

REFERENCE MATERIAL

FOR

HEALTH AND BEHAVIOR

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RESIDENTIAL CARE FACILITIES FOR THE ELDERLY**5-1000 HEALTH CONDITION RELOCATION ORDER
AND INTERDISCIPLINARY TEAM REVIEW****5-1000****GENERAL STATEMENT**

Health and Safety Code Sections (1569.54 (b) and (c) provide for the resident of a Residential Care Facility for the Elderly to request an independent review by the Department's Interdisciplinary Team when issued a Health Condition Relocation Order. A Health Condition Relocation Order is issued by the **Regional** Office when retention of the resident in the facility is considered inappropriate due to the existence of one or more health conditions that cannot be legally cared for in a residential care facility for the elderly. Health and Safety Code Section 1569.54(b) and residential care facility for the elderly Regulation Section 87638 define and explain the procedure. An order may be issued when the resident has other health conditions which, while not prohibited, appear to be severe enough to endanger the resident or appear to be beyond the ability of the licensee or facility staff to care for properly.

The Interdisciplinary Team review process is initiated by the resident or resident's responsible person and follows its own unique rules and requirements. Independent of the Interdisciplinary Team review process, however, the licensee may request an administrative review (i.e. appeal) of the relocation order and other related deficiencies. Even though the outcome of the Interdisciplinary Team review process may affect the outcome of the administrative review (appeal) process, or vice versa, the Interdisciplinary Team review process should operate independently of the Community Care Licensing Division's administrative review of a licensee's appeal.

5-1005 ISSUING HEALTH CONDITION RELOCATION ORDER**5-1005**

The LIC 9105 form, "Client Request: Health-Condition Relocation Review" is used to inform the resident of the relocation order.

- Depending on **Regional** Office procedure, discuss the relocation with the licensing **program manager** or **regional** manager prior to completing the LIC 9105.
- The reason(s) for relocation of the resident must be stated in the LIC 809, and in the LIC 9105 to be issued at the facility.
- The space provided at about the middle of the LIC 9105 next to the phrase "three working days" must be filled in with the date of the third working day following the date of the LIC 9105.
 - Section 87638(b)(1) of the residential care facilities for the elderly regulations defines "working days" to be any day except Saturday, Sunday, or an official State holiday.
 - Do not include the date of the LIC 9105 when computing the three working days time period.

5-1005 ISSUING HEALTH CONDITION RELOCATION ORDER**5-1005**

(Continued)

- The first copy of the LIC 9105 is given directly to the resident, and the second copy is given to the licensee or designee signing the accompanying LIC 809.
 - If neither the licensee nor a designee of the licensee is present (which would be a violation of residential facility for the elderly Regulations Section 87563[a]), the licensee's copy of the LIC 9105 should be attached to the LIC 809, and a copy of both forms should be left at the facility and mailed via certified mail to the licensee's address of record. The LIC 809 for the facility visit should indicate that the LIC 9105 form is being issued, and that a copy of the LIC 9105 was given to the affected resident at the facility.
- If the resident has a known responsible person, immediately send that person or agency via certified mail, a photocopy of the front and reverse side of the first page (resident's copy) of the LIC 9105.

If there is no known responsible person for this resident:

- Send a photocopy of the front and reverse side of the first page of the LIC 9105, via certified mail, to the resident's representative payee, if any, unless the representative payee is the facility licensee; and
- Immediately contact the Office of the State Long Term Care Ombudsman, either by telephoning that agency's toll-free number (1-800-231-4024) or by telephoning the local Long Term Care Ombudsman office, and provide the information contained in the LIC 9105.
 - During the call, indicate the name and telephone number of the appropriate contact person at the **Regional** Office.
 - Document the telephone call using the LIC 812, Detailed Supportive Information, and file this document in the confidential section of the **Regional** Office licensing file.

**5-1010 RESIDENT'S REQUEST FOR INTERDISCIPLINARY
TEAM REVIEW****5-1010**

If the resident or the resident's responsible person wishes to request an Interdisciplinary Team review:

- The request must be in writing and the bottom portion of the LIC 9105 is reserved for this purpose.
 - It is not required that the LIC 9105 form be used to request a review of the Health Condition Relocation Order. A letter or any written request from the resident or responsible person, no matter how informal, should be accepted.

It is not mandatory that the box next to the "I DO NOT WANT a review of my relocation order" on the LIC 9105 form be checked, although doing so would clarify that an Interdisciplinary Team review is not being requested.

- The resident or responsible person must forward the written request for an Interdisciplinary Team review directly to the facility licensee or representative (this may include facility staff), and must do so within three working days following the resident's receipt of the relocation order (LIC 9105).
 - If this time frame is not met, the **Regional** Office should decide if sufficient grounds exist to discontinue the Interdisciplinary Team review process. If the review process is discontinued for this reason, the **Regional** Office notifies the licensee, resident, and responsible person, if any, of this determination by letter.

5-1015 LICENSEE SUBMISSION OF LIC 9105**5-1015**

Within two working days of receipt of the resident's written request for an Interdisciplinary Team review, the licensee is required to mail or deliver the LIC 9105 to the **Regional** Office. Upon receipt, the resident's request should be routed to the Licensing Program **Manager** as a priority action item. Failure by the licensee to forward the review request to the **Regional** Office in a timely manner is a violation of Section 87638(c) of the residential care facilities for the elderly regulations.

If and when it is learned that the resident's request for an interdisciplinary team review has not been forwarded by the licensee, issue a serious deficiency requiring that the licensee mail or personally deliver the resident's request to the **Regional** Office within 24 hours.

**5-1020 REGIONAL OFFICE AND INTERDISCIPLINARY
TEAM COORDINATOR****5-1020**

If an Interdisciplinary Team review is requested by the resident and or representative:

- Within three working days following receipt of the client's request for an Interdisciplinary Team review (as forwarded by the licensee):
 - The **Regional** Office must send an acknowledgement by certified mail to the resident and the resident's responsible person, if any, indicating that the resident's request has been received and a photocopy of the back of the LIC 9105 outlining the documents that need to be forwarded.
 - Sample letter (Attachment A) is provided for this purpose.
- Residential care facilities for the elderly regulations Section 87701.5(e) requires that the licensee submit specific information to the **Regional** Office within ten working days of the date of the resident's review request. This information is necessary for the Interdisciplinary Team to perform an appropriate review of the health condition relocation order. The documents include a current medical assessment and a current appraisal/reappraisal of the physical, mental condition and care needs of the resident.
 - **Regional** Office staff should track this deadline to ensure that subsequent steps of the review process are not held up as the result of failure by the licensee to submit the required information.
 - If necessary, issue a deficiency with a plan of correction timeframe no longer than two working days to require that the licensee submit the information specified in Section 87701.5(g) of the residential care facility for the elderly regulations.
- As soon as all documents are received, contact the Interdisciplinary Team Coordinator, Policy Development Bureau by telephone to alert him/her that an Interdisciplinary Team request is being faxed (within 24 hours.) Leave your name and telephone number in case the fax is not received or incomplete. Do not mail required documentation. The following documents must be faxed: LIC 9105; LIC 809; LIC 812, if applicable; Physician's report; Appraisal/Reappraisal; written statement from the placement agency, if applicable; and Licensing Information System Facility Profile.

**5-1020 REGIONAL OFFICE AND INTERDISCIPLINARY
TEAM COORDINATOR (Continued)****5-1020**

- When received, the Interdisciplinary Team Coordinator logs in the resident's request for review and contacts the Interdisciplinary Team. The team will notify the Interdisciplinary Team Coordinator the week that the unannounced visit is scheduled. An acknowledgement form will be faxed to the Licensing Program Analyst/Licensing Program **Manager** of record stating the week the Interdisciplinary Team will be reviewing the resident.
- The Interdisciplinary Team has 30 days from issuance of the Health Condition Relocation Order to review and send the decision letter to the resident or responsible person, if any, with a copy to the **Regional** Office Manager, Licensing Program **Manager**, Licensing Program Analyst and licensee. Due to this timeframe, it is critical that the Interdisciplinary Team Coordinator receive the documentation from the licensee as soon as possible. Do not wait for letters from family members, power of attorney letters or doctors' letters in support of resident remaining in care. These can be forwarded later after the Interdisciplinary Team review is scheduled.
- If the **Regional** Office is notified that the resident has moved, relocated to a higher level of care or passed away, contact the Interdisciplinary Team Coordinator as soon as possible to cancel the Interdisciplinary Team review. If the resident has relocated to another residential care facility for the elderly, the licensee involved must be ordered to relocate the resident and develop a relocation plan appropriate to the circumstances, unless the **Regional** office determines that the resident's placement in the new facility is appropriate.
 - If the new residential care facility for the elderly placement is not appropriate and the resident is required to be relocated, the resident's right to request an Interdisciplinary Team review does not extend to this new setting. Specifically, there cannot be a second review of the same health condition(s) which caused relocation from the original facility.
- Determinations regarding relocation are made jointly by the Interdisciplinary Team based upon the medical and social observations. The Licensing Program Analyst or Licensing Program **Manager** is notified of the Interdisciplinary Teams decision prior to notification being mailed to the resident or responsible person. The written response conveying the decision to retain or relocate is forwarded by certified mail to the resident or responsible person and copies to the **Regional** Office. If the decision is made that the resident needs to be relocated, the **Regional** Office staff is available to work with the licensee and family to develop a relocation plan.
- A timeline for the Relocation Review Process is attached for your quick reference. See Attachment B.

ATTACHMENT A
SAMPLE LETTER

Date

Facility Name:

Facility ID #:

DEPARTMENT OF SOCIAL SERVICES
Community Care Licensing Division
(Regional Office Address)Resident/responsible person
Address

RE: RESIDENT REQUEST FOR HEALTH CONDITON RELOCATION ORDER REVIEW

Dear,

This letter is to acknowledge receipt of your request for a review of the Health Condition Relocation Order issued (order date) by the Department of Social Services pursuant to Section 1569.54(a)(1) of the California Health and Safety Code.

The facility licensee is required to submit to the Department by (date) the documentation specified on the back of the LIC 9105 form, RESIDENT REQUEST: HEALTH-CONDITION RELOCATION REVIEW, which you may have completed when you requested a review of the relocation order. Attached to this letter is a copy of the reverse side of the LIC 9105 form which describes the relocation review process and the information that the licensee must now forward to this office.

The Interdisciplinary Team will review the relocation order and any other relevant information available, and may also visit the facility. By (date), the Department will notify you, in writing, of the decision of the Interdisciplinary Team and the disposition of the relocation order. Please be advised that the decision of the Interdisciplinary Team is final, as provided in Health and Safety Code Section 1569.54(c).

If you have any questions about the review process please write to the Licensing Program Analyst at the above address or telephone him/her at () ().

Sincerely,

(Regional Manager or designee)
Regional Office

ATTACHMENT B

Timeline for Residential Care for the Elderly Facilities Health Condition Relocation Order Review

RELOCATION REVIEW PROCESS

TIMELINE

Health Condition Relocation Order Review (LIC 9105) to resident:	At time of issuance
Copy of LIC 9105 to known responsible person or agency – via certified mail:	Within 1 working day
The resident/responsible party must return the LIC 9105 to the licensee:	Within 3 working days from receipt of the relocation order
The licensee shall mail or deliver the LIC 9105 to the Regional Office:	Within 2 working days
The Regional Office will send an acknowledgement of receipt of the request for the review.	Within 3 working days
The licensee shall submit specified documentation to the Regional Office.	Within 10 working days from date of resident's review request
IDT final decision will be mailed to the resident/responsible party:	Not more than 30 days from date of review request

ADULT RESIDENTIAL FACILITY**5-1025 HEALTH CONDITION RELOCATION ORDER AND INTERDISCIPLINARY TEAM REVIEW****5-1025****GENERAL STATEMENT**

General Licensing Requirements Section 80094.5 provide for the client's right of an Adult Residential Facility to request an independent review by the Department's Interdisciplinary Team when issued a Health Condition Relocation Order. A Health Condition Relocation Order is issued by the **Regional** Office when retention of the client in the facility is considered inappropriate due to the existence of one or more health conditions that cannot be legally cared for in an Adult Residential Facility. General Licensing Requirements Section 80094 define and explain the procedure. An order may be issued when the client has other health conditions which, while not prohibited, appear to be severe enough to endanger the client or appear to be beyond the ability of the licensee or facility staff to care for properly.

The Interdisciplinary Team review process is initiated by the client or authorized representative and follows its own unique rules and requirements. Independent of the Interdisciplinary Team review process, however, the licensee may request an administrative review (i.e., appeal) of the relocation order and other related deficiencies. Even though the outcome of the Interdisciplinary Team review process may affect the outcome of the administrative review (appeal) process, or vice versa, the Interdisciplinary Team review process should operate independently of Community Care Licensing Division's administrative review of a licensee's appeal.

5-1030 ISSUING FACILITY HEALTH CONDITION RELOCATION ORDER**5-1030**

The LIC 9105A form, "Client Request: Health-Condition Relocation Order" is used to inform the client of the relocation order.

- Depending on **Regional** Office procedure, discuss the relocation with the licensing **program manager** or **regional** manager prior to completing the LIC 9105A.
- The reason(s) for relocation of the client must be stated in the LIC 809, and in the LIC 9105A to be issued at the facility.
- The space provided at about the middle of the LIC 9105A next to the phrase "ten working days" must be filled in with the date of the tenth working day following the date of the LIC 9105A.
 - Section 80094.5 (b)(1) of the General Licensing Requirements defines "working days" to be any day except Saturday, Sunday, or an official state holiday.
 - Do not include the date of the LIC 9105A when computing the ten working days time period.

5-1030 ISSUING FACILITY HEALTH CONDITION RELOCATION ORDER (Continued) 5-1030

- The first copy of the LIC 9105A is given directly to the client, and the second copy is given to the licensee or designee signing the accompanying LIC 809.
- If neither the licensee nor a designee of the licensee is present (which would be a violation of General Licensing Requirements Section 80064), the licensee's copy of the LIC 9105A should be attached to the LIC 809, and a copy of both forms should be left at the facility and mailed via certified mail to the licensee's address of record. The LIC 809 for the facility visit should indicate that the LIC 9105A form is being issued, and that a copy of the LIC 9105A was given to the affected client at the facility.
- If the client has an authorized representative, immediately send that person or agency via certified mail, a photocopy of the front and reverse side of the first page (client's copy) of the LIC 9105A.

If there is no authorized representative for the client:

- Send a photocopy of the front and reverse side of the first page of the LIC 9105A, via certified mail, to the client's representative payee, if any, unless the representative payee is the facility licensee.

5-1035 CLIENT'S REQUEST FOR INTERDISCIPLINARY TEAM REVIEW 5-1035

If the client or the client's authorized representative wishes to request an Interdisciplinary Team review:

- The request must be in writing and the bottom portion of the LIC 9105A is reserved for this purpose.
- It is not required that the LIC 9105A form be used to request a review of the Health Condition Relocation Order. A letter or any written request from the client or authorized representative, no matter how informal, should be accepted.

It is **not** mandatory that the box next to the "I DO NOT WANT a review of my relocation order" on the LIC 9105A form be checked, although doing so would clarify that an Interdisciplinary Team review is not being requested.

5-1035 CLIENT'S REQUEST FOR INTERDISCIPLINARY TEAM REVIEW 5-1035
(Continued)

- The client or authorized representative must forward the written request for an Interdisciplinary Team review directly to the facility licensee or representative (this may include facility staff), and must do so within ten working days following the client's receipt of the relocation order (LIC 9105A).
 - If this time frame is not met, the **Regional** Office should decide if sufficient grounds exist to discontinue the Interdisciplinary Team review process. If the review process is discontinued for this reason, the **Regional** Office notifies the licensee, client, and responsible person, if any, of this determination by letter.

5-1040 LICENSEE SUBMISSION OF LIC 9105A 5-1040

Within two working days of receipt of the client's written request for an Interdisciplinary Team review, the licensee is required to mail or deliver the LIC 9105A to the **Regional** Office. Upon receipt, the client's request should be routed to the licensing program **manager** as a priority action item. Failure by the licensee to forward the review request to the **Regional** Office in a timely manner is a violation of Section 80054 of the General Licensing Requirements.

If and when it is learned that the client's request for an Interdisciplinary Team review has not been forwarded by the licensee, issue a serious deficiency requiring that the licensee mail or personally deliver the client's request to the **Regional** Office within 24 hours.

5-1045 REGIONAL OFFICE AND INTERDISCIPLINARY TEAM COORDINATOR 5-1045

If an Interdisciplinary team review is requested by the client and/or a representative:

- Within five working days following receipt of the client's request for an Interdisciplinary Team review (as forwarded by the licensee):
 - The **Regional** Office must send an acknowledgment by certified mail to the client and the client's authorized representative, if any, indicating that the client's request has been received and a photocopy of the back of LIC 9105A outlining the documents that need to be forwarded.
 - Sample letter (Attachment A) is provided for this purpose.

**5-1045 REGIONAL OFFICE AND INTERDISCIPLINARY TEAM
COORDINATOR (Continued)****5-1045**

- General Licensing Requirements Section 80094.5 (e) requires that the licensee submit specific information to the **Regional** Office within 20 working days of the date of the client's review request. This information is necessary for the Interdisciplinary Team to perform an appropriate review of the Health Condition Relocation Order. The documents include a current medical assessment, current functional capabilities assessment and a written statement from the placement agency, if applicable.
 - **Regional** Office staff should track this deadline to ensure that subsequent steps of the review process are not held up as the result of failure by the licensee to submit the required information.
 - If necessary, issue a deficiency with a plan of correction timeframe no longer than two working days to require that the licensee submit the information specified in Section 80094.5 (g) of the General Licensing Requirements.
- As soon as all documents are received, contact the Interdisciplinary Team Coordinator, Policy Development Bureau by telephone to alert him/her that an Interdisciplinary Team request is being faxed (within 24 hours). Leave your name and telephone number in case fax is not received or incomplete. Do not mail required documentation. The following documents must be faxed: LIC 9105A; LIC 809; LIC 812, if applicable; Physician's Report; Functional Capabilities Assessment; written statement from placement agency, if applicable; and Licensing Information System Facility Profile.
- When received, the Interdisciplinary Team Coordinator logs in the client's request for review and contacts the Interdisciplinary Team. The team will notify the Interdisciplinary Coordinator the week that the unannounced visit is scheduled. An acknowledgement form will be faxed to the Licensing Program Analyst/Licensing Program **Manager** of record stating the week that the Interdisciplinary Team will be reviewing the client.
- The Interdisciplinary Team has 30 calendar days from receipt of **Regional** Office documentation of the Health Condition Relocation Order to review and send the decision letter to the client or authorized representative with a copy to the **Regional Manager**, Licensing Program **Manager**, Licensing Program Analyst and licensee. Due to this timeframe, it is critical that the Interdisciplinary Team Coordinator receive **Regional** Office documentation from licensee as soon as it arrives. Do not wait for letters from family members, power of attorney letters or doctors' letters in support of client in care. These can be forwarded later after Interdisciplinary Team is scheduled.

**5-1045 REGIONAL OFFICE AND INTERDISCIPLINARY TEAM
COORDINATOR (Continued)****5-1045**

- If the **Regional** Office is notified that the client has moved, relocated to a higher level of care or passed away, contact the Interdisciplinary Team Coordinator as soon as possible to cancel the Interdisciplinary Team review. If the client has relocated to another Adult Residential Facility, the licensee involved must be ordered to relocate the client and develop a relocation plan appropriate to the circumstances, unless the **Regional Office** determines that the client's placement in the new facility is appropriate.
 - If the new Adult Residential Facility placement is not appropriate and the client is required to relocate, the client's right to request an Interdisciplinary Team review does not extend to this new setting. Specifically, there cannot be a second review of the same health condition(s) that caused relocation from the original facility.
- Determinations regarding relocation are made jointly by the Interdisciplinary Team based upon the medical and social observations. The Licensing Program Analyst or Licensing Program **Manager** are notified of the Interdisciplinary Team's decision prior to notification being mailed to the client or authorized representative. A written response conveying the decision to retain or relocate is then prepared and forwarded by certified mail to the client or authorized representative and copies to the **Regional** Office. If the decision is made that the client needs to be relocated, the **Regional** Office staff is available to work with the licensee and family to develop a relocation plan.
- A timeline for the Relocation Review Process is attached for your quick reference. See Attachment B.

ATTACHMENT A
SAMPLE LETTER

Date

DEPARTMENT OF SOCIAL SERVICES
Community Care Licensing Division
(Regional Office Address)

Facility Name:
Facility ID #:

Client/Authorized Representative
Address

RE: CLIENT REQUEST FOR HEALTH CONDITION RELOCATION ORDER REVIEW

Dear,

This letter is to acknowledge receipt of your request for a review of the Health Condition Relocation Order issued (order date) by the Department of Social Services pursuant to Section 80094.5 of the General Licensing Regulations.

The facility licensee is required to submit to the Department by (date) the documentation specified on the back of the LIC 9105A form, CLIENT REQUEST: HEALTH CONDITION RELOCATION ORDER REVIEW, which you may have completed when you requested a review of the relocation order. Attached to this letter is a copy of the reverse side of the LIC 9105A form that describes the relocation review process and the information that the licensee must now forward to this office.

The Interdisciplinary Team will review the relocation order and any other relevant information available, and may also visit the facility. By (date), the Department will notify you, in writing, of the decision of the Interdisciplinary Team and the disposition of the relocation order. Please be advised that the decision of the Interdisciplinary Team is final.

If you have any questions about the review process, please write to (Licensing Program Analyst) at the above address or telephone her/him at () ().

Sincerely,

(Regional Office Manager or designee)
Regional Office

ATTACHMENT B

Timeline for Adult Residential Facilities Health Condition Relocation Order Review

RELOCATION REVIEW PROCESS

TIMELINE

Health Condition Relocation Order Review (LIC 9105A) to client:	At time of issuance
Copy of LIC 9105A to authorized representative, if any and responsible person via certified mail or delivery:	Within 1 working day
The client/authorized representative must return the LIC 9105A for appeal to the licensee:	Within 10 working days from receipt of the relocation order
The licensee shall mail or deliver LIC 9105A to the Regional Office:	Within 2 working days
The Regional Office will send an acknowledgement of receipt of the request for the review.	Within 5 working days
The licensee shall submit specified documentation to the Regional Office:	Within 20 working days from licensee's receipt of the client's review request
The IDT final decision will be mailed to the client/authorized representative:	Not more than 30 days after the receipt of required information.

5-2010 CHILDREN WITH SPECIAL HEALTH CARE NEEDS

5-2010

GENERAL STATEMENT

The following information is to update the field on the current law regarding foster family homes, small family homes, certified family homes, foster family agencies, and group homes (including former “N” facilities) providing care for, or involved in the placement of, children with special health care needs.

The statutory materials referenced herein are Sections 17710, 17730, 17731, 17732 and 17736 of the Welfare and Institutions Code as amended by AB 636 (effective October 1, 1993). During the period of time a licensee accepts children with special health care needs, these statutory sections are to be applied in addition to existing regulations.

Procedures:

- Do not evaluate the medical care provided to children with special health care needs. Licensing staff are statutorily barred from evaluating the in-home health care services provided by these facilities. Any questionable or unusual circumstances encountered by the Licensing Program Analyst (County Licensing Worker) relating to health care should be reported to the child’s caseworker and documented in the confidential section of the facility file.
(Welfare and Institutions Code 17730; California Code of Regulations 87045)
- There are to be no focused visits for facilities caring for children with special health care needs.
- The Licensing Program Analysts must indicate in the Licensing Report that the facility is caring for children with special health care needs and applicable statutes and regulations must be used to cite facilities out of compliance with these requirements. For citation purposes, the appropriate Welfare and Institutions Code and California Code of Regulations Sections have been identified in each paragraph.
- When citing for violations of these requirements, a reasonable plan of correction should be developed to allow the licensee to come into compliance whenever possible. For example, consider a foster family home caring for six children, where one of the children has suddenly become dependent upon a feeding tube, but whose primary care physician has documented that his/her condition is not expected to last for more than two months. A 30-day plan of correction, extended at the end of that time for another 30-days, would enable the home to come into compliance without having to remove the children, and should be considered by the Licensing Program Analyst.

5-2010 GENERAL STATEMENT (Continued)**5-2010**

- Violation of any of these statutory requirements constitutes a serious deficiency and civil penalties are to be assessed on homes (excluding foster family homes and certified family homes) failing to comply with a plan of correction.
- There are now two capacity limits for foster family homes and small family homes: the regular licensed capacity determined by the number of bedrooms and available beds and the special health care needs capacity. Except as explained below, the special health care needs capacity shall be no more than two placements and shall be enforced only during the time care is provided to children with special health care needs. Under no circumstances should the regular licensed capacity of the home be exceeded.
(Welfare and Institutions Code 17732)
- Owing to the complexity and degree of specialization of special health care needs legislation, it is recommended that the special health care needs caseload be administered by one Licensing Program Analyst in each **Regional** Office.

5-2200 SPECIAL HEALTH CARE NEEDS**5-2200**

A child has special health care needs if the child is either technology-dependent or medically fragile and, as a result, requires substantial in-home health care that can be provided by non-medical personnel such as a licensee trained to provide that care. In the following discussion, medical terminology is explained in Section 5-2610.

5-2210 I. TECHNOLOGY-DEPENDENT**5-2210**

Conditions requiring specialized in-home health care may include one or more of the following technology dependencies:

Enteral feeding tube [including gastrostomy tube and button, percutaneous endoscopic gastrostomy, and nasogastric tube], total parenteral feeding [parenteral hyperalimentation], a cardiorespiratory [apnea] monitor, intravenous therapy, a ventilator, oxygen support, urinary catheterization, renal dialysis [in-home], ministrations imposed by tracheostomy, colostomy, ileostomy or other medical or surgical procedures [such as an ileal conduit] or special medication regimens, including injection and intravenous medication.

(Welfare and Institutions Code 17710(g))

5-2210 I. TECHNOLOGY-DEPENDENT (Continued)**5-2210**

A technology-dependent child needs both a medical device to compensate for the loss of a vital body function and ongoing medical or nursing care to avert death or further disability. The ongoing medical care, usually required for substantial parts of each day, may be provided by a Professional Nurse or by a trained and skilled parent or other lay caretaker. (U.S. Congress, Office of Technology Assessment, "Technology-Dependent Children: Hospital v. Home Care-A Technical Memorandum," OTA-TM-H-38 (Washington, D.C.: U.S. Government Printing Office, May 1987.))

Technology-dependent children fall into four distinct groups:

1. Children who are dependent at least part of each day on mechanical ventilators including devices that apply negative pressure and devices that use positive pressure to force air into the lungs.
2. Children requiring prolonged intravenous administration of nutritional substances or drugs.
3. Children who are dependent daily on another device for their respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support, enteral tube feeding, or total parenteral feeding.
4. Children with prolonged dependence on other medical devices that compensate for vital bodily functions.

This group includes:

- a. Infants requiring apnea (cardiorespiratory) monitors;
- b. Children requiring renal dialysis due to chronic kidney failure; and
- c. Children requiring other medical devices such as urinary catheters, ileostomy or colostomy bags as well as substantial nursing care in connection with their disabilities.

5-2220 II. MEDICALLY FRAGILE**5-2220**

A medically fragile child has a condition which can rapidly deteriorate and result in permanent injury or death. Medically fragile children require frequent nursing care. They must be closely monitored for signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics must be determined. If abnormalities are observed, a report or referral may be needed. Implementation of prescribed procedures, changes in treatment regimen in accordance with prescribed procedures, or emergency procedures, may also be required.

5-2220 II. MEDICALLY FRAGILE (Continued)

5-2220

Medically fragile children are typically infants or young children who are prone, despite the correct administration of medications and/or medical procedures, to sudden relapses that call for rehospitalization or the intervention of a health care professional to avoid further disability.

Medical fragility often, but not always, is associated with:

1. Acquired Immune Deficiency Syndrome (Human Immunodeficiency Virus positive and symptomatic)

Symptoms include failure to thrive, recurrent bacterial infections, pneumonia, inflammation of the middle ear (otitis media), recurrent mumps (parotitis), persistent oral yeast infections (candidiasis), enlargement of the liver and spleen (hepatosplenomegaly), and neurological disorders such as seizures, muscular incoordination (ataxia) and cognitive (perception and memory) deficits.

2. Premature Birth

The premature infant is small, usually weighs less than 2.5kg, and tends to have thin, shiny, pink skin through which the underlying veins are easily seen.

Medical fragility results from the immature functioning of organ systems and may include: respiratory problems such as respiratory distress syndrome and apnea; nutritional problems caused by small stomach capacity and immature sucking and swallowing reflexes with a constant risk of aspiration; and metabolic disorders such as abnormal blood sugar level (hypo/hyperglycemia), jaundice (hyperbilirubinemia), growth retardation (from metabolic acidosis) and hypothermia.

3. Congenital Defects such as Hydrocephalus, Sickle Cell Anemia and Cystic Fibrosis.

Hydrocephalus is an excess of cerebrospinal fluid in the ventricle cavities of the brain. Symptoms include paralysis of the lower limbs (paraparesis), muscular incoordination (ataxia), incontinence, seizures, lung complications and many more problems. The threat of infection is always present. Surgical intervention shunts the cerebrospinal fluid to normal or artificial locations for absorption or excretion, but the reoperation rate is high.

Sickle cell anemia is a chronic hereditary blood disorder in which the red blood cells assume a crescent shape. Children exhibit episodes of bone marrow failure (which can quickly lead to profound and life-threatening anemia), acute pooling of blood in the liver and spleen (frequently causing death in affected infants), and severe abdominal pain with vomiting, back and joint pain, and sometimes stroke. In addition to the acute crises, infections, sometimes fatal, are common, especially in early childhood. Progressive deterioration of liver and kidney function may also be seen.

5-2220 II. MEDICALLY FRAGILE (Continued)

5-2220

Cystic fibrosis is a hereditary disease of the exocrine glands that usually begins in infancy and primarily affects the digestive and respiratory systems. Respiratory symptoms include coughing, gagging and vomiting, due to the persistence of infection and airway obstruction caused by thick, tenacious mucous. Gastrointestinal disorders include abdominal distentions, vomiting, rapid dehydration, loss of appetite (advanced disease), inability to digest nutrients, weight loss, and failure to grow. Frequent hospitalizations are necessary.

4. Seizure Disorders (Severe in frequency, type or duration)

Young children with seizures must be monitored closely in case they stop breathing. A child may experience a lengthy grand mal seizure or go from one seizure to another as in status epilepticus. Should the seizures fail to stop, emergency treatment by paramedics/emergency room will be necessary.

5. Severe Asthma

Infants receiving drugs such as epinephrine, theophylline, or corticosteroids either orally or using an aerosol machine or intermittent positive pressure breathing machine for severe chronic asthma, may be prone to a sudden and rapid decline in their condition resulting in status asthmaticus, a refractory asthmatic attack that can lead to respiratory failure and requires intensive care with the participation of a pediatrician, anesthesiologist, and bronchopulmonary specialists.

6. Bronchopulmonary Dysplasia

Bronchopulmonary Dysplasia is a chronic lung disorder in infants who have been treated for respiratory distress with intermittent mandatory ventilation. Treatment is often in the form of chronic diuretic therapy provided with orally administered drugs such as chlorothiazide that require the state of hydration and serum electrolytes to be closely monitored. The course of resolution of Bronchopulmonary Dysplasia may be both slow and unpredictable. The infant may need rehospitalization if signs of a respiratory infection develop or there is increased respiratory distress. Some infants may die even after many months of care.

7. Severe Gastroesophageal Reflux

Gastroesophageal Reflux is quite common in infants and results from a relaxed cardiac valve, the sphincter that prevents reflux of gastric contents back into the esophagus. Because gastric contents are highly acidic, reflux can result in injury to the esophageal mucosa, and Gastroesophageal Reflux is generally accompanied by heartburn and forceful vomiting. In severe cases Gastroesophageal Reflux may be accompanied by symptoms of aspiration pneumonia, such as wheezing, choking, cyanosis or apnea. Failure to thrive, and weight loss may also result. If the condition is not diagnosed and treated appropriately, infants may be delayed in growth and development milestones.

5-2220 II. MEDICALLY FRAGILE (Continued)**5-2220**

Although most children will recover spontaneously from symptoms of Gastroesophageal Reflux by 18 months of age, patients may need frequent hospitalization for vomiting, diarrhea, episodes of gagging, failure to thrive, and a lack of interest in food.

Medical management is initiated with thickened formulas, positional therapy, and medications. About 18 percent of infants also undergo surgery for antireflux.

5-2230 III. IN-HOME HEALTH CARE**5-2230**

On the one hand, to qualify as a child with special health care needs, the in-home health care must be of a kind that can be provided by non-medical personnel such as a licensee trained to provide this care. Children requiring in-home health care that a licensee could not be trained to provide, such as children requiring hospital or intensive skilled nursing care, may not be cared for in children's residential facilities under the special health care needs program.

(Welfare and Institutions Code 17710(h) and (i), 17730, 17736(b))

On the other hand, to qualify as a child with special health care needs, a technology-dependent or medically fragile child must be in need of substantial in-home health care as a result of his/her special medical needs. Children not requiring substantial in-home health care may reside in community care facilities under the "incidental medical services" provision of the Community Care Facilities Act (Health and Safety Code, Section 1507) and do not have special health care needs.

Substantial in-home health care consists of those nursing services prescribed for a child which cannot be performed safely and/or effectively without a substantial amount of scientific knowledge or technical skill.

Examples of skilled and non-skilled nursing services include:

1. Skilled Observation and Assessment: Observation and assessment are skilled services when (a) there is a likely possibility for complications or acute episodes or (b) the child's condition requires the identification or evaluation of the child's need for possible modification or treatment or initiation of additional medical procedures.

5-2230 III. IN-HOME HEALTH CARE (Continued)

5-2230

2. Skilled Therapeutic Procedures:
 - a. Intravenous therapy and injections
 - b. Insertion, removal and irrigation of urinary catheters
 - c. Renal dialysis
 - d. Administration of oxygen and mechanical ventilation
 - e. Tracheostomy aspiration and care
 - f. Gastrostomy and Nasogastric tube feeding
3. Nonskilled Nursing Services: The following services are ordinarily nonskilled, but may be considered skilled because of special medical complications.
 - a. Routine administration of medication such as the administration of suppositories, ointments, lotions, pills, enemas or medications given by liquid medication dispenser, puffer, dropper or nebulizer.
 - b. First Aid, CPR.
 - c. Insertion of insulin pump needles, urine glucose testing and blood glucose testing using a monitoring kit approved for home use. [These tests are classified under Federal regulations as “so simple and accurate as to render the likelihood of erroneous results negligible or pose no reasonable risk of harm to the patient if the test is performed incorrectly.” (42 Code of Federal Regulations 493.15(b) and (c).)]
 - d. Apnea monitoring prescribed as a precautionary measure – for example, to a crib death sibling owing to the suspected familial nature of crib death.
 - e. Routine care of a child with an ileal conduit, colostomy or ileostomy.
 - f. Routine care of an indwelling urinary catheter except for irrigation, insertion and removal of the tube.

5-2230 III. IN-HOME HEALTH CARE (Continued) 5-2230

- g. Procedures self-administered by older children free of severe mental or physical disabilities, when performed with the knowledge and guidance of the child's primary care physician and supervised by an adult trained in all aspects of the procedure, including likely complications. Procedures frequently self-administered include: injection of insulin; administration of oxygen or aerosolized agents; and clean intermittent urinary catheterization.

5-2300 FOSTER FAMILY HOMES, SMALL FAMILY HOMES CERTIFIED HOMES 5-2300**5-2310 I. FACILITY IDENTIFICATION 5-2310**

A child may have special health care needs, if the child's medical records indicate that the child has one or more of the following conditions:

1. Conditions requiring dependence on one or more of the following: Gastrostomy feeding tube, central venous catheter, apnea monitor, intravenous therapy, ventilator, oxygen support, urinary catheterization, renal dialysis, tracheostomy, colostomy, ileostomy, ileal conduit, injections, intravenous medications.
2. Acquired Immune Deficiency Syndrome, premature birth, hydrocephalus, sickle cell anemia, cystic fibrosis, severe seizure disorders, severe asthma, bronchopulmonary dysplasia, severe gastroesophageal reflux.

Procedures

- In identifying children with special health care needs do not consider members of the licensee's own family including adopted children, guardianships, or conservatorships.
- Review each child's medical records. For children meeting the above criteria, but not previously identified as having special health care needs, the Licensing Program Analyst shall cite the need for a medical assessment on the LIC 809. The plan of correction shall require the licensee to obtain a written determination of the child's need for skilled in-home nursing services. The determination shall be made by the medical unit or health care professional employed by or on contract with the placing agency to screen children for special health care needs.

(California Code of Regulations 87069(c), 80069(c))

5-2310 I. FACILITY IDENTIFICATION (Continued)**5-2310**

If it is determined that the child is receiving, or will need, skilled in-home nursing services, then the facility shall be evaluated as a specialized foster care home.

- For independent placements with any of the above medical conditions, ensure that the licensee has on file a determination by the child's physician of the need for skilled nursing services.

(California Code of Regulations 87069(c), 80069(c))

If it is determined that skilled nursing services are required, a plan of relocation shall be developed.

(Health and Safety Code 1502(a)(1))

- If it is verified that a child does not need skilled in-home medical services and the reason given is that medical treatment is self-administered by the child, the Licensing Program Analyst shall ensure that the following documents are on file for each self-administered procedure:

1. The name, address and telephone number of the health care professional supervising the child's self-care and a letter from the health care professional, specifying the plan for ongoing supervision and a schedule of follow-up visits.

(California Code of Regulations 87070(b)(8) and (15); 80070(b)(7), 83070(b)(9))

2. A letter from the health care professional who provided the training, specifying that the licensee has successfully completed training on medical procedures(s) self-administered by the child).

(California Code of Regulations 87017(b)(1), 87018(b); 80065(a), 80066(a)(6))

- Any queries should be addressed to the child's social worker or physician, and, if necessary, a state medical consultant.
- The determination as to whether a child with special health care needs can be adequately cared for in a foster family home, small family home, or certified family home is the responsibility of the child's individualized health care plan team. If there are concerns about the appropriateness of a placement, the Licensing Program Analyst should contact the child's physician, caseworker, or State medical consultant.

5-2320 II. FACILITY RECORDS

5-2320

In addition to regular record keeping requirements, the following additional records must be kept on file.

1. California Code of Regulations 87010.2: Prohibition on Certification Pending Licensure and Dual Licensure for Foster Family Homes Caring for Children with Special Health Needs

An applicant/licensee may not be certified pending licensure and may not hold any day care, other residential or health care facility license for the same premises as the foster family home while caring for children with special health care needs.

Procedures:

- Ensure that the home is licensed. Children with special health care needs may not be placed in certified pending foster family homes.
(Welfare and Institutions Code 17710(i))
- If a licensee cares for a child with special health care needs and holds any license as specified above, the licensee shall be cited on the LIC 809 and the Licensing Program Analyst shall ensure that the alternate license is surrendered to the licensing agency.
(California Code and Regulations 87010.2(a))
- If an applicant for a foster family home license plans to care for children with special health care needs, the Licensing Program Analyst should ensure that any alternate license is surrendered to the licensing agency prior to licensure.
(California Code of Regulations 87010.2(b))

2. Fire Clearances

Procedures:

- All existing regulations, policies and procedures for fire clearances and limitations on ambulatory and bedridden status apply to facilities caring for children with special health care needs.
- A child is not necessarily nonambulatory or bedridden because he/she has special health care needs and a facility does not require a fire clearance solely because the home is caring for children with special health care needs.
- In determining whether a child with special health care needs is nonambulatory or bedridden, the Licensing Program Analyst should, in borderline cases, consult with the child's individualized health care plan team.

5-2330 III. CHILDREN'S RECORDS

5-2330

1. Welfare and Institutions Code 17710(a) and (i): Appropriate Placement

Foster Family Homes and Small Family Homes: Each child with special health care needs must have been adjudged a dependent of the court pursuant to Section 300 of the Welfare and Institutions Code; OR if not adjudged a court dependent must either be in the custody of the county welfare department (eg. emergency custody is obtained pending Section 300 adjudication by the juvenile court) or have a developmental disability and be receiving services and case management from a regional center.

Certified Family Homes: Each child with special health care needs must have been adjudged a dependent of the court pursuant to Section 300 of the Welfare and Institutions Code; OR if not adjudged a court dependent must have a developmental disability and be receiving services and case management from a regional center.

Procedures:

- Compliance with this section requires the licensee to have written documentation which identifies the child with special health care needs as a child falling into one of the above categories. Acceptable documents include a county placement agreement or regional center admissions agreement. Improper documentation shall be cited on the LIC 809.

(California Code of Regulations 87070.1(a)(1), 80070(b)(6))

- Licensees caring for independent placements with special health care needs shall be cited on the LIC 809, and a plan of relocation must be developed.

(Foster Family Homes & Small Family Homes: Welfare and Institutions Code 17710(a); Health and Safety Code 1502(a)(1))

(Certified Family Homes: Welfare and Institutions Code 17710(i)(3); Health and Safety Code 1502(a)(1))

- A copy of each child's documentation should be kept in the facility file.

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

2. Welfare and Institutions Code 17731(c), California Code of Regulations 87075.1(a): Medical Assessments

Each child with special health care needs must have an individualized health care plan. The plan is drafted by the individualized health care plan team convened by the child's placement worker. The team drafts the health care plan, monitors the specialized in-home health care (services identified by the child's primary care physician as appropriately administered by a health care professional or properly trained lay provider) and, as explained below, is empowered to make terminations that specified requirements need not be met. The team must include the child's primary care physician or his/her designee, any involved medical team, the placement worker, and the health care professional designated by the team to monitor the child's individualized health care plan.

The plan should include the following information:

1. Name, address and telephone number of the physician or other health care professional responsible for monitoring the child's ongoing health care and the appropriate number of on-site hours and off-site hours of monitoring needed to be provided by the designated monitor. Also, the plan should include the name, address and telephone number of any health care professional who is providing in-home medical services to the child.
(Welfare and Institutions Code 17731(c)(8); California Code of Regulations 8707511(a)(1))
2. Documentation by the child's primary care physician specifying the specialized health care that is to be administered in the home by a health care professional or responsible adults, including the licensee, trained by a health care professional.
(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 87075.1(a)(2), (4))
3. Arrangements for in-home health support services if required. This refers to the delivery of necessary medical equipment and supplies such as special formula, wheelchairs, oxygen and ventilator equipment. Also, it will usually not be possible to train the licensee to provide all the needed medical services. For example, a child receiving mechanical ventilation will usually require the services of a Respiratory Therapist in addition to care provided by the licensee. In these cases, the child's individualized health care plan must identify all available and funded medical services that are to be provided to the child in the home. This includes assistance from Registered Nurses, Licensed Vocational Nurses, Public Health Nurses, Physical Therapists, Respiratory Therapists, and respite care workers.
(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 87075.1(a)(3), (5))

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

Procedures:

- Verify that the licensee has an individualized health care plan on file for each child with special health care needs. The licensee may not accept a child with special health care needs unless the licensee has obtained an individualized health care plan for the child.

(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 87070.1(a)(2), 87075.1(a))

- Verify the plan is current. An individualized health care plan must be updated at least every six months.

(Welfare and Institutions Code 17731(c)(10); California Code of Regulations 87070.1(a)(3))

- Verify that each health care plan has the information listed above. In particular, the plan must clearly state what the licensee or health care professional providing in-home medical services is supposed to do. Missing information shall be cited on the LIC 809 using the section numbers indicated above.

- The individualized health care plan may be included in a child's needs and services plan, or if the child is a regional center placement, the individual program plan. If so, the Licensing Program Analyst should ensure that all the information required by both plans is included. It is also acceptable that the individualized health care plan be the child's hospital discharge plan provided that all relevant information is incorporated.

(Welfare and Institutions Code 17731(c)(1) and (c)(2); California Code of Regulations 87075.1(a))

- Verify that the licensee or health care professional providing in-home medical services is providing those services identified in each child's individualized health care plan.

(Welfare and Institutions Code 17732(c)(1); California Code of Regulations 87078(a))

- Cite improper documentation on the LIC 809.

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

- Restraints and Postural Supports

“Restraining Device”: means any physical or mechanical device, material, or equipment attached or adjacent to a child’s body which the child cannot remove easily and which restricts the child’s freedom of movement. Restraining devices include leg restraints, arm restraints, soft ties or vests, wheelchair safety bars, and full length bedrails.

Pursuant to Sections 80072(8) and 87072(a)(7), a child with special health care needs have the right to be free from any restraining device imposed for purposes of discipline or convenience, and not required to treat the child’s specific medical symptoms.

However, to assure compliance with Section 17736 of the Welfare and Institutions Code, an exception may be granted to Section 80072(a)(8) and 87072(a)(7) under the following circumstances. When restraints are prescribed in a child’s individualized health care plan, restraining devices may be used for the protection of a child with special health care needs during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures.

The restraining device, which shall not have a locking device, must be applied for no longer than the time required to complete the treatment and shall be applied in conformance with the child’s individualized health care plan. The child’s individualized health care plan must include all of the following:

- The specific medical symptoms that require use of the restraining device.
- An evaluation of less restrictive therapeutic interventions and the reasons for ruling out these other practices as ineffective.
- A written order by the child’s physician or other health care professional lawfully authorized to prescribe care. The order must specify the duration and circumstances under which the restraining device is to be used.

(This complies with Federal and Driver’s Health Services standards: 42 CFR 483.33(a); Federal Interpretative Guidelines (Guidance to Surveyors – Long Term Care Facilities: “Interpretative Guidelines: 483.13(a)”; 22 California Code of Regulations 72319(b), (d), (e) and (i)(1))

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

Pending new regulations, postural supports as specified in Sections 80072(a)(8)(A) and 87072(a)(7)(A) (these include bed rails that extend from the head to half the length of the bed when used only for assistance with mobility) and protective devices as specified in Sections 80072(a)(8)(G) and 87072(a)(7)(G), may be used without the approval of the licensing agency if prescribed in the individualized health care plan for a child with special health care needs. The use of a postural support or protective device and the method of application shall be specified in the child's health care plan and approved in writing by the child's physician or other health care professional lawfully authorized to provide care.

(This follows Department of Health Services regulations: 22 California Code of Regulations 72319(k)(1))

3. California Code of Regulations 87068.4: Foster Family Homes Caring for a Child with Special Health Care Needs and a Child without Special Health Care Needs

The licensee of a foster family home caring for one child with and one child without special health care needs must ensure that each child's needs and services plan contains the following information:

Written verification by the child's placement worker that the needs of the child can be met by the facility.

Procedures:

- Verify that the needs and services plans of each foster child contains a determination by his/her placement worker that the needs of the child can be met in the home. Improper documentation shall be cited on the LIC 809.

(California Code of Regulations 87068.4(a), (a)(1) and (a)(2))

- A plan of relocation will be required if the needs of the children cannot be met.

(California Code of Regulations 87068.1(d)(2), 87068.3(b)(1)(B))

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

4. Welfare and Institutions Code 17732(a): Acceptance of a Third Child

Ordinarily, no more than two children may be placed in a foster family home, small family home or certified family home caring for children with special health care needs. Provided the licensed capacity of the home is not exceeded, a third child with or without special health care needs may be accepted only if no other home in the county or regional center catchment area is available to meet the child's needs at the time of placement, Also, the home must be able to meet the needs of every child in placement, and each individualized health care plan team must determine that the two child limit may be exceeded without jeopardizing the health and safety of their child.

Procedures:

- The third child is the child most recently placed. If there is more than one, any one of these children may be designated as the third child by the Licensing Program Analyst.
- The Licensing Program Analyst shall document on the LIC 809 that the requirements listed below have been met. If these requirements have not been met, the Licensing Program Analyst shall issue a citation on the LIC 809 for exceeding the two child limit without obtaining the necessary determinations and/or documents.

(Cite Welfare and Institutions Code 17732(a) and the appropriate sections below.)

- A plan of relocation must be developed whenever the required determinations indicate that the conditions specified below cannot be met.
- No other Placement Available

If a third child with or without special health care needs is in residence, verify that the licensee has on file a written statement from the county social worker or regional center caseworker responsible for the third child, that there are no other foster family homes, small family homes or certified family homes available to meet the needs of the child.

(Welfare and Institutions Code 17732(a)(1))

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

- Needs of all Children in the Home Can be Met

If a third child is placed, verify that the licensee has on file a written statement from each child's placement worker that the home can meet the psycho/social needs of his or her child, regardless of whether the child has special health care needs.

(Welfare and Institutions Code 17732(a)(2))

Each time there is an increase or turnover in children and the two child limit is exceeded, all placement workers must submit new determinations for their placement(s).

Accordingly, the Licensing Program Analyst should ensure that all certifications are current.

(Welfare and Institutions Code 17732(a)(2))

- Each Health Care Team has determined that the Two Child Limit may be exceeded.

If a third placement with or without special health care needs is in residence, verify that the licensee has on file documentation from the individualized health care plan team for each special health care needs child that the two child limit may be exceeded without jeopardizing the child's health and safety.

(Welfare and Institutions Code 17732(a)(3))

Each time there is an increase or turnover in children and the two child limit is exceeded, all teams must submit new documentation for their placement(s) with special health care needs. Accordingly, the Licensing Program Analyst should ensure that all determinations are current.

(Welfare and Institutions Code 17732(a)(3))

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

5. Welfare and Institutions Code 17732(b): Acceptance of a Fourth, Fifth, or Sixth Child into a Small Family Home Caring for Children with Special Health Care Needs

A fourth, fifth, or sixth child with or without special health care needs may be accepted by a small family home caring for children with special health care needs provided that the licensed capacity of the home is not exceeded and only if no other home in the county or regional center catchment area is available to meet the needs of the child at the time of placement. In addition, the home must be able to meet the needs of the child at the time of placement. In addition, the home must be able to meet the needs of every child in placement, the health care plan team for each child with special health care needs must determine that the two child limit can be exceeded without jeopardizing the health and safety of the child, at least one child in the home, with or without special health care needs, is to be a regional center placement, and the home must meet the additional personnel and physical plant requirements described in Sections 5-2340 and 5-2350.

Procedures:

- The ordering of placements corresponds to the order of placement date. Allot sixth, fifth, fourth, and third designations to children by admission date, starting with the most recent. If there is more than one child placed on the same day, the allocation of numbers between these children is arbitrary.
- The Licensing Program Analyst shall document on the LIC 809 that the requirements listed below have been met. If these requirements have not been met, the Licensing Program Analyst shall issue a citation on the LIC 809 for exceeding the two child limit without obtaining the necessary determinations and/or documents.

(Cite Welfare and Institutions Code 17732(b) and the appropriate sections below.)

- A plan of relocation must be developed whenever the required determinations indicate that the conditions specified below cannot be met, and/or the facility has no regional center placements.

5-2330 III. CHILDREN'S RECORDS (Continued)

5-2330

- No other Placement Available

If four or more placements (at least one of which has special health care needs) are in residence, verify that the licensee has on file a written statement completed at the time the child was placed, that no other foster family home, small family home or certified family home was available to meet the needs of the child. Statements should be completed by the placement worker responsible for the fourth, fifth, and sixth child, whichever is applicable, and of the third child.

(Welfare and Institutions Code 17732(a)(1))

Note that this is a one time requirement for each child. If, for example, a home caring for children with special health care needs that is otherwise in compliance accepts a fifth child, no updated determination for the fourth or third placements is necessary.

- Needs of all Children in the Home can be Met

If four or more placements (at least one of which has special health care needs) are in residence, verify for every child in the home that the licensee has on file a written statement from the child's placement worker that the small family home can meet the psychological and social needs of the child.

(Welfare and Institutions Code 17732(a)(2) and (b))

Each time there is an increase or turnover in children and the two child limit is exceeded, all placement workers must submit new determinations for their placement(s). Accordingly, the Licensing Program Analyst should ensure that all certifications are current.

(Welfare and Institutions Code 17732(a)(2) and (b))

- Health Care Plan Teams have Determined that the Two Child Limit may be Exceeded

If four or more placements (at least one of which has special health care needs) are in residence, verify that the licensee has on file documentation by the individualized health care.

(Welfare and Institutions Code 17732(a)(3) and (b))

5-2330 III. CHILDREN'S RECORDS (Continued)**5-2330**

Each time there is an increase or turnover in children and the two child limit is exceeded, all health care plan teams must submit new documentation for their placement(s) with special health care needs. The Licensing Program Analyst should ensure that all determinations are current.

(Welfare and Institutions Code 17732(a)(3) and (b))

- At Least One Child is a Regional Center Placement

Verify that the licensee has on file a regional center placement agreement for at least one child (with or without special health care needs).

(Welfare and Institutions Code 17732(b)(1))

5-2340 IV. PERSONNEL RECORDS**5-2340**

1. Welfare and Institutions Code 17731(c), California Code of Regulations 87065.1(a): Training of the Licensee, Staff and other Adults Caring for Children with Special Health Care Needs

Non-exempt Training

Prior to the placement of a special health care needs child, the licensee must complete training sufficient to meet the specialized medical needs of the child. Other personnel caring for a child with special health care needs must complete training prior to providing medical services for the child.

(Welfare and Institutions Code 17731(c)(3), (4) and (5); California Code of Regulations 87065.1(a))

Should the condition of the child with special health care needs change, the licensee and other personnel caring for the child must also complete any additional training required to meet the child's new needs.

(Welfare and Institutions Code 17731(c)(3), and (c)(5); California Code of Regulations 87065.1(a))

Training must include hands-on instruction. The training must be provided by a physician or other health care professional.

(Welfare and Institutions Code 17731(c)(3), California Code of Regulations 87065.1(a))

5-2340 IV. PERSONNEL RECORDS (Continued)

5-2340

“Health Care Professional” means a physician or an individual who is licensed or certified pursuant to Division 2 of the Business and Professions Code to perform the necessary client care procedures prescribed by a physician. Such health care professionals include the following: Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, Physical Therapist, Occupational Therapist and Respiratory Therapist.

(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 87001(h)(1))

Health care professionals cannot exceed their legal scopes of practice. For example, Licensed Vocational Nurses and Psychiatric Technicians are not independent practitioners. The Licensed Vocational Nurse must function under the direction of a Registered Nurse or licensed physician. The Psychiatric Technician must function under the direction of a physician, Registered Nurse, psychologist, social worker, rehabilitation therapist or other professional. These health licensees may contribute to, but cannot independently develop, an individualized health care plan. While the Licensed Vocational Nurse or Psychiatric Technician may monitor the child’s in-home care services, such health licensee is not authorized to independently initiate changes in treatment. Licensed Vocational Nurses and Psychiatric Technicians can provide training and patient education only in the areas within the health licensee’s scope of practice.

Certified nursing assistants and home health aides are certified under the Health and Safety Code and are not health care professionals.

Exempt Training

The licensee or other adult caring for children with special health care needs who is a licensed health care professional is exempt from the training requirements for a specific child if the responsible individualized health care plan team documents that training for the child is unnecessary on the basis of his/her professional qualifications and expertise.

When the specialized medical needs of a child change, the licensee or other adult caring for a child with special health care needs who is a licensed health care professional is exempt from additional training required to meet the child’s new needs if the responsible individualized health care plan team documents that the specific additional training for the child is unnecessary on the basis of his/her professional qualifications and expertise.

5-2340 IV. PERSONNEL RECORDS (Continued)

5-2340

Procedures:

- General training or prior experience in providing a specific health care service does not fulfill this requirement.
- No training or additional training shall be exempted unless the licensee has on file for each person for whom the exemption is requested:
 1. A valid license or certificate indicating that he/she is a qualified health care professional authorized, within the scope of practice of the profession, to perform the medical procedures required by the child.
 2. Documentation that the responsible individualized health care plan team has determined that the training or additional training for the child is unnecessary on the basis of his/her qualifications.

(Welfare and Institutions Code 17731(c)(6) (initial training)
(Welfare and Institutions Code 17731(c)(7) (additional training))
- Ensure that the licensee has on file for each non-exempted adult (including the licensee) caring for children which special health care needs, a written statement from the health care professional who provided the training that the training or additional training has been successfully completed.
- A copy of the above documentation shall be kept in the facility file for the licensee and staff.
- Licensees with inappropriate documentation shall be cited on the LIC 809.

(California Code of Regulations 87066(a)(6); 80066(a)(6))
- Failure to complete non-exempt training shall be cited on the LIC 809.

(Cite the appropriate Welfare and Institutions Code/California Code of Regulations sections listed above under non-exempt training.)

2. California Code of Regulations 87065.1(b); Additional Requirements for Personnel in a Foster Family Home Caring for Children with Special Health Care Needs

Persons caring for children in a foster family home with special health care needs children must be in good health as verified by a health screening report and a Tuberculosis test performed by or under the supervision of a physician and not over one year prior to or seven days after initial presence in the home.

5-2340 IV. PERSONNEL RECORDS (Continued)

5-2340

The licensee of a facility caring for children with special health care needs must maintain employee records containing the employee's name, driver's license number (if the employee will transport foster children), date of employment, a statement signed by the employee that he/she is at least 18 years of age, home address and telephone number, past related experience, job duties, and, if applicable, termination date.

Procedures:

- For each person caring for children, verify that the licensee has on file a health screening, including a Tuberculosis test, neither of which is over one year prior to the initial presence of that person in the facility.
(California Code of Regulations 87066(a))

Licensees permitting persons in poor health to care for children with special health care needs shall be cited on the LIC 809, accordingly.
(California Code of Regulations 87065.1(b))

- The licensee of a foster family home caring for children with special health care needs must maintain personnel records on any employee hired.

These records must be available for review and kept for at least three years after the termination of employment. Failure to maintain personnel records shall be cited on the LIC 809.
(California Code of Regulations 87066(b), (c) and (d))

3. Welfare and Institutions Code 17732(b)(2): Caregiver Assistance for Small Family Homes Operating as Specialized Foster Care Homes Caring for Four or More Children

The licensee must be assisted by one or more caregivers in administering specialized in-home health care to children and shall not leave the facility without substituting a trained respite caregiver during the licensee's absence, whenever four or more children are physically present at the facility.

1. Exception: Even though four or more children are physically present in the home, the licensee may either dispense with the assistant caregiver or leave the caregiver solely in charge while the licensee is absent from the facility for those hours, including night hours, during which the following applies:

5-2340 IV. PERSONNEL RECORDS (Continued)

5-2340

None of the four or more children present requires the services of a trained health care provider to administer specialized in-home health care as documented in the individualized health care plan for each child with special health care needs.

For example, consider a home caring for five children of which two have special health care needs. Suppose the two children have special health care needs because they require feeding tubes at meal times. If the health care team for one child determines that no assistant caregiver would be required for this child between 9 PM and 6 AM and the team for the other child determines that no assistant caregiver would be required for this other child between 10 PM and 7 AM, assistance would not be needed on site between 10 PM and 6 AM.

Procedures:

- Ensure that there is a list of caregiver assistants, including hours on duty. The list should indicate that an assistant caregiver is physically present in the home as required above.
- For those hours for which the individualized health care plan team for each child with special health care needs has documented that the child will not require assistance, ensure that documentation from each team is on file.

(Welfare and Institutions Code 17732(b)(2))
- Copies of all rosters, schedules and any team waivers for assistant caregivers shall be maintained in the facility file.
- Inappropriate documentation shall be cited on the LIC 809.

(Welfare and Institutions Code 17732(b)(2)(A); 80066(a)(e))
- Licensees without required assistance shall be cited on the LIC 809.

(Welfare and Institutions Code 17732(b)(2))
- If additional caregiver assistance appears warranted, the Licensing Program Analyst shall document the reasons on an LIC 809 and consult with his/her **licensing program manager**.

(Welfare and Institutions Code 17732(b)(2))

5-2340 IV. PERSONNEL RECORDS (Continued)

5-2340

- Except during those hours in which an assistant caregiver is not required, ensure that no on-duty assistant caregiver doubles as a respite caregiver.

(Welfare and Institutions Code 17732(b)(2))

4. Welfare and Institutions Code 17732(b)(3): On-Call Assistance for Small Family Homes Operating as Specialized Foster Care Homes Caring for Four or More Children

On-call assistance must be available at all times to respond in care of emergency and must be in addition to any emergency services used by the home.

Procedures:

- Verify that the licensee has on file a current list of each on-call assistant by name, job title, and hours on duty. The list shall also indicate the following:
 1. On-call assistant coverage at all times four or more children, at least one of which has special health care needs, are present in the home.
 2. Telephone numbers at which each on-call assistant can be reached.
 3. No on-call assistant is used as an assistant caregiver or a respite caregiver.

(Welfare and Institutions Code 17732(b)(3))

- A copy of the list shall be maintained in the facility file.
- Inappropriate documentation shall be cited on the LIC 809.
(California Code of Regulations 80066(a),(e))
- Licensees without required on-call assistance shall be cited on the LIC 809.

(Welfare and Institutions Code 17732(b)(3))

5-2350 V. PHYSICAL PLANT

5-2350

Procedures:

- Verify that bedrooms occupied by children with special health care needs are large enough to allow the storage of each child's personal items and any required assistive devices, including wheelchairs, and any medical equipment, adjacent to the child's bed. The area must also be large enough to allow unobstructed bedside ministrations of medical procedures and medications.
(Welfare and Institutions Code 17732(b)(4))
- Bedrooms for licensees should be located so that alarms on ventilators, apnea monitors and similar medical equipment are audible.
(Welfare and Institutions Code 17732(b)(4))
- Verify that there is sufficient space for the safe operation of all medical equipment in dining and recreation areas.
(Welfare and Institutions Code 17732(b)(4))
- Facilities not meeting the above requirements shall be cited on the LIC 809 and a plan of correction developed.
- Small Family Homes Operating as Specialized Foster Care Homes Caring for Four or More Children

The home must have sufficient space to accommodate the needs of all children in the home. In addition to the above physical plant requirements, this means that the home should have sufficient bedrooms for assistant caregivers and any other staff required to sleep at the facility as well as for their children. Bedrooms for staff should be located so that alarms and ventilators, apnea monitors and similar medical equipment are audible and should not be used as a passageway nor for any other purpose.

(Welfare and Institutions Code 17732(b)(4))
- If a small family home does not meet the space requirement, the licensee shall be cited on the LIC 809 and the plan of correction shall include a plan of relocation.

5-2400 GROUP HOMES**5-2400****5-2410 I. FACILITY IDENTIFICATION****5-2410**

A child may have special health care needs, if the child's medical records indicate that the child has one or more of the following conditions:

1. Conditions requiring dependence on one or more of the following: Gastrostomy feeding tube, central venous catheter, apnea monitor, intravenous therapy, ventilator, oxygen support, urinary catheterization, renal dialysis, tracheostomy, colostomy, ileostomy, ileal conduit, injections, intravenous medications.
2. Acquired Immune Deficiency Syndrome, premature birth, hydrocephalus, sickle cell anemia, cystic fibrosis, severe seizure disorders, severe asthma, bronchopulmonary dysplasia, severe gastroesophageal reflux.

Procedures:

- In identifying children with special health care needs do not consider members of the licensee's own family including adopted children, guardianships, or conservatorships.
- Review each child's medical records. For children meeting the above criteria, but not previously identified as having special health care needs, the Licensing Program Analyst shall cite the need for a medical assessment on the LIC 809. The plan of correction shall require the licensee to obtain a written determination of the child's need for skilled in-home nursing services. The determination shall be made by the medical unit or health care professional employed by or on contract with the placing agency to screen children for special health care needs.

(California Code of Regulations 80069(c))

If it is determined that the child is receiving, or will need, skilled in-home nursing services, then the facility shall be evaluated as a specialized foster care home.

- For independent placements with any of the above medical conditions, ensure that the licensee has on file a determination by the child's physician of the need for skilled nursing services.

(California Code of Regulations 80069(c))

If it is determined that skilled nursing services are required, a plan of relocation shall be developed.

(Health and Safety Code 1502(a)(1))

5-2410 I. FACILITY IDENTIFICATION (Continued)**5-2410**

- If it is verified that a child does not need skilled in-home medical services and the reason given is that medical treatment is self-administered by the child, the Licensing Program Analyst shall ensure that the following documents are on file for each self-administered procedure:
 1. The name, address and telephone number of the health care professional supervising the child's self-care and a letter from the health care professional, specifying the plan for ongoing supervision and a schedule of follow-up visits.

(California Code of Regulations 80070(b)(7) and (9))
 2. A letter from the health care professional who provided the training, specifying that the licensee has successfully completed training on the medical procedure(s) self-administered by the child.

(California Code of Regulations 80065(a), 80066(a)(6))
- Queries should be addressed to the child's social worker or physician, and, if necessary, a State medical consultant.
- The determination as to whether a child with special health care needs can be adequately care for in a group home is the responsibility of the child's individualized health care plan team. If there are concerns about the appropriateness of a placement, the Licensing Program Analyst should contact the child's physician, caseworker, or State medical consultant.

5-2420 II. FACILITY RECORDS**5-2420****Procedures:**

- All existing regulations, policies and procedures for fire clearances and limitations on ambulatory and bedridden status apply to facilities caring for children with special health care needs.
- A child is not necessarily nonambulatory or bedridden because he/she has special health care needs and a facility does not require a fire clearance solely because the home is caring for children with special health care needs.
- In determining whether a child with special health care needs is nonambulatory or bedridden, the Licensing Program Analyst should, in borderline cases, consult with the child's individualized health care plan team.

5-2430 III. CHILDREN'S RECORDS

5-2430

1. Placement Restrictions

While there are no capacity limits on group homes accepting children with special health care needs, the following restrictions apply to the placement of these children in group homes.

a. Welfare and Institutions Code 17710(a): Appropriate Placement

Each child with special health care needs must have been adjudged a dependent of the court pursuant of Section 300 of the Welfare and Institutions Code; OR if not adjudged a court dependent must either be in the custody of the county welfare department (eg. emergency custody is obtained pending section 300 adjudication by the juvenile court) or have a developmental disability and be receiving services and case management from a regional center. Special health care needs children who have not been adjudged dependents of the court and who are not in the custody of the county welfare department and who are not receiving services through a regional center cannot be cared for in a group home.

Procedures:

- Compliance with this section requires the licensee to have written documentation which identifies the child with special health care needs as a child falling into one of the above categories. Acceptable documents include a county placement agreement or regional center admissions agreement. Improper documentation shall be cited on the LIC 809.

(California Code of Regulations 80070(b)(6))

- Licensees caring for independent placements with special health care needs shall be cited on the LIC 809, and a plan of relocation must be developed.

(Welfare and Institutions Code 17710(a); Health and Safety Code 1502(a)(1))

- A copy of each child's documentation should be kept in the facility file.

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

b. Welfare and Institutions Code 17732(d): Length of Stay

Except for special health care needs children placed in group homes before January 1, 1992, no special health care needs child may be placed in a group home or combination of group homes for more than 120 calendar days unless approved by the California Department of Social Services.

The 120 calendar day cap is the total number of days a special health care needs child may spend in group home placement throughout the entire time the child is a special health care needs child. The 120 day period may be spent in a single placement or used cumulatively over several placements in the same group home or different group homes. For example, a child with special health care needs may be initially placed in a group home for 90 days. This means that at a later date the child may again be placed either in the same group home or in another group home, but only for a maximum period of 30 days. A child placed in a group home for 120 days or whose 120 day allotment has been exhausted after multiple group home placements, may only remain in a group home or be placed in another group home with the approval of the Deputy Director of the Children and Family Services Division.

Procedures:

- Ensure that for each child with special health care needs, the child's admissions agreement indicates the number of days the child may remain in the group home without exceeding the 120 day limitation period.
(California Code of Regulations 84068.2(c)(3))
- Otherwise, a copy of the letter from the Deputy Director granting permission to exceed the 120 day limitation must be obtained from the child's placement worker and kept by the licensee as part of the child's records. The number of calendar days the child may remain in the group home pursuant to any extension granted by the Deputy Director must be documented in the child's admission agreement.
(California Code of Regulations 84068.2(c)(3))
- A child with special health care needs placed in a group home before January 1, 1992, may continue to reside in the home indefinitely. However, once the child leaves, any subsequent group home placement is subject to the 120 day ceiling.

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

- Licensees lacking the required documentation for special health care needs children placed after January 1, 1992, shall be cited on the LIC 809.
(California Code of Regulations 84068.2(c)(3))
- A plan of relocation shall be developed for any child with special health care needs whose stay in a group home exceeds the 120 day limitation period or the expiration of the extension period granted by the Deputy Director of Children and Family Services.
(Welfare and Institutions Code 17732(d))

c. Welfare and Institutions Code 17721(d): Purpose of the Placement

Placement of a child with special health care needs in a group home must be on an emergency basis for the purpose of arranging a subsequent placement in a less restrictive setting such as with the child's natural parents or relatives, with a foster parent or with a foster family agency.

Procedures:

- For each special health care needs child, ensure that the child's needs and services plan describes the emergency necessitating group home placement. The plan must also contain a plan of relocation to a less restrictive setting.
(Welfare and Institutions Code 17732(d))
- Licensees without proper documentation are to be cited on the LIC 809.
(California Code of Regulations 84068.2(b)(1)) and (c)(3))
- Licensees accepting children with special health care needs on a nonemergency basis shall be cited on the LIC 809 and a plan of relocation shall be developed.
(Welfare and Institutions Code 17732(d))

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

d. Welfare and Institutions Code 17732(d): Child's Needs

A child with special health care needs is not to be placed in a group home unless the specific needs of the child can be met and there is a commonality of needs with the other children in the facility.

Procedures:

- For each child in the home, ensure that the licensee has on file written verification in the child's needs and services plan that the needs of the child can be met by the facility.
- Failure to keep the required documentation shall be cited on the LIC 809.
(California Code of Regulations 84068.2(c)(2))
- The licensee shall be cited on the LIC 809 and a plan of relocation shall be developed if it is determined that the child's needs cannot be met.
(Welfare and Institutions Code 17732(d); California Code of Regulations 84068.4(c))

2. Welfare and Institutions Code 17731: Medical Assessments

For children with special health care needs placed in the group home as of November 1, 1993, refer to Medical Assessments, Section 5-2330.

Each child with special health care needs placed in a group home after November 1, 1993, must have an individualized health care plan. The plan is drafted by the individualized health care plan team convened by the child's placement worker. The team drafts the health care plan, monitors the specialized in-home health care (services identified by the child's primary care physician as appropriately administered by a health care professional or properly trained lay provider) and, as explained below, is empowered to make determinations that specified requirements need not be met. The team must include the child's primary care physician or his/her designee, any involved medical team, and the placement worker.

The plan should include the following information:

1. Identification of each health care professional or agency that is to provide medical services to the child in the home including assistance from Registered Nurses, home health agencies, Licensed Vocational Nurses, Public Health Nurses, Physical Therapists, Respiratory Therapists and respite care workers.

(Welfare and Institutions Code 17731(c)(8))

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

2. Documentation by the child's primary care physician specifying the specialized health care that is to be administered in the home by a health care professional.
(Welfare and Institutions Code 17731(c)(1))
3. Arrangements for in-home health support services if required. This refers to the delivery of necessary medical equipment and supplies such as special formula, wheelchairs, oxygen and ventilator equipment.
(Welfare and Institutions Code 17731(c)(1))

Procedures:

- Verify that the licensee has an individualized health care plan on file for each child with special health care needs. The licensee may not accept a child with special health care needs unless the licensee has obtained an individualized health care plan for the child.
(Welfare and Institutions Code 17731(c)(1))
- Verify the plan is current. An individualized health care plan must be updated at last every six months.
(Welfare and Institutions Code 17731(c)(10))
- Verify that each health care plan has the information listed above. In particular, the plan must clearly state what the health care professional providing in-home medical services is supposed to do. Missing information shall be cited on the LIC 809 using the section numbers indicated above.
- The individualized health care plan may be included in a child's needs and services plan, or if the child is a regional center placement, the individual program plan. If so, the Licensing Program Analyst should ensure that all the information required by both plans is included. It is also acceptable that the individualized health care plan be the child's hospital discharge plan provided that all relevant information is incorporated.
(Welfare and Institutions Code 17731(c)(1) and (c)(2))
- Verify that the health care professional providing in-home medical services is providing those services identified in each child's individualized health care plan.
(Welfare and Institutions Code 17732(c)(1); California Code of Regulations 87078(a))

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

- Cite improper documentation on the LIC 809.
- Restraints and Postural Supports

“Restraining Device” means any physical or mechanical device, material, or equipment attached or adjacent to a child’s body which that child cannot remove easily and which restricts the child’s freedom of movement. Restraining devices include leg restraints, arm restraints, soft ties or vests, wheelchair safety bars, and full length bed rails.

Pursuant to Section 80072(8), a child with special health care needs has the right to be free from any restraining device imposed for purposes of discipline or convenience, and not required to treat the child’s specific medical symptoms.

However, to ensure compliance with Section 17736 of the Welfare and Institutions Code, an exception may be granted to Section 80072(a)(8) under the following circumstances. When restraints are prescribed in a child’s individualized health care plan, restraining devices may be used for the protection of a child with special health care needs during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. The restraining device, which shall not have a locking device, must be applied for no longer than the time required to complete the treatment and shall be applied in conformance with the child’s individualized health care plan. The child’s individualized health care plan must include all of the following:

- The specific medical symptoms that require use of the restraining device.
- An evaluation of less restrictive therapeutic interventions and the reasons for ruling out these other practices as ineffective.
- A written order by the child’s physician or other health care professional lawfully authorized to prescribe care. The order must specify the duration and circumstances under which the restraining device is to be used.

(This complies with Federal and Department of Health Services standards: 42 CFR 483:33(a); Federal Interpretative Guidelines (Guidance to Surveyors – Long Term Care Facilities: “Interpretative Guidelines: 483.13(a)”); 22 California Code of Regulations 72319(b), (d), (e) and (i)(1)).

5-2430 III. CHILDREN'S RECORDS (Continued)

5-2430

Pending new regulations, postural supports as specified in Section 80072(a)(8)(A) (these include bed rails that extend from the head to half the length of the bed when used only for assistance with mobility) and protective devices as specified in Section 80072(a)(8)(G), may be used without the approval of the licensing agency if prescribed in the individualized health care plan for a child with special health care needs. The use of a postural support or protective device and the method of application shall be specified in the child's health care plan and approved in writing by the child's physician or other health care professional lawfully authorized to provide care.

(This follows Department of Health Services regulations: 22 California Code of Regulations 72319(k)(1))

5-2440 IV. PERSONNEL RECORDS

5-2440

1. Welfare and Institutions Code 17731(c) and 17736(b): Health Care Professionals Caring for Special Health Care Needs Children Placed after November 1, 1993

Special health care needs children placed in a group home after November 1, 1993 must be cared for by a health care professional approved by the child's individualized health care plan team.

Procedures:

- For each child with special health care needs placed after November 1, 1993, verify that the licensee has on file a current list of health care professionals providing in-home medical services to the child by name, job title, hours on duty and a telephone number where the health care professional can be reached in case of emergency. Improper documentation shall be cited on the LIC 809.
(California Code of Regulations 80066(a); 84066(b)(3))
- For each child with special health care needs placed in a group home after November 1, 1993, verify that the responsible individualized health care plan team has determined and documented that each health care professional caring for the child has the necessary qualifications and expertise to meet the child's in-home health care needs. This documentation must be updated by the health care plan team each time the child's special health care needs change. Licensees without appropriate determinations/documentation shall be cited on the LIC 809.
(Welfare and Institutions Code 17731(c)(7))

5-2440 IV. PERSONNEL RECORDS (Continued)

5-2440

- Licensees providing nonprofessional in-home medical services or permitting such services to be administered by health care professionals determined not to be qualified by the child's individualized health care plan team, shall be cited on the LIC 809. The plan of correction shall require the licensee to obtain appropriately qualified health care professionals to treat the child.

(Welfare and Institutions Code 17736(b)(2))

“Health Care Professional” means a physician or an individual who is licensed or certified pursuant to Division 2 of the Business and Professions Code to perform the necessary client care procedures prescribed by a physician. Such health care professionals include the following: Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, Physical Therapist, Occupational Therapist and Respiratory Therapist.

(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 87001(h)(1))

Health care professionals cannot exceed their legal scopes of practice. For example, Licensed Vocational Nurses and Psychiatric Technicians are not independent practitioners. The Licensed Vocational Nurse must function under the direction of a Registered Nurse or licensed physician. The Psychiatric Technician must function under the direction of the physician, Registered Nurse, Psychologist, Social Worker, Rehabilitation Therapist or other professional. These health licensees may contribute to, but cannot independently develop, an individualized health care plan. While the Licensed Vocational Nurse or Psychiatric Technician may monitor the child's in-home care services, such health licensee is not authorized to independently initiate changes in treatment. Licensed Vocational Nurses and Psychiatric Technicians can provide training and patient education only in the areas within the health licensee's scope of practice.

Certified nursing assistants and home health aides are certified under the Health and Safety Code and are not health care professionals.

2. Training of the Licensee, Staff and other Adults Caring for Children with Special Health Care Needs Placed as of November 1, 1993

Special health care needs children placed in a group home as of November 1, 1993, may be cared for by the licensee or staff, if suitably trained. Refer to Training of the Licensee, Staff and other Adults Caring for Children with Special Health Care Needs, Section 5-2340.

5-2450 V. PHYSICAL PLANT**5-2450****Procedures:**

- Verify that bedrooms occupied by children with special health care needs are large enough to allow the storage of each child's personal items and any required assistive devices, including wheelchairs, and any medical equipment, adjacent to the child's bed.

The area must also be large enough to allow unobstructed bedside ministrations of medical procedures and medications.

(Welfare and Institutions Code 17732(b)(4))

- Bedrooms for staff should be located so that alarms on ventilators, apnea monitors and similar medical equipment are audible.
(Welfare and Institutions Code 17732(b)(4))
- Verify that there is sufficient space for the safe operation of all medical equipment in dining and recreation areas.
(Welfare and Institutions Code 17732(b)(4))
- If the facility does not meet the above requirements, the licensee shall be cited on the LIC 809 and a plan of correction developed.

5-2510 I. FACILITY IDENTIFICATION**5-2510**

A child may have special health care needs, if the child's medical records indicate that the child has one or more of the following conditions:

1. Conditions requiring dependence on one or more of the following: Gastrostomy feeding tube, central venous catheter, apnea monitor, intravenous therapy, ventilator, oxygen support, urinary catheterization, renal dialysis, tracheostomy, colostomy, ileostomy, ileal conduit, injections, intravenous medications.
2. Acquired Immune Deficiency Syndrome, premature birth, hydrocephalus, sickle cell anemia, cystic fibrosis, severe seizure disorders, severe asthma, bronchopulmonary dysplasia, severe gastroesophageal reflux.

5-2510 I. FACILITY IDENTIFICATION (Continued)

5-2510

Procedures:

- Review each child's medical records. For children meeting the above criteria, but not previously identified as having special health care needs, the Licensing Program Analyst shall cite the need for a medical assessment on the LIC 809. The plan of correction shall require the foster family agency to obtain a written determination of the child's need for skilled in-home nursing services from the child's physician or, if the child is in county custody or is receiving case management from the regional center, by the medical unit or health care professional employed by or on contract with the placing agency to screen children for special health care needs.
(California Code of Regulations 80069(c))
- The Licensing Program Analyst shall ensure that the foster family agency keeps a copy of the assessment in the child's case record and provides a copy to the certified parent.
(California Code of Regulations 80069(a)(1), 80070(b)(8))
- If it is determined that the child is receiving, or will need, skilled in-home nursing services, then the certified family home in which the child has been placed by the foster family agency must be operated as a specialized foster care home.
- The foster family agency shall not accept for placement a child requiring skilled nursing services who is not in county custody or receiving regional center services and case management.
(Welfare and Institutions Code 17710(i); Health and Safety Code 1502(a)(1))
- If it is verified that the child does not need skilled in-home medical services and the reason is that medical treatment is self-administered by the child, the Licensing Program Analyst shall ensure that the following documents are on file in the child's case record or facility case record, as appropriate, for each self-administered procedure:
 1. The name, address and telephone number of the health care professional supervising the child's self-care and a letter from the health care professional, specifying the plan for ongoing supervision and a schedule of follow-up visits.
(California Code of Regulations 80070(b)(7) and (9))

5-2510 I. FACILITY IDENTIFICATION (Continued)**5-2510**

2. A letter from the health care professional who provided the training, specifying that the certified parent has successfully completed training on the medical procedure(s) self-administered by the child.

(California Code of Regulations 88069.7(b)(6), 80065(a), 80066(a)(6))

- Any queries should be addressed to the child's social worker or physician, and, if necessary, a State medical consultant.
- The determination as to whether a child with special health care needs can be adequately cared for in a certified family home is the responsibility of the child's individualized health care plan team. If there are concerns about the appropriateness of a placement, the Licensing Program Analyst should contact the child's physician, caseworker, or State medical consultant.

5-2520 II. CHILDREN'S RECORDS**5-2520**

1. Welfare and Institutions Code 17710(i): Appropriate Placement

Each child with special health care needs must have been adjudged a dependent of the court pursuant to Section 300 of the Welfare and Institutions Code; OR if not adjudged a court dependent must have a developmental disability and be receiving services and case management from a regional center.

Procedures:

- Compliance with this section requires the foster family agency to have written documentation which identifies the child with special health care needs as a child falling into one of the above categories. Acceptable documents include a county placement agreement or regional center admissions agreement.
- Verify that a copy of at least one of these documents is on file in the child's case records. Improper documentation shall be cited on the LIC 809.

(California Code of Regulations 88070(F) and (N))

- Should a child with special health care needs not fit into any of the categories mentioned, the foster family agency shall be cited on the LIC 809 for accepting a child with special health care needs for placement without the appropriate legal status, and a plan of relocation must be developed.

(Welfare and Institutions Code 17710(i))

5-2520 II. CHILDREN'S RECORDS (Continued)

5-2520

2. Welfare and Institutions Code 17731(c): Medical Assessments

Each child with special health care needs must have an individualized health care plan. The plan is drafted by the individualized health care plan team convened by the child's placement worker. The team drafts the health care plan, monitors the specialized in-home health care (services identified by the child's primary care physician as appropriately administered by a health care professional or properly trained lay provider) and, as explained below, is empowered to make determinations that specified requirements need not be met. The team must include the child's primary care physician or his/her designee, any involved medical team, the placement worker, and the health care professional designated by the team to monitor the child's individualized health care plan.

The plan should include the following information:

1. Name, address and telephone number of the child's physician and the Registered Nurse employed by or on contract with the foster family agency to monitor the child's ongoing health care and appropriate number of on-site hours and off-site hours of monitoring needed to be provided by the nurse. Also, the plan should include the name, address and telephone number of any health care professional who is providing in-home medical services to the child.

(Welfare and Institutions Code 17731(c)(8))

2. Documentation by the child's primary care physician specifying the specialized health care that is to be administered in the home by a health care professional or responsible adults, including the certified foster parent, trained by a health care professional.

(Welfare and Institutions Code 17731(c)(1))

3. Arrangements for in-home health support services if required. This refers to the delivery of necessary medical equipment and supplies such as special formula, wheelchairs, oxygen and ventilator equipment. Also, it will usually not be possible to train the licensee to provide all the needed medical services. For example, a child receiving mechanical ventilation may require the services of a Respiratory Therapist in addition to care provided by the licensee. In these cases, the child's individualized health care plan must identify all available and funded medical services that are to be provided to the child in the home. This includes assistance from Registered Nurses, Licensed Vocational Nurses, Public Health Nurses, Physical Therapists, Respiratory Therapists, and respite care workers.

(Welfare and Institutions Code 17731(c)(1))

5-2520 II. CHILDREN'S RECORDS (Continued)

5-2520

Procedures:

- Verify that the foster family agency has an individualized health care plan in the case records for each child with special health care needs. The foster family agency may not place a child with special health care needs unless the agency has obtained an individualized health care plan for the child and provided a copy to the certified parents.
(Welfare and Institutions Code 17731(c)(1); California Code of Regulations 88069.7(b)(3), 88069(a)(1))
- Verify the plan is current. An individualized health care plan must be updated at least every six months and kept on file in the child's case records. A copy of the update must be given to the certified parents.
(Welfare and Institutions Code 17731(c)(10))
- Verify that each health care plan has the information listed above. In particular, the plan must clearly state what the certified parent or health care professional providing in-home medical services is supposed to do. Missing information shall be cited on the LIC 809 using the section numbers indicated above.
- The individualized health care plan may be included in a child's needs and service's plan, or if the child is a regional center placement, the individual program plan. If so, the Licensing Program Analyst should ensure that all the information required by both plans is included. It is also acceptable that the individualized health care plan be the child's hospital discharge plan provided that all relevant information is incorporated.
(Welfare and Institutions Code 17731(c)(1) and (c)(2))
- Cite improper documentation on the LIC 809.

3. Welfare and Institutions Code 17732(a): Acceptance of a Third Child

Ordinarily, no more than two children may be placed in a certified family home caring for children with special health care needs. Provided the certified capacity of the home is not exceeded, a third child with or without special health care needs may be placed only if no other certified family home, or foster family home/small family home in the county or regional center catchment area is available to meet the needs of the child at the time of placement. Also, the home must be able to meet the needs of every child in placement, and each individualized health care plan team must determine that the third child may be accepted without jeopardizing the health and safety of their child.

5-2520 II. CHILDREN'S RECORDS (Continued)

5-2520

Procedures:

- The third child is designated to be the child with the most recent placement date. If there is more than one, any one of these children may be designated as the third child by the Licensing Program Analyst.
- The Licensing Program Analyst shall document on the LIC 809 that the requirements listed below have been met. If these requirements have not been met, the Licensing Program Analyst shall issue a citation on the LIC 809 for placing a third child without obtaining the necessary determinations and/or documents.

(Cite Welfare and Institutions Code 17732(a) and the appropriate sections below.)

- A plan of relocation must be developed whenever the required determinations indicate that the conditions specified below cannot be met.
- No other Placement Available

If a third child with or without special health care needs is placed by a foster family agency, verify that the agency has placed in the child's case records a written statement from the county social worker or regional center caseworker responsible for the third child, that there are no other foster family homes, small family homes or certified family homes available to meet the needs of the child.

(Welfare and Institutions Code 17732(a)(1))

- Needs of all Children in the Home Can be Met

If a third child with or without special health care needs is placed by a foster family agency, verify that the agency has placed in the case records for each child, a written statement from the child's county social worker or regional center caseworker that the home can meet the psychological and social needs of his or her child, regardless of whether the child has special health care needs.

(Welfare and Institutions Code 17732(a)(2))

Each time there is an increase or turnover in children and the two child limit is exceeded, the agency must obtain for the case records of each child, new determinations from the child's placement worker. Accordingly, the Licensing Program Analyst should ensure that all certifications are current.

(Welfare and Institutions Code 17732(a)(2))

5-2520 II. CHILDREN'S RECORDS (Continued)

5-2520

- Each Health Care Team has Determined that the Two Child Limit may be Exceeded

If a third child with or without special health care needs is placed by a foster family agency, verify that the case records for each child with special health care needs contain documentation from the child's individualized health care plan team that the two child limit may be exceeded without jeopardizing the health and safety of the child.

(Welfare and Institutions Code 17732(a)(3))

Each time there is an increase or turnover in children and the two child limit is exceeded, the foster family agency must obtain for the case records of each child with special health care needs, new documentation from the child's team. Accordingly, the Licensing Program Analyst should ensure that all determinations are current.

(Welfare and Institutions Code 17732(a)(3))

5-2530 III. PERSONNEL RECORDS

5-2530

1. Welfare and Institutions Code 17731(c): Registered Nurse

Prior to the placement of a special health care needs child, the foster family agency must employ or contract with a Registered Nurse to supervise and monitor the child's in-home health care.

The cumulative total of the supervisory hours specified in the individualized health care plan of each child with special health care needs assigned to a Registered Nurse as part of his/her regular caseload must not exceed forty hours per week.

Procedures:

- Verify that the foster family agency has on file for each Registered Nurse a copy of a valid license authorizing the him/her practice as a Registered Nurse. Failure to maintain this documentation shall be cited on the LIC 809.

(California Code of Regulations 80066(a)(6))

- Compute using the individualized health care plan for each child with special health care needs the cumulative total hours of monitoring for each Registered Nurse. Ensure that no nurse has a caseload exceeding 40 hours per week.

5-2530 III. PERSONNEL RECORDS (Continued)**5-2530**

- Foster family agencies failing to monitor a child's in-home medical services as specified in the child's individualized health care plan, and foster family agencies using unqualified or "over-worked" monitors, shall be cited on the LIC 809.
(Welfare and Institutions Code 17731(c)(8) and (9); California Code of Regulations 80065(a))
- If the foster family agency is in compliance, the Licensing Program Analyst shall document on the LIC 809 that the above personnel requirements have been met.

2. Training Requirements**Procedures**

- The Licensing Program Analyst shall cite on the LIC 809, failure by the foster family agency to maintain documentation of the completion of training or, if training is exempted, documentation of professional qualifications and team waivers, in the specialized foster care home case record.
(California Code of Regulations 80069.7(b)(6))
- Failure by the foster family agency to ensure that all non-exempt training and additional training is completed by the certified foster parent and other persons caring for a child with special care needs shall be cited on the LIC 809.
(California Code of Regulations 88065(a)(5))

5-2600 REFERENCE MATERIAL**5-2600****5-2610** I. GLOSSARY OF MEDICAL TERMS**5-2610**

Acquired Immune Deficiency Syndrome – Acquired Immune Deficiency Syndrome. A secondary immunodeficiency syndrome resulting from Human Immunodeficiency Virus infection and characterized by opportunistic infections, malignancies, neurologic dysfunction, and a variety of other syndromes.

Aerosol Therapy – The function of aerosol therapy is the inhalation of a solution of liquid medication suspended in droplet form in the air (aerosol) for direct deposition in the tracheobronchial tree. Aerosols are generated by nebulizers powered by heat, hand, compressed gas, ultrasound, or intermittent positive breathing machine. Administration is achieved with the encouragement of deep breathing. Nebulization through a tracheostomy tube requires the use of a special adapter. **Complications:** nebulizers and connections can be a source of infection; improper use of the nebulizer can diminish the effect of treatment.

Alkalosis – A condition in which the alkalinity of the body tends to increase beyond normal due to excesses of alkalites or withdrawal of acid or chlorides from the blood.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Anoxia – Oxygen deficiency.

Apnea – Cessation of breathing, usually of a temporary nature. It is characterized by a gradual increase in the rate of breathing until it ends in a gasp followed by the gradual decrease until the respiration ceases, then breathing begins again. Another form is sometimes noticed when the respiration gradually increases in force and frequency and then suddenly ceases. The child may require stimulation such as rubbing the child's back or turning the child over. In an acute episode, CPR may be required.

Apnea Monitor – A device which uses a mattress, chest belt or electrodes, designed to sound an alarm when the infant ceases to breathe.

Asphyxia – A decrease in the amount of oxygen and an increased amount of carbon dioxide in the body as a result of some interference with respiration.

Ataxia – Muscular incoordination, especially manifested when voluntary movements are attempted.

Atelectasis – A collapsed or airless condition of the lung.

Aspiration – To draw in or out by suction. Foreign bodies may be sucked into the nose, throat, or lungs on inspiration.

Asthma – A generally chronic disorder characterized by wheezing, coughing, difficulty in breathing, and a suffocating feeling, usually caused by an allergy to ingested substances. Status asthmaticus is a more or less continuous asthmatic state which may last for hours or days, and is resistant to treatment.

Atomizer (Nebulizer) – Apparatus for changing jet of liquid into a spray.

Bronchopulmonary Dysplasia – A chronic lung disorder in infants who have been treated for respiratory distress with intermittent mandatory ventilation. At 28 days of age they will have respiratory distress, characteristic x-ray changes, and an ongoing need for oxygen.

Candidiasis – Yeast infection.

Cardiac Sphincter – Plain muscle about the esophagus at the cardiac opening (upper orifice of stomach connecting with the esophagus).

Catheter – A flexible tube for evacuating or injecting fluids. The tube may be made of elastic, elastic web, rubber, glass, or metal.

Chlorothiazide – Drug used as a diuretic and antihypertensive.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Colostomy – Incision of the colon (large intestine) for purpose of making a more or less permanent fistula (tube like passage) between the bowel and abdominal wall for the discharge of fecal matter.

Congenital Defects – Structural defects present at birth.

Corticosteroids – Any of a number of steroid substances obtained from the cortex of the adrenal gland.

Cystic Fibrosis – A congenital disease, usually in children, characterized by fibrosis (an excessive growth of fibrous connective tissue in an organ, part, or tissue), malfunctioning of the pancreas, and by frequent respiratory infections.

Debilitating Diseases – Diseases which cause weakness or feebleness of the body.

Diabetes – A disorder of carbohydrate metabolism, characterized by hyperglycemia and glycosuria and resulting in inadequate production or utilization of insulin.

Dialysis – A process in which a liquid to be purified is enclosed in a thin, membranous sack and exposed to water or any other solvent which continually circulates or changes outside the sack.

Used for children with acute or chronic renal failure. In-home dialysis techniques include, automatic peritoneal dialysis, home hemodialysis, and continuous ambulatory peritoneal dialysis.

In automatic peritoneal dialysis, dialysate is pumped in and out of the peritoneal cavity by a machine called a cycler. The inflow, dwell and outflow of 2 liters of dialysate takes about one hour and the procedure is usually performed nightly for about eight hours. Continuous ambulatory peritoneal dialysis is employed continuously, 24 hours a day, seven days a week, and dwell times are generally four to eight hours. Complications: bleeding, inflammation of the peritoneum (peritonitis), and entrance of air into the peritoneum causing pain and poor fluid drainage. Other complications include perforations of internal organs, collapsed lung (atelectasis), protein loss, excess sodium in the blood (hypernatremia) and low blood pressure (hypotension).

A home hemodialysis system has three essential components: a tubing system for conducting blood from the patient to the membrane unit; a membrane unit where blood and dialysate come into contact with opposite surfaces of the cellophane membrane and dialysis takes place; and a dialysate supply system. Most children receiving chronic maintenance hemodialysis require four to eight hour treatments three times a week. **Technical complications:** low blood pressure (hypotension), hemorrhage due to systemic heparinization (inhibition of coagulation of blood with heparin) or accidental blood line separation, depletion of blood potassium (hypokalemia), obstruction of blood vessels by air (air embolism), pyrogenic reactions (fever induced within the first few minutes of intravenous infusion of a pyrogen), destruction of red blood cells (hemolysis) due to improper dialysate preparation, and seizures.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Digitalis – Foxglove. Drug used to increase the force of muscular contraction of the heart.

Digoxin – A heart stimulant administered orally or by injection.

Drug exposed infants – Infants born to mothers who took drugs during pregnancy.

Enteral – Within the intestine. An enteral feeding tube is used to directly install a nutrient mixture into or just proximal to the upper end of the small bowel.

Epilepsy – Recurrent transient attacks of disturbed brain function. Characterized by various combinations of the following: motor, sensory, or psychic malfunction; with or without convulsions; altered or complete loss of consciousness. Status epilepticus is a rapid succession of epileptic attacks without regaining consciousness during the intervals.

Epinephrine – Adrenaline.

Exocrine Gland – Gland that secretes externally either directly or through a duct.

Failure to Thrive Syndrome – Failure of a child to develop mentally and physically as he/she should.

Fetal Alcohol Syndrome – A group of characteristics, including severe mental and growth retardation, peculiar to infants born to chronic alcoholics who drank heavily throughout pregnancy.

Fibrin – A whitish, filamentous protein deposited as fine interlacing filaments which are entangled red and white blood cells and platelets, the whole forming a clot.

Foley Catheter – A catheter which is left inside the bladder by means of an inflated balloon filled with sterile water.

Fundoplication – Nissen fundoplication consists of attaching a small portion of the stomach to the esophagus to increase the closing pressure of the cardiac sphincter. The procedure is used in gastrostomy patients to prevent reflux of gastric acid back into the esophagus. The ability to belch or vomit is lost after fundoplication and may not be regained for many months following repair.

Gastroesophageal Reflux – Backward flow of stomach contents into the esophagus generally accompanied by heartburn and forceful vomiting.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Gastrointestinal Disorders – Disorders pertaining to the stomach and intestine.

Gastrostomy – Surgical creation of an artificial opening into the stomach.

Gastrostomy Button – A small flexible silicon device inserted into the gastrostomy site. This is often used on children in preference to having the gastrostomy tube permanently in place. A tube is inserted through the button opening when feeding.

Gastrostomy Tube – The flexible tube which is inserted through the stomach onto the abdominal wall. Another method of inserting the tube is from the abdominal wall into the stomach.

Gastrostomy Tube Feeding – The passing of food through the gastrostomy tube when the medical condition results in the patient being unable to swallow. Typically, the feeding catheter is attached to a syringe or feeding bag and the lower end of the catheter is clamped off. The syringe/feeding bag and catheter are filled with formula (filling the catheter prevents large amounts of air from entering the stomach and causing abdominal distension). The feeding catheter is attached to the gastrostomy tube/button/PEG and the syringe/feeding bag is elevated above the stomach level. The feeding flows by gravity over 15 to 30 minutes. Flow rate is controlled by altering the height and a pump may be used for the child on continuous infusion or feedings that are done for several hours. The syringe is refilled before it empties to prevent air from entering the stomach. After feeding, the g-tube is flushed with water to rinse the feeding tube of food particles. The syringe is then lowered below the stomach level to facilitate burping, and the feeding catheter is removed. **Complications**: leakage of stomach contents; feeding catheter becomes dislodged during feeding; misplaced or broken equipment; redness and irritation around the stoma; plugging of the g-tube; dislodgment of the g-tube; vomiting and/or diarrhea; bleeding around the g-tube; tissue build up at the g-tube site; fever; and g-tube site infection.

Glycosuria – The presence of sugar in the urine.

Hemolysis – Destruction of red blood cells. May be caused by bacterial toxins, snake venoms, and immune bodies.

Heparin – Drug used to inhibit coagulation of the blood.

Heparin Lock – A small tube (catheter) called a heparin lock is inserted in the child for the administration of intravenous drugs. The inside of the catheter must be rinsed with a heparin solution to prevent any blood clots from forming, which can clog the tube.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

A syringe is used to introduce the heparin into the lock and the tube must be flushed at least daily and after any drug or fluid is given through the tube. Complications: a health care professional must be notified if any of the following signs are observed around the lock: redness, swelling/puffiness; leaking/drainage; red streak along the skin near the heparin lock; or pain around the entry spot.

Hepatosplenomegaly – Enlargement of the liver and spleen.

Human Immunodeficiency Virus - Infection caused by one of several related retroviruses that become incorporated into host cell DNA and result in a wide range of clinical presentations varying from asymptomatic carrier states to severely debilitating and fatal disorders.

Hydrocephalus – An abnormal condition caused by an increase in the volume of cerebrospinal fluid within the skull.

Hyperbilirubinemia – Excessive amount of bilirubin (the orange colored or yellowish pigment in the liver secretion, bile) in the blood causing jaundice.

Hyper/Hypo-glycemia – Excess/deficiency of sugar in the blood.

Hypernatremia – Excess of sodium in the blood.

Hyperplasia – Excessive proliferation of normal cells in the normal tissue arrangement of an organ.

Hyper/Hypo-tension – High/low blood pressure.

Hypokalemia – Depletion of blood potassium levels. Commonly manifested by episodes of muscular weakness or paralysis.

Hypothermia – Having a body temperature below normal.

Ileal Conduit – A section of the ileum (lower portion of the small intestine) is resected and attached to the ureters. One end of this ileal segment is sutured closed and the other is brought to the skin as an ileostomy to drain the urine. This technique is widely used to divert urine after, for example, a cystectomy (removal of the bladder) or if the child has a spastic bladder.

Ileostomy – The surgical creation of an opening through the abdominal wall into the ileum (lower portion of the small intestine) often for the discharge of fecal matter. Performed for birth defects, trauma (eg. burns) and other malfunctions.

Intensive Oral Medication Regimen – Any regimen of medication as prescribed by a physician which could involve the observation of symptoms; counting and recording the pulse and respirations; taking and counting the temperature, testing body fluids and changing medications doses in accordance with the physician's orders; and the following of medication effects and side effects.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Intradermal – Within the substance of the skin.

Intravenous Therapy – The administration of drugs into the vein.

Jejunostomy – Surgical creation of a permanent opening into the second portion of the small intestine extending from the duodenum (first portion of the small intestine which receives the food mass from the stomach) to the ileum.

Jejunostomy Tube – The flexible tube which is inserted into the jejunum.

Jejunostomy Feeding – The passage of food through the jejunostomy tube when the medical condition results in the patient being unable to swallow.

Meningitis – Inflammation of the membranes of the spinal cord or brain caused by bacteria and viruses.

Nasogastric Tube – A thin tube passed through the nose or mouth to the stomach for feeding.

Nasogastric Tube Feeding – In nasogastric tube feeding, the tube is inserted through one nostril and guided toward the back of the throat. If the child is able to help, the child is asked to swallow the tube to help it pass and is quickly inserted. A syringe is connected to the tube and used to inject air into the stomach and a stethoscope is used to listen for gurgling sounds in the stomach. When the plunger on the syringe is pulled back, the appearance of stomach contents indicates the tube is in the correct place. The syringe is filled with the right amount of food. The bottom of the syringe is held about 6 inches from the level of the stomach and food is allowed to flow by gravity. The tube is tightly clamped to prevent leakage of food into the lungs and pulled out quickly. Complications: vomiting; and violent coughing with flow of air through the tube during respiration indicates that the tube is in the lungs.

Neurological Disorders – Disorders of the nervous system such as amnesia, impaired consciousness, vertigo, insomnia, or chronic pain.

Ostomy Care – Routine care of a child with an ileal conduit, colostomy, or ileostomy requires meticulous skin care. Inspection of the stoma and surrounding areas for redness, bleeding and skin growth, cleaning/replacing the pouch and adhesive, and monitoring the stools.

Ostomy Pouch – The bag used to collect the discharge from the body after, for example, a colostomy or ileostomy. The bag is attached to the surface of the body by adhesive.

Otitis – Inflammation of ear. The condition is differentiated as externa, media, and interna, depending upon the portion of the ear which infected.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Oxygen Administration – Oxygen therapy aims to ensure the continuous flow of adequate oxygen to vital organs. Oxygen delivery is usually affected using a nasal catheter, nasal cannula, mask or tracheostomy, and utilizes equipment including gas cylinders, liquid oxygen systems, and oxygen concentrators (an oxygen concentrator provides oxygen from the air and operates on household power). **Complications**: fluid in the lung (pulmonary congestion, pulmonary edema), intra-alveolar hemorrhages, fibrin deposition, hyperplasia of the alveolar cells, cessation of breathing (apnea) and death.

Paraparesis – Partial paralysis affecting the lower limbs.

Parenteral – Situated or occurring outside the intestines. Injections, for example, are parenteral, and may be intravenous (into the vein), intramuscular (into the muscle), or subcutaneous (into the skin).

Parenteral Feeding (Hyperalimentation) – Providing the total caloric needs by intravenous route for a patient who is unable to take food orally. Although this is extremely difficult, patients have been maintained in a healthy state for prolonged periods by placing a catheter through the subclavian vein in the superior vena cava (a major blood vessel near the heart).

Parotitis – Mumps.

Percutaneous Endoscopic Gastrostomy – The stomach is punctured and a silicone feeding tube is inserted into the stomach using an insertion wire and fed through the abdomen wall. The catheter is held in place by an internal crosshead dome that seats snugly against the stomach lining and an external bolster that fits snugly against the skin. Unlike gastrostomy tubes, which are surgically inserted while a patient is under general anesthesia, percutaneous endoscopic gastrostomy insertion does not have to be performed under general anesthesia and does not require operating room facilities (if necessary, percutaneous endoscopic gastrostomys can be inserted at the bedside).

Peritoneal Cavity – Region containing all the abdominal organs except the kidney.

Peritonitis – Inflammation of the peritoneum (membrane lining the abdominal cavity). Symptomized by chills, fever, rapid pulse rate, intense abdominal pain, persistent vomiting, and constipation.

Pneumonitis – Pneumonia.

Premature Infants – Live-born infants delivered before 37 weeks from the day of the last menstrual period.

Pulmonary Congestion – The presence of an excessive amount of blood or tissue fluid in the lung.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Pulmonary Edema – A condition in which the lung tissues contain an excessive amount of tissue fluid.

Pyrogen – Any substance that produces fever.

Reflux – Return flow. Usually refers to the constant regurgitation of gastric juices or food often found in drug exposed infants.

Respiratory Distress Syndrome – A disorder, primarily of prematurity, manifested by dyspnea (insufficient oxygenation of the blood), rapid breathing, reflexive grunting on expiration, cyanosis (bluish or grayish discoloration of the skin due to a deficiency of oxygen in the blood), limpness, cardiac failure or arrest, and respiratory disease.

Resuscitation – Act of bringing a person back to full consciousness.

Retrolental Fibroplasia – Condition in which an opaque fibrous membrane develops on the posterior surface of the lens. Occurs chiefly in premature infants weighing less than 2000 gm., especially those subjected to high oxygen concentrations while in the incubator for a considerable period of time.

Sepsis – Pathological state usually febrile (feverish), resulting from the presence of microorganisms or their poisonous products in the blood stream.

Seizure – A convulsion. Often present in an epileptic attack.

Sickle Cell Anemia – A chronic blood disorder in which the red blood cells assume a crescent shape.

Spina Bifida – Congenital defect in the walls of the spinal canal caused by a lack of union between the laminae of the vertebrae. As a result of this deficiency the membranes of the cord are pushed through the opening forming a tumor known as spina bifida.

Subcutaneous – Beneath the skin.

Theophylline – A white crystalline powder with action resembling caffeine.

Tracheostomy – Operation of cutting into the trachea (cartilaginous tube from the larynx to the bronchial tubes) usually for insertion of a tube to overcome tracheal obstruction.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)

5-2610

Tracheostomy Aspiration - Periodic suctioning through the tracheostomy tube is done when the child wakes up, before sleep, and as needed. Suctioning is imperative because the child is unable to produce an effective cough and because of the increased amount of secretions. Asepsis necessitates hand scrubbing, wearing sterile gloves, and the use of sterilized equipment. Suctioning is controlled by opening and closing the side vent of the catheter. The catheter is inserted to a distance a ¼ inch longer than the tracheostomy tube. Suction is turned on and the catheter is slowly and evenly withdrawn, using a rotating motion. Suction is applied only when the catheter is being withdrawn and never exceeds 3 to 4 seconds. **Complications:** oxygen deficiency (anoxia); bronchial spasms; lowered venous return to the heart and coronary circulation (due to increased positive pressure in the chest caused by forced expiration from a cough against the catheter); cardiac arrhythmias and arrest; inadequate aspiration; vomiting and aspiration of vomited material; infection of the area suctioned; torn muscles and other musculoskeletal problems from vigorous coughing; and trauma to the trachea and bronchi from too much negative pressure or over vigorous movement of the catheter.

Tracheal Stenosis – Construction or narrowing of the trachea.

Universal Precautions – Precautions used to avoid infection from blood and other body fluids. Includes: using gloves and possibly masks, face shields and gowns when handling blood and body-fluids; washing hands immediately after gloves are removed; and careful handling of needles and other sharp instruments during and after procedures.

Urinary Catheterization – Introduction of a catheter (tube for evacuating or injecting fluids) through the urethra into the bladder for withdrawal of urine. Catheterization may be intermittent (inserted and removed several times a day) or indwelling (a Foley catheter is inserted into the bladder on a monthly basis and urine is drained to a bag strapped to the child's leg). Catheterization may be indwelling or intermittent. Clean intermittent catheterization is often prescribed for children with spina bifida or paraplegia whose bladder, sphincter muscle, and/or message to and from the brain does not work correctly. Intermittent catheterization must be performed every three to four hours while the child is awake. **Complications:** precipitation of infection and hemorrhaging.

Ventilator – Mechanical ventilation is used to mechanically control or assist patient breathing – for example, to aid premature infants with neuromuscular disorders (eg. polio) or chronic respiratory failure. One type of ventilator is the intermittent positive pressure breathing machine which delivers a volume of air or an oxygen-air mixture under increased pressure to the airway at a set rate. In controlled ventilation, the child breathes with the machine, having no spontaneous respirations as in respiratory paralysis. When set for assisted ventilation, the cycled positive pressure is released from the machine when it is triggered by the least inspiration from the child. Flow ceases when the pressure in the mouth or intratracheal tube reaches a positive pressure preset by the pressure control on the apparatus. When the inspiratory flow ceases, expiration occurs passively through an expiratory valve.

5-2610 I. GLOSSARY OF MEDICAL TERMS (Continued)**5-2610**

Complications: mechanical failure; low blood pressure (hypotension); respiratory alkalosis (decreased levels of carbonic acid in the bloodstream and other body fluids caused by hyperventilation); gastric dilation from swallowed air; aspiration of vomited material (requires immediate removal of the respirator and suctioning); and improper settings in the machine or accidental resettings.

Two other types of ventilator are volume controlled ventilators and body-tank-type. The former apparatus delivers a preset volume to the child regardless of the pressure to deliver the inspiratory volume. Expiration is passive. The latter device alternately creates and releases a vacuum inside a chest shell (cuirass) worn by the child over the diaphragm and upper trunk. Such ventilators were commonly used prior to the availability of the intermittent positive pressure breathing machines and volume controlled devices.

5-2620 II. ASSEMBLY BILL 636**5-2620**

SEC. 1. Section 17710 of the Welfare and Institutions Code is amended to read:

17710. Unless otherwise specified in this part:

(a) "Child with special health care needs" means a child who has a condition that can rapidly deteriorate resulting in permanent injury or death or who has a medical condition which requires specialized in-home health care, and who either has been adjudged a dependent of the court pursuant to Section 300, has not been adjudged a dependent of the court pursuant to Section 300 but is in the custody of the county welfare department, or has a developmental disability and is receiving services and case management from a regional center.

(b) "County" means the county welfare department.

(c) "Department" means the State Department of Social Services.

(d) "Individualized health care plan team" means those individuals who develop a health care plan for a child with special health care needs in a specialized foster care home, as defined in subdivision (i) or group home, which shall include the child's primary care physician or other health care professional designated by the physician, any involved medical team, and the county social worker or regional center worker, and any health care professional designated to monitor the child's individualized health care plan pursuant to paragraph (8) of subdivision (c) of Section 17731 including, if the child is in a certified home, the Registered Nurse employed by or under contract with the certifying agency to supervise and monitor the child. The child's individualized health care plan team may also include, but shall not be limited to, a Public Health Nurse, representatives from the California Children's Services Program or the Child Health and Disability Prevention Program, regional centers, the county mental health department and where reunification is the goal, the parent or parents, if available.

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In addition, where the child is in a specialized foster care home, the individualized health care plan team may include the prospective specialized foster parents, who shall not participate in any team decision pursuant to paragraph (6) of subdivision (c) of Section 17731 or pursuant to paragraph (3) of subdivision (a), or subparagraph (A) of paragraph (2) of subdivision (b), of Section 17732.

(e) “Director” means the Director of Social Services.

(f) “Level of Care” means a description of the specialized in-home health care to be provided to a child with special health care needs by the foster family.

(g) Medical conditions requiring special in-home health care require dependency upon one or more of the following: enteral feeding tube, total parenteral feeding, a cardiorespiratory monitor, intravenous therapy, a ventilator, oxygen support, urinary catheterization, renal dialysis, ministrations imposed by tracheostomy, colostomy, ileostomy, or other medical surgical procedures or special medication regimens, including injection, and intravenous medication.

(h) “Specialized in-home health care” includes, but is not limited to, those services identified by the child’s primary care physician as appropriately administered in the home by any of the following:

(1) A parent trained by health care professionals where the child is being placed in, or is currently in, a specialized foster care home.

(2) Group home staff trained by health care professionals pursuant to the discharge plan of the facility releasing the child where the child was placed in the home as of November 1, 1993, and is currently in the home.

(3) A health care professional, where the child is placed in a group home after November 1, 1993. The health care services provided pursuant to this paragraph shall not be reimbursable costs for the purpose of determining the group home rate under Section 11462.

(i) “Specialized foster care home” means any of the following foster homes where the foster parents reside in the home and have been trained to provide specialized in-home health care to foster children:

(1) Licensed foster family homes, as defined in paragraph (5) of subdivision (a) of Section 1502 of the Health and Safety Code.

(2) Licensed small family homes, as defined in paragraph (6) of subdivision (a) of Section 1502 of the Health and Safety Code.

(3) Certified family homes, as defined in subdivision (d) of Section 1506 of the Health and Safety Code, that have accepted placement of a child with special health care needs who is under the supervision and monitoring of a Registered Nurse employed by, or on contract with, the certifying agency, and who is either of the following:

(A) A dependent of the court under Section 300.

(B) Developmentally disabled and receiving services and case management from a regional center.

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SEC. 2. Section 17730 of the Welfare and Institutions Code is amended to read:

17730. The department shall develop a program to establish specialized foster care homes for children with special health care needs with persons specified in subdivision (h) of Section 17710. The department shall limit the use of group homes for children with special health care needs pursuant to subdivisions (d) and (e) of Section 17732. The program shall conform to the requirements set forth in this chapter, and shall be integrated with the foster care and child welfare services programs authorized by Article 5 (commencing with Section 11400) of Chapter 2 of Part 3 and Chapter 5 (commencing with Section 16500) of Part 4.

The department, in administering the licensing program, shall not evaluate or have any responsibility for the evaluation of the in-home health care provided in specialized foster care homes or group homes.

This program shall be conducted by county welfare departments in conformance with procedures established by the department in accordance with this chapter.

SEC 3. Section 17731 of the Welfare and Institutions Code is amended to read:

17731. (a) The county shall develop a plan to place children with special health care needs in foster care. This plan shall be submitted to the State Department of Social Services and the State Department of Health Services, not later than April 1, 1990, before the beginning placement of children with special health care needs in specialized foster care homes. This subdivision shall invalidate any placement made before April 1, 1990. A county that has not submitted a plan by April 1, 1990, shall not continue to make placements of children with special health care needs until the plan has been submitted.

(b) Unless a local lead agency has been designated within the county, as described in Item 4260-113-890 of the Budget Act of 1989, the county department of social services shall be the lead agency with the responsibility of developing the plan to be submitted pursuant to subdivision (a). The county plan shall be formalized in an interagency agreement between the county department of social services and the other county and private agencies that are the involved parties.

(c) The county plan shall meet all the requirements specified in this subdivision. The regional center shall not be required to submit a plan. However, all requirements specified in this subdivision shall be met prior to a regional center placement of a child who is not a court dependent and who has special health care needs.

(1) Prior to the placement of a child with special health care needs, an individualized health care plan, which may be the hospital discharge plan, shall be prepared for the child and, if necessary, in-home health support services shall be arranged. The individualized health care plan team shall be convened by the county department of social services case worker or the regional center caseworker, to discuss the specific responsibilities of the person or persons specified in subdivision (h) of Section 17710 for provision of in-home health care in accordance with the individualized health care plan developed by the child's physician or his or her designee. The plan may also include the identification of any available and funded medical services that are to be provided to the child in the home, including, but not limited to, assistance from Registered Nurses, Licensed Vocational Nurses, Public Health Nurses, Physical Therapists, and respite care workers.

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The individualized health care plan team shall delineate in the individualized health care plan the coordination of health and related services for the child and the appropriate number of hours needed to be provided by any health care professional designated to monitor the child's individualized health care plan pursuant to paragraph (8), including, if the child is in a certified home, the Registered Nurse employed by or on contract with the certifying agency to supervise and monitor the child.

(2) A child welfare services case plan or regional center individual program plan shall be developed in accordance with applicable regulations, and arrangements made for nonmedical support services.

(3) Foster parents shall be trained by health care professionals pursuant to the discharge plan of the facility releasing the child being placed in, or currently in, foster care. Additional training shall be provided as needed during the placement of the child and to the child's biological parent or parents when the child is being reunified with his or her family.

(4) Children with special health care needs shall be placed in the home of the prospective foster parent subsequent to training by a health care professional pursuant to the discharge plan of the facility releasing the child being placed in foster care.

(5) Assistant caregivers, on-call assistants, respite care workers, and other personnel caring for children with special health care needs shall complete training or additional training by a health care professional in accordance with paragraph (3).

(6) No foster parent who is a health care professional shall be required to complete any training or additional training determined by the responsible individualized health care plan team to be unnecessary on the basis of his or her professional qualifications and expertise.

(7) No health care professional shall provide in-home health care to any child with special health care needs placed in a group home after November 1, 1993, unless the individual health care plan team for the child:

(A) Documents that the health care professional has the necessary qualifications and expertise to meet the child's in-home health care needs.

(B) Updates the documentation provided pursuant to subparagraph (A) each time the child's special health care needs change.

(8) Specialized foster care homes and group homes caring for children with special health care needs shall be monitored by the county or regional center according to applicable regulations. The health care plan for each child with special health care needs shall designate which health care professional shall monitor the child's ongoing health care, including in-home health care provided by persons specified in subdivision (h) of Section 17710. Where the child is placed in a certified home, the designated health care professional shall be the Registered Nurse employed by or on contract with the foster family agency to supervise and monitor the child.

(9) The workload of the health care professional supervising or monitoring a child's ongoing health care in a certified home shall be based on the cumulative total hours specified in the individualized health care plans for children assigned to the health care professional. In no case shall the health care professional's regular workload based on the cumulative total hours specified in the individualized health care plans for children assigned to the health care professional be more than 40 hours per week.

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(10) The child's individualized health care plan shall be reassessed at least every six months during the time the child is placed in the specialized foster care home, to ensure that specialized care payments are appropriate to meet the child's health care needs.

(11) The placement agencies shall coordinate the sources of funding and services available to children with special health care needs in order to maximize the social services provided to these children and to avoid duplication of programs and funding.

SEC 4. Section 17732 of the Welfare and Institutions Code is amended to read:

17732. No more than two foster care children shall reside in a specialized foster care home with the following exceptions:

(a) A specialized foster care home may have a third child with or without special health care needs placed in that home provided that the licensed capacity, as determined by the department pursuant to paragraph (6) of subdivision (a) of Section 1502 of the Health and Safety Code is not exceeded and provided that all of the following conditions have been met:

(1) The child's placement worker has determined and documented that no other placement is available.

(2) For each child in placement and the child to be placed, the child's placement worker has determined that his or her psychological and social needs will be met by placement in the home and has documented that determination. New determinations shall be made and documented each time there is an increase or turnover in foster care children and the two child capacity limit is exceeded.

(3) The individualized health care plan team responsible for the ongoing care of each child with special health care needs involved has determined that the two child limit may be exceeded without jeopardizing the health and safety of that child, and has documented that determination. New determinations shall be made and documented each time there is an increase or turnover in foster care children and the two child capacity limit is exceeded.

(b) A licensed small family home, but not a certified home, may exceed the placement limit specified in subdivision (a) and accept children with or without special health care needs up to the licensed capacity as determined by the department pursuant to paragraph (6) of subdivision (a) of Section 1502 of the Health and Safety Code if the conditions in subdivision (a) have been met for both the third child and each child placed thereafter, and the following additional conditions have been met:

(1) At least one of the children in the facility is a regional center client monitored in accordance with Section 56001 and following to Title 17 of the California Code of Regulations.

(2) Whenever four or more foster care children are physically present in the facility, the licensee of the small family home has the assistance of a caregiver to provide specialized in-home health care to the children except that:

(A) Night assistance shall not be required for those hours that the individualized health care plan team for each child with special health care needs has documented that the child will not require specialized medical services during that time.

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(B) The department may determine that additional assistance is required to provide appropriate care and supervision for all children in placement. The determination shall only be made after consultation with the appropriate regional center and any appropriate individualized health care plan teams.

(3) On-call assistance is available at all times to respond in case of an emergency. The on-call assistant shall meet the requirements of paragraph (5) of subdivision (c) of Section 17731.

(4) The home is sufficient in size to accommodate the needs of all children in the home.

(c) Notwithstanding Section 1523 of the Health and Safety Code, a foster family home which has more than three children with special health care needs in its care as of January 1, 1992, and which applies for licensure as a small family home in order to continue to provide care for those children, shall be exempt from the application fee.

(d) Except for children with special health care needs placed in a group home before January 1, 1992, no child with special health care needs may be placed in any group home or combination of group homes for longer than a short-term placement of 120 calendar days. The short-term placement in the group home shall be on an emergency basis for the purpose of arranging subsequent placement in a less restrictive setting, such as with the child's natural parents or relatives, with a foster parent or foster family agency, or with another appropriate person or facility. The 120-day limitation shall not be extended, except by the approval of the director or his or her designee. For children placed after January 1, 1992, the 120-day limitation shall begin on the effective date of the amendments to this section made during the 1993 portion of the 1993-94 Regular Session.

(e) A child with special health care needs shall not be placed in a group home unless the child's placement worker has determined and documented that the group home has a program that meets the specific needs of the child being placed and there is a commonality of needs with the other children in the group home.

SEC. 5 Section 17736 of the Welfare and Institutions Code is amended to read:

17736. Notwithstanding any other provision of law, including Sections 1250, 1251, 1254, 1270, 1501, 1502, 1505, 1507, 1521, 1530.6 (as added by Chapter 391 of the Statutes of 1977), 1550, 11002, and 11154 of the Health and Safety Code, Sections 2502, 2725, 2732, and 2795 of the Business and Professions Code, all of the following shall apply:

(a)(1) Counties and regional centers shall be permitted to place children with special health care needs in foster family homes, small family homes, and group homes pursuant to Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code.

(2) Foster family agencies shall be permitted to place children with special health care needs in certified homes pursuant to Chapter 3 (commencing with Section 1500) of Division 2 of the Health and Safety Code.

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(b) Counties, regional centers and foster family agencies shall permit all of the following:

(1) A foster parent, an assistant caregiver, an on-call assistant, and a respite caregiver meeting the requirements of paragraphs (3), (5), and (6) of subdivision (c) of Section 17731 to provide, in a specialized foster care home, specialized in-home health care to a foster child, as described in the child's individualized health care plan.

(2) The licensee and other personnel meeting the requirements of paragraphs (3), (5), and (6) of subdivision (c) of Section 17731 to provide, in a group home, specialized in-home health care to a child, as described in his or her individualized health care plan, provided that the child was placed as of November 1, 1993.

SEC. 6. Upon recommendation of the Director of Social Services, the Department of Finance may authorize the transfer of amounts, cumulatively not to exceed four million three hundred seventy-nine thousand dollars (\$4,379,000), from Item 5180-101-001(a) of the Budget Act of 1993, local assistance, State Department of Social Services, Aid to Families with Dependent Children to either Item 5180-141-001(a) of the Budget Act of 1993, local assistance, State Department of Social Services, County Administration or Item 5180-151-001(d) of the Budget Act of 1993, local assistance, State Department of Social Services, Child Welfare Services, or both, in order to provide incentives and assistance to counties in the area of specialized care, pursuant to subparagraph (B) of paragraph (4) of subdivision (e) of Section 11461 of the Welfare and Institutions Code.

SEC. 7. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order that children with special medical needs may receive care in certified family homes at the earliest possible time, it is necessary that this bill take effect immediately.