ALCOHOLIC BEVERAGE REGULATION ADMINISTRATION
ALCOHOLIC BEVERAGE CONTROL BOARD

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Alcoholic Beverage Control Board ("Board"), pursuant to the authority set forth in D.C. Official Code § 25-351(a) (2001) and Section 303 of Title 23 of the District of Columbia Municipal Regulations ("DCMR"), 51 DCR 4309 (April 30, 2004), hereby gives notice of the adoption of emergency rules replacing the existing section 304 of Title 23 DCMR to impose a three (3) year moratorium on the issuance of any new retailer's license class CN, CT, CX, DN, DT, and DX in a portion of Adams Morgan which shall be known as the Adams Morgan Moratorium Zone.

The Board conducted a public hearing, pursuant to D.C. Official Code § 25-354 (2001), on July 7, 2004 to consider the written request of the Kalorama Citizens Association ("KCA") and the Reed-Cooke Neighborhood Association ("RCNA") to extend and modify the current Adams Morgan Moratorium Zone for a five year period. The Board received a significant amount of detailed testimony and comments, both in favor and in opposition to the moratorium proposal submitted by the KCA and RCNA, including comments from Ward One Councilmember Jim Graham, Advisory Neighborhood Commission ("ANC") 1C, the Metropolitan Police Department ("MPD"), the Adams Morgan Community Association ("AMCA"), the Coalition of Latino Business, the Adams Morgan Business and Professional Association, the Coalition of Concerned Adams Morgan Commercial Property Owners, as well as numerous District of Columbia residents and other District of Columbia organizations. The Board found the testimony provided by the KCA and RCNA to warrant an extension of the moratorium on any new retailer's licenses class CN, CT, CX, DN, DT and DX based upon the appropriateness standards set forth in D.C. Official Code §§ 25-313(b) (2001).

In reaching its decision, the Board gave great weight to the written recommendations of ANC 1C as required by section 13(d)(3) of the Advisory Neighborhood Councils Act of 1975, effective October 10, 1975, D.C. Law 1-21, D.C. Official Code § 1-309.10(d)(3) (2001), as amended, and D.C. Official Code § 25-609 (2001). ANC 1C voted to reject the petition filed by the KCA and RCNA by a 4-3 vote taken at its monthly business meeting on May 5, 2004. The ANC 1C Resolution, in opposing the written request of the KCA and RCNA, stated that the current moratorium has failed to reduce vehicular or pedestrian traffic, make parking more available, clean up trash, reduce the rodent population, reduce noise, or promote desirable retail uses in the community. However, pursuant to subsection 303.1 of Title 23 DCMR (2004), the Board in rendering its decision on a moratorium request is required to determine whether the present conditions in the moratorium area – after considering the appropriateness standards set forth in D.C. Official Code §§ 25-313 and 25-314 (2001) – justify an extension of the moratorium, notwithstanding any perceived failures or successes of the previous moratorium. As discussed below, the Board did find merit based upon the testimony and comments it received from ANC 1C regarding the need to promote desirable retail uses in the Adams Morgan Moratorium Zone. However, in considering the appropriateness standards set

forth in D.C. Official Code §§ 25-313(b) (2001), the Board found the testimony and evidence put forward by the KCA, RCNA, Councilmember Jim Graham, and individual citizens of Adams Morgan to reveal that significant problems with peace, order, and quiet, particularly with respect to noise, litter, disorderly conduct, crowd control, and vehicular and pedestrian safety, as well as parking problems to still exist during late evening hours in the Adams Morgan Moratorium Zone. Additionally, the testimony provided by MPD revealed a number of significant public safety issues, including a large number of calls for police service and traffic congestion problems caused by patrons of ABC establishments in the Adams Morgan Moratorium Zone. While the Board recognizes the vibrant late night activity which continues to attract patrons to Adams Morgan, the Board is also responsible for addressing the concerns of Adams Morgan residents, which based upon the submitted testimony and evidence, endure late at night: loud noise, the disorderly departure of some patrons of ABC establishments, a variety of parking and vehicular and pedestrian safety problems, and excessive amounts of litter throughout neighborhood streets, including pizza paper plates, which are often from patrons of ABC establishments. As a result, the Board decided to continue the restriction on the issuance of new tavern and nightclub licenses within the Adams Morgan Moratorium Zone. The Board is also prohibiting the issuance of new class CX and DX, club and multipurpose facility licenses, which could also negatively impact upon peace, order, and quiet in the Adams Morgan Moratorium Zone by operating late at night without any statutory food service requirements.

While the Board found that the KCA and RCNA established the need for a moratorium on the issuance of new class CN, CT, CX, DN, DT, and DX licenses, the Board found the KCA's and RCNA's arguments for other license restrictions to not be warranted in other areas. First, the Board recognizes that the written petition filed by the KCA and RCNA specifically requests an exception to allow the issuance of new class B licenses for full service grocery stores that meet the requirements promulgated under D.C. Official Code §§ 25-303(c), 25-332(c), or 25-333(c) (2001), in an effort to allow full service grocery stores such as Harris Teeter and Safeway to locate and/or operate in the Adams Morgan Moratorium Zone with a class B license. However, the Board found, based upon the testimony submitted and the lack of evidence presented by the KCA and RCNA to the contrary, that new retailer's licenses class A and B should be excluded from the moratorium extension. Specifically, the Board found based upon the testimony and evidence presented, including by supporters of the moratorium petition, that including a prohibition on the issuance of new class A and other class B licenses to establishments is not appropriate as the aforementioned problems with peace, order, and quiet and vehicular and pedestrian safety within the current Adams Morgan Moratorium Zone primarily occur after 10 p.m., during which times class A and class B establishments are legally required to close. Rather, the testimony revealed that the primary concern of the KCA and RCNA was with the late night, after 10 p.m., peace, order, and quiet, and vehicular and pedestrian safety problems caused by patrons of class C and class D establishments. Second, while the KCA and RCNA established a need to place some limits on the number of new late-night drinking establishments, based upon the reasons set forth above, the Board did not agree with the KCA's and RCNA's overconcentration argument – a consideration under D.C. Official Code § 25-314(a)(4) (2001) – as the

Board also found merit in the testimony and comments it received regarding the need for new class CR restaurants – in addition to class DR restaurants which were not requested in the KCA's and RCNA's petition – in the Adams Morgan Moratorium Zone. Specifically, the Board found based upon the testimony and comments submitted by Councilmember Graham, the Coalition of Concerned Adams Morgan Commercial Property Owners, the AMCA, and the Coalition of Latino Business, as well as individual residents of Adams Morgan that there is a need for additional class CR restaurants within the Adams Morgan Moratorium Zone to spur commercial development and occupancy, to facilitate diversity, and to address the needs of a growing residential population in Adams Morgan. The Board found this restaurant exception also to be consistent in giving great weight to ANC 1C with its comments regarding the need to promote desirable retail uses in the community. As a result, the Board has excluded a prohibition on class CR restaurants from this rulemaking. However, to ensure that newly issued restaurant licenses are not able to circumvent the prohibition on the issuance of any new class CN, CT, CX, DN, DT, and DX licenses, the Board is prohibiting any new class CR or class DR license issued within the Adams Morgan Moratorium Zone from changing its license class to a class CN, CT, CX, DN, DT, or DX, for the duration of the moratorium period. It should be noted that although the issue of restaurants applying for entertainment endorsements was raised in Councilmember Graham's testimony, the existence of entertainment endorsements have not yet been enacted into law. However, the Board does note that it is seriously concerned about new restaurants obtaining entertainment endorsements without close community scrutiny and will be treating any such application as a substantial change. Third, the Board did not find the testimony or evidence it received to warrant either the prohibition on lateral expansion of the service or sale of alcoholic beverages into any adjoining or adjacent space, property, or lot, or the placement of any cap on the number of permitted class CT, CN, or DN licenses, as was requested by the petitioners. Specifically, the Board received testimony and comment in opposition to such changes, including from ANC 1C, and also received testimony from Councilmember Graham supporting license changes from restaurants to taverns.

The Board decided to change the geographical boundaries of the Adams Morgan Moratorium Zone in accordance with the boundaries described in the written petition of the KCA and the RCNA. The Board notes that changing the geographical boundaries of the Adams Morgan Moratorium Zone was necessary in order to clarify the street boundaries of the Adams Morgan Moratorium Zone subsequent to the District of Columbia's redistricting after the year 2000 census. The Board decided in favor of a three (3) year moratorium instead of the five (5) year moratorium period sought by the petitioners. Testimony and comments submitted by the petitioners, Councilmember Graham, ANC 1C, business associations, community organizations, and individual residents revealed that while problems with criminal activity, litter, noise, parking, and vehicular and pedestrian safety still exist in the Adams Morgan Moratorium Zone to justify the moratorium extension, these problems may begin to improve in the future with the formation of a Business Improvement District and are worth re-examining at the end of the three year moratorium period. The statements set forth above reflect the written reasons for the Board's decision as required by subsection 303.1 of Title 23 DCMR (2004).

The emergency action is necessary to prevent the filing of applications for the issuance of new retailer's licenses class CN, CT, CX, DN, DT, and DX which the Board has determined pursuant to D.C. Official Code § 25-313(b) (2001) would:

(1) have an adverse effect on peace, order, and quiet; and
(2) have an adverse effect on residential parking needs and vehicular and pedestrian safety.

These emergency rules were adopted by the Board on July 14, 2004. The rules became effective on that date. The emergency rules will expire 120 days from the date of effectiveness or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first. The Board also gives notice of its intent to adopt these proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Pursuant to D.C. Official Code § 25-211(b)(2) (2001), these proposed rules are also being transmitted to the Council of the District of Columbia, and the final rules may not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first.

Title 23 DCMR, Chapter 3 (Limitations on Licenses), is amended by replacing the existing section 304 to read as follows:

304 ADAMS MORGAN MORATORIUM ZONE

304.1 No new Retailer's License Class CN, CT, CX, DN, DT, or DX shall be issued for a period of three (3) years from the effective date of this section in the area that extends approximately fourteen (1400) hundred feet in all directions from the intersection of 18th Street and Belmont Road, N.W., Washington D.C. This area shall be known as the Adams Morgan Moratorium Zone.

304.2 The Adams Morgan Moratorium Zone is more specifically described as beginning at 18th Street and Vernon Street, NW ; and proceeding on both sides of all streets, unless otherwise noted; West on Vernon Street to 19th Street; Northwest on 19th Street to Wyoming Avenue; Southwest on Wyoming Avenue to 20th Street; Northwest on 20th Street to Belmont Road; East on Belmont Road to 19th Street; Northwest on 19th Street to Biltmore Street; East on Biltmore Street to Cliffbourne Street; North on Cliffbourne Street to Calvert Street; East on Calvert Street to Lanier Place; Northeast on Lanier Place to Adams Mill Road; Southeast on Adams Mill Road to Columbia Road; Northeast on Columbia Road to Ontario Road; South on Ontario Road to Euclid Street; East on Euclid Street to 17th Street; South on 17th Street to Kalorama Road; Southwest on Kalorama Road to Ontario Road; South on Ontario Road to Florida Avenue; Southwest on Florida Avenue to U Street; West on U Street

(North side only); across 18th Street to the South corner of 18th and Vernon Streets, N.W., Washington D.C.

304.3 The following license classes shall be exempt from the Adams Morgan Moratorium Zone:

(a) All hotels, whether present or future;

(b) Restaurants applying for new Retailer's licenses Class CR and DR; and

(c) Retailer's licenses Class A and B

304.4 Any new Retailer's licenses Class CR or DR issued during the moratorium period within the Adams Morgan Moratorium Zone shall be prohibited from changing its license class to a Class CN, CT, CX, DN, DT, or DX.

304.5 Nothing in this section shall prohibit the Board from approving the transfer of ownership of a retailer's license Class CN, CT, CX, DN, DT, and DX within the Adams Morgan Moratorium Zone that was in effect or for which an application was pending prior to the effective date of this section, subject to the requirements of Title 25 of the D.C. Official Code and this title.

304.6 Nothing in this section shall prohibit the Board from approving the transfer of a license from a location within the Adams Morgan Moratorium Zone to a new location within the Adams Morgan Moratorium Zone.

304.7 A license holder outside the Adams Morgan Moratorium Zone shall not be permitted to transfer its license to a location within the Adams Morgan Moratorium Zone, unless exempt by section 304.3.

304.8 Nothing in this section shall prohibit a valid protest of any transfer or change of a license class.

304.9 The moratorium shall have a prospective effect and shall not apply to any license granted prior to the effective date of this section or to any application for licensure pending on the effective date of this section.

304.10 This section shall expire three (3) years after the date of publication of the notice of final rulemaking.

Copies of the proposed rulemaking can be obtained by contacting Fred Moosally, General Counsel, Alcoholic Beverage Regulation Administration, 941 North Capitol Street, N.E., 7th Floor, Washington, D.C. 20002. All persons desiring to comment on the proposed rulemaking must submit their written comments, not later than thirty (30) days after the date of publication of this notice in the D.C. Register, to the above address.

ALCOHOLIC BEVERAGE REGULATION ADMINISTRATION
ALCOHOLIC BEVERAGE CONTROL BOARD

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Alcoholic Beverage Control Board ("Board"), pursuant to the authority set forth in D.C. Official Code § 25-351(a) (2001) and Section 303 of Title 23 of the District of Columbia Municipal Regulations ("DCMR"), 51 DCR 4309 (April 30, 2004), hereby gives notice of the adoption of emergency rules replacing the existing section 305 of Title 23 DCMR to impose a five (5) year moratorium on the issuance of any new retailer's license class CN, CR, CT, CX, DN, DR, DT, and DX in a portion of Georgetown which shall be known as the Georgetown Moratorium Zone.

The Board conducted a public hearing, pursuant to D.C. Official Code § 25-354 (2001), on May 12, 2004 to consider the written request of Advisory Neighborhood Commission ("ANC") 2E to extend the current Georgetown Moratorium Zone for a five year period. The written request of ANC 2E to extend the Georgetown Moratorium Zone for a five year period was also supported at the May 12, 2004 public hearing by the Citizens Association of Georgetown ("CAG"), the Georgetown Business Improvement District, and Karen Tammany Cruse, a Georgetown resident. Additionally, written comments supporting ANC 2E's request to continue the Georgetown Moratorium were also received from Georgetown University and the Metropolitan Police Department ("MPD"). The Board found the written request filed by ANC 2E, based upon the testimony and comments it received, to warrant an extension of the existing moratorium for a five year period based upon the appropriateness standards set forth in D.C. Official Code §§ 25-313 and 25-314 (2001). Specifically, under D.C. Official Code § 25-313(b)(2001), the testimony put forward by ANC 2E and Karen Tammany Cruse revealed that significant problems with peace, order, and quiet, including late night noise, rowdiness, crime, litter, as well as parking and vehicular and pedestrian safety still exist in the Georgetown Moratorium Zone. Additionally, the testimony of MPD indicated that there are a large number of complaints involving noise and disorderly behavior around the closing time of ABC establishments as well as traffic congestion and parking problems in the Georgetown Moratorium Zone. Furthermore, under D.C. Official Code § 25-314(a)(4) (2001), the testimony of ANC 2E, CAG, the Georgetown Business Improvement District, and Georgetown University revealed that efforts to seek a balance over the past several years between ABC establishments and other commercial retail would be harmed by not continuing the Moratorium and would result in an overconcentration of ABC establishments that would negatively impact upon the Georgetown Moratorium Zone. The Board also noted that there were no parties on record in opposition to the moratorium request of ANC 2E. These are the written reasons for the Board's decision as required by subsection 303.1 of Title 23 DCMR (2004).

The emergency action is necessary to prevent the filing of applications for the issuance of new retailer's licenses class CN, CR, CT, CX, DN, DR, DT, and DX which the Board has determined pursuant to D.C. Official Code §§ 25-313 and 25-314 (2001) would:

(1) have an adverse effect on peace, order, and quiet;
(2) have an adverse effect on residential parking needs and vehicular and pedestrian safety; and
(3) contribute to an overconcentration of licensed establishments adversely affecting the Georgetown Moratorium Zone area described below.

These emergency rules were adopted by the Board on July 7, 2004. The rules became effective on that date. The emergency rules will expire 120 days from the date of effectiveness or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first. The Board also gives notice of its intent to adopt these proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Pursuant to D.C. Official Code § 25-211(b)(2)(2001), these proposed rules are also being transmitted to the Council of the District of Columbia, and the final rules may not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first.

Title 23 DCMR, Chapter 3 (Limitations on Licenses), is amended by replacing the existing section 305 to read as follows:

305. GEORGETOWN MORATORIUM ZONE

305.1 No Retailer's licenses Class CN, CR, CT, CX, DN, DR, DT, or DX shall be issued for a period of five (5) years from the effective date of this section in the area that extends approximately 1800 feet in all directions from the intersection of Wisconsin Avenue and N Street, N.W., Washington, D.C. This area shall be known as the Georgetown Moratorium Zone.

305.2 The Georgetown Moratorium Zone is more specifically described as beginning at the intersection of 33rd and Q Streets; East on Q Street to Wisconsin Avenue; Southeast on Wisconsin Avenue to Q Street; East on Q Street to 29th Street; South on 29th Street to P Street; East on P Street to 28th Street; South on 28th Street to O Street; East on O Street to 27th Street; South on 27th Street to the Northwest Boundary of Rock Creek Park; Southwest along the Northwest Boundary of Rock Creek to the North Bulkhead of the Potomac River; West along the North Bulkhead of the Potomac River to the Key Bridge; North on the Key Bridge to M Street; West on M Street to 36th Street; North on 36th Street to O Street; East on O Street to 35th Street; North on 35th Street to P Street; East on P Street to 34th Street; North on 34th Street to Volta Place; East on Volta Place to 33rd Street; North on 33rd Street to Q Street.

305.3 The following establishments shall be exempt from the Georgetown Moratorium Zone:

(a) All hotels, whether present or future; and

(b) Establishments located in or to be located in Georgetown Park, Georgetown Park II, Prospect Place Mall, Georgetown Court, and Washington Harbor.

305.4 Nothing in this section shall prohibit the Board from approving the transfer of ownership of a Class C or D Retailer's license within the Georgetown Moratorium Zone that was in effect or for which an application was pending prior to the effective date of this section, subject to the requirements of Title 25 of the D.C. Official Code and this title.

305.5 Nothing in this section shall prohibit the Board from approving the transfer of a license from a location within the Georgetown Moratorium Zone to a new location within the Georgetown Moratorium Zone.

305.6 A license holder outside the Georgetown Moratorium Zone shall not be permitted to transfer its license to a location within the Georgetown Moratorium Zone.

305.7 Nothing in this section shall prohibit a valid protest of any transfer or change of license class.

305.8 The moratorium shall have a prospective effect and shall not apply to any license granted prior to the effective date of this section or to any application for licensure pending on the effective date of this section.

305.9 This section shall expire five (5) years after the date of publication of the notice of final rulemaking.

Copies of the proposed rulemaking can be obtained by contacting Fred Moosally, General Counsel, Alcoholic Beverage Regulation Administration, 941 North Capitol Street, N.E., 7th Floor, Washington, D.C. 20002. All persons desiring to comment on the proposed rulemaking must submit their written comments, not later than thirty (30) days after the date of publication of this notice in the D.C. Register, to the above address.

ALCOHOLIC BEVERAGE REGULATION ADMINISTRATION
ALCOHOLIC BEVERAGE CONTROL BOARD

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Alcoholic Beverage Control Board ("Board"), pursuant to the authority set forth in D.C. Official Code § 25-351(a) (2001) and Section 303 of Title 23 of the District of Columbia Municipal Regulations ("DCMR"), 51 DCR 4309 (April 30, 2004), hereby gives notice of the adoption of emergency rules replacing the existing section 308 of Title 23 DCMR to impose a three (3) year moratorium on the issuance of any new retailer's license class A, B, CN, CR, CT, CX, DN, DT, and DX in a portion of Glover Park which shall be known as the Glover Park Moratorium Zone.

The Board conducted a public hearing, pursuant to D.C. Official Code § 25-354 (2001), on July 7, 2004 to consider the written request of Advisory Neighborhood Commission ("ANC") 3B and the Glover Park Citizens Association ("GPCA") to renew the current Glover Park Moratorium Zone for a five year period. The Board found the testimony provided by ANC 3B and the GPCA to warrant an extension of the existing moratorium based upon the appropriateness standards set forth in D.C. Official Code §§ 25-313 and 25-314 (2001). Specifically, under D.C. Official Code § 25-313(b) (2001), the testimony put forward by ANC 3B and the GPCA revealed that significant problems with peace, order, and quiet, including criminal activity, noise, and litter, as well as parking problems still exist in the Glover Park Moratorium Zone. Additionally, the testimony of the Metropolitan Police Department indicated that a number of public safety issues, including a large number of calls for police service and traffic congestion problems are caused by patrons of ABC establishments in the Glover Park Moratorium Zone. Furthermore, under D.C. Official Code § 25-314(a) (2001), written comment from the Department of Parks and Recreation indicated that patrons of existing ABC establishments negatively impact upon the operations of the Guy Mason Recreation Center, including by littering the play areas of children. Finally, the testimony of ANC 3B and the GPCA revealed that a proper balance between ABC establishments and other commercial retail currently exists and that not continuing the moratorium would result in an overconcentration of ABC establishments, as set forth in D.C. Official Code § 25-314(a)(4) (2001), that would negatively impact the Glover Park Moratorium Zone. The Board also noted that there were no parties on record in opposition to the moratorium. The Board decided in favor of a three (3) year moratorium instead of the five (5) year moratorium period sought by the petitioners. Testimony provided by the petitioners and other individuals at the July 7, 2004 public hearing revealed that while problems with criminal activity, litter, noise, and parking still exist in the Glover Park Moratorium Zone to justify the moratorium extension, these problems are beginning to stabilize, if not improve. These are the written reasons for the Board's decision as required by subsection 303.1 of Title 23 DCMR (2004).

The emergency action is necessary to prevent the filing of applications for the issuance of new retailer's licenses class A, B, CN, CR, CT, CX, DN, DT, and DX which the Board has determined pursuant to D.C. Official Code §§ 25-313 and 25-314 (2001) would:

(1) have an adverse effect on peace, order, and quiet;
(2) have an adverse effect on residential parking needs and vehicular and pedestrian safety;
(3) have an adverse effect on the operations of a nearby recreation center; and
(4) contribute to an overconcentration of licensed establishments adversely affecting the Glover Park Moratorium Zone area described below.

These emergency rules were adopted by the Board on July 14, 2004. The rules became effective on that date. The emergency rules will expire 120 days from the date of effectiveness or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first. The Board also gives notice of its intent to adopt these proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Pursuant to D.C. Official Code § 25-211(b)(2) (2001), these proposed rules are also being transmitted to the Council of the District of Columbia, and the final rules may not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first.

Title 23 DCMR, Chapter 3 (Limitations on Licenses), is amended by replacing the existing section 308 to read as follows:

308 GLOVER PARK MORATORIUM ZONE

308.1 No new Retailer's License Class A, B, CN, CR, CT, CX, DN, DT, or DX shall be issued for a period of three (3) years from the effective date of this section in the area that extends approximately one thousand two hundred feet (1,200 ft.) in all directions from 2436 Wisconsin Avenue, N.W., Washington D.C. This area shall be known as the Glover Park Moratorium Zone.

308.2 The Glover Park Moratorium Zone is more specifically described as beginning at Tunlaw Road and Fulton Street; East on Fulton Street to Wisconsin Avenue; South on Wisconsin Avenue to Edmunds Street; East on Edmunds Street to Massachusetts Avenue; Southeast on Massachusetts Avenue to Observatory Circle; Southeast around Observatory Circle to Calvert Street; West on Calvert Street to Wisconsin Avenue; Southeast on both sides of Wisconsin Avenue to 35th Street; South on 35th Street to Whitehaven Parkway; West on Whitehaven Parkway to 37th Street; North on 37th Street to U Street; West on U Street to a point of intersection of Huidekoper Place and W Street; West on W Street to 39th Street; North on 39th Street to Davis Place; East on Davis Place to Tunlaw Road; North and Northwest on Tunlaw Road to Fulton Street.

308.3 All hotels, whether present or future, shall be exempt from the Glover Park Moratorium Zone.

308.4 Nothing in this section shall prohibit the Board from approving the transfer of ownership of a retailer's license class A, B, CN, CR, CT, CX, DN, DT, and DX within the Glover Park Moratorium Zone that was in effect or for which an application was pending prior to the effective date of this section, subject to the requirements of Title 25 of the D.C. Official Code and this title.

308.5 Nothing in this section shall prohibit the Board from approving the transfer of a license from a location within the Glover Park Moratorium Zone to a new location within the Glover Park Moratorium Zone.

308.6 A license holder outside the Glover Park Moratorium Zone shall not be permitted to transfer its license to a location within the Glover Park Moratorium Zone.

308.7 Nothing in this section shall prohibit a valid protest of any transfer or change of a license class.

308.8 The moratorium shall have a prospective effect and shall not apply to any license granted prior to the effective date of this section or to any application for licensure pending on the effective date of this section.

308.9 This section shall expire three (3) years after the date of publication of the notice of final rulemaking.

Copies of the proposed rulemaking can be obtained by contacting Fred Moosally, General Counsel, Alcoholic Beverage Regulation Administration, 941 North Capitol Street, N.E., 7th Floor, Washington, D.C. 20002. All persons desiring to comment on the proposed rulemaking must submit their written comments, not later than thirty (30) days after the date of publication of this notice in the D.C. Register, to the above address.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of a new Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Home and Community-Based Waiver Services for Persons with Mental Retardation and Developmental Disabilities." These rules establish eligibility requirements and other general standards for participation in the Medicaid Home and Community-Based Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These rules also establish standards governing reimbursement by the Medicaid program for personal care services furnished by Waiver providers. The Waiver will enable the District to provide home and community-based services to individuals aged 18 or over who would otherwise require institutional care in an intermediate care facility for persons with mental retardation.

The Centers for Medicare and Medicaid Services (CMS), formerly the federal Health Care Financing Administration has advised the District that the maintenance and expansion of all approved services to persons served by the Waiver is essential to the continuation of the Waiver. These rules establish the general terms and conditions governing the provision of all Waiver services. Emergency action is necessary for the immediate preservation of the health, safety and welfare of Waiver participants who are in need of Waiver services.

On March 26, 2004, a notice of emergency and proposed rules was published in the D.C. Register (51 DCR 3317). These rules amend the previously published rules by amending the eligibility requirements to include the criteria for the level of care determination and income levels and requiring providers to submit a quality assurance plan with each provider application.

The emergency rulemaking was adopted on July 14, 2004 and became effective on that date. The emergency rules will remain in effect for one hundred and twenty days or until November11, 2004, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Amend Title 29 DCMR by adding the following new Chapter 19 to read as follows:

CHAPTER 19 HOME AND COMMUNITY-BASED WAIVER SERVICES FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

1900 GENERAL PROVISIONS

1900.1 The purpose of this chapter is to establish criteria governing Medicaid eligibility for Home and Community-based Waiver Services for Persons with Mental Retardation and Developmental Disabilities (Waiver) and to establish conditions of participation for providers of Waiver services.

1900.2 The Waiver is authorized pursuant to section 1915 (c) of the Social Security Act, approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) and shall be effective through November 19, 2007, plus any extensions thereof.

1900.3 The Waiver shall be operated by the Department of Human Services, Mental Retardation and Developmental Disabilities Administration (MRDDA) under the supervision of the Department of Health, Medical Assistance (MAA).

1900.4 Enrollment of persons eligible to receive Waiver services shall not exceed the ceiling established by CMS.

1901 COVERED SERVICES

1901.1 Services available under the Waiver shall include the following:

(a) Adaptive equipment, as set forth in section 928 of Title 29 DCMR;
(b) Adult companion, as set forth in section 944 of Title 29 DCMR;
(c) Attendant care, as set forth in section 927 of Title 29 DCMR;
(d) Case management, as set forth in section 940 of Title 29 DCMR;
(e) Chore services, as set forth in section 929 of Title 29 DCMR;
(f) Day habilitation, as set forth in section 945 of Title 29 DCMR;
(g) Dental services, as set forth in section 936 of Title 29 DCMR;
(h) Environmental accessibility adaptation services, as set forth in section 926 of Title 29 DCMR;
(i) Family training, as set forth in section 942 of Title 29 DCMR;
(j) Homemaker services, as set forth in section 938 of Title 29 DCMR;
(k) Independent habilitation, as set forth in section 993 of Title 29 DCMR;
(l) Nutritional counseling, as set forth in section 930 of Title 29 DCMR;

(m) Occupational therapy, as set forth in section 935 of Title 29 DCMR;
(n) Personal care services, as set forth in sections 5004 and 1910 of Title 29 DCMR;
(o) Personal emergency response system (PERS), as set forth in section 907 of Title 29 DCMR;
(p) Physical therapy services, as set forth in section 934 of title 29 DCMR;
(q) Preventive, consultative and crisis support, as set forth in section 937 if Title 29 DCMR;
(r) Prevocational services, as set forth in section 920 of Title 29 DCMR;
(s) Residential habilitation, as set forth in section 946 of Title 29 DCMR;
(t) Respite care, as set forth in section 994 of Title 29 DCMR;
(u) Skilled nursing, as set forth in section 933 of Title 29 DCMR;
(v) Speech, hearing and language services, as set forth in section 932 of Title 29 DCMR;
(w) Supportive employment, as set forth in section 929 of Title 29 DCMR; and
(x) Transportation, as set forth in section 943 of title 29 DCMR.

1902 ELIGIBILITY REQUIREMENTS

1902.1 An individual eligible to receive Waiver services shall meet all of the following requirements:

(a) Have a special income level equal to 300% of the SSI federal benefit or be aged and disabled with income at 100% of the federal poverty level or be medically needy as set forth in 42 CFR 435.320, 435.322, 435.324 and 435.330;
(b) Be mentally retarded and developmentally disabled;
(c) Be eighteen (18) years of age or older;
(d) Be a resident of the District of Columbia as defined in D.C. Official Code § 7-1301.03(22);
(e) Have a level of care determination that the individual requires services furnished in an intermediate care facility for persons with mental retardation (ICF/MR) or persons with related conditions pursuant to the criteria set forth in section 1902.4; and
(f) Meet all other eligibility criteria applicable to Medicaid recipients including citizenship and alienage requirements.

1902.2 Waiver services shall not be furnished to a person who is an inpatient of a hospital, ICF/MR or nursing facility.

1902.3 Each individual enrolled in the Waiver shall be re-certified annually as having met all of the eligibility requirements as set forth in subsection 1902.1 for continued participation in the Waiver.

1902.4 An individual shall meet the level of care determination set forth in section 1902.1(e) if one of the following criteria has been met:

(a) The individual's primary disability is mental retardation with an intelligence quotient (IQ) of 59 or less;

(b) The individual's primary disability is mental retardation with an intelligence quotient of 60-69 and the individual has at least one of the following handicapping conditions:

(1) Mobility deficits;
(2) Sensory deficits;
(3) Chronic health problems;
(4) Behavior problems;
(5) Autism;
(6) Cerebral Palsy;
(7) Epilepsy; or
(8) Spina Bifida.

(c) The individual's primary disability is mental retardation with an intelligence quotient of 60-69 and the individual has severe functional limitations in at least three of the following major life activities:

(1) Self care;
(2) Understanding and use of language;
(3) Functional academics;
(4) Social skills;
(5) Mobility;
(6) Self-direction;
(7) Capacity for independent living; or
(8) Health and safety.

(d) The individual has autism, cerebral palsy, prader willi or spina bifida, and has severe functional limitations in at least three of the major life activities set forth in sections 1902.4 (c)(1) through 1902.4 (c)(8).

1903 PROVIDER QUALIFICATIONS

1903.1 Each prospective provider shall complete an application to participate in the Medicaid program and submit to MAA the following information:

(a) A description of ownership and a list of major owners or stockholders owning or controlling five percent (5%) or more outstanding shares;
(b) A list of Board members and their affiliations;
(c) A roster of key personnel, their qualifications and a copy of their position descriptions;
(d) Copies of job descriptions, resumes, licenses and certifications of all staff providing services;
(e) Addresses of all sites where services will be provided to clients;
(f) A copy of the most recent audited financial statement of the organization;
(g) A completed provider application;
(h) A copy of the basic organizational documents of the provider, including an organizational chart and current Articles of Incorporation;
(i) A copy of the Bylaws or similar documents regarding conduct of the provider's internal affairs;
(j) A copy of the business license or certificate of good standing;
(k) A copy of the Joint Commission on Accreditation of Health Care Organization's certification, if required;
(l) A copy of the Certificate of Need approval, if required;
(m) A copy of the Certificate of Occupancy;
(n) Program policies and procedures;
(o) Staffing ratios, if required;
(p) A quality assurance plan; and
(q) Any other documentation deemed necessary to support the approval as a provider.

1903.2 MAA shall notify each prospective provider, in writing, of the approval or disapproval to become a provider of Waiver services, no later than 45 days of receipt of all required documentation. If additional information is requested by MAA, the provider shall have 30 days from the date of the request to submit the additional information. If an application is disapproved, the notice shall set forth the reason for disapproval. Failure to submit all required documentation may result in disapproval.

1903.3 Each provider shall enter into a provider agreement with MAA for the provision of Waiver services.

1903.4 The provider agreement shall specify the services to be provided, methods of operation, financial and legal requirements, and identification of the population to be served.

1903.5 Each provider shall be subject to the administrative procedures set forth in Chapter 13 of Title 29 DCMR during the provider's participation in the program.

1903.6 Each provider shall comply with all applicable provisions of District and federal law and rules applicable to the Title XIX of the Social Security Act, and all District and federal law and rules applicable to the service or activity provided pursuant to these rules.

1904 INDIVIDUAL HABILITATION PLAN (IHP) OR INDIVIDUAL SERVICE PLAN (ISP)

1904.1 The IHP or ISP shall be developed by the Interdisciplinary Team (IDT) for each client.

1904.2 At a minimum, the composition of the IDT team shall include the client, the client's parent, guardian or other individual directly involved in the client's life and the case manager.

1904.3 The IHP or ISP shall be reviewed and updated annually by the IDT team. The IHP or ISP may be updated more frequently if there is a significant change in the client's status or any other significant event in the client's life which affects the type or amount of services and supports needed by the client or if requested by the client.

1904.4 A written plan of care shall be developed for each client by staff within the MRDDA Waiver Unit. The plan of care shall describe medical and other services to be furnished to the client, the frequency of the services and the type of provider to furnish the services. The plan of care shall be consistent with the IHP or ISP.

1904.5 MAA shall not reimburse a provider for services that are not authorized in the IHP or ISP, not included in the written plan of care, furnished prior to the development of the IHP or ISP, not prior-authorized by MRDDA or furnished pursuant to an expired IHP or ISP.

1904.6 After notification by MRDDA that a service has been authorized, each provider shall develop a written plan which shall address how the service will be delivered to each client.

1904.7 Each provider shall submit to the client's case manager a quarterly review which summarizes the client's condition, progress made toward achieving the desired goals and outcomes and identification and response to any issue relative to the provision of the service.

1905 LEVEL OF CARE

1905.1 When an individual is determined to be likely to require a level of care as set forth in section 1902.1(e) of these rules and meets all other eligibility requirements, the individual or his or her authorized representative shall be informed by the case manager, as evidenced by the signed Waiver Beneficiary Freedom of Choice Form of:

(a) any feasible alternatives under the Waiver; and
(b) the choice of either institutional or home and community- based services.

1905.2 Each individual who is not given the choice of home or community-based services as an alternative to institutional care in an ICF/MR as set forth in subsection 1909.1, shall be entitled to a fair hearing in accordance with 42 CFR Part 431, Subpart E.

1905.3 A registered nurse or qualified mental retardation professional, employed by MRDDA, shall perform the initial evaluation of the level of care and make a level of care determination.

1905.4 Re-evaluations of the level of care shall be conducted every twelve (12) months or earlier when indicated.

1905.5 Each re-evaluation shall be performed by persons with the same educational and professional qualifications as those for persons conducting the initial evaluations.

1905.6 Written documentation of each evaluation and re-evaluation shall be maintained for a minimum period of three (3) years, except when there is an audit or investigation, the records shall be maintained until the review has been completed.

1906 CLIENT RIGHTS

1906.1 Each provider shall develop and adhere to policies which ensure that each client receiving services has the following rights:

(a) To be treated with courtesy, dignity and respect:
(b) To participate in the planning of his or her care and treatment;
(c) To receive treatment, care and services consistent with the IHP and ISP;
(d) To receive services by competent personnel who can communicate with the client;
(e) To refuse all or part of any treatment, care or service and be informed of the consequences;

(f) To be free from mental and physical abuse, neglect and exploitation from persons providing services;

(g) To be assured that for purposes of record confidentiality, the disclosure of the contents of the client's records is subject to all the provisions of applicable District and federal laws and rules;

(h) To voice a complaint regarding treatment or care, lack of respect for personal property by persons providing services without fear of reprisal;

(i) To have access to his or her records; and

(j) To be informed orally and in writing of the following:

(1) Services to be provided, including any limitations;

(2) The amount charged for each service, the amount of payment required by the client and the billing procedures, if applicable;

(3) Whether services are covered by health insurance, Medicare, Medicaid or any other third party source;

(4) Acceptance, denial, reduction, or termination of services;

(5) Complaint and referral procedures;

(6) The name, address and telephone number of the provider; and

(7) The telephone number of the hotline maintained by MRDDA.

1906.2 Each provider shall notify MRDDA and MAA, Office of Disabilities and Aging of any client incidents as set forth in MRDDA's Policy and Procedure entitled "Incident Management System".

1906.3 MRDDA shall notify MAA in writing of any complaints regarding treatment, care and services rendered by Waiver providers.

1907 RECORDS AND CONFIDENTIALITY OF INFORMATION

1907.1 Each provider shall allow appropriate personnel of MAA, MRDDA and other authorized agents of the District of Columbia government and the federal government full access to all records during announced and unannounced audits and reviews.

1907.2 Each provider shall maintain all records, including but not limited to progress reports, financial records, medical records, treatment records, and any other documentation relating to costs, payments received and made, and services provided, for six years or until all audits, investigations or reviews are completed, whichever is longer.

1907.3 Each client's record shall include, but not be limited to, the following information:

(a) General information including each client's name, Medicaid identification number, address, telephone number, age, sex, name, and telephone number of emergency contact person, physician's name, address and telephone number and case manager's name and telephone number;
(b) A copy of the beneficiary freedom of choice form;
(c) A copy of the current IHP or ISP;
(d) A record of all services(s) provided, including description and dates of service;
(e) A record of all prior authorizations for services;
(f) A record of all requests for change in services;
(g) A record of the client's initial and annual health history;
(h) A discharge summary, if applicable; and
(i) Any other records necessary to demonstrate compliance with all rules and requirements, guidelines and standards for the implementation and administration of this Waiver.

1907.4 Each provider shall secure client treatment records in a locked room or file cabinet and limit access only to authorized employees.

1907.5 The disclosure of treatment information by a provider shall be subject to all provisions of applicable federal and District laws and rules, for the purpose of confidentiality of information.

1908 INITIATING, CHANGING OR TERMINATING ANY APPROVED SERVICE

1908.1 The case manager shall be responsible for initiating, changing, or terminating Waiver services for each client in accordance with the IHP or ISP and identifying those clients for whom home and community-based services are no longer an appropriate alternative.

1908.2 The case manager shall notify MAA in writing whenever any of the following circumstances occur:

(a) Death of a client;
(b) Hospitalization of a client or any other circumstance in which Waiver services are interrupted for more than seven days;
(c) The client is discharged or terminated from services; or
(d) Any other delay in the implementation of Waiver services.

1908.3 Each provider shall notify the client or the client's representative and the case manager, in writing of the intent to terminate services at least fifteen (15) days prior to termination. The written notice shall state the reason for the termination.

1908.4 When the health and safety of the client or provider agency personnel is endangered, the fifteen (15) day advance notice shall not be required. The provider shall notify the client or client's representative and case manager as soon as possible and a written notice sent on the date of termination.

1909 FAIR HEARINGS

1909.1 Each client shall be entitled to a fair hearing in accordance with 42 CFR 431 and D.C. Official Code § 4-210.01 if the government:

(a) Fails to offer the client a choice of either institutional care in an ICF/MR or home and community-based waiver services;
(b) Denies a waiver service requested by the client;
(c) Terminates, suspends or reduces a waiver service;
(d) Fails to give a client the provider of his or her choice; or
(e) Terminates, suspends or reduces Medicaid eligibility.

1909.2 The Department of Human Services shall be responsible for issuing each legally required notice to the client or client's representative regarding the right to request a hearing as required in subsection 1909.1.

1909.3 The content of the notice issued pursuant to subsections 1909.1 and 1909.2 shall comply with the requirements set forth in 42 CFR 431.210 and D.C. Official Code § 4-205.55.

1910 PERSONAL CARE SERVICES

1910.1 Each provider shall comply with standards governing personal care services set forth in §§ 5000 through 5004 and 5006 of Title 29 DCMR.

1910.2 Each provider shall be reimbursed $13.50 per hour for services rendered by personal care aides.

1910.3 Reimbursement for personal care services shall not exceed sixteen (16) hours per day per client regardless of the Medicaid funding source.

1999 DEFINITIONS

When used in this Chapter, the following terms and phrases shall have the meanings ascribed:

Client-An individual who has been determined eligible to receive services under the Home and Community-based Waiver for Persons with Mental Retardation and Developmental Disabilities.

Individual Habilitation Plan (IHP)- That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (DC Law 2-137; D.C. Official Code §7-1304.03).

Individual Support Plan (ISP)- The successor to the Individual Habilitation Plan as defined in the court-approved *Joy Evans* Exit Plan.

Interdisciplinary Team (IDT)- A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons which has the responsibility of performing a comprehensive evaluation of each client and participating in the development, implementation and monitoring of the client's ISP. The IDT team shall also include the client or client's representative.

Intermediate Care Facility for Persons with Mental Retardation- Shall have the same meaning as set forth in section 1905(d) of the Social Security Act.

Mentally retarded- Shall have the same meaning as set forth in D.C. Official Code § 7-1301.03 (19).

Quality assurance plan- A written plan which describes the process by which the provider will evaluate the quality and appropriateness of services delivered to each client. The plan should describe the process for identifying, evaluating and resolving any problem related to the services rendered.

Qualified mental retardation professional- Shall have the same meaning as set forth in 42 CFR § 483.430(a).

Provider- Any entity that meets the Waiver service requirements, has signed an agreement with MAA to provide those services, and is enrolled by MAA to provide Waiver services.

Registered Nurse- A person who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 et *seq*) or licensed as a registered nurse in the jurisdiction where services are provided.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Mental Health, pursuant to the authority set forth in sections 114 and 209 of the Mental Health Service Delivery Reform Act of 2001 (Act), effective December 18, 2001, D.C. Law 14-56, D.C. Official Code §§ 7-1131.14 and 1231.09 (2001), respectively, hereby gives notice of the of the adoption, on an emergency basis, of the following new Title 22A D.C. Municipal Regulations, Chapter 5. The new Chapter 5, entitled Use of Restraints and Seclusion, sets forth the rules regarding the use of restraints and seclusion by hospitals, residential treatment centers, site-based mental health crisis emergency programs certified by the Department of Mental Health and DMH contracted psychiatric crisis stabilization programs, including pre-requisites for the use of restraints and placement in seclusion, documentation and monitoring requirements, staff training requirements, and post-restraint or post-seclusion actions.

This emergency action is required to comply with the requirements of the Act. The Act was enacted to comply with the Consent Order in *Dixon et al. v. Anthony A. Williams, et al.* (Consent Order). The Consent Order governs the process for transitioning the newly established Department of Mental Health back to the District of Columbia government and requires the Department of Mental Health to implement rules regarding protections for consumers of mental health services and mental health supports described in Title II of the Act.

The Act requires the Department of Mental Health to promulgate rules regarding consumers' rights prior to October 1, 2001. Currently, the District of Columbia has no rules with respect to the use of restraints and seclusion. Thus, emergency action is necessary to establish rules regarding the use of restraints and seclusion and for the immediate preservation of the public peace, health, safety, welfare and morals.

The emergency rules were adopted on August 23, 2004, and became effective immediately upon that date. The emergency rules will expire on November 21, 2004 (120 days after that effective date), or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first.

The Director also gives notice of intent to take final rulemaking action to adopt the proposed rules in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

Chapter 5 is amended as follows:

Chapter 5

Use of Restraints and Seclusion

500 PURPOSES AND APPLICATION

500.1 The purpose of these rules is to:

(a) Provide a safe and therapeutic environment for consumers;

(b) Significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion;

(c) Establish positive, trusting relationships among consumers, families of consumers, and mental health provider staff;

(d) Employ restraints and seclusion in an emergency, only in accordance with this chapter, and other applicable federal and District laws and regulations;

(e) Reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques;

(f) Promote, facilitate and implement the use of consumer's advance instructions regarding treatment preferences in the event of a psychiatric emergency;

(g) Facilitate appropriate placements and transfers for consumers, as necessary, such that the degree of control over consumers in the treatment environment reduces or eliminates the need for repeated or sustained use of restraints and seclusion in an emergency;

(h) Promote, facilitate, and implement initial and continuing education and training programs for mental health provider staff charged with applying, monitoring, and documenting the use of restraints and seclusion in an emergency; and

(i) Aid in the development of internal and external quality improvement processes to identify and implement ways in which the use of restraints and seclusion in an emergency may be reduced or eliminated in favor of more positive behavioral management techniques with less potential risk.

500.2 The rules in this chapter are applicable to all mental health providers in the District. For purposes of this chapter, a mental health provider (MH provider(s)) is any entity that:

(a) Is operated, licensed, or certified by the Mayor to provide mental health services or mental health supports; or

(b) Has entered into an agreement with the Mayor to provide mental health services or mental health supports.

500.3 Consumers have the right to be free from restraints or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

500.4 Restraints include devices and techniques designed and used to control a consumer's behavior in an emergency, as further described in §502.

500.5 Seclusion is the involuntary confinement of a consumer in a room or area where the consumer is physically prevented from leaving, as further described in §503.

500.6 An "emergency" which may require the use of restraints or seclusion occurs when a consumer experiences a mental health crisis and is presenting an imminent risk of serious injury to self or others.

500.7 Restraints and seclusion, as further described in §503 and 504 of this chapter, may only be used during an emergency by trained staff, in accordance with the requirements of this chapter, working at one of the following:

(a) A hospital when administering inpatient or emergency psychiatric services;

(b) A residential treatment center (RTC) licensed pursuant to 29 DCMR §948;

(c) Site-based mental health crisis emergency programs certified by the Department of Mental Health (DMH); or

(d) DMH contracted psychiatric crisis stabilization programs.

500.8 Except for the MH providers specifically identified in §500.7, restraints and seclusion may not be used by any other MH provider under any circumstances. An MH provider not specifically authorized to use restraints or seclusion must comply with the requirements of §§519, 520 and 521 of this chapter.

500.9 Restraints and seclusion shall not include:

(a) General protective security measures including, without limitation, locked wards, or other special security measures adopted in youth residential treatment centers, maximum security psychiatric hospitals or forensic units in psychiatric hospitals, or specific security measures ordered by a court;

(b) Time-out as further described in §504.2; or

(c) Protective measures as further described in § 517.

501 **GENERAL PROVISIONS REGARDING THE USE OF RESTRAINT AND SECLUSION**

501.1 Each MH provider shall comply with the requirements of this chapter regarding the use of restraints and seclusion. Each MH provider shall have a policy addressing the use of restraint and seclusion that satisfies the requirements of §519.

501.2 Restraints or seclusion shall only be used in an emergency in compliance with the following:

(a) The use of restraints or seclusion is, in the written opinion of the attending physician, necessary to prevent serious injury to the consumer or others;

(b) Less restrictive treatment techniques have been tried or considered and determined to be ineffective to prevent serious injury to the consumer or others; and

(c) The attending physician gives a written order for the use of restraints or seclusion. If the consumer's treating physician is available in person at the time the emergency arises, he or she is deemed to be the attending physician for purposes of this chapter.

501.3 Any use of restraints or seclusion with a consumer shall be:

(a) Implemented in the least restrictive manner possible;

(b) Implemented in accordance with safe and appropriate techniques, which include:

(1) The application of restraints or placement in seclusion by trained and educated MH provider staff in a manner that is designed to prevent serious harm to the consumer or others;

(2) The application of restraints or placement in seclusion that is appropriate for the severity of the consumer's condition or behavior, as well as the consumer's chronological and developmental age, size, gender, physical, mental, and emotional condition, and personal history, including any history of trauma, physical, sexual or mental abuse; and

(3) The application of restraints or placement in seclusion such that it is assured that the consumer is allowed to maintain normal bodily processes, breathing patterns, and blood circulation during the entire time the restraint is employed.

(c) Continually assessed, monitored, and evaluated; and

(d) Ended at the earliest possible time.

501.4 All restraints shall be sanitized after each use.

501.5 The health and safety of the consumer are of paramount importance at all times. If a consumer demonstrates a need for medical attention in the course of an episode of restraints or seclusion, medical priorities shall supersede behavioral priorities, the use of restraints or seclusions shall be terminated immediately, and the consumer shall receive immediate medical attention.

501.6 Restraints and seclusion are not treatment modalities. Neither the use of restraints nor the placement of a consumer in seclusion shall be included as a mental health support or mental health service in a consumer's service plan. However, a service plan may address the need for a reduction or elimination of the use of restraints or seclusion in an emergency, through the use of alternative behavior management techniques or other less restrictive interventions.

501.7 Restraints or seclusion shall never:

(a) Be used as a means of coercion, discipline, convenience, or retaliation;

(b) Be used in any manner that obstructs the airways or impairs breathing;

(c) Take the form of pepper spray, mace, handcuffs, or electronic devices, such as stun guns; or

(d) Be used simultaneously with another method of restraint, unless otherwise permitted by this chapter.

501.8 An order for restraints or seclusion shall never be written in a non-emergency situation, as a standing order, or on an as-needed basis.

501.9 Restraints shall only be used in a manner consistent with the manufacturer's instructions for care and use of the devices.

501.10 The effects of and any conditions, symptoms or injuries resulting from any restraint or seclusion used with a consumer shall be documented in the consumer's clinical record.

501.11 Specific policies and procedures for employing each method of restraint and seclusion are set forth in this chapter. Any use of a restraint or seclusion on a consumer by a MH provider's staff that is not in accordance with this chapter shall constitute a violation of this chapter, and may constitute a violation of other District or federal laws or regulations.

502 CONSUMER RIGHTS REGARDING THE USE OF RESTRAINTS AND SECLUSION

502.1 All MH provider staff shall treat each consumer receiving mental health services and supports with consideration and respect for the consumer's dignity, autonomy and privacy at all times.

502.2 Each consumer shall be provided a verbal explanation of the MH provider's Restraint and Seclusion Policy at intake or the next subsequent contact with the consumer. If the consumer is a minor or a legally incompetent adult, the consumer's parent(s) or legal guardian(s) shall also be given copies.

502.3 Each MH provider shall communicate its restraint and seclusion policy in a language the consumer, or the consumer's parent(s) or legal guardian(s) understand. When necessary, the MH provider shall provide interpreters or translators, including those for American Sign Language.

502.4 Each MH provider shall request consumers to sign an acknowledgement of the explanation of the MH provider's Restraint and Seclusion Policy and document the acknowledgement in each consumer's clinical record.

503 RESTRAINTS GENERALLY

503.1 Restraints shall include devices and techniques designed and used to control a consumer's behavior in an emergency.

503.2 Methods of restraint that may be prescribed in an emergency for consumers receiving services from an MH provider identified in § 500.7 of this chapter include:

(a) Four-point restraints;

(b) Five-point restraints;

(c) Physical Holds

(d) Legally mandated restraints;

(f) Medical restraints; and

(g) Drugs used as a restraint.

503.3 Four-point restraints are the use of soft bracelets encasing the wrists and ankles of a consumer lying on a bed (face up unless medically contraindicated), which are secured to the bed frame. Only restraint devices approved by the federal Food and Drug Administration for four-point restraints may be used.

503.4 Five-point restraints are a four-point restraint with the addition of a strap, which is placed over the consumer's upper torso and under the arms and secured to the bed frame.

503.5 A physical hold is the application of physical force by a staff person without the use of any mechanical device, for the purpose of restraining the free movement of a consumer's body. A physical hold does not include briefly holding without undue force a consumer in order to calm or comfort him or her, or holding a consumer's hand to safely escort him or her from one area to another.

503.6 Legally mandated restraints are the mechanical restraint of a consumer during transport from a hospital to District of Columbia Superior Court or Federal Court. Legally mandated restraints may also be applied in accordance with the order of a U.S. Marshal, a judge or other law enforcement official.

503.7 Medical restraints are the short-term use of physical restraint to facilitate completion of an emergency medical or surgical procedure. Medical restraint is limited to the duration of the emergency medical or surgical procedure.

503.8 A drug used as a restraint is a medication that is used to control extreme behavioral symptoms during an emergency. Drugs administered to a consumer on a regular basis as part of the consumer's regular prescribed medical regimen to treat mental, emotional or behavioral disorders or to assist the consumer in gaining self-control in accordance with the consumer's service plan shall not constitute the use of a drug as a restraint, even if the purpose of the drug is to control ongoing behavior.

504 SECLUSION GENERALLY

504.1 Methods of seclusion that may be prescribed pursuant to this chapter include the confinement of a consumer alone in a room or an area from which the consumer:

(a) Is physically prevented from leaving; or

(b) Believes he or she cannot leave at will.

504.2 Time out is not a form of restraint or seclusion. Time-out means a voluntary procedure used to assist consumers to regain emotional control by providing access to a quiet area or unlocked quiet room away from his or her immediate environment. A consumer who is physically prevented from leaving an area or led to believe he or she cannot leave an area at will is in seclusion, not in time out.

504.3 Seclusion is contraindicated for consumers who:

(a) Exhibit suicidal behaviors;

(b) Exhibit self-injurious behaviors; or

(c) Have certain medical conditions that preclude seclusion, as determined by a physician.

505 **PROHIBITIONS ON THE USE OF RESTRAINTS AND SECLUSION**

505.1 In employing restraints and seclusion, the following measures are strictly prohibited:

(a) The use of restraining nets;

(b) Ambulatory restraints (restraints which allow the consumer to walk around while restrained, such as wristlets or anklets);

(c) The simultaneous use of restraints and seclusion, unless the consumer is continually monitored face-to-face by a trained staff member, in accordance with the MH provider's DMH approved face to face monitoring policy;

(d) Restraint in the prone, face-down position unless determined medically necessary by the attending physician;

(e) "As needed" orders for restraints or seclusion;

(f) The use of restraints or seclusion in excess of twenty-four (24) hours, unless there is a court order authorizing a longer duration;

(g) The use of any restraint around a consumer's neck;

(h) Covering of the consumer's face with any material or object during the process of restraint or seclusion; and

(i) The use of unofficial restraints or seclusion, which includes any restraint or seclusion applied without an attending physician's written authorization.

505.2 If an MH provider described in §500.7 intends to simultaneously use restraint and seclusion, the MH provider shall submit its face-to-face monitoring policy to DMH's chief clinical officer for review and approval. A face-to-face monitoring policy shall require a one-on-one assignment of a trained staff person to the doorway of the seclusion room for the duration of the simultaneous use of the restraint and seclusion. An MH provider shall not simultaneously use restraint and seclusion without the prior written approval from DMH's chief clinical officer of its face-to-face monitoring policy.

506 **INITIATING THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINTS OR SECLUSION**

506.1 Unless otherwise specified in this section or in federal regulations, only a physician licensed to practice medicine in the District, may order the use of restraints or seclusion. Such orders shall be in writing, except as set forth in §506.2.

506.2 In emergency situations in which a physician is not immediately present, a consumer may be placed in restraints or seclusion by a registered nurse (RN) before a written physician's order is obtained. In such cases:

(a) A verbal order shall be obtained from the attending or treating physician and documented immediately. If a verbal order is not obtained from the attending or treating physician within fifteen (15) minutes, the restraints or the seclusion shall be terminated;

(b) The RN in charge shall document as soon as possible:

(1) Justification for the use of restraints or seclusion;

(2) Alternative strategies which failed to manage the consumer's behavior or why other strategies were considered but deemed impractical or unsafe;

(3) The consumer's current behaviors and mental and emotional status; and

(4) The consumer's physical status;

(c) The physician issuing the verbal order shall conduct a face-to-face assessment of the consumer within one (1) hour of the consumer being placed into restraints or seclusion; and

(d) If the physician does not conduct the face-to-face assessment within one hour of initiation of the restraints or seclusion so as to confirm the initial verbal order, the consumer shall be released at that time.

506.3 The physician ordering the restraints or seclusion shall be available for consultation with MH provider staff throughout the period the consumer is restrained or secluded.

506.4 Any order for the use of restraints or seclusion shall not exceed the following durational limitations:

(a) Four (4) hours for adults;

(b) Two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; and

(c) One (1) hour for children under nine (9) years of age.

506.5 Any orders for restraints or seclusion may only be renewed for up to a maximum of twenty-four (24) hours.

506.6 If the emergency precipitating the use of restraints or seclusion with the consumer continues beyond the limitations of the initial order, the RN shall immediately contact the physician to receive further instructions.

506.7 If the emergency precipitating the use of restraints or seclusion ends and the restraints or seclusion are discontinued before the expiration of the original order, a new order shall be obtained prior to reinitiating seclusion or reapplying restraints.

506.8 Any new order for the use of restraint or seclusion, or any order continuing the use of a specific restraint or seclusion for a consumer, or order for the use of a new restraint or placement in seclusion following expiration of an initial order for restraint or seclusion shall be given in accordance with this section.

506.9 Each written order for restraints and seclusion shall state:

(a) The name of the physician giving the order;

(b) The date and time the written order was given;

(c) Whether the order was for the "initial" implementation of a restraint or placement in seclusion or the "continued" use of a restraint or seclusion;

(d) The specific restraints (four-point or five-point) or form of seclusion ordered, including the authorized duration of the restraints or seclusion;

(e) Any special instructions needed due to the consumer's medical condition, physical disability, or history of abuse;

(f) If required, the need for monitoring of specific medical conditions or more frequent monitoring of vital signs; and

(g) The behavioral criteria for discontinuation of restraints or seclusion, and whether the consumer has been informed of the criteria for discontinuation.

506.10 For each order for restraint or seclusion, the physician shall also document in the consumer's clinical record, a note separate from the order, which shall include:

(a) Any less restrictive techniques, such as behavioral interventions or non-physical interventions used, attempted, or considered prior to ordering the use of restraints or seclusion, as well as the reasons those techniques were not used or were ineffective;

(b) Whether there are any pre-existing medical conditions or any physical disabilities that would place the consumer at potentially greater risk during the use of restraints or seclusion;

(c) To the extent known, whether the consumer has a history of trauma, sexual, or physical abuse that would place the consumer at greater psychological risk during the use of restraints or seclusion;

(d) The basis, including a description of the consumer's behavior and the circumstances leading to the use of restraint or seclusion, and justification for ordering the use of the specific restraint or seclusion; and

(e) A summation of the consumer's mental status at the time of the face-to-face evaluation by the physician.

506.11 The criterion for release of a consumer from restraints or seclusion is that the consumer no longer presents an imminent risk of serious injury to self or others, rather than that a period of time has passed.

507 SPECIFIC PROCEDURES FOR THE USE OF SECLUSION

507.1 When secluding a consumer, the following procedures shall be observed:

(a) All potentially dangerous articles shall be removed from the consumer's person and the seclusion area;

(b) If unclothed, the consumer shall be offered clothing at the earliest possible time;

(c) The consumer shall not be placed in any room or environment where there are potentially hazardous conditions, such as electrical outlets, frayed wires, high temperatures, high humidity, or light fixtures in disrepair; and

(d) The consumer shall be continually monitored as described in §§508.3 and 508.4 of this chapter, and the physical, mental, and emotional needs of the consumer shall be given prompt attention at all times.

507.2 If the MH provider secludes a consumer under the age of eighteen (18):

(a) The consumer shall be continuously monitored by staff who shall be inside the seclusion area; and

(b) The room shall not be locked or otherwise secured in any manner;

508 **MONITORING THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINT OR SECLUSION**

508.1 Within one (1) hour after initiation of the use of restraint or seclusion and following the discontinuation of any restraints or seclusion of a consumer pursuant to this chapter, the physician shall conduct a face-to-face assessment of the physical, behavioral, mental, and emotional status of the consumer, including without limitation:

(a) The consumer's physical, mental, and emotional state;

(b) The consumer's behavior;

(c) The appropriateness and effectiveness of the restraints or seclusion employed;

(d) Any complications resulting from the use of the restraint or seclusion; and

(e) Any medications ordered and the reasons for their use.

508.2 Such examination shall be documented in the consumer's clinical record, including the date and time of the examination, the name of the individual making the examination, and the findings of the examination.

508.3 In addition to an assessment by the consumer's physician, a trained and competent staff person shall, in person, continuously monitor and observe and regularly assess the consumer throughout the restraint or seclusion. This monitoring and assessment shall be documented and shall include at a minimum:

(a) Fifteen (15) minute assessments for signs of injury or medical distress;

(b) Hourly assessments of nutrition and hydration needs;

(c) Fifteen (15) minute assessments for circulation and hourly opportunities for range of motion in extremities;

(d) Elicitation of vital signs at implementation of restraints or seclusion, with vital sign checks every fifteen (15) minutes for the first thirty (30) minutes, and if stable, then hourly and then again upon release from restraints. If unable to elicit vital signs at any time, the staff shall document efforts to obtain vital signs and the reasons it could not be done;

(e) Hourly assessments of hygiene and elimination needs;

(f) Fifteen (15) minute assessments of mental health status; and

(g) Minimally, fifteen (15) minute assessments for readiness for discontinuation of restraints or seclusion.

508.4 Remote observation of a consumer via video camera or other device or technique is not permissible to meet the requirements of §508.3.

508.5 The consumer shall be released from restraints and seclusion when there is an assessed stabilization of behavioral status such that the consumer no longer presents an imminent risk of serious injury to self or others, or when the order for restraints or seclusion expires and is not renewed, whichever is earlier.

508.6 Restraints and seclusion may be terminated upon authorization of an RN or physician, except in the case of an emergency, when any staff may remove a consumer from restraints or seclusion to administer emergency treatment, evacuate the consumer from a hazardous condition such as fire or flood, or if for any reason the restraint or seclusion is causing harm to the consumer's physical health or safety.

509 POST EVENT ANALYSIS OF THE USE OF FOUR-POINT AND FIVE-POINT RESTRAINT OR SECLUSION

509.1 All staff involved in the use of restraint or seclusion shall, within twenty-four (24) hours of the application of restraint or seclusion, conduct a post event analysis among themselves regarding the events surrounding the emergency that required the use of restraints or seclusion. The post event analysis is separate from the more formal treatment team debriefing described in §§510 that is conducted by the consumer's team.

509.2 The MH provider's nursing supervisor, the nursing supervisor's designee or risk manager shall chair the post event analysis meeting. The post event analysis shall, at a minimum, include a discussion of:

(a) The emergency that required the use of restraints or placement in seclusion, including a discussion of the precipitating factors that led up to the use of restraint or placement in seclusion;

(b) Alternative techniques that might have prevented the use of the restraint or seclusion;

(c) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraints or seclusion; and

(d) The outcome of the intervention, including any injuries that may have resulted from the use of restraints or seclusion.

509.3 Issues, concerns, and recommendations from the post event analysis meeting, shall be documented, by the person chairing the meeting, in a manner consistent with standard peer review and continuous quality improvement practices.

510 **TREATMENT TEAM DEBRIEFING MEETING REGARDING THE USE OF FOUR-POINT AND FIVE POINT RESTRAINTS OR SECLUSION**

510.1 The consumer's treatment team shall conduct a treatment team debriefing following each incident of restraint or seclusion. If use of restraint or seclusion occurred at a site-based mental health crisis emergency program certified by DMH or at a DMH-contracted psychiatric crisis stabilization program, the treatment team members shall be deemed to include a representative from the consumer's assigned core service agency and the consumer's ACT team, if the consumer is currently authorized to receive ACT services.

510.2 The treatment team debriefing is a face-to-face meeting, which shall include treatment team members, the consumer, and the consumer's family members or personal representatives if the consumer so consents and they are available.

510.3 The treatment team debriefing shall include discussions about the causes giving rise to the emergency requiring the use of restraint or seclusion and how this information can be used to prevent future occurrences.

510.4 The treatment team debriefing meeting shall be initiated by the consumer's treatment team within twenty-four (24) hours following each incident of restraint or seclusion, or within the next business day in the case of weekends and holidays. The treatment team debriefing shall result in the following outcomes:

(a) Assisting the consumer and staff in understanding the precipitants which may have evoked the behaviors necessitating the use of restraints or seclusion;

(b) Assisting the consumer in developing appropriate coping mechanisms or alternative behaviors that could be effectively utilized should similar situations, emotions, or thoughts present again;

(c) Assisting the staff in developing appropriate alternatives to the use of restraints or seclusion; and

(d) Developing and documenting, for inclusion in the service plan, a specific plan of interventions designed to avoid the future need for the use of restraints or seclusion.

510.5 MH provider staff shall document, in the consumer's clinical record, the time and place of the treatment team debriefing, the names of all individuals participating in the treatment team debriefing, the names of the MH provider staff excused from the treatment team debriefing and the reason for their absence, and any changes to the consumer's service plan that result from the debriefing.

510.6 The consumer shall be offered and provided any needed or desired counseling or treatment for any trauma that may have resulted from the use of restraints or seclusion.

510.7 MH provider staff shall notify the chief clinical officer or medical director for the MH provider each time restraints or seclusion for a consumer are used for a period of more than twelve (12) hours or when two (2) or more separate orders for restraints or seclusion of a consumer are given within twelve (12) hours of each other.

511 PHYSICAL HOLDS

511.1 A physical hold is the application of physical force by a trained or qualified staff person without the use of any mechanical device, for the purpose of restraining free movement of a consumer's body. A physical hold does not include briefly holding without due force a consumer in order to calm or comfort him or her, or holding a consumer's hand to safely escort him or her from one are to another.

511.2 A trained or qualified staff person may use physical holds, without a physician's order, for up to fifteen (15) minutes in an emergency where physical violence against self, another person, or property is occurring. A physical hold is used solely for the purpose of preventing harm to the consumer, the staff person, others or property.

511.3 The attending or treating physician shall order any use of a physical hold that will last longer than fifteen (15) minutes.

511.4 A second trained or qualified staff person shall be assigned to observe the consumer during the use of a physical hold.

511.5 For any use of a physical hold longer than fifteen (15) minutes, the procedures set forth in §§506.3, 506.6, 506.7, 506.8, 506.9, 506.10, and 506.11of this chapter shall be followed.

511.6 Any order for a physical hold shall not exceed a total of one (1) hour.

511.7 The MH provider shall conduct a post event analysis and a treatment team debriefing in accordance with the requirements of §§509 and 510, respectively, for any use of a physical hold longer than fifteen (15) minutes.

512 MEDICAL RESTRAINTS

512.1 Medical restraints may be used to administer medical or surgical treatment to an uncooperative consumer, if:

(a) In the written opinion of a physician licensed to practice medicine in the District, medical or surgical treatment is necessary to prevent the immediate serious injury or death of the consumer; and

(b) The procedures set forth in §§ 506.3, 506.9, 506.10 and §§508.1, and 508.2, governing the use of restraints, are followed.

512.2 The MH provider shall document in the consumer's clinical record that all attempts to gain the consumer's cooperation through less restrictive means have failed, or that making such attempts would delay the necessary emergency treatment and further jeopardize the consumer's life and safety.

512.3 The documentation in the consumer's clinical record shall also describe the circumstances that give rise to the medical emergency, as well as the reasons why restraints are deemed necessary to administer the needed treatment.

512.4 In the event the consumer is a minor or an adult with a legal guardian, the parent or guardian's consent shall be obtained if possible. If the parent or guardian is not available, the MH provider shall document all attempts to gain the parent's or guardian's consent, or that making such attempts would delay the necessary emergency treatment and further jeopardize the consumer's life and safety.

512.5 The least restrictive and most comfortable restraints available shall be used as necessary to accomplish the emergency medical or surgical procedure. The restraints may only be applied for the duration of the procedure and then shall be removed.

512.6 The use of restraints to perform routine medical procedures, such as phlebotomy, urine screen, or x-ray is prohibited, unless informed consent to the restraint is obtained from the consumer or the consumer's surrogate healthcare decision-maker pursuant to 22A DCMR, Chapter 1. The consent shall be in writing and placed into the consumer's clinical record for each procedure.

513 LEGALLY MANDATED RESTRAINTS

513.1 This chapter does not govern the use of legally mandated restraints. Legally mandated restraints are restraints ordered by a court-of-law, or restraints that are applied, monitored, and removed at the discretion of a law enforcement officer, such as a Deputy United States Marshal, an agent of the Secret Service, or an officer of the Metropolitan Police Department.

514 DRUG(S) USED AS A RESTRAINT

514.1 Only a physician licensed to practice medicine in the District may order a drug(s) to be used as a restraint.

514.2 A drug(s) used as a restraint is permitted only in an emergency when the consumer presents an imminent risk of serious injury to self or others and when alternative techniques are determined to be ineffective to prevent serious injury to the consumer or others.

514.3 The use of drugs to control extreme behavior shall not be administered with the intention of immobilizing the consumer's movements or rendering unconscious.

514.4 The physician ordering a drug(s) to be used as a restraint shall conduct a face-to-face assessment of the consumer within one hour of administration of the medication.

514.5 Each verbal or written order for a drug(s) to be used as a restraint shall state:

(a) The name of the physician giving the order;

(b) The date and time the written order was given;

(c) The specific medication and dosage to be administered;

(d) The target symptom or behavior for which the drug is ordered;

(e) Any special instructions needed due to the consumer's medical condition, physical disability or history of abuse; and

(f) If required, the need for monitoring of specific medical conditions or more frequent monitoring of vital signs.

514.6 For each order, the physician or RN shall also document in the consumer's clinical record, a note separate from the order, which shall include:

(a) Any less restrictive techniques, such as behavioral interventions or non-physical interventions used, attempted, or considered prior to ordering the drug;

(b) Whether there are any pre-existing medical conditions or any physical disabilities that would place the consumer at potentially greater risk due to the use of the drug; and

(c) The basis, including a description of the consumer's behavior and the circumstances leading to the use of the drug.

514.7 A trained competent staff person shall regularly assess the consumer for the first two hours after the drug is administered. This assessment shall be documented and include:

(a) Assessments for signs of injury or medical distress shall be done every fifteen (15) minutes; and

(b) Elicitation of vital signs upon administering the drug with checks every fifteen (15) minutes. If unable to elicit vital signs at any time, the staff shall document efforts to obtain vital signs and the reasons it could not be done.

515 USE OF RESTRAINTS OR SECLUSION WITH SPECIAL POPULATIONS

515.1 Consideration should be given to removing dentures or other dental devices either prior to the use of restraints or seclusion, or at the earliest opportunity after initiation of restraints or seclusion.

515.2 Only soft restraints may be used with frail consumers. Leather restraints should never be used with frail consumers as these may cause lesions or fractures, especially in cases of osteoporosis.

515.3 Consumers affected by mental retardation or developmental disability who become agitated or violent should be carefully assessed for an underlying medical condition that may be causing the behavioral change.

515.4 Children and youth residing in inpatient hospital settings or residential treatment centers shall receive an assessment to identify those who have experienced physical, psychological, or sexual trauma, including abuse, and those at high risk for seclusion and restraint events for any reason. The assessment shall include a review of the child or youth's medical condition and any disability.

515.5 The assessment referenced in §515.4 shall be completed within twenty-four (24) hours of admission.

515.6 The use of restraint or seclusion with children or youth who have been sexually or physically abused within the past two years is strictly prohibited.

515.7 For children and youth residing in hospitals or RTCs, initial service plans shall include positive interventions to avoid the use of seclusion and restraints, especially for children most likely to lose self-control.

515.8 Restraint and seclusion shall never be used for someone who is deaf or is unable to speak

516 INJURY OR DEATH AS A RESULT OF RESTRAINT OR SECLUSION

516.1 If a consumer is injured during the process of being placed in restraints or seclusion or while in restraints or seclusion, MH provider staff shall:

(a) Immediately obtain medical treatment from qualified medical personnel for the consumer;

(b) Document in the consumer's clinical records the injuries and any treatment provided for these injuries;

(c) Complete and submit an unusual incident report to the DMH Office of Accountability; and

(d) Document, in the consumer's record, any injuries to staff resulting from the use of restraints or seclusion during an emergency.

516.2 Any death that occurs while a consumer is in the process of being restrained or secluded, while the consumer is in restraints or seclusion, or any death that could reasonably have been the result of the use of restraint or seclusion shall be:

(a) Documented in the consumer's clinical record;

(b) Reported immediately (but no later than one (1) hour after discovery of the death) to the DMH Office of Accountability; and

(c) Reported to any other federal or District agencies as required by federal and District laws and regulations.

516.3 Staff involved in applying restraints or seclusion to abate an emergency that results in injury to the consumer or staff shall meet with supervisory staff to evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. The meeting and evaluation of the circumstances that caused the injury and development of a plan to prevent future injuries may occur in conjunction with either the post event analysis described in §509 or the treatment team debriefing described in §510.

517 PROTECTIVE MEASURES

517.1 Protective measures involve the use of gerichairs, chairs with trays, bed rails, straps, mitts or other devices which restrict freedom of movement or access to one's body in order to prevent falls, maintain posture and for other medical purposes.

517.2 All MH providers may use protective measures in accordance with the requirements of this chapter.

517.3 Protective measures shall be used only as a last resort when other adaptive or assistive devices, physical therapy, or environmental changes are inadequate to prevent injury to the consumer.

517.4 The application of any protective measure that involves a physical restraint (a device, material, or apparatus that the consumer cannot easily remove) may only be applied in accordance with the procedures set forth in §§ 506.1 – 506.11 and §508 of this chapter. All other protective measures may be applied pursuant to the procedures set forth in this section.

517.5 A RN may initiate the use of protective measures but shall obtain a physician's verbal order within one (1) hour of initiating protective measures. The initiation of protective measures shall be based on a documented assessment of the consumer's history and condition that indicates the strong probability that substantial harm to the consumer will occur in the absence of such measures.

517.6 If the consumer is a minor or an adult who has a legal guardian, the MH provider staff shall notify the parent(s) or legal guardian(s) that the consumer has been placed in protective measures promptly after the initiation of these measures.

517.7 Use of protective measures requires a written time limited order by the attending or treating physician. An order for protective measures may be written for up to twenty-four (24) hours.

517.8 Scheduled observations for consumers in protective measures shall be made every fifteen (15) minutes and documented in the consumer's clinical record.

517.9 Trained nursing staff shall periodically assess any consumer in protective measures. The protective measures shall be discontinued as soon as alternative measures for safety are feasible.

517.10 Physical needs of consumers in protective measures shall be promptly met. The consumer's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, range of motion, meals, and hygiene shall be provided and documented throughout the use of the protective measures. The consumer shall be monitored and assisted by:

(a) Recording the consumer's physical condition every fifteen (15) minutes;

(b) Assessing for safety, circulation and comfort every fifteen (15) minutes;

(c) Providing an opportunity for hourly access to the bathroom (or more often as appropriate) while the consumer is awake;

(d) Providing an opportunity for regular meals with any needed special precautions taken;

(e) Providing an opportunity for fluids at least every one (1) hour while the consumer is awake, with fluid type and amount recorded when consumed;

(f) Providing an opportunity for range of motion of extremities every two (2) hours while the consumer is awake; and

(g) Providing an opportunity for a bath or shower at least once each twenty-four (24) hours or more often when necessary.

517.11 A service plan update is required for any consumer in protective measures in excess of twenty-four (24) hours. The service plan shall address the use of alternative interventions to reduce the need for protective measures.

517.12 All protective devices shall be sanitized after each use.

517.13 Protective devices shall only be used in a manner consistent with the manufacturers instructions for case and use of the devices.

518 **NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN(S) OF USE OR CONTINUATION OF RESTRAINTS OR SECLUSION**

518.1 If the consumer is a minor or an adult with a legal guardian, the MH provider staff shall notify the parent(s) or legal guardian(s) of the consumer who has been restrained or secluded within two hours of the initiation or continuation of any restraints or seclusion.

518.2 The MH provider staff shall document in the consumer's clinical record that the parent(s) or legal guardian(s) were notified of the use of the restraints, including the date and time of notification and the name of the MH provider staff member providing the notification.

518.3 In the event the parent(s) or legal guardian(s) cannot be located, diligent effort to contact them shall be documented.

519 **MH PROVIDER POLICIES AND PROCEDURES**

519.1 Each MH provider shall establish, maintain, and adhere to written policies and procedures regarding the use of restraints and seclusion for consumers that comply with applicable federal and District laws and regulations. A MH provider that is not specifically authorized to use restraint and seclusion pursuant to §§500.7 shall establish a policy strictly prohibiting the use of restraints and seclusion at any time, although the policy shall also require reporting of the use of restraint or seclusion and staff training.

519.2 The written policies and procedures for the MH providers identified in §500.7 shall describe the following:

(a) How respect for consumers and their families will be maintained prior to, during, and after the utilization of any method of restraint or seclusion;

(b) The use of a consumer's advance instructions regarding treatment preferences in the event of a psychiatric emergency and how those treatment preferences will be honored.

(c) The process or opportunity for a consumer who is in restraints or seclusion to maintain personal care, participate in personal care processes, engage in normal bodily functioning (including access to toilets), receive nourishment and fluids, exercise limbs, have a systematic release of restrained limbs, and receive other necessary care during and immediately after the utilization of any restraints or seclusion;

(d) The process for ensuring and monitoring the safety and hygiene of a consumer who is in restraints or seclusion;

(e) The DMH-approved policy for face-to-face monitoring required by §505.2 for MH providers using restraints and seclusion simultaneously;

(f) The process for monitoring the space used for restraint or seclusion to ensure a comfortable room temperature and necessary light at all times;

(g) How the physical, mental, and emotional well being of the consumer will be promoted and maintained at all times during the use of restraint and seclusion;

(h) How the consumer's modesty, appropriate visibility to others, and comfortable body temperature will be maintained and monitored at all times during the use of restraint and seclusion;

(i) Which staff are responsible for examining and monitoring the consumer prior to, during, and after the utilization of any method of restraint or seclusion;

(j) Which staff have authority to order the initiation of and discontinuation of restraints and seclusion;

(k) What techniques staff should use prior to using restraints or seclusion;

(l) What assistance shall be provided to a consumer who has been placed in restraints or seclusion to assist the consumer in meeting the criteria for discontinuation of the restraints or seclusion, which staff are responsible for providing this assistance, and documentation requirements;

(m) Which staff are responsible for reporting any injuries or death of a consumer being placed in or while in restraints or seclusion;

(n) The training requirements for all staff that have direct contact with consumers as required by these rules;

(o) The process for debriefing the consumer and the consumer's family, if appropriate, and MH provider staff following the use of any restraint or seclusion;

(p) The process for reviewing compliance with the MH provider's restraint and seclusion policy by all MH provider staff;

(q) The process for complying with reporting requirements and other external mandates regarding the use of restraints or seclusion on consumers; and

(r) Information on how a consumer may contact the District's Protection and Advocacy program, including the name of the program and its address and phone number.

519.3 MH providers shall include consumers and families in formulating the MH provider's restraint and seclusion policy.

519.4 Each MH provider shall ensure that all MH provider staff, including administrative, clerical, and support staff, comply with the MH provider's restraint and seclusion policy.

520 MH PROVIDER REPORTING REQUIREMENTS

520.1 Each MH provider shall provide certification of its compliance with this chapter to DMH within thirty (30) days of the effective date of this chapter and annually thereafter. The MH provider shall prepare its initial and annual certification of compliance with this chapter using a format approved by DMH.

520.2 If a MH provider has provided a written attestation of its compliance with federal rules and regulations governing the use of restraints and seclusion to the District's Medicaid Administration Agency (MAA), the MH provider shall also provide DMH with a copy of the MAA attestation.

520.3 Each MH provider shall report the death of a consumer or other serious injury that may have reasonably resulted from the use of restraint or seclusion to DMH in accordance with DMH's unusual incident reporting policy as set forth in §516.1 and 516.2, and applicable federal and District laws and regulations.

520.4. Each use of restraint or seclusion shall be reported to the MH provider's quality improvement committee for review, discussion, trend analysis and any recommendations for programmatic or treatment changes.

520.5 The DMH Deputy Director for Accountability may require an external review of a MH provider's use of seclusion and restraint based on increasing or excessive utilization patterns, injuries to staff or consumers, or deviations from this policy.

520.6 The MH provider shall also comply with any reporting requirements deemed necessary by DMH.

521 STAFF EDUCATION AND TRAINING

521.1 Each MH provider identified in §500.7 shall design and implement a training and education program for all MH provider staff aimed at minimizing the use of restraint and seclusion and maximizing safety for consumers and MH provider staff when restraint or seclusion are used.

521.2 Each MH provider shall require all staff members to receive effective, ongoing, competency-based education and training on the following:

(a) Understanding and appropriately responding to underlying behaviors of consumers that precipitate the use of restraints or seclusion;

(b) Techniques to identify staff interactions, consumer medical conditions, and environmental factors that may trigger consumer behavior resulting in the use of restraints or seclusion;

(c) The use of de-escalation and other non-physical behavior management techniques, such as mediation, conflict resolution, active listening, and verbal and observational methods, to reduce or eliminate the use of restraints and seclusion;

(d) The safe use of restraints and seclusion, including the ability to recognize and respond to signs and symptoms of physical, mental, medical or emotional distress, or impairments or injury in consumers who are restrained or secluded; and

(e) Cardiopulmonary resuscitation (CPR), including certification and periodic re-certification in CPR.

521.3 Each MH provider identified in §500.7 shall require all staff members who are authorized to physically apply restraints or seclusion to receive ongoing training and demonstrate competence in the safe use of restraints and seclusion, including:

(a) Acceptable techniques for physically holding a consumer;

(b) Acceptable take-down procedures; and

(c) Acceptable means for applying and removing all types of restraints used, including protective measures.

521.4 Each MH provider identified in §500.7 shall require all staff members who are authorized to perform fifteen (15) minute assessments of consumers in restraints or seclusion to receive ongoing training and demonstrate competence in:

(a) Taking vital signs and interpreting their relevance;

(b) Recognizing nutritional and hydration needs;

(c) Checking circulation and range of motion in extremities;

(d) Addressing hygiene and elimination needs;

(e) Addressing physical and psychological status and comfort;

(f) Assisting consumers in meeting behavioral criteria for the discontinuation of restraints or seclusion; and

(g) Recognizing when to contact a physician or emergency medical services to evaluate or treat a consumer's physical condition.

521.5 Each MH provider identified in §500.7 shall require all staff members who are authorized to initiate the use of restraints or seclusion, or to perform evaluations of consumers who are in restraints or seclusion to receive education about and demonstrate competence in:

(a) Recognizing how age, developmental considerations, gender issues, cultural issues, ethnicity, traumatology, and history of sexual or physical abuse may affect the way in which a consumer reacts to physical contact; and

(b) The use of behavioral criteria for the discontinuation of restraints or seclusion and how to assist a consumer in meeting the criteria.

521.6 All staff employed by MH providers shall demonstrate their competencies, as specified in this section, on an annual basis.

521.7 Each MH provider shall ensure adequate levels of staffing and appropriate staffing configurations at all times, based on factors such as the physical environment, consumer diagnosis and needs, co-occurring conditions, acuity levels, and the age or developmental status of each consumer.

521.8 Each MH provider shall include an annual evaluation of the factors set forth in §521.2 in its staff performance evaluation or quality improvement program.

521.9 Each MH provider shall document in the staff personnel records that necessary training; education and competency have been successfully completed. Documentation shall include the date training was completed, the type of training completed, and the name of the individual certifying the completion of training.

521.10 All training programs and materials used by each MH provider shall be made available, upon written request, for review by DMH.

522 VIOLATIONS OF THIS CHAPTER

522.1 If the consumer or any third party believes that the consumer's rights with respect to the use of restraints or seclusion have been violated for any reason, such consumer or third party may file a grievance in accordance with the procedures prescribed in 22A DCMR, Chapter 3.

522.2 Violations of this chapter may subject the MH provider to sanctions to be determined by DMH. Sanctions may include reporting to the Center for Medicare and Medicaid Services and/or suspension or revocation of the MH provider's licensure or certification, depending on the nature of the violation.

599 DEFINITIONS

"Assertive community treatment or "ACT" -- intensive, integrated rehabilitative, crisis, treatment, and community support provided to adult consumers with serious and persistent mental illness by an interdisciplinary team, in accordance with the requirements of 22 DCMR Chapter 34.

"Assertive Community Treatment team" or "ACT team" - the mobile inter-disciplinary team of qualified practitioners and other staff involved in providing ACT to a consumer.

"Attending physician" -- the physician on duty or on call at the MH provider at the time an emergency requiring the use of restraints/seclusion occurs. In some instances, the attending physician may also be the consumer's treating physician.

"Cardiopulmonary resuscitation" – an emergency technique to revive somebody whose heart has stopped beating that involves clearing the person's airways and then alternating heart compression with mouth-to-mouth respiration.

"Consumer" -- an adult, child, or youth who seeks or receives mental health services or mental health supports in the District of Columbia under Chapter 5 of Title 21 of the District of Columbia Code, or Chapter 5 of Title 24 of the District of Columbia Code, regardless of whether the person's status is voluntary, non-protesting, or involuntary.

"Consumer statement of treatment preferences" – a document or form completed by a consumer in accordance with District of Columbia Official Code §7-1231.01 that indicates the consumer's preferences regarding the use of seclusion or restraints and less restrictive alternatives to be used or attempted in a psychiatric emergency situation. A consumer statement of treatment preferences may be contained in either a Declaration of Advance Instructions or Durable Power of Attorney for Healthcare.

"Core services agency" - a DMH-certified community-based provider of mental health rehabilitation services that has entered into a Human Care Agreement with DMH to provide specified services and serves as the clinical home for consumers enrolled in and eligible to receive mental health rehabilitation services.

"DMH" -- the Department of Mental Health, the successor in interest to the District of Columbia Commission on Mental Health Services.

"Emergency" – a situation in which a consumer is experiencing a mental health crisis and is presenting an imminent risk of serious injury to self or others.

"Inpatient mental health service" -- residence and treatment provided in a psychiatric hospital or unit, which is licensed or operated by the Mayor.

"Mayor" – means the Mayor of the District of Columbia or any executive branch agency the Mayor may designate for purposes of this chapter.

"Mental health provider" or "MH Provider" – any entity that is (1) operated, licensed, or certified by the Mayor to provide mental health services or mental health supports; or (2) that has entered into an agreement with the Mayor to provide mental health services or mental health supports.

"Physical hold" -- the application of physical force without the use of any mechanical device, for the purpose of restraining the free movement of a consumer's body.

"Physician" -- a person licensed under the laws of the District of Columbia to practice medicine, or a person who practices medicine in the employment of the government of the United States.

"Registered nurse" or "RN" -- a person licensed as a registered nurse in accordance with applicable District of Columbia laws and regulations.

"Restraints" -- a physical restraint or a drug that is used for the purpose of restraint. Restraints do not include a physical hold of fifteen (15) minutes or less in duration.

"Seclusion" -- any confinement of a consumer alone in a room or an area which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.

"Serious injury" -- any significant impairment of the physical or mental condition of a person, as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else, as well as emotional trauma requiring specific services and supports in addition to or beyond those mental health services and supports already being received by the person.

"Service plan" – the individualized recovery plan for adults or the individualized plan of care for children/youth, which includes the consumer's treatment goals, strengths, challenges, objectives, and interventions.

"Site-based crisis emergency provider" – an MH provider certified by DMH to provide crisis emergency services in accordance with 22 DCMR 3419 and provides crisis emergency services pursuant to the terms of a human care agreement with DMH. The modifier, "site-based" refers specifically to those services provided in the physical facility of the crisis emergency provider (in contrast to its community-based, outreach services). A site-based crisis emergency provider must have the ability to provide psychiatric emergency treatment including the continuous availability of an on-site or on-call psychiatrist, the continuous availability of a formulary of psychotropic medications, nursing staff continually available to give emergency orders for the use of restraints and the appropriate equipment.

"Staff" -- those individuals with responsibility for managing a person's health care or participating in an emergency and who are employed by the MH provider on a full-time, part-time, or contract basis, including without limitation physicians, nurses, orderlies, resident physicians, interns, and direct care workers.

"Treating physician" – the physician, who may be a psychiatrist, responsible for the regular and ongoing mental health treatment of the consumer. In some instances, the consumer's treating physician may also be the attending physician.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the Register. Comments should be filed with Anne M. Sturtz, General Counsel, Department of Mental Health, 64 New York Ave, N.E., Fourth Floor, Washington, D.C. 20002 or anne.sturtz@dc.gov. Additional copies of these rules are available from the Office of the General Counsel, Department of Mental Health.