SUBCHAPTER 28F – ADMISSION AND DISCHARGE

SECTION .0100 - ADMISSIONS

10A NCAC 28F .0101 REGIONS FOR DIVISION INSTITUTIONAL ADMISSIONS

(a) Except as otherwise provided in rules codified in this Chapter and Chapters 26 through 29 of this Title and except for State-wide programs and cross-regional admissions approved by the Division Director based upon the clinical need of the individual or for the purpose of accessing available beds or services, a person seeking admission to a regional institution of the Division shall be admitted only to the institution which serves the region of the state which includes the person's "county of residence" as defined in G.S. 122C-3.

(b) For state operated hospitals and developmental centers, the regions of the state and the counties which constitute the regions are as follows:

(1) Western Region: Broughton Hospital, and J. Iverson Riddle Developmental Center shall serve Alleghany, Alexander, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Davidson, Gaston, Graham, Haywood, Henderson, Iredell, Jackson, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Polk, Rowan, Rutherford, Stanly, Surry, Swain, Transylvania, Union, Watauga, Wilkes, Yadkin, and Yancey County;

(2) Central Region: Central Regional Hospital, Murdoch Developmental Center, Whitaker Psychiatric Residential Treatment Program (PRTF), and Wright School shall serve Alamance, Anson, Caswell, Chatham, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Halifax, Harnett, Hoke, Lee, Montgomery, Moore, Orange, Person, Randolph, Richmond, Rockingham, Stokes, Vance, Wake, and Warren County; and

(3) Eastern Region: Cherry Hospital and, Caswell Developmental Center shall serve Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Hertford, Hyde, Johnston, Jones, Lenoir, Martin, Nash, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Robeson, Sampson, Scotland, Tyrrell, Washington, Wayne, and Wilson County.

(c) For state-operated Alcohol and Drug Abuse Treatment Centers (ADATCs) the regions of the state and the counties which constitute the regions are as follows:

(1) Western Region: Julian F. Keith ADATC shall serve Alexander, Alleghany, Anson, Ashe, Avery, Buncombe, Burke, Cabarrus, Caldwell, Catawba, Cherokee, Clay, Cleveland, Davidson, Davie, Forsyth, Gaston, Graham, Guilford, Haywood, Henderson, Iredell, Jackson, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Montgomery, Polk, Randolph, Rowan, Rutherford, Stanly, Stokes, Surry, Swain, Transylvania, Union, Watauga, Wilkes, Yadkin, and Yancey County;

(2) Eastern Region: Walter B. Jones ADATC shall serve Alamance, Beaufort, Bertie, Bladen, Brunswick, Camden, Carteret, Caswell, Chatham, Chowan, Columbus, Craven, Cumberland, Currituck, Dare, Duplin, Durham, Edgecombe, Franklin, Gates, Granville, Greene, Halifax, Harnett, Hertford, Hoke, Hyde, Johnston, Jones, Lee, Lenoir, Martin, Moore, Nash, New Hanover, Northampton, Onslow, Orange, Pamlico, Pasquotank, Pender, Perquimans, Person, Pitt, Richmond, Robeson, Rockingham, Sampson, Scotland, Tyrrell, Vance, Wake, Warren, Washington, Wayne, and Wilson County.

History Note: *Authority G.S. 122C-3; 143B-147; S.L. 2023-3;*
Eff. February 1, 1976;
Amended Eff. June 1, 2009; April 1, 1990; July 1, 1983;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019;
Amended Eff. May 1, 2024.

SECTION .0200 – VOLUNTARY ADMISIONS, INVOLUNTARY COMMITEMENTS AND DISCHARGES OF ADULTS FROM REGIONAL PSYCHIATRIC HOSPITALS

10A NCAC 28F .0201 SCOPE

The rules in this Section apply to admissions, commitments and discharges of all clients to and from the regional psychiatric hospitals of the Division. The criteria and procedures shall be followed by staff of the hospitals and by

area program staff making referrals to the hospitals and serving clients following discharge from the hospitals. Rule .0213 of this Section contains provisions that relate only to minors from non-single portal area programs. Until the effective date of the repeal of Rules .0128 and .0129, Rules .0211 and .0212 shall supersede.

History Note: *Authority G.S. 122C-211; 122C-212; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0202 EXPLANATION OF TERMS

For the purposes of the rules in this Section the following terms shall have the meanings indicated:

(1) "Area program staff" means professionals who are employees of the area authority or who contract with the area authority or are employed by an agency which contracts with the area authority and who are clinically privileged by the area authority.
(2) "Authorization" means the process whereby area program staff approve of the hospitalization of a client currently residing in their catchment area, and agree that the hospitalization shall be included in their bed day utilization count.
(3) "Continuity of care" means the seamless integration of both inpatient and outpatient services into a unified plan of care for clients served by the area authority.
(4) "County of residence" has the meaning specified in G.S. 122C-3.
(5) "County where currently residing" means the county where the client was living immediately prior to hospitalization.
(6) "Division" means the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
(7) "Eligible Psychologist" means a licensed practicing psychologist who has at least two years' clinical experience.
(8) "Facility" has the meaning specified in G.S. 122C-3.
(9) "Hospital" means one of the regional psychiatric hospitals of the Division.
(10) "Mental illness" has the meaning specified in G.S. 122C-3.

History Note: *Authority G.S. 122C-3; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0203 AUTHORIZATION OF HOSPITALIZATION BY AREA PROGRAM

(a) Designated area program staff shall authorize all hospitalizations for individuals residing in an area program's catchment area.
(b) This authorization shall be done when the individual is evaluated by the area program for referral to the hospital for admission and shall be reviewed in accordance with area program policy.
(c) When such authorization is for an individual residing in a facility within the catchment area but whose county of residence is outside the catchment area, the authorizing area program shall notify the area program serving the individual's county of residence within 24 hours.
(d) Authorization for continuing hospitalization is the responsibility of the area program serving the individual's county of residence.

History Note: *Authority G.S. 122C-211(e); 122C-261(f); 122C-262; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0204 AUTHORIZATION OF HOSPITALIZATION WHEN INDIVIDUAL ARRIVES DIRECTLY AT HOSPITAL

(a) When an individual from an area program arrives at the hospital for admission without area program authorization, the hospital shall contact designated personnel of the individual's county of residence area program, before admission is approved.
(b) If the area program does not respond within one hour, the hospital is deemed to have been authorized to admit, and shall contact the area program on the next working day to obtain authorization for continuation of the hospitalization.

History Note: *Authority G.S. 122C-3; 122C-211; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0205 WRITTEN EVALUATION BY AREA PROGRAM
(a) Area program staff shall evaluate each individual prior to authorization and referral to the hospital unless G.S. 122C-262 applies.
(b) The evaluation shall be in writing and shall include the following:
(1) identifying information, e.g., client's full name (including maiden name), address, birthdate, race;
(2) referral source;
(3) presenting problem;
(4) if available, medications and pertinent medical and psychiatric information, including the DSM-IV diagnoses, history of treatment, side effects, allergies, last injection date, recent laboratory work;
(5) name, address and phone number of legally responsible person and next of kin, if applicable;
(6) legal charges pending, if applicable; and
(7) name and telephone number of the area program staff members to contact for further information including staff to call after regular working hours.
(c) The evaluation shall accompany the individual to the hospital.

History Note: *Authority G.S. 122C-53(a); 122C-55(a); 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0206 ADDITIONAL INFORMATION FOR TREATMENT
The following client information, if available, shall be sent with the evaluation which accompanies the individual to the hospital. If not immediately available, it shall be sent, together with any information required by Rule .0205 of this Section but not provided in the evaluation, by the authorizing area program to the appropriate hospital admissions office within one working day of the client's admission to the hospital. This information, which shall be used by hospital staff in developing the client's treatment plan, shall include but need not be limited to the following:
(1) name of client's mental health center therapist and psychiatrist and case manager, if applicable;
(2) county of residence;
(3) name, address and telephone number of the individuals in the client's family and social support network who may provide information for use in plan development;
(4) previous admissions to any state facility, i.e., psychiatric, substance abuse, developmental disabilities;
(5) current psychiatric and other medications, including compliance with medications and aftercare instructions;
(6) alternatives attempted or considered prior to referral to the hospital;
(7) goal of hospitalization specifying the treatment objectives that the hospital should address;
(8) specific suggestions for programming and other treatment planning recommendations; and
(9) release plans, which include information relevant to placement and other special considerations of the client upon discharge from the hospital.

History Note: *Authority G.S. 122C-261; 122C-262; 122C-263; 122C-264; 122C-265; 122C-266; 122C-267; 122C-268; 122C-268.1; 122C-269; 122C-270; 122C-271; 122C-272; 122C-273; 122C-274; 122C-275; 122C-276; 122C-277; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0207 COMMUNICATION TO AREA PROGRAM REGARDING ADMISSION/DENIAL

(a) In all instances where area program staff have evaluated, authorized, and referred the individual to a hospital with a recommendation for admission, the area program staff shall call the hospital admission office to inform it of the authorization and referral, and advise it as to the name and phone number of an area program contact person.
(b) If the opinion of the examiner at the hospital is that the individual does not meet inpatient criteria, the examiner shall contact designated area program staff to discuss the individual's condition prior to releasing the individual. Unreasonable delay shall not occur as a result of the foregoing and in no event shall the individual be detained by the hospital for more than 24 hours.
(c) If the opinion of the examiner is that the individual does meet inpatient criteria, the hospital shall contact designated area program staff within 24 hours to notify them of the admission.
(d) When the hospital staff does not accept a client for admission, the hospital staff, client, area program staff, and if applicable, family or legally responsible person, shall discuss where in the community the client shall be returned and shall discuss with the client options for receiving services.

History Note: *Authority G.S. 122C-132; 122C-221; 122C-261; 122C-262; 122C-263; 122C-264; 122C-265; 122C-266; 122C-267; 122C-268; 122C-268.1; 122C-269; 122C-270; 122C-271; 122C-272; 122C-273; 122C-274; 122C-275; 122C-276; 122C-277; 122C-261; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0208 GENERAL CRITERIA FOR ADMISSION

(a) Admission staff shall evaluate the individual to determine that:
(1) there is the presence of mental illness;
(2) the individual is in need of treatment or further evaluation at the facility; and
(3) admitting the individual to the hospital is an appropriate treatment modality.

(b) The individual shall currently reside in the region served by the hospital unless one or more of these exceptions occurs:
(1) A transient resident of another state who requires hospitalization shall be admitted to the hospital serving the region in which the client is found.
(2) A defendant who is ordered to a state mental health facility for determination of capacity to proceed to trial (G.S. 15A-1002) may be admitted to the Forensic Unit at Dorothea Dix Hospital.
(3) An individual whose treatment needs have necessitated a cross regional admission from the hospital in his region may be admitted as arranged by the Division's Chief of Mental Health Services or his designee.
(4) In case of emergency, a client may be admitted to a hospital outside of the region of residence. Subsequent transfer may include transfer to the appropriate regional hospital and such transfer shall be in accordance with G.S. 122C-206.
(5) A client from any catchment area of the state may be considered for admission to the Clinical Research Unit of Dorothy Dix Hospital. In the case of a client of another regional hospital, application shall be made in accordance with G.S. 122C-206.

(c) An individual shall not be admitted to a hospital if the:
(1) primary need is custodial care pending rest home or nursing home placement;
(2) treatment needs can be met locally;
(3) admission is sought primarily because of a lack of living space or financial support; or
(4) primary medical or surgical problem can be more appropriately treated in a general hospital.

History Note: *Authority G.S. 122C-3; 122C-132; 122C-206; 122C-221; 122C-261; 122C-262; 122C-263; 122C-264;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0209 COORDINATION AND CONTINUITY OF CLIENT CARE

(a) Each hospital in conjunction with each area program shall develop a process to assure ongoing communication between the hospital and area program regarding clients in treatment at the hospital. This process shall include provisions for case collaboration, particularly around treatment issues and issues related to discharge planning and community care. For minor clients and for adult clients adjudicated incompetent, such collaboration shall include the legally responsible person. The process shall include but is not limited to the following:

(1) specifically designated staff at both the hospital and area program to facilitate communication;
(2) routinely scheduled case management contact at hospital site;
(3) hospital staff visitation to area programs;
(4) telephone conferences; and
(5) a discharge plan developed in collaboration among hospital and area program staff and client.

(b) The process for ongoing communication shall be incorporated into each area program's written agreement with the state hospital.

History Note: *Authority G.S. 90-21.1; 122C-3; 122C-132; 122C-221; 122C-223; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0210 NOTIFICATION OF CLIENT HEARING AND/OR DISCHARGE

(a) The hospital shall give the authorizing area program 72 hours notice of planned discharge of all clients except those clients for whom unplanned discharge precludes 72 hours notice. In those cases notice shall be given within 24 hours. If there is a disagreement between the hospital and area program regarding the planned discharge of a voluntary client, the disagreement shall be resolved by the procedures specified in Rule .0212 of this Section.

(b) The hospital shall provide 24 hours notice to the authorizing area program prior to a court hearing, of the recommendations to be made at the hearing. At the time of this notification, a collaborative discharge contingency plan shall be developed in case the judge does not order commitment.

(c) The Post-Institutional Plan, together with the items specified in Rule .0211 of this Section, shall be sent to the authorizing area program within 24 hours of discharge.

(d) A discharge summary shall be sent to the authorizing area program prior to the first scheduled appointment and in any case no later than 15 days after discharge.

History Note: *Authority G.S. 122C-112; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0211 PLACEMENT OF CLIENTS OUTSIDE THEIR COUNTY OF RESIDENCE

Note: Until the effective date of the repeal of Rule .0128 of this Section, this Rule shall supersede.

(a) If a discharge plan proposes that a client live in a facility outside his county of residence, hospital staff shall notify the authorizing area program so that the area program can begin making such a living arrangement. Hospital staff shall provide the authorizing area program with information which shall include:

(1) the client's status, diagnosis and needs;
(2) information regarding the facility being considered; and
(3) information regarding the facility's ability to serve the client being considered to live there.

(b) The authorizing area program shall contact the area program in the county of the facility to share client information, and collaboratively develop a plan for appropriate services provision, authorization, and payment.
(c) When a client discharged from a hospital moves to a facility outside his county of residence, the hospital shall send, at the time of discharge, the following records to the authorizing area program serving the client's county of residence:

(1) hospital's psychiatric evaluation;
(2) social history, such as family constellation, order of birth, and developmental history; and
(3) post-institutional plan.

In addition, the hospital discharge summary shall be sent to the authorizing area program within 15 days of discharge. This area program shall share the information with the area program serving the client in the county of the facility.

History Note: *Authority G.S. 122C-3; 122C-112; 122C-117; 143B-147;*
Eff. February 1, 1989;
Amended Eff. July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0212 RESOLUTION OF DIFFERENCES OF OPINION

(a) Differences of opinion between area authority/county program staff and hospital staff regarding admission, treatment or discharge issues shall be resolved through negotiation involving hospital and area authority/county program staff, clients, legally responsible persons, and with client consent, family members.
(b) If resolution of issues regarding authorization, admission or discharge is not reached by the Directors of the two organizations, the dispute shall be resolved following the procedures as set forth in 10A NCAC 26A .0200; 10A NCAC 27G .0810 through .0812 continuing to the final level of appeal, if necessary, with procedures in G.S. 150B, Article 3 Administrative Hearings.
(c) During the resolution of differences of opinion between area authority/county program and hospital staff, the client shall be provided with the more conservative and secure treatment option.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1989;
Amended Eff. November 1, 2005; July 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0213 REFERRALS OF MINORS FROM A NON-SINGLE PORTAL AREA

(a) In a non-single portal area, in addition to area program staff, a licensed physician or eligible psychologist may refer a minor directly to a hospital. This person shall be known as the "referring agent."
(b) As part of the referring process, the referring agent shall provide the evaluation and other information specified in Rules .0205 and .0206 of this Section.
(c) To assure appropriate planning for treatment, discharge, and aftercare, when a licensed physician or eligible psychologist makes a referral pursuant to this Rule, he or she shall be asked by the hospital to agree in writing to:

(1) continued involvement with the child and family during hospital treatment;
(2) participation in identification and coordination of community services that are essential to discharge planning; and
(3) provision of aftercare, as needed.

(d) If the referring agent does not sign the agreement described in Paragraph (c) of this Rule, the hospital staff shall consult with the minor's legally responsible person to determine a practitioner to participate in discharge and aftercare planning. The area program staff shall be considered as an option. The selected practitioner shall be considered to be the referring agent.
(e) For purposes of Rules .0207 through .0212 of this Section, the referring agent shall perform the consultation, communication and notice functions described for area program staff. The area program staff also shall participate and shall receive the notices prescribed in those Rules.

History Note: *Authority G.S. 122C-112; 143B-147;*
Eff. February 1, 1989;

Amended Eff. July 1, 1996; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0300 - MEDICAL STAFF BYLAWS OF NORTH CAROLINA REGIONAL MENTAL HOSPITALS

10A NCAC 28F .0301 ORGANIZATION OF STAFFS

The medical and dental staffs of the four psychiatric hospitals shall organize themselves in conformity with the model bylaws and rules set forth in Rule .0308 of this Section. Rule .0308 of this Section shall be the model bylaws and rules used by each such association in drafting of bylaws and rules for itself and each such association shall have bylaws and rules in substantial conformity to those in Rule .0308 of this Section.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0302 APPLICANTS FOR MEMBERSHIP

Applicants for membership on the medical staffs shall be duly licensed or authorized to practice medicine or dentistry in the State of North Carolina according to those standards set forth by the North Carolina State Board of Medical Examiners or the North Carolina State Board of Dental Examiners. No applicant shall be denied staff membership on the basis of sex, race, creed, color, or national origin. Staff members shall indicate their acceptance of membership on the medical staff by signed agreement that they will abide by the medical staff bylaws, rules, and regulations and by the bylaws of the governing body.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0303 MEDICAL DIRECTOR OF HOSPITAL

The medical director of a hospital shall be a member of the hospital medical staff and shall be a medical doctor duly licensed to practice medicine in the State of North Carolina with approved training and experience in the practice of psychiatry.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0304 APPLICATION PROCESS

Applicants for the medical staff may be appointed or reappointed by the Director of the hospital with concurrence of the Director of Clinical Services and after consultation with the credentials committee. Appointment to the medical staff shall confer upon the appointee only such privileges as may hereinafter be provided. Determination of privileges will be made by the Director and Director of Clinical Services after recommendation of the executive committee of the medical staff. Such determination is based on applicant's training, experience, demonstrated competence, and conducted satisfactory performance of duties.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0305 RESTRICTION OR TERMINATION OF STAFF PRIVILEGES

Should the superior of any physician or dentist recommend restriction or termination of the employment of any physician or dentist of the medical staffs for personal conduct or performance of duties issues as specified in the State Personnel Manual, such recommendation will be forwarded in writing to the Director and Director of Clinical Services who in turn may, within a period of five days, refer said recommendation to the executive committee of the medical staff for review. The result of this review will be forwarded to the Director within five days. If the Director and Director of Clinical Services accept the recommendation of the executive committee of the medical staff, said recommendation will be made known to the physician or dentist in question. Further appeal may be made in accordance with the standard grievance procedure established by the State Personnel Act. Any physician or dentist may be suspended by the Director and Director of Clinical Services for flagrant misconduct pending the appeal mechanism as state above.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0306 EMERGENCY AND TEMPORARY PRIVILEGES

The Director and Director of Clinical Services shall have the authority to grant emergency and temporary privileges to a qualified physician who is not a member of the medical staff for a period of time not to exceed 30 days.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0307 DIVISIONS OF STAFF

The medical staff shall be divided into honorary, visiting, active, and resident staffs. Officers, standing and special committees shall be elected and appointed with duties assigned, including meeting schedules and attendance requirements, in accordance with the model bylaws.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0308 MEDICAL STAFF BYLAWS FORM

(a) Preamble

(1) Recognizing that the medical and dental staff is responsible for the quality of medical care in the hospital and must take steps to assume this responsibility, and that the best interests of the patient are protected by concerned effort, subject to the authority of the Division of Mental Health Services, the physicians and dentists practicing in (fill in name) hospital hereby organize themselves in conformity with the bylaws, rules, and regulations hereinafter stated.

(2) For the purpose of these bylaws the words "medical staff" shall be interpreted to include all physicians and dentists who are privileged to attend to patients in (fill in name) hospital.

(3) The term "governing body" means the Director of the Division of Mental Health Services.

(4) Whenever the term "director" appears, it shall be interpreted to refer to the Director of (fill in name) hospital as duly appointed by the Director of the Division of Mental Health Services, North Carolina Department of Human Resources.

(5) Whenever the term "Director of Clinical Services" appears, it shall be interpreted to mean that person responsible for all medical and clinical services where the Director is a non-medical administrator.

(6) Whenever the term "paramedical staff" appears, it shall be interpreted to include the professional members of the Department of vocational rehabilitation, rehabilitation services, departments of physical therapy, psychology, nursing, social services, pharmacy, medical records, physicians' assistants, and nurse practitioners.

(7) These bylaws, rules, and regulations of the medical staff shall state the policies under which the medical staff regulates itself, creating and defining an atmosphere and framework within which members of the medical staff act with a reasonable degree of freedom and confidence. These medical staff bylaws, rules, and regulations shall provide for an effective formal means by which the medical staff may participate in the development of facility policy relative both to facility management and patient care not inconsistent with the North Carolina statutes and policies of the Division of Mental Health Services.

(b) Name of Organization. The name of this organization shall be "The Medical Staff of (fill in name) Hospital."

(c) Purpose. The purpose of this organization shall be as follows:

(1) to insure that the best possible care is rendered to all patients admitted to this hospital or treated by physicians and paramedical staff in the employ of this hospital;

(2) to provide a means whereby problems of medico-administrative nature may be discussed by the medical staff with the administration of the hospital and the Division of Mental Health Services;

(3) to initiate and maintain rules and regulations for self-governance of the medical staff;

(4) to provide an active education and training program and to maintain educational and training standards;

(5) to carry out through the hospital all appropriate duties of the Division of Mental Health Services;

(6) to carry out research in the fields of mental health;

(7) to attain and maintain the standards of the accreditation council of psychiatric facilities (Joint Commission on Accreditation of Hospitals);

(8) to insure a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;

(9) to promote the well-being of the medical staff, permitting them to practice medicine in a congenial atmosphere and with the support and stimulus of working with their colleagues; and

(10) to advise and assist the Division of Mental Health Services and management of (fill in name) hospital in their responsibilities of providing an environment conducive to the practice of medical care of high quality, and to promote liaison with county, state and national professional societies, and with medical colleagues in community hospitals.

(d) Qualifications for Membership

(1) Licensing. Applicants for membership on the medical staffs shall be duly licensed or authorized to practice medicine or dentistry in the State of North Carolina according to those standards set forth by the North Carolina State Board of Medical Examiners or the North Carolina State Board of Dental Examiners. Externs, interns, and resident physicians must have appropriate recognition and authorization by the North Carolina State Board of Medical Examiners. Physicians' assistants and nurse practitioners shall have at least one physician supervisor appointed by the Director or Director of Clinical Services of the hospital.

(2) Criteria for Membership. No applicant shall be denied membership on the basis of any other criteria not related to professional competence or good standing with the North Carolina State Board of Medical Examiners or the North Carolina State Board of Dental Examiners.

(3) Ethics. Acceptance of membership on the medical staff shall constitute the staff member's agreement that he will strictly abide by the principles of medical ethics of the American Medical Association or the American Dental Association, whichever is applicable.

(4) Medical Director. The medical director shall be a member of the hospital medical staff and shall be a medical doctor duly licensed to practice medicine in the State of North Carolina with approved training and experience in the practice of psychiatry.

(5) Appointments

(A) Appointments to the medical staff shall be made by the Director of the hospital with concurrence of the Director of Clinical Services.

(B) The Director shall consult with the credentials committee of the medical staff before taking action on any application or cancelling any appointment previously made.

(C) Appointment to the medical staff of (fill in name) hospital shall confer upon the appointee only such privileges as may hereinafter be provided.

(D) Initial appointments shall be for a period extending to the end of the current medical staff year of the hospital. Reappointments shall be for a period of not more than two medical

staff years. For the purpose of these bylaws the medical staff year commences on the first day of July and ends the 30th day of June of each year.

(6) Appointment Procedure

(A) Application for membership on the medical staff shall be presented in writing conforming to the requirements laid down by the North Carolina State Personnel Department and such other requirements as may be determined by the Director of the Division of Mental Health Services. The application shall state the qualifications and references of the applicant and shall signify his agreement to abide by the bylaws, rules and regulations of the medical staff. The application for employment on the medical staff shall be presented to the Director and Director of Clinical Services who shall transmit it to the Secretary of the medical staff.

(B) The Secretary of the medical staff shall present the application immediately to the credentials committee. This committee shall review the application and the applicant in order to determine suitability and eligibility for employment in the hospital.

(C) The credentials committee shall submit a report of findings to the Director and to the Director of Clinical Services as soon as possible and in all cases within one month recommending that the application be accepted, deferred, or rejected. Wherever a recommendation to defer is made, it must be accompanied by reasons for the deferment and must be followed by a subsequent report to accept or reject the applicant within a period of 30 days. Any recommendation for appointment shall include a delineation of privileges.

(D) The Director of the hospital in concurrence with the Director of Clinical Services shall either accept the recommendation of the credentials committee or shall refer it back for further consideration stating the reasons for such action. After further consideration the credentials committee will report to the Director and Director of Clinical Services who will take final action on the application.

(E) When a final decision has been made by the Director and Director of Clinical Services, they shall be authorized to transmit this decision to the candidate for employment, and if the candidate accepts employment, to secure his signed agreement to be governed by the bylaws, rules, and regulations.

(F) It is recommended that the Director and Director of Clinical Services may utilize the consultative services of the credentials committee in reviewing the credentials of paramedical personnel who are being considered for appointment to responsible positions of leadership at (fill in name) hospital.

(7) Reappointment Process

(A) At least 60 days prior to the final scheduled governing body meeting in the medical staff year, the executive committee of the medical staff shall review all pertinent information available on each practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the medical staff and for the granting of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Director of Clinical Services. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

(B) Recommendations for reappointment shall normally be made by the credentials committee and shall normally be considered at the annual meeting.

(C) Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgement in the treatment of patients, his ethics and conduct, his attendance at medical staff meetings and participation in staff affairs, his compliance with the hospital bylaws and the medical staff bylaws, rules and regulations, his cooperation with hospital personnel, his use of the hospital's facilities for patients, his relations with other practitioners, and his general attitude toward other practitioners, and his general attitude toward patients, the hospital and the public.

(D) Thereafter, the procedure provided in Part (d)(6)(C) to Part (d)(6)(F) of this Rule relating to recommendations on applications for initial appointment shall be followed.

(8) Appeals

(A) Should the superior of any physician or dentist recommend restriction or termination of the employment of any physician or dentist of the medical staffs, such recommendation will be forwarded in writing to the Director and Director of Clinical Services who in turn may, within a period of five days, refer said recommendation to the executive committee of the medical staff for review. The result of this review will be forwarded to the director within five days. If the Director and Director of Clinical Services accept the recommendation of the executive committee of the medical staff, said recommendation will be made known to the physician or dentist in question. The physician or dentist may, if he wishes, appeal his case to the regional director of mental health. Further appeal can be made by the physician or dentist in question to the Director of the Division of Mental Health Services, the Secretary of the North Carolina Department of Health and Human Services, and finally, to the State Personnel Board within a period not to exceed two weeks. Should the Director and Director of Clinical Services disagree with the recommendation of the executive committee of the medical staff committee, they can proceed with their decision after consulting with the regional director of mental health.

(B) (A) of this Subpart does not preclude the right of the Director and Director of Clinical Services to suspend any physician or dentist from his duties for flagrant misconduct pending the appeal mechanism as in (A) of this Subpart. Any superior recommending termination or restriction of the rights and privileges of a physician or dentist of the staff of this hospital must show cause for such recommendations. If the cause is basically performance, evidence shall be presented of two successive verbal warnings having been given as well as a written warning having been previously forwarded to the physician or dentist in question.

(9) Emergency and Temporary Privileges

(A) Regardless of his departmental staff status, in the case of an emergency, the physician attending any patient shall be expected to do all in his power to save the life of any patient at (fill in name) hospital including the calling of such consultation as may be available or desirable. For the purpose of this Subpart, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

(B) The Director and Director of Clinical Services of the hospital shall have the authority to grant temporary privileges to a qualified physician who is not a member of the medical staff. Such a physician shall work under the direct supervision of the Director and of the Director of Clinical Services of the hospital. Such temporary privileges shall last until the credentials committee meets, but not to exceed 30 days.

(e) Categories in the Medical Staff

(1) Divisions of Medical Staff. The medical staff shall be divided into honorary, visiting, active, and resident staffs.

(2) Honorary Staff. The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be physicians who have retired from active hospital service or physicians of outstanding reputation not necessarily resident in the community. The honorary staff is not eligible to vote or hold office, ordinarily does not admit patients, and shall have no assigned duties.

(3) Visiting Medical Staff

(A) The visiting medical staff shall consist of physicians of recognized professional ability who are active in programs carried out by the hospital or who have signified willingness to accept such appointment.

(B) The duties of the members of the visiting medical staff shall be to give their services in the care of patients on request of any member of the active medical staff or duties as designated by the Director or Director of Clinical Services of (fill in name) hospital.

(C) Consultants may be considered members of the visiting staff.

(4) Active Medical Staff

(A) The active medical staff shall consist of those physicians who are employed either full-time or part-time by (fill in name) hospital.

(B) The active medical staff shall consist of physicians who have been selected to transact all business of the medical staff and attend patients who are in the hospital and to whom all

such patients shall be assigned. Only members of the active medical staff shall be eligible to hold office on committees of the medical staff.

(C) Members of the full-time active medical staff shall be required to attend three-fourths of the medical staff meetings.

(D) Members of the active medical staff shall be required to attend meetings of all committees upon which they agree to serve by virtue of appointment or election.

(E) Each active staff physician may have one and not more than two physicians' assistants and nurse practitioners under his supervision and responsibility in (fill in name) hospital, after first having the individual's credentials approved by the credentials committee and medical staff. These individuals will be registered and function in conformity with North Carolina General Statute 90-18(13), 1971.

(5) The House Staff

(A) The house staff consists of interns, assistant residents, and residents, who shall be assigned to the clinical departments in such numbers as may from time to time be decided by the Director and Director of Clinical Services.

(B) Members of the house staff must be graduates of or students in good standing of approved and recognized schools of medicine. Members of the house staff will perform such duties as may seem appropriate to the Director of the service to which they are assigned. Graduates of medical schools approved and recognized other than those in the United States, Canada, or Puerto Rico must present a valid certificate from the Educational Council for Foreign Medical Graduates, or a similar organization approved by the North Carolina State Board of Medical Examiners as an added condition of appointment.

(f) Determination of Qualifications

(1) Classification of Privileges

(A) Determination of privileges granted to members of the medical staff will be made by the Director and Director of Clinical Services of the hospital after recommendations of the executive committee of the medical staff. In determining these recommendations the executive committee of the medical staff shall consult with the medical staff and the members of the credentials committee.

(B) Restricting the privileges of any physician or dentist by reason of age or disability will be the duty of the Director and Director of Clinical Services at the request of the credentials committee. Any restrictions will be made known in writing to the involved physician or dentist. Should the physician or dentist refuse the recommended restriction or restrictions, he may appeal.

(2) Determination of Privileges

(A) Determination of initial privileges shall be based on an applicant's training, experience, and demonstrated competence. Determination of such recommended privileges shall be made by the credentials committee.

(B) Determination of extension of further privileges shall be based upon the applicant's training, experience and demonstrated competence, and his continued satisfactory performance of duties in the hospital.

(C) It shall be the duty of the credentials committee to recommend specific rights and privileges of each physician and dentist as practicing at (fill in name) hospital. Such recommendation will be made part of the minutes of that committee. This will include those physicians given the right to perform specialized procedures such as an electrocardiogram and liver biopsies. It shall in like manner be the duty of the credentials committee to recommend rights and privileges of paramedical staff.

(g) Officers and Committees

(1) Officers. The officers of the medical staff shall be the president, vice president, and secretary. Ultimate authority and accountability remain with the governing body and with the Director and Director of Clinical Services.

(2) Requirements to be Officers. Officers must be members of the active medical staff at the time of appointment or nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(3) Election of Officers

(A) The president, the vice president, and the secretary shall be elected at the annual meeting of the medical staff. All officers shall be members of the active medical staff. Only members of the active medical staff shall be eligible to vote.

(B) The nominating committee shall consist of members of the active medical staff appointed by the president of the medical staff. This committee shall offer one or more nominees for each office.

(C) Nominations may also be made from the floor at the time of the annual meeting or be made by petition signed by at least five members of the active staff and filed with the Secretary of the medical staff at least 30 days prior to the annual meeting.

(4) Term. Elected officers shall serve a one year term from their election date or until a successor is elected. They shall take office on the first day of the medical staff year.

(5) Vacancies. Vacancies of the officers during the medical staff year shall be filled by the president of the medical staff.

(6) President. The president shall serve as the chief administrative officer of the medical staff to do the following:

(A) act in coordination and cooperation with the Director and Director of Clinical Services in all matters of mutual concern within the hospital;

(B) call, preside at, and be responsible for the agenda of all general meetings of the medical staff;

(C) serve as chairman of the medical staff executive committee;

(D) serve as ex officio member of all other medical staff committees without vote;

(E) be responsible for the enforcement of medical staff bylaws, rules, and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(F) appoint committee members to all standing, special, and multidisciplinary medical staff committees except elected members of the executive committee and joint conference committee;

(G) represent the views, policies, needs, and grievances of the medical staff to the governing body and to the Director and Director of Clinical Services;

(H) receive and interpret the policies of the governing body to the medical staff and report to the governing body on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;

(I) be responsible for the educational activities of the medical staff; and

(J) be the spokesman for the medical staff in its external professional and public relations.

(7) Absence of President. In the absence of the president, the vice president shall assume all the duties and have the authority of the president. He shall be a member of the executive committee of the medical staff and of the joint conference committee. He shall automatically succeed the president when the latter fails to serve for any reason.

(8) Secretary-Treasurer. The Secretary-treasurer shall be a member of the executive committee of the medical staff. The Secretary shall keep accurate and complete minutes of all medical staff meetings, call medical staff meetings on order of the president, attend to all correspondence, and perform such other duties as ordinarily pertain to his office. He shall be the Secretary of the ad hoc bylaws committee whenever it convenes, unless this becomes a standing committee.

(h) Committees

(1) Committees shall be designated as standing and special. All committee members other than elected members of the executive and the joint conference committee shall be appointed by the president of the medical staff. Committees shall be known as committees of the medical staff of the hospital and can include, other than members of the active medical staff, persons representing disciplines from within and without the hospital. Committee reports shall be filed in the Director's and director of clinical service's offices. The report of all committee meetings will be brought to the attention of the executive committee. It shall be the duty of the president or his designee to compile and present these committee reports for the consideration of the executive committee at its next regular meeting.

(2) The executive committee shall be composed of the president, vice president, secretary, and two other elected members of the medical staff. The Director and Director of Clinical Services shall be ex officio members.

(3) The executive committee shall be empowered to act on behalf of the medical staff. The committee shall meet at least monthly, and shall maintain a permanent record of its proceedings and actions. The Director and Director of Clinical Services shall attend all meetings of this committee. Functions and responsibilities of the executive committee include the following:

(A) to receive and act upon the reports of medical staff committees;

(B) to consider and recommend action to the Director and Director of Clinical Services all matters of a medico-administrative nature;

(C) to implement the approved policies of the medical staff;

(D) to make recommendations to the governing body;

(E) to take all reasonable steps to ensure professionally ethical conduct on the part of all members of the medical staff and to initiate such prescribed corrective measures as are indicated;

(F) to fulfill the medical staff's accountability to the governing body for the diagnosis, treatment and care rendered to the patients in the facility; and

(G) to ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the facility.

(4) The following committees are essential and report to the executive committee of the medical staff:

(A) administrative committees which include the joint conference committee, the credentials review committee, and the accreditation committee; and

(B) clinical committees which include patient care evaluation, utilization review, medical records, tissue review, pharmacy and therapeutics, infections, and research.

(5) Committees may be combined consistent with proper management.

(i) Meetings

(1) Annual Meeting. The annual meeting of the medical staff shall be held near the end of the hospital fiscal year. At this time, the officers and committees shall make such reports as may be desirable; committee recommendations and committee appointments for the ensuing year shall be made.

(2) Monthly Meeting. The medical staff shall meet monthly to review the clinical work of the hospital since its last meeting and make recommendations for improvement. It will hear reports from the executive committee and the other standing committees. Business and other executive sessions of the medical staff will be conducted by the active staff except that other categories of the medical staff may be present and participate but without the right to vote.

(3) Special Meetings

(A) Special meetings of the medical staff may be called at any time by the Director, Director of Clinical Services, president of the medical staff or by written request of at least five members stating the purpose of the meeting. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Sufficient written notice of any meeting shall be provided at least 48 hours before the time set for the meeting.

(B) The joint conference committee will meet quarterly with the governing body.

(4) Attendance at Meetings

(A) Members of the active medical staff shall attend at least three-fourths of the regular staff meetings unless excused by the executive committee for just cause. Absence from more than one-fourth of the regular staff meetings of the year, unless excused by the executive committee for just cause such as sickness or absence from the community shall be considered a basis for disciplinary action.

(B) Reinstatement of members of the active staff to positions rendered vacant because of absence from meetings may be made on application, the procedure being the same as in the case of original appointment.

(C) Members of the honorary and visiting categories of medical staff shall not be required to attend meetings but it is expected that they will attend and participate in these meetings unless unavoidably prevented from doing so.

(D) A member of any category of the staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present.

(5) Quorum. Fifty percent of the total membership of the active medical staff shall constitute a quorum.

(6) Agenda

(A) The agenda at any regular meeting shall be as follows:

(i) business, which includes call to order, acceptance of the minutes of the last regular and of all special meetings, unfinished business, communications, reports of standing and of special business committees, and new business; and

(ii) medical, which includes review and analysis of the clinical work of the hospital, reports of standing and of special medical committees, discussion and recommendations for improvement of the professional work of the hospital, and adjournment.

(B) The agenda at special meetings shall be as follows:

(i) reading of the notice calling the meeting,

(ii) transaction of the business for which the meeting was called, and

(iii) adjournment.

(7) Robert's Rules. Unless specified otherwise, Robert's Rules of Order will be followed at all medical staff meetings where business is conducted and at all committee meetings, except each committee may adopt its own rules or suspend the rules if a majority of members agree.

(8) Amendments. Amendments to these bylaws shall be made upon consideration and recommendation of the medical staff, the Director and Director of Clinical Services, and with approval of the governing body.

(9) Signatures. Adoption by the medical staff shall be indicated by signatures of the Director and Director of Clinical Services and the Director of the Division of Mental Health Services as the governing body.

History Note: *Authority G.S. 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0400 - HOSPITAL BEHAVIOR THERAPY PROGRAMS

10A NCAC 28F .0401 SCOPE

(a) The purpose of Rules .0401 through .0406 of this Section shall be to set forth the requirements and general framework for behavior therapy programs used in the treatment of mental illness.

(b) The rules in this Section shall apply to behavior therapy programs in the regional psychiatric hospitals of the Division.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0402 DEFINITIONS

For the purposes of the rules in this Section the following terms shall have the meaning indicated:

(1) Behavior therapy shall be defined as the systematic application of principles of conditioning and learning for the purpose of changing or remediating human behavior. In addition, behavior therapy shall meet the expanded definition set forth in Division publication HOSPITAL BEHAVIOR THERAPY PROGRAMS, APSR 115-2 (09/08/80), adopted pursuant to G.S. 150B-14(c).

(2) Hospital shall mean one of the regional psychiatric hospitals of the Division.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0403 IDENTIFICATION OF BEHAVIOR THERAPY PROGRAMS

The Director of each hospital shall be responsible for the identification of treatment programs in the hospital that qualify as behavior therapy according to the definition given in Rule .0402(1) of this Section including the referenced definition in APSR 115-2 of the Division's administration publications system.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0404 REQUIRED FACILITY MANUALS

The Director of each hospital shall be responsible for the development of a manual which shall establish the framework and general operating procedures for behavior therapy programs in the hospital. The manual shall not be overly constraining on the behavior therapy programs but shall serve as a general guide to clinical practice, within the legal and ethical constraints relating to client rights and accepted professional practice. The manual shall be available for information and inspection by hospital clients, staff, and the general public. Each manual shall address the following:

(1) definition of key terms employed;
(2) patients rights including but need not be limited to:
    (a) consent; and
    (b) disallowed procedures;
(3) staff qualifications;
(4) peer review procedures including a time schedule;
(5) training for personnel;
(6) records and documentation; and
(7) use of aversive (i.e., the application of noxious stimuli) and intrusive procedures including specifically:
    (a) documentation of alternative, positive approaches attempted, and documentation of consent to the specific program employed;
    (b) statement of minimum client rights to be observed for all patients in the program, citing relevant statutes and standards which shall include client rights as set forth in G.S. 122C-51 through 122C-58 and 122C-62 and 10A NCAC 28A, B, C and D, Division publication HUMAN RIGHTS FOR CLIENTS OF STATE OWNED AND OPERATED FACILITIES, APSM 95-1 (07/01/89), adopted pursuant to G.S. 150B-14(c).
    (c) specific time schedule for peer review; and
    (d) approval procedures, to include review by the Human Rights Committee, as provided in 10A NCAC 28A .0207 DUTIES.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Amended Eff. March 1, 1990; April 1, 1981;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0405 REQUIRED PROGRAM MANUAL

(a) The Director of each behavior therapy program of a regional psychiatric hospital shall be responsible for the development of an operations manual which shall communicate the purpose and operating procedures of the program. The manual shall be available for information and inspection by hospital clients, staff, and the general public.

(b) The manual shall contain, but need not be limited to, the following:

(1) definition of key terms employed;
(2) the target populations and behaviors;
(3) the choice of treatment methods and techniques;
(4) goals of treatment;
(5) voluntary participation of the client; and

(6) evaluation of treatment.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0406 INSTITUTIONAL BEHAVIOR THERAPY COMMITTEE

(a) The Director of each hospital shall establish an institutional behavior therapy committee to:

(1) review, at least annually, program-wide applications of behavior therapy (e.g., Behavior Therapy Ward);
(2) be available for consultation to unit or program directors; and
(3) investigate an established program or an individual application of behavior therapy upon request of the hospital director.

(b) The committee shall consist of six persons, the majority of whom are professionals with training and experience in the field of behavior therapy. Among the six shall also be a representative of the Human Rights Committee and a psychiatrist.

(c) All committee members, with the exception of the representative of the Human Rights Committee, shall be division employees unless the hospital director requests from the Division director the appointment of one member outside the Division.

History Note: *Authority G.S. 143B-147;*
Eff. October 8, 1980;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0500 - DESIGNATION OF RESEARCH FACILITIES IN REGIONAL PSYCHIATRIC HOSPITALS

10A NCAC 28F .0501 SCOPE

The rules in this Section establish procedures by which a regional psychiatric hospital may be designated as a facility where adults who are not otherwise admissible as clients, because of an absence of mental illness, may be voluntarily admitted for the purposes of research.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. December 1, 1988;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0502 APPLICATION

(a) Application for designation shall be made to the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, 3001 Mail Service Center, Raleigh, NC 27699-3001.

(b) The application for designation shall be in letter form and shall include the following:

(1) name and address of facility;
(2) description of the organization of research within the facility;
(3) description of the types of research currently conducted at the facility;
(4) description of the types of research for which designation is requested;
(5) description of the conditions under which individuals, admitted under this designation, would be housed and maintained;
(6) assurance of an active Human Rights Committee including its operating rules; and
(7) description of the procedures by which the medical records and statistics would be maintained for the individuals who would be admitted under terms of G.S. 122C-210.2.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*

Eff. December 1, 1988;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0503 REVIEW PROCESS

Upon receipt of the application and prior to granting designation, the Division director shall evaluate the application according to the following criteria:

(1) consistency of the research, currently conducted and proposed, with division goals and priorities;
(2) adequacy of procedures by which medical records and statistics would be maintained separate from those kept for regularly admitted clients;
(3) existence of an active Human Rights Committee with adequate operating rules which give the committee the authority to monitor the care of individuals admitted for research;
(4) adequacy of the facility's capacity to house and maintain persons admitted under this designation in a safe manner; and
(5) any other criteria deemed relevant by the Division director.

History Note: *Authority G. S. 122C-112(b)(3); 122C-210.2;*
Eff. December 1, 1988;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0504 DESIGNATION

(a) The Division director shall notify the applicant of his decision in writing within 60 days of receipt of a complete application.
(b) Designation shall be for a specified period of time, not to exceed two years, and stated in the written decision.
(c) The Division director shall terminate the designation upon finding that the facility no longer meets the qualifications for designation or upon request by the facility director that designation be terminated.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. December 1, 1988;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0600 - VOLUNTARY ADMISSION OF ADULTS WHO ARE NOT OTHERWISE ADMISSIBLE AS CLIENTS TO DESIGNATED RESEARCH FACILITIES IN REGIONAL PSYCHIATRIC HOSPITALS

10A NCAC 28F .0601 SCOPE

The rules in this Section establish standard procedures and uniform criteria for voluntary admissions of adults to regional psychiatric hospitals designated as research facilities within the provisions of Part I of Article 5 of Chapter 122C of the General Statutes. These individuals would not otherwise be admissible as clients under G.S. 122C-211 because of an absence of mental illness. Their reason for being admitted is to serve in approved research projects.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0602 EXPLANATION OF TERMS

For the purposes of the rules in this Section the following terms shall have the meanings indicated:

(1) "Hospital" means one of the regional psychiatric hospitals of the Division.
(2) "Designated research facility" means a regional psychiatric hospital which has met the requirements of 10A NCAC 28F, .0500.
(3) "Principal investigator" means the person, or his designee, who has overall responsibility for the conduct for the proposed research.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0603 APPLICATION FOR ADMISSION

The application for admission to participate in a specific research program shall be in writing and signed by the individual requesting admission to a designated research facility.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0604 GENERAL CRITERIA FOR VOLUNTARY ADMISSION

(a) When an individual request admission to a designated research facility the admission staff shall determine from the principal investigator that admission to the hospital is for a specific research project that has been approved by the facility's Human Rights Committee and the designated Institutional Research Committee.

(b) Upon admission to the designated research facility, the admission staff shall:

(1) verify that the individual has been informed by the principal investigator of the nature of the procedures which will be employed as part of the research protocol; and

(2) verify that the individual has signed the informed consent form covering participation in the research project.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0605 RECORD KEEPING

(a) A client record shall be maintained for each individual and shall include but not be limited to:

(1) application for admission;
(2) signed informed consent form covering participation in the project;
(3) physical examination and review of systems;
(4) description of procedures performed;
(5) special tests;
(6) adverse reactions and incidents; and
(7) termination summary.

(b) A complete description of medications administered shall be placed in the client record when it no longer would interfere with the purpose of the research to do so.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0606 DISCHARGE

(a) An individual who has been admitted under the provisions of these rules shall be kept in the hospital no longer than is indicated by the research protocol under which he was admitted.

(b) An individual who has been admitted under the provisions of these rules shall be discharged upon his own request. The discharge request shall be in writing.

(c) An individual who has been admitted under the provisions of these rules may be discharged by the facility at any time.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*

Eff. January 1, 1989;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0607 PAYMENT FOR PARTICIPATION

Reasonable compensation may be paid to individuals admitted under the provisions of these rules, for their services in participation in research projects, provided that such compensation is paid from research grant funds.

History Note: *Authority G.S. 122C-112(b)(3); 122C-210.2;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0700 - ADMISSION OF DEAF CLIENTS TO STATE PSYCHIATRIC HOSPITALS AND TRANSFER OF DEAF CLIENTS TO DOROTHEA DIX HOSPITAL

10A NCAC 28F .0701 PURPOSE AND SCOPE

(a) The purpose of the rules in this Section is to set forth procedures for State psychiatric hospitals when establishing policy for the:

(1) admission of deaf clients to State psychiatric hospitals; and
(2) transfer of deaf clients from State psychiatric hospitals to the Dorothea Dix Hospital Deaf Unit (DDHDU).

(b) These Rules shall be used in conjunction with the transfer requirements in G.S. 122C-206 and rules contained in 10A NCAC 28F .0200.

History Note: *Authority G.S. 122C-206; 143B-147;*
Eff. March 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0702 DEFINITIONS

For the purpose of the rules in this Section, the following terms shall have the meanings specified:

(1) "Certified interpreter" means an interpreter who is certified by the National Registry of Interpreters for the Deaf (NRID), or has received an A or B degree in the North Carolina Interpreter Classification System.
(2) "Clinical impressions" mean information provided by the Regional Adult Coordinator of Mental Health Services for the Deaf to assist in differentiating psychiatric conditions from the cultural norms of deafness.
(3) "Deaf client" means an individual who is admitted to a State psychiatric hospital and:
    (a) has a severe to profound hearing loss;
    (b) utilizes any modality of sign language as the primary means of communication; or
    (c) would benefit from a signing environment.
(4) "Dorothea Dix Hospital Deaf Unit" means the statewide 17-bed co-ed psychiatric unit for deaf adults (age 18 and above) located on the Dorothea Dix Hospital campus.
(5) "Regional adult coordinator of mental health services for the deaf" means the professional who provides mental health services for deaf adults through the Division's designated regional deaf service centers.

History Note: *Authority G.S. 122C-206; 143B-147;*
Eff. March 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0703 ADMISSION OF DEAF CLIENTS TO STATE PSYCHIATRIC HOSPITALS

(a) Except for Dorothea Dix Hospital, upon admission of a deaf client to a State psychiatric hospital, the hospital shall adhere to the following procedures:

(1) within 24 hours, the responsible professional designated by the hospital director shall notify the Regional Adult Coordinator of Mental Health Services for the Deaf to arrange an assessment of the deaf client;

(2) within 60 hours of notification by the hospital, the Regional Adult Coordinator shall perform the assessment which shall become part of the primary client record and shall include, but not be limited to:

(A) an evaluation of the deaf client's language and communication abilities;

(B) cultural and social information;

(C) clinical impression; and

(D) recommendations.

(b) Each State psychiatric hospital that admits a deaf client shall be responsible for obtaining and providing interpreter services from the time of admission until the client is transferred.

History Note: *Authority G.S. 122C-206; 143B-147;*
Eff. March 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0704 TRANSFER OF DEAF CLIENTS TO THE DOROTHEA DIX DEAF UNIT

(a) A voluntarily admitted deaf client, who has been determined by the treatment team to require a hospital stay of 15 days or more, shall be eligible for transfer to the DDHDU at the time of such determination.

(b) An involuntarily admitted deaf client who, after the initial court hearing is committed shall be eligible for transfer to the DDHDU after the initial court hearing.

(c) Upon transferring a client to the DDHDU, as determined in Paragraphs (a) or (b) of this Rule, the responsible professional at the sending facility shall:

(1) comply with the transfer requirements set forth in G.S. 122C-206 and 10A NCAC 28F .0200; and

(2) explain and ensure that the process for transfer is interpreted by the Regional Coordinator or a certified interpreter.

History Note: *Authority G.S. 122C-206; 143B-147;*
Eff. March 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0705 DOROTHEA DIX HOSPITAL DEAF UNIT

(a) The Director of Admissions at Dorothea Dix Hospital shall forward the information required in Rule .0704 of this Section to the Coordinator of the Deaf Unit.

(b) The Director of Admissions, the Coordinator of the Deaf Unit, and the responsible professional at the sending facility shall mutually determine the date of transfer.

(c) The Director of Admissions and the Coordinator of the Deaf Unit may refuse to accept a transfer if the client is determined to be inappropriate for transfer:

(1) the Coordinator of the Deaf Unit shall consult with the State Coordinator of Mental Health Services for the Deaf; and

(2) such refusal of transfer shall be documented by both facilities involved, in order to provide background information should a review of the decision be requested.

(d) The Dorothea Dix Hospital Admissions Office shall:

(1) complete a new "Identification/Face Sheet-Form A" upon receiving a transferred client; and

(2) incorporate into the primary client record, information which is generated by the DDHDU.

(e) The DDHDU treatment team and the appropriate area program shall be responsible for discharge planning, and shall ensure that:

(1) all transferred clients shall be directly discharged from the DDHDU to the community;

(2) a copy of the aftercare plan is shared with the appropriate Regional Coordinator upon consent of the client, the legally responsible person, and with the sending hospital; and

(3) transportation for discharged clients shall be provided in accordance with established transportation policy of Dorothea Dix Hospital.

History Note: *Authority G.S. 122C-206; 143B-147;*
Eff. March 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0800 – GENERAL RULES FOR MR CENTERS

10A NCAC 28F .0801 VOLUNTARY ADMISSIONS TO MR CENTERS

(a) The procedures of this Rule shall apply to all state institutions for the mentally retarded.
(b) Any minor, or parent of any minor, or guardian of any minor may request voluntary admission to a mental retardation facility for such person by signing a standard form requesting voluntary admission. Such forms shall be available at each mental retardation center.
(c) Any adult, or any incompetent adult's guardian may request voluntary admission for the person to any mental retardation center of the Division by signing a standard form requesting admission for the person to the mental retardation center. Such forms shall be available at each mental retardation center.
(d) Admissions shall be considered appropriate when community resources to meet the needs of the individual have been explored and it is determined that community services are not available.
(e) Except in emergency cases, a person shall be admitted only if he has been comprehensively evaluated by an interdisciplinary team of mental retardation specialists.
(f) All admissions to the regional mental retardation centers shall be considered time limited, goal-oriented, and subject to periodic review to determine the appropriateness of continued treatment, training, or discharge.
(g) Parents, guardians, and applicants shall be counseled prior to admission on the relative advantages and disadvantages of institutionalization and the goals of treatment or training.
(h) Any minor resident of a center for the mentally retarded may be removed from the center at any time by the parent or guardian of the minor.
(i) Any adult resident of a center for the mentally retarded who has been voluntarily admitted and has not been judicially declared to be incompetent may leave the center without permission at any time.
(j) Except in emergency cases, children less than six years of age shall not be admitted to a center for the mentally retarded.

History Note: *Authority G.S. 122C-112; 122C-114; 143B-147;*
Eff. February 1, 1976;
Amended Eff. April 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0802 CRITERIA FOR ADMISSION

Except in cases of admission for respite care persons shall be admitted to a regional mental retardation center of the division only upon the determination by the center that the following criteria are met:

(1) The parent or parents, guardian or guardians, or person or persons standing in loco parentis cannot reasonably provide for the habilitation and maintenance needs of the person due to the person's retardation or the person's mental retardation accompanied by physical handicaps;
(2) There is no community-based program available to the person which can provide for the habilitation and maintenance needs of the person; and
(3) The habilitation and maintenance needs of the person can best be met at the mental retardation center.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-241; 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0803 RESPITE CARE

(a) Persons may be admitted to the regional mental retardation centers for respite care. Respite care may be afforded a person for one of the following three reasons:

(1) Regular Respite Care. A parent, guardian or other person responsible for the care of a mentally retarded person requires relief from the care of a mentally retarded person for such reasons as a family vacation or the need for home rest.

(2) Respite Care for Behavior Management. A parent, guardian or other person responsible for the care of a mentally retarded person requires relief from the care of a mentally retarded person who is presenting severe behavioral problems which either disrupt or interfere with normal family functioning. Respite care for this purpose is offered to allow the family time to rest as well as to explore local community resources and services, which could be utilized following discharge.

(3) Emergency Respite Care. The death or temporary loss of a parent, guardian or other responsible person, or any other situation leaves the mentally retarded person without supervision or care. Respite care for this purpose is offered to provide temporary care while community resources and services which could be utilized following discharge can be explored by the agency initiating the application.

(b) Respite care admissions shall normally be for a period not to exceed 30 days. If a caregiver requests, an additional 30 days may be granted and the admission status shall be changed from respite care to some other category.

(c) Respite care admissions, except emergency respite care admissions, shall be scheduled and all required admission data supplied at least two weeks prior to admission.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-241; 143B-147;*
Eff. February 1, 1976;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0804 PRIORITY OF ADMISSION

Equal priority for admission to a mental retardation center shall be given to all applicants except that first priority shall be given to Willie M. class members according to the provisions of 10A NCAC 29A .0101 through .0106 which are available in division publication APSR 45-8.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-241; 143B-147; S.L. 1981, Ch. 859;*
Eff. February 1, 1976;
Amended Eff. March 1, 1990; February 1, 1982; September 30, 1981;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0805 REGIONS

A prospective resident may be admitted only to the regional mental retardation center located in the region in which he is domiciled, except that the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services may permit the admission of a person with special needs to a regional mental retardation center other than that located in the region in which the person is domiciled, when the center to which the person is seeking admission offers a special program not available at the center in the region in which the person is domiciled.

History Note: *Authority G.S. 122C-122; 122C-181; 122C-241; 143B-147;*
Eff. February 1, 1976;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0806 DISCHARGE

A resident of a mental retardation center of the division shall be discharged if one or more of the following occur:

(1) One or more of the criteria for admission seen in Rule .0802 of this Section is not met;

(2) The resident completes the habilitation program for which he was admitted and the criteria for admission seen in Rule .0802 of this Section are not otherwise met;

(3) The resident requests discharge and the resident is not a minor or judicially declared incompetent;
(4) The resident's parent or guardian requests discharge and the resident is a minor;
(5) The resident's guardian requests discharge and the resident has been judicially declared incompetent;
(6) The director of the mental retardation center determines that it is not in the best interest of the resident or the center for the resident to be retained at the center; and
(7) When the term of a planned contractual agreement with the resident, the resident's parent, the resident's guardian, or the person standing in loco parentis to the resident has expired and agreement has not been reached on a new contract.

History Note: *Authority G.S. 122C-112; 122C-181; 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .0900 – VOLUNTARY ADMISSION AND DISCHARGE TO ALCOHOLIC REHABILITATION CENTERS (ARCS)

10A NCAC 28F .0901 SCOPE

The rules in this Section apply to voluntary admissions and discharges of all clients to alcoholic rehabilitation centers (ARCs). The criteria and procedures shall be followed by staff of ARCs and by area program staff making referrals to ARCs.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-211; 2C-212; 143B-147;*
Eff. April 1, 1981;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0902 PROCEDURES FOR VOLUNTARY ADMISSION AND DISCHARGE

(a) Evaluation. Any person voluntarily seeking admission shall receive an evaluation to include a physical examination by a staff physician of the ARC within 24 hours of the time of presentation for admission. Only those persons who have been determined to be in need of treatment or evaluation available at the ARC and who will be able to benefit from the program and services offered at the ARC shall be admitted. In making the decision, consideration shall be given to the effects of any previous treatment efforts in reducing or exacerbating the person's problems.
(b) Evaluation in Writing. The evaluation shall be in writing and shall state whether the person is in need of admission for treatment or further evaluation of alcoholism or drug dependency.
(c) Nonacceptance. If the examining physician at the ARC determines that the person is not in need of admission for treatment or further evaluation, or that another facility to which application for admission is made does not provide the requisite evaluation or indicated treatment services, the person shall not be accepted as a client, but other appropriate suggestions and referrals shall be made as indicated to meet the person's need. If the person is not admitted to the ARC, personnel from the ARC shall notify the referral source and specify reasons for nonacceptance and inform the referral source as to the status of the person's receiving services from another provider. If it is determined the client can be more appropriately served in the community, based on evaluation of the client's needs and consideration of resources available in the community, the client shall be referred to the community program.
(d) Leaving Against Medical Advice. A client, a client's parent if a minor, or a client's guardian, if a minor or incompetent, upon the client's leaving an ARC against the advice of the attending physician will be given the opportunity, though not required, to sign a form relieving the ARC and the staff of the ARC from liability for any consequences of the client's departure from the ARC. Such forms shall be available at every state ARC.
(e) Contracts. There shall be written agreements between area authorities and alcoholic rehabilitation centers specifying policies and procedures in admitting, providing services to, referring and discharging persons.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-211; 122C-212; 143B-147;*
Eff. April 1, 1981;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .0903 APPOINTMENTS FOR ADMISSION

(a) Arrival at an ARC without an appointment may result in admission being delayed because of lack of bed space. However, if bed space is not available, ARC staff shall contact the appropriate area program or the closest emergency room in order to arrange for placement of the client until bed space is available.

(b) Individuals transporting persons seeking admission to an ARC shall remain with the person until a determination has been made as to the availability of bed space.

History Note: *Authority G.S. 122C-112; 122C-181; 122C-211; 143B-147;*
Eff. February 1, 1982;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

SECTION .1000 - PROBATION AND DISCHARGE

10A NCAC 28F .1001 PROBATION AND DISCHARGE

(a) A patient at an alcohol and drug abuse treatment center may be placed on probation by the clinical team for failure to adhere to the prescribed treatment plan or any other violation of the rules and regulations of the alcohol and drug abuse treatment center. Persons placed on probation shall be counseled to assure that they understand the rules, including their right to file a grievance as specified in 10A NCAC 28B .0203 STATE FACILITY GRIEVANCE PROCEDURE AND REPORTS, Division publication HUMAN RIGHTS FOR CLIENTS IN STATE OWNED AND OPERATED FACILITIES, APSM 95-1, 07/01/89, adopted pursuant to G.S. 150B-14(c).

(b) Probation shall be for a period of one week from the detection of the violation.

(c) Patients committing one of the violations listed in Part (a) of this Rule while on probation may be discharged by vote of the clinical team, who will ensure the patients' understanding of the right to file a grievance as cited in Paragraph (a) of this Rule.

History Note: *Authority G.S. 122C-181; 143B-147;*
Eff. February 1, 1976;
Amended Eff. August 1, 1990; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.

10A NCAC 28F .1002 CENTER RULE VIOLATION

Any patient who commits one or more of the following acts may be immediately discharged from an alcoholic rehabilitation center:

(1) drinking alcohol,
(2) taking unauthorized drugs,
(3) possession of alcohol,
(4) possession of unauthorized drugs,
(5) unacceptable social behavior,
(6) theft, or
(7) violent behavior.

Persons exhibiting violent behavior as a result of serious emotional or psychiatric problems may be transferred to other institutions of the division better able to treat the emotional or psychiatric problems.

History Note: *Authority G.S. 122C-181; 143B-147;*
Eff. February 1, 1976;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. August 24, 2019.