is not provided by any other agency locally in San Marcos. The resource they provide is essential for youth and to providing the support and safety that is needed during these crises. Additionally, they provide free family counseling, crisis intervention, parenting classes, school-based groups, truancy intervention, advocacy for youth and families, and trauma support in the greater San Marcos Area. As a community we are dependent on their expertise, services and support they offer.

The letter of support is to highlight the vital role they have in our community and the importance for them to continue to receive funding. Not only are the services vital to the health of our community, GSYMC fills a gap that is not provided by any other organization locally. Without any hesitation continual investment in their agency has a positive impact on the youth and families on our community.

Thank you for time and consideration of this request.

Sincerely,

Cristal Lopez

Cristal Lopez, MA

Youth Services Director | Core Four Partnership
Community Action, Inc. of Central Texas



Community Action, Inc.
of Central Texas

— DEVELOPING OPPORTUNITIES —

FW: Support Letter for GSMYC

Shabnam Ejaz <sejaz@gsmyc.org>

Tue 7/23/2024 1:39 PM

To: Victoria Berry <vberry@gsmyc.org>

From: Sydney Moore <sydnorris@gmail.com>**Sent:** Tuesday, July 23, 2024 1:32 PM**To:** Shabnam Ejaz <sejaz@gsmyc.org>**Subject:** Support Letter for GSMYC

To whom it may concern:

I am writing to express my heartfelt support for the grant application submitted by the Greater San Marcos Youth Council. As a resident of San Marcos, Texas, and a recipient of services from your organization, I have experienced firsthand the significant impact of their programs on our family. My 3 children have all received counseling services through GSMYC.

Living in Hays County, we have benefited immensely from the services provided by the Greater San Marcos Youth Council, particularly through the Family and Youth Services (FAYS) program. As our children transitioned into their school-age years, your organization seamlessly continued to support our family's needs, ensuring a holistic approach to their development and well-being.

The programs offered by the Youth Council have not only provided practical assistance but also fostered a supportive environment that has positively influenced our family dynamics. From educational support to youth empowerment initiatives, your commitment to serving the community has been evident throughout our engagement with your services.

I wholeheartedly endorse the grant application of the Greater San Marcos Youth Council. GSMYC's dedication to improving the lives of families in San Marcos and the surrounding areas is commendable and essential for the continued growth and well-being of our community.

Sincerely,

Sydney Moore (parent of Taylor Moore, Sam Moore and Olivia Stephens)
208 W Mimosa Cir
San Marcos, Texas 78666
sydnorris@gmail.com

Letter of Support

Vanessa Garcia <vanessa.victoria1978@gmail.com>

Tue 7/23/2024 12:06 PM

To: Felicia Zuniga <fzuniga@gsmc.org>

To whom it may concern:

I am writing to express gratitude for the support that we have received from GSMYC. My daughter was having a really rough time this year with a few students who would taunt her daily. Instead of sharing this with us immediately she internalized it and eventually came to a point where she was causing her self harm. I was at a loss but I remember speaking to the ladies of GSMYC at an event that was held at the elementary school that I work for. I contacted the office and was able to get my daughter signed up. I have seen great improvement in my daughter and am forever grateful for all of the help and support we have both received at GSMYC.

Vanessa