PRTF
Interpretive Guidelines

The Kansas Department for Aging and Disability Services (KDADS)

- Yellow highlighted standards are standards that the Mental Health Medical Consultant (MHMC) will review
- Green highlighted standards are standards that both the QA field staff and the MHMC will review
- Non-highlighted standards are standards that the QA field staff will review
- Red highlighted standards are possible Critical Health and Safety Concerns

Standard	Inquiries and Indicators	Guidance and Interpretations
A. A written program description must guide the agency's operations and delivery of services. Each PRTF is required to develop its own policies, procedures and program description to implement the requirements in this document. The program description must be on file for review by any federal or state agency and the facilities accrediting body during site visits and must be submitted annually on January 1 of each year to the Department of Social and Rehabilitation Services and the Juvenile Justice Authority. B. The program description will include the facility location, legal ownership, an administration table of organization, the philosophy, vision and mission of the program and explain in detail how the facility will meet the requirements in this document. The description will include detail regarding the population served by the PRTF, including the number of residents served, age groups, and other relevant characteristics of the population. (This information can be located in different documents and kept together in a file to be readily accessible during any site visit.) C. If providing substance abuse treatment services on site, the PRTF must be licensed by Addiction and Prevention Services (AAPS) to provide said services employing AAPS certified substance abuse counselors. If sub-contracting substance abuse treatment services, the provider used must be AAPS certified to do so. The activities included in the service must be intended to achieve identified plan of care goals or objectives and be designed to achieve the resident's discharge from inpatient status at the earliest possible time. Services provided must be in accordance with 42CFR 441.154-441.156	INDICATORS 1. Review program description, including requirements of B. 2. Review p/p 3. Ask to see AAPS license and/or list of AAPS providers under contract	
§441.151 General requirements		
(a) Inpatient psychiatric services for individuals under age 21 must be: (1) Provided under the direction of a physician; (2) Provided by— (i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited	INQUIRES and INDICATORS 1. Review charts to verify age of current residents 2. Review the written certification of need for each sampled resident (441.151(a)(4) to verify that the document includes information as to why:	

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by the Joint Commission on Accreditation of Healthcare Organizations; or (ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State. (3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following— (i) The date the individual no longer requires the services; or (ii) The date the individual reaches 22; and (4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with §441.152. (b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in §483.352 of this chapter must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion. [66 FR 7160, Jan. 22, 2001] *(a)(1)(i) Under the direction of a physician means: Under the direction of a physician licensed and board eligible or board certified in the state where the PRTF is located. These physicians may be employed by or contracted with the PRTF.* *(a)(1)(ii) The physician must provide for the clinical oversight of all services provided by the PRTF.* *A physician who is licensed and board eligible or a board certified psychiatrist (or a physician who is not a psychiatrist BUT is working in conjunction with a psychologist consistent with 441.156) must be available to oversee the medical needs of the resident including medication management, plan of care development, and can order seclusion and restraint consistent with CFR 42 subpart G of part 483.*	a. Ambulatory care resources available in the community do not meet the treatment needs of the recipient; (The certification should include a discussion of the available ambulatory resources in the community and why the resident is not appropriate for those settings.) b. The treatment the resident is receiving or will receive in the PRTF is not available in the less restrictive setting; 1. Review p/p 2. Review physician personnel file or contract for compliance with (a)(1) 3. Review physician job description 4. Ask for Accreditation certificate and recommendations. 5. Review CBST and Screen (certification of need)	
§441.152 Certification of need for services		

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(a) A team specified in §441.154 must certify that— (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient; (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. (b) The certification specified in this section and in §441.153 satisfies the utilization control requirement for physician certification in §§456.60, 456.160, and 456.360 of this subchapter. [43 FR 45229, Sept. 29, 1978, as amended at 61 FR 38398, July 24, 1996] *(a) Certification and recertification of the need for services is defined in the Kansas definitions section of this document. The LMHP certifying and re-certifying the need for services must be independent of the facility.*	INQUIRES and INDICATORS 1. Review the written certification of need for each sampled resident (441.152) to verify that the document includes information as to why: a. The resident's treatment requires inpatient setting; (441.152(a)) and b. This setting can be expected to improve the resident's condition or prevent further regression. (The treatment plan should be directed toward discharge and eventually reintegrating the individual into the community setting.) 441.152(3) 2. If the certification of need was made for a resident who did not have the Medicaid under 21 benefit before admission, but applied for Medicaid while in the facility; 441.152(b) 1. Review CBST and Screen (certification of need)	
§441.153 Team certifying need for services		
Certification under §441.152 must be made by terms specified as follows: (a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that— (1) Includes a physician; (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and (3) Has knowledge of the individual's situation. (b) For an individual who applies for Medicaid while in the facility of program, the certification must be— (1) Made by the team responsible for the plan of care as specified in §441.156; and (2) Cover any period before application for which claims are made.	INDICATORS 1. Review CBST and Screen (certification of need) 2. Ensure recertification's are in the file.	

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(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (§441.156) within 14 days after admission. *(a)(1) The team responsible for the certification and recertification of services will be the LMHP certifier in conjunction with the Community-Based Services Team (CBST). This must include a face-to-face assessment by an independent LMHP. Recertification must occur within 90 days of admission and within every 60 days thereafter.*		
§441.154 Active treatment		
Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, described in §441.155 that is— (a) Developed and implemented no later than 14 days after admission; and (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time. *(a)(1) Active treatment is:* *(i) The implementation of services immediately upon admission outlined in a plan of care* *(ii) The continuous and intentional interaction between the resident and staff* *(iii) Designed to meet the mental health needs of the resident that necessitated the admission to the PRTF* *(iv) Supervised by the psychiatrist who is responsible for the care of the resident* *(v) Designed to achieve the goal of the resident's discharge from the PRTF at the earliest possible time* *(vi) Determining length of stay based on the individual's needs and not on the program structure* *(a) (2)Each resident shall be prescribed an individualized program:* *(i) To address their specific needs and maximize functioning in activities of daily living, education, and vocational preparation* *(ii) That includes obtaining all medically necessary services the resident needs while a resident of the facility* *(iii) Designed to improve the person's mental health*	INQUIRES and INDICATORS Review individual treatment plans for each resident in the sample. Review each individual plan to ensure: 1. The resident's activity, therapy, and events schedule are individualized; (ensure that all residents do not follow the same schedule; and incorporate and address resident's individual treatment objectives. 2. Active treatment begins immediately. 3. Treatment plans have goals that are measurable 4. Treatment plans identify progress made by the resident toward achieving their goals and objectives. 5. Weekly family involvement is documented. 6. Family involvement in the treatment planning process is documented. 7. Review discharge planning documentation for coordination of services with community and family. 8. All medically necessary services is determined by the admission and ongoing assessments of the treatment team based on the input from family, therapists, JJA, KDADS, foster care, etc. These services should be based on why the resident required admission or necessitated by resident's impending discharge. Observe/interview residents to determine that: 1. Resident schedules are individualized. (Residents do not all follow the same schedule). 2. Residents have input into their treatment plan and	GUIDANCE and INTERPRETATION (a)(1)(ii) and (a)(2)(ix) Continuous interaction by staff should include ongoing engagement with the residents regardless of the activity, time or day Intentional interaction by staff with the residents should be based on the resident's individual treatment plan goals and objectives and focus on meeting the needs of the residents (a)(2)(v) Weekly family involvement may consist of face to face interaction, phone conversations, email, Skype, etc. Documentation should indicate if the family is unable/unwilling to be involved or if family involvement is not possible due to legal reasons. The facility must also document attempts to contact the family. (a)(2)(iii) Improvement should be indicated by the progress made by the resident toward meeting their goals and objectives listed in their treatment plan. Treatment notes, including the front line

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resiliency and recovery *(iv) Built upon the strengths and preferences of the resident and their family identified in the plan of care* *(v) Including weekly family involvement with a focus towards the resident and family's presenting problem(s) with assistance given to identify resources and discover solutions* *(vi) Consisting of multiple and various treatment offerings provided immediately upon admission and continuing during the day, evening, and weekends* *(vii) That includes discharge planning upon admission and based on the resident's needs and achievement of goals and objectives identified in an individualized, measurable and goal-directed treatment plan.* *(viii) Where all PRTF service staff in regular contact with the resident are aware of each resident's needs, goals and services identified on the plan of care* *(ix) Where staff engage residents in continuous and intentional interaction designed to meet the resident's needs regardless of the setting or activity during all waking hours including day, evening, and weekends* *(a)(3) Facilities providing active treatment will:* *(i) Establish individual, program, and treatment modality outcome measures relevant to the resident and population being served* *(ii) Integrate treatment effectiveness into the program design. Outcome measures direct the treatment programs and modalities provided* *(iii) Provide a safe, nurturing, non-hostile and therapeutic milieu to residents* *(iv) Document the delivery and response to treatment* *(v) Provide a flexible schedule to facilitate family involvement in treatment*	understand their treatment plan. 3. Residents state they feel safe and treatment is effective for them. 4. Residents have multiple treatment modalities available to meet their needs. 5. Observe residents to determine if they are making progress toward the goals and objectives on their treatment plan. 6. Observe residents to determine what treatment offerings they are offering. 7. Observe residents to ensure that their needs are being met. Observe/interview staff to determine that: 1. Staff has input into the treatment planning and understands the treatment plans of the residents. 2. Staff is trained on interacting with residents in purposeful, therapeutic ways and engages residents 24/7. 3. Staff is able to state how the assist resident in reaching their treatment goals, why they are engaging residents in certain activities, are able to state triggers and crisis plans of individual residents. 4. Observe staff to determine how often they engage the residents concerning what is identified on their treatment plans. 5. Observe staff to determine how often they have positive interaction with the residents. 6. Observe staff to determine if they are consistently engaging the residents. Review clinical record/facility information 1. Review the progress notes to determine the quantity and frequency of interaction between the staff and residents. Look for documentation that the staff interactions relate to individual resident's treatment plan goals and objectives for every activity on the daily schedule. 2. Compare admission date to first service 3. Look at variation/frequency/duration of services during the day, evening and weekends 4. Review P and P 5. Check for evidence of discharge planning	staff notes should refer in some way back to the treatment plan goals and progress toward meeting those goals.

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	6. Check for components of active treatment 7. Check to see if any assessments were administered at the PRTF for use in developing the treatment plan. 8. Check for the activities during waking hours 9. Review initial assessments 10. Review resident's daily schedule to ensure that activities are individualized to meet resident's needs. 11. Observe the treatment environment 12. Check that activities of daily living (ADL's) are being monitored and assistance provided when needed. 13. Check that barriers to treatment are identified and addressed.	
§441.155 Individual plan of care		
(a) "Individual plan of care" means a written plan developed for each recipient in accordance with §§456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary. (b) The plan of care must— (1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care; (2) Be developed by a team of professionals specified under §441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge; (3) State treatment objectives; (4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and (5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge. (c) The plan must be reviewed every 30 days by the team specified in §441.156 to— (1) Determine that services being provided are or	INQUIRES and INDICATORS 1. Review residents records. Ensure that the treatment plan includes the following:: a. Based upon input from the CBST and the treatment team b. The diagnostic evaluation includes examination of the medical, psychological, social, behavioral, and developmental aspects of the resident's situation; c. Documentation in the resident's record verifies that the resident and legal guardian were consulted during the development of the plan of care. 441.155(2) d. Each resident plan must identify individualized treatment objectives based upon the diagnostic evaluation; 441.155(3) and e. The resident's activity, therapy, and events schedule are individualized; (ensure that all residents do not follow the same schedule (441.155(4)) and incorporate and address the resident's individual treatment objectives) 441.155(4) 2. Verify certification of need or that an exception is completed prior to the admission date. 3. Review post-discharge planning documentation:	441.155 (b) (4) look for frequency and duration of services to verify that therapies, activities and experiences are being carried out to meet the objectives. 441.155 (b) (1) If a child's admission history and physical is not being performed by an MD, DO, PA, or APRN, the minimum standard would be for an RN to do a nursing assessment or KAN Be Healthy screen and for this to be co-signed by an MD, DO, PA, or APRN indicating it has been reviewed prior to the plan of care being completed.

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were required on an inpatient basis, and (2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient. (d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for— (1) Recertification under §§456.60(b), 456.160(b), and 456.360(b) of this subchapter; and (2) Establishment and periodic review of the plan of care under §§456.80, 456.180, and 456.380 of this subchapter. [43 FR 45229, Sept. 29, 1978, as amended at 46 FR 48560, Oct. 1, 1981; 61 FR 38398, July 24, 1996] *(a) Each resident must have a written individual plan of care, which is goal-oriented and specific, describing the services to be provided.* *(b) The plan of care should;* *(1) Include strengths and preferences and address any other needs which have been identified, including the assessment of trauma and family resources and be implemented no later than 24 hours after admission and immediately after returning from an inpatient hospitalization or unexcused leave of absence from the facility (See 42C.F.R.441.154)* *(2) Be based upon input from the Community Based Services Team and community treatment team to which the youth will be discharged.* *(3) Be related to overall treatment goals that address the residents immediate and long range therapeutic needs* *(4) Includes criteria and plan for post discharge which is updated at each of the 30 day reviews* *a. Discharge planning for the residents shall begin as soon as possible upon admission to the PRTF. This process should include the CMHC staff where the youth will be discharging to if determined, the treatment team and other facility staff, and the resident and their legal guardian when possible.*	441.155(5) a. Shows efforts to coordinate inpatient services with community based services once the resident has been discharged; Look for communication with the community mental health center that the resident will be discharged to. 441.155(5) b. Addresses continuity of care in the community; and c. Includes evidence of preparation of the resident for discharge during their residential stay. 4. Verify that the treatment plan is reviewed and modified by the individual treatment team at least once every 30 days. 441.155(c). a. Evidence that changes were made according to the resident's progress, incidents of seclusion and restraint, or other events that may have impacted their plan of care. 441.155(c)(2) b. The plan review confirms that the services being provided to the resident are still required to be provided on an residential basis. 441.155(c)(1) 1. Observe residents to determine that: a. Resident schedules are individualized (Residents do not all follow the same schedule)441.155; and b. Activity groups and therapies are relevant to the resident's condition, and treatment objectives. 441.155(3)-(4)	

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The CMHC and the legal guardian should remain in contact with the facility treatment team to assist in any transition discharge planning. Discharge criteria will be established when writing the plan of care *b. Prior to discharge, the PRTF shall submit documents related to the residents care in their facility to any mental health provider who will be providing aftercare. The key component on this document shall include:* *i. Medical needs including allergies* *ii. Medication; dosage; clinical rationale; prescriber* *iii. Discharge diagnosis* *iv. Prevention plan to address symptoms of harm to self or others* *v. Any other essential recommendations* *vi. Appointments with after discharge service providers- date, time, place* *vii. Contact information for internal providers* *viii. Contact information for CMHC/PRTF Liaisons* *ix. CMHC Crisis line number* *x. Education contact number from PRTF* *c. For any resident receiving or who has received psychotropic medication during their stay the clinical rational for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge will also be clearly stated on the discharge summary. Residents on psychotropic medication must leave the facility with*		

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a prescription written for at least a 30-day supply of medication. The residents should also leave the facility with a minimum of three-day's worth of prescriptions when applicable. The expectation is that the PRTF will receive notification ten days before the child must leave the PRTF to ensure proper discharge planning. If the discharge must occur prior to a ten-day notification, it is the PRTF's responsibility in conjunction with the custodial case manager or community case manager to ensure proper persons are notified of the residents pending discharge, including discharge date and assisting with appointment setting in the community. The PRTF must ensure proper identification of individuals who pick up the resident upon discharge. *(c) The treatment team must review the plan of care within thirty days and subsequent reviews within 30 days thereafter, evidenced through documentation, which meets state and federal requirements. The plan of care and subsequent reviews support the continued need for PRTF services and is evidenced by the participation of the resident and, if appropriate, one or more members of the resident's family as well as clinical signatures.*		Evidence of participation: The treatment team according to 441.156 (c) and (d) (e.g. psychiatrist, psychologist, physician, social worker, registered nurse, and occupational therapist) must sign each plan of care. For residents, family members, and CMHC liaisons we are looking for evidence of participation instead of a signature. This can be evidenced by interviews, progress notes, verbal permission, etc. Verbal permission is when the PRTF receives verbal permission from the family member or CMHC liaison to sign their names on the plan only if they participated in the treatment plan review by phone.
§441.156 Team developing individual plan of		

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care		
(a) The individual plan of care under §441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility. (b) Based on education and experience, preferably including competence in child psychiatry, the team must be capable of— (1) Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities; (2) Assessing the potential resources of the recipient's family; (3) Setting treatment objectives; and (4) Prescribing therapeutic modalities to achieve the plan's objectives. (c) The team must include, as a minimum, either— (1) A Board-eligible or Board-certified psychiatrist; (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. (d) The team must also include one of the following: (1) A psychiatric social worker. (2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals. (3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals. (4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. *(a) The treatment team must include the resident, resident's*	INQUIRES and INDICATORS 1. Review a random sample of personnel files of all team members who developed the resident's individual plans of care. 441.156(b) a. Each team member should show experience with mental illness, adolescents, and other related fields. b. Each team member identified in (c) and (d) should have one of the credentials of 441.156(c) and (d) and their resume should indicate experience in the following: i. Assessment of immediate and long range therapeutic needs, development of priorities and personal strengths and liabilities; ii. Assessment of family resources; iii. Establishment of treatment objectives, and iv. Prescription of treatment modalities. c. Verify that each team member is currently licensed and/or certified as applicable. 1. Review clinical record 2. Look for evidence of family and CMHC involvement.	

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family, and the Community Mental Health Center (CMHC) representative or designated liaison and LMHP. *(c)(3) Certification by the state means licensed by the state.*		
§483.356 Protection of residents		
(a) Restraint and seclusion policy for the protection of residents. (1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. (2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis. (3) Restraint or seclusion must not result in harm or injury to the resident and must be used only— (i) To ensure the safety of the resident or others during an emergency safety situation; and (ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired. (4) Restraint and seclusion must not be used simultaneously. (b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). (c) Notification of facility policy. At admission, the facility must— (1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;	INQUIRES and INDICATORS 483.356(a) Review the facility's policies regarding the use of restraint and seclusion to verify: 1. The policies for use of restraint and seclusion meet the requirements set forth for the protection of residents, and 2. The facility definitions of restraint and seclusion are consistent with the following: Restraint: means a ``personal restraint,'' ``mechanical restraint,'' or ``drug used as a restraint''. Seclusion: means the involuntary confinement of a resident alone in a room or-in an area from which the resident is physically prevented from leaving. 483.356(a) 1. Review a sample of resident records: a. Documentation of the behaviors leading to restraint or seclusion usage should provide clear evidence that there was risk to the resident or others. 2. Interview direct care staff to determine their knowledge concerning: a. Management of behaviors that do not pose an immediate threat to the resident or others; b. Less restrictive interventions usually attempted prior to seclusion or restraint; c. Environmental, staffing, or program issues which make it difficult to manage residents with behavior issues; d. The impact of staff turnover; and e. The orientation program for new employees	GUIDANCE and INTERPRETATION 483.356(a) The facility must establish a policy for the use of restraint and seclusion. The policy must address emergency safety intervention (ESI), which is defined in this subpart as the use of restraint or seclusion as an immediate response to an emergency safety situation. In addition, the facility policy should include, at minimum, the facility's procedures regarding all requirements for protection of residents. The purpose of such facilities is to provide residents with the high level of psychiatric services that they require and which are unavailable to them in the outside community. Residents are not placed in psychiatric residential treatment facilities to control criminal behavior therefore there should be very limited need for any type of law enforcement personnel or the use of law enforcement restraint devices. Residents are placed in PRTFs to treat psychiatric illnesses, not curtail criminal activities. The use of any type of law enforcement restraint devices such as handcuffs, manacles, shackles, etc. are prohibited within a PRTF. These types of devices are not considered safe, appropriate health care interventions for use by facility staff to restrain residents in PRTFs. If facilities call law enforcement for assistance, they are legally responsible to follow law enforcement instructions. 483.356(a)(1) Restraint or seclusion, including drugs used as restraint, are not to be used as

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(2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators; (3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and (4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s). (d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization. *(a) (1) (i)Any type of mechanical device shall not be used as a restraint unless it meets the definition of medical mechanical restraint.* *(a)(1)(ii) The use of restraint or seclusion should be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others. The facility shall demonstrate effective treatment approaches and alternatives to the use of restraint and/or seclusion. Active treatment does not include the routine use of restraint and seclusion.* *(a)(1)(iii) A written plan to address the limited use of restraint and/or seclusion shall be developed by the PRTF and be available at the request of the Department for Aging and Disability Services, Juvenile Justice Authority, or the Division of Health Care Finance within KDHE.* *(a)(2)(i) Practices must be consistent with CMS interpretive guidelines, therefore the following language has been adopted.* *The use of restraint (includes drugs used as a restraint) or*	regarding staff behavior 3. Interview residents concerning their recent occurrences of restraint or seclusion. Ask the resident to describe the episode including their precedent behaviors, the staff actions and the outcome o the episode. Compare this information to the information charted in the resident's record concerning the behavioral episode. 4. During general observations in the resident areas note and inquire further about: a. Residents that appear over medicated b. Residents sleeping throughout the day c. Residents that are school age and not receiving educational programming, and d. Residents who do not appear alert, functional, and able to participate in their treatment. 483.356(a)(2) Review a sample of resident records: 1. Verify that restraints or seclusion are not being implemented or administered on a PRN or standing order basis. 2. Verify that each order includes the justification and a specified time period for the restraint or seclusion. Justification should include a description of the less restrictive methods used for the emergency situation before restraint or seclusion were ordered. 483.356(a)(3) Identify any restraint or seclusion involving harm or injury to the resident during the restraint or seclusion episode. While reviewing reports surveyors should be cognizant of what types of restraint or seclusion is being used by the facility and how restraints are applied. The following types of restraints are prohibited in a PRTF: 1. Restraints that may impair the breathing (obstructing the airways of the resident by putting pressure on the	coercion, discipline, convenience, or retaliation. 1. Discipline – restraint and seclusion are never to be used as a means to punish or penalize a resident for the sake of controlling behavior. 2. Coercion – (depriving the resident of the exercise of his free will by the use or threat of physical or moral force). Staff may not use intimidation to prevent an individual from free movement or verbal expression. 3. Convenience – (for the staff or facility) Staff may not employ restraint or seclusion as a compensation for inadequate staff or programming. 4. Retaliation – Staff or facility practice must never use restraint or seclusion as a means to retaliate, reciprocate, or extract revenge on a resident for behavior exhibited. Examine closely how frequently emergency safety interventions are employed. Repeated application of such interventions within short intervals of time may raise serious questions about the resident's right to be free from unnecessary restraint or seclusion and indicate the need for further investigation by the surveyor. 483.356(a)(3)(i) ***Emergency Safety Situation*** (ESS) means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that requires an emergency safety intervention as defined in this section. ***Emergency Safety Intervention*** (ESI) means the use of restraint or seclusion as an immediate response to an emergency safety situation. An ESI is to be used only in response to an emergency safety situation. It is not a preventative measure, but is is a reaction to an

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seclusion must not be a planned or anticipated intervention. In order to ensure a resident receives active treatment and is free from abuse, it is necessary that an order be given for each instance of restraint or seclusion. *(a)(2)(ii) After all less restrictive measures have been attempted to end the emergency safety situation, a resident must be assessed by a physician, or other licensed practitioner permitted by the state to order restraint or seclusion, who will then give a one-time order for* ***that*** *specific resident in* ***that*** *particular emergency safety situation. Once that order has expired, it may not be renewed on a planned, anticipated, or as-needed basis.* *(a)(2)(iii)Drugs or medication used for standard treatment of the resident's medical or psychiatric condition shall not be considered a restraint. Standard treatment for the resident's medical condition shall mean the following.* *A. Medication is used within the pharmaceutical parameters approved by the FDA and the Manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters.* *B. The use of the medication follows national practice standards established or recognized by the medical community and/or professional medical association or organization* *C. The use of medication to treat a specific resident's clinical condition is based on the resident's symptoms, overall clinical situation, and on the physician's or other Independent Licensed Practitioner's knowledge of the residents expected and actual response to the medication.* *D. The standard use of a medication to treat the resident's condition enables the resident to more effectively or appropriately function in the world around them than would be possible without the use of the medication. If the overall effect of a medication is to*	back or chest of the individual); 2. Restraints that restrict the resident's ability to communicate during an emergency safety intervention. During the review of the restraint and seclusion reports, note whether in each case 1. There was adequate staff involved to ensure that the restraints were properly applied. 2. The resident was assessed to ensure the restraints were properly applied. The facility should be able to provide a report which summarizes the facility investigation into any injuries received during an restraint or seclusion. 483.356(a)(3)(i) 1. Review a sample of resident records to determine that: a. Documentation identifies the extent of the behaviors which created the emergency safety situation; and b. The documented behavior supports potential harm to the resident or others. 2. Interview a sample of the staff. Request that they explain how the safety of the resident and others is ensured during an emergency safety situation and ensure that their responses are consistent with the facility policies. 483.356(a)(3)(ii) 1. Review the facility restraint and seclusion policies to ensure that the policies include the criteria for discontinuing restraint or seclusion based on the safety of the resident and of others. 2. Review a sample of resident records to determine if there is a pattern of residents staying in restraint or seclusion until the maximum time allowed by the order or of residents remaining in restraint or seclusion after behaviors have ceased (eg sleeping) Documentation should verify that residents are taken out of restraint and seclusion when the emergency	emergency safety situation that cannot be contained with any less restrictive measures. The emergency safety intervention is the most restrictive measure and is used as the last resort to ensure the safety of the resident and others. 483.356(a)(3)(i) Approved intervention safety programs are: * MANDT * TCI-Therapeutic Crisis Intervention * CPI-Crisis Prevention Institute-Nonviolent Crisis Intervention * MAB-Managing Aggressive Behavior * SCM-Safe Crisis Management * PIP-Peaceful Intervention Program (de-escalation only, does not teach physical holds) 483.356(a)(3)(ii) The use of restraint or seclusion should be evaluated on a continual basis (483.362(a) and 483.364(b) for continual monitoring criteria) and ended at the earliest

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reduce the residents ability to effectively or appropriately interact with the world around the resident, then the medication is not being used a standard treatment for the resident's condition *(a)(2)((iv) The use of psychopharmacological medication used in excess of the resident's standard plan of care should be considered a restraint. All rules, regulations, and guidelines governing the use of restraints apply when these drugs are used as a restraint. This includes:* *A. Drugs or medications used to control behavior or restrict the individual's freedom of movement* *B. Drugs or medications used in excessive amounts or in excessive frequency* *C. Neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics, or other medications used for calming rather than for the medication's indicated treatment* *(d) The Kansas State Protection and Advocacy Organization is the Disability Rights Center of Kansas (DRC).* *Disability Rights Center of Kansas (DRC)* *635 S.W. Harrison Street, Suite 100* *Topeka, Kansas 66603-3726* *Voice: 785-273-9661* *Toll free Voice: 1-877-776-1541* *Toll free TDD: 1-877-335-3725* *Fax: 785-273-9414*	safety situation has ceased. 483.356(a)(4) Review a sample of resident records and facility incident reports to ensure that restraint and seclusion are not used at the same time. 483.356(b) Review a sample of resident records to determine if the intervention that was implemented took into account the resident's: 1. Chronological and developmental age; 2. Size; 3. Gender; 4. Physical, medical, and psychiatric condition; and 5. Personal history (either in treatment plan or treatment notes) (including any history of physical, mental, sexual abuse or trauma) 483.356(c)(1) and 483.356(c)(3) Review a sample of resident records to verify that the policy was discussed upon admission and the appropriate signatures were recorded. 483.356(c)(2) During the process of resident record reviews note any instances where a communication barrier was identified for either the resident or the legal guardian. Review the corresponding documentation of the information provided at the time of admission concerning the facility policies on restraint and seclusion. Ensure that any communication barriers were addressed. 483.356(c)(4) Interview residents to verify if they received a copy of the facilities policy at admission.	possible time based on the assessment and evaluation of the resident's condition. 483.356(a)(4) The facility must not utilize restraint, including psychopharmaceutical drugs used as restraint at the same time as utilizing seclusion. There may be isolated instances where both physical and psychopharmaceutical restraints are required during one emergency safety situation. The resident record must include documentation to explain why the first restraint was insufficient and the second restraint was added. If restraint is necessary as a means of safely transporting the resident to seclusion, a separate order is not required. However, the initial order for the seclusion must include the physical transport restraint and be consistent with the requirements for restraint/seclusion orders. 483.356(b) An intervention should be appropriate for the resident's particular physical and mental state, as well as the resident's behavior. Staff must also take into account the resident's past history of abuse or trauma when performing the emergency safety intervention, while at the same time utilizing the safest possible method. This will ensure the safety of both the resident and the staff. In addition, the risk(s) associate with any drug used as a restraint must be weighed against the type and severity of the behavior the resident is exhibiting. 483.356(c)(1) "Minor" is defined under State law and, for the purpose of this subpart, as a resident who has been declared legally incompetent by the applicable State court. The facility must ensure

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	483.356(d) 1. Facility policies and procedures should require that contact information for the P&A organization, how to contact the P&A organization and why the organization might be contacted, be provided to the resident and/or their guardian upon admission. 2. Interview a sample of residents' and/or parents/legal guardians to determine: a. If they understood the information provided to them, and b. If they understood what type of information should be reported to the P&A organization. 1. Review restraint/seclusion logs 2. Review rights notice including compliance with (d). 3. Check admission packets for rights notice 4. Ask for other effective treatment approaches and alternatives used by the facility 5. Review written plan to limit use of r/s. 6. Ask about use of interpreters when needed	that its policies on restraint and seclusion are discussed at the time of admission and the resident and/or their guardian signs to indicate they received the information (a copy of the policy provided to them) and understood the information provided. 483.356(d) This information must be provided to the resident and/or parent/legal guardian upon admission. The contact information must be presented in a manner and language understandable to the resident. If the facility is unsure of which State Protection and Advocacy (P&A) organization to refer the resident to, the facility may provide the contact information for the national P&A organization. The following are guidelines for the use of PRN standing orders for psychoactive medications used for agitation, psychosis, aggression, mood stabilization or calming: • These guidelines apply to neuroleptics, anxiolytics, antihistamines, and atypical neuroleptics. **Other medication classes are excluded from these guidelines.** • These guidelines do not apply to routine medications given on a regular dosage schedule. • These guidelines do not apply to routine HS medications for sleep or over the counter PRN medications such as Mylanta or calamine lotion. • These guidelines are not intended to interfere with anti-anxiety medication prescribed to calm a client who is anxious unless the dosage is such that the resident's freedom of movement is affected. • Review the chart to see that the PRN

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		medication was specific to **the individual clinical need of the resident** based on the resident's behavior and symptoms seen during their stay at the facility. • **Review the chart to assess that no order for medication was given or administered for the convenience of the staff. This can also be obtained by interview of staff and observing on the unit.** • Review the chart and order sheet to see if any PRN standing orders for agitation, psychosis, aggression, mood stabilization and calming are routinely started at admission unless there is recent history of this behavior or a clinical opinion of the physician that this resident can become aggressive quickly. The resident's baseline behaviors on the unit should be assessed before starting these medications. • Review the chart to see if there is documentation that verbal or other de-escalation techniques were used prior to PRN medication administration. Clinical exceptions would situations that include attempts of severe harm to self or others. Look for documentation that this was done. • Review the chart to assess if the PO administration route was attempted prior to IM route unless severe behavior warrants this. Documentation should include why the IM route was needed. • Review the chart to see if there is a reason and description of why the PRN medication is needed including **behavioral symptoms.** This means more than "child is agitated." More descriptive detail should be documented such as "head banging" or "attempted to

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		strike staff." Did the staff explore why the resident is exhibiting this behavior? • Review the chart to assess of if there is documentation of the resident's **response** to the medication. It should state more than just "effective." Descriptions of the resident behavior such as "able to follow directions", able to participate in game, "not pacing", etc. should be present. **NOTE:** If the resident is totally unable to interact or move about after the medication administration this would constitute the use of a "Chemical Restraint." • IF a resident requires three (3) dosages or more of a PRN medication for agitation, psychosis, aggression or calming within a seven day period, that resident should be assessed face to face by a physician or a physician designee that can prescribe. The assessment is to include a review of the resident's routine medication regime to assess for potential adjustments to the routine medications. Review the chart to see if this occurred. **As a reminder: A medication ordered at such a dose (amount) or frequency that reduces the client's ability to effectively or appropriately interact with the world around the resident or restrict the individual's freedom of movement is a Chemical Restraint and all Standards applicable to restraints would apply.**
§483.358 Orders for the use of restraint or seclusion		
(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.	INQUIRES and INDICATORS 483.358(a) 1. Review the facility policy for restraint and seclusion orders to determine: a. If the policies state who is responsible for ordering restraint or seclusion; and	GUIDANCE and INTERPRETATION 483.358(a) The facility's policy should indicate (in conformity with applicable state law) what licensed health care practitioners may order the use of restraint or seclusion in the facility. The policies should also state the types, amounts, and

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(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion. (c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. (d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention. (e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. (f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to— (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention.	b. If the policies are consistent with state law. 2. Review a sample of resident records to verify that if any use of restraint or seclusion was ordered: a. The person ordering the restraint or seclusion was qualified to order restraint or seclusion according to the facility policy and state law; and b. Physician orders were obtained for any physical restraint used during medical transport to a hospital. 3. Interview licensed personnel to determine their knowledge of who may order restraint or seclusion and how and when that order must be obtained and documented. Ensure that their responses are consistent with facility policy and state law. 4. Review personnel files to determine whether staff permitted to order restraint or seclusion in the facility are currently licensed and/or certified and have received training on the ESIs. 483.358(b) It is expected that the treatment team physician will order the use of restraint or seclusion. IN those instances where someone else ordered the restraint or seclusion, the resident record must document efforts to reach the treatment team physician before contacting the alternate practitioner. 483.358(c) 1. Review a sample of resident's records to verify that: a. The less restrictive safety interventions used were appropriate for the resident based on the information in treatment plan; b. The resident record documents those precursor behaviors which indicated that the resident was escalating to a possible emergency safety situation; and c. Other less restrictive interventions were considered or attempted and documented. 483.358(d)	frequency of training required for these practitioners in the area of emergency safety interventions. Board eligible and board certified psychiatrist shall meet the requirement for "physician trained in the use of emergency safety interventions". Other licensed practitioners permitted by the State and the facility shall complete the state approved training program in order to meet the requirement for being "trained in the use of emergency safety interventions" 483.358(b) The "treating" physician is the physician who is responsible for the management and care of the resident. If the treating physician does not give the order for the emergency intervention, it is important that the facility staff consult with the treating physician, as soon as he/she is available, because information regarding the resident's history may have a significant impact on the selection of seclusion or restraint intervention. If the physician ordering the use of restraint and seclusion is not the resident's treatment team physician, then the ordering physician or other licensed practitioner must consult with the resident's treatment team physician within 24 hours of the restraint and seclusion being ordered. 483.358(c) In emergency situations where an unanticipated behavior requires immediate protection of the individual or others, the measure chosen should be the least restrictive intervention possible. Documentation should detail the less restrictive measures utilized prior to the application of the restraint or seclusion.

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(g) Each order for restraint or seclusion must include— (1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion; (2) The date and time the order was obtained; and (3) The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use. (h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: (1) Each order for restraint or seclusion as required in paragraph (g) of this section. (2) The time the emergency safety intervention actually began and ended. (3) The time and results of the 1-hour assessment required in paragraph (f) of this section. (4) The emergency safety situation that required the resident to be restrained or put in seclusion. (5) The name of staff involved in the emergency safety intervention. (i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes. (j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. [66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28116, May 22, 2001] *(a) Other than a physician, the only licensed practitioner permitted by the state to order seclusion or restraint is a physician's assistant (PA) working under protocol, or an advanced practice registered nurse (APRN) working under protocol, a PhD psychologist, or the head of the treatment facility or their designee who*	1. Review the verbal orders within a sample of resident records to determine: a. That orders for restraint or seclusion were received by a registered nurse; or b. Other licensed staff (defined as those licensed practitioners permitted by state law to receive verbal orders); and c. The verbal orders were verified in a signed, written form within the timeframe specified by the facility. 483.358(e)(1) and (2) 1. Review the facility policies and procedures regarding timeframes for emergency safety interventions. Ensure they are consistent with the regulations at 483.358(e). 2. Review a sample of resident records to verify that: a. The facility followed its policy on the restraint and seclusion timeframes; and b. The actual time the restraint or seclusion is in place is no longer than the timeframe ordered by the practitioner. 3. Interview direct care staff to determine whether they are familiar with the regulatory timeframes for the application of restraint or seclusion by age. 483.358(f)(1)-(4) 1. Review facility policy to determine: a. Who conducts the one hour assessments; b. What must be included in each assessment; and c. When the facility requires the assessment to be completed. 2. Review a sample of resident records for the 1-hour assessment to verify that: a. Assessments were performed within the specified timeframe; b. The appropriate person performed the assessments; c. The assessment was conducted face to face; and d. Documentation of each assessment included	Staff should document interventions that have been attempted prior to implementing seclusion or restraint. The effectiveness or ineffectiveness of the interventions should be evaluated and incorporated into the resident's treatment plan and these should also be used as a basis for planning for future interventions. 483.358(d) The facility's policy should conform to state law regarding the receipt of verbal orders. The policy should also indicate who, other than a registered nurse, may receive a verbal order. The verbal order can only be received by a registered nurse or other licensed staff. If the facility identifies "other licensed staff" this should coincide with state law. The policy should also include the timeframe in which a physician or other licensed practitioner must co-sign the verbal order. 483.358(e)(1) and (2) A restraint or seclusion must be used only until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired. The timeframes specified in these requirements are maximums per age group. The ordering practitioner has the discretion to decide that the order be written for a shorter period of time. Throughout the restraining or seclusion period staff should be assessing, monitoring, and re-evaluating the resident so that he or she is released from the restraint or seclusion at the earliest possible time. If restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying restraints. At the point in which a new order for restraint or seclusion has been obtained, all requirements for monitoring and

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must be a physician, PA, APRN, or a LMHP as defined in the definitions section of this document and the state Medicaid Plan. *(c) See the definition of licensed practitioner permitted by the State in (a) above.* *(d) Licensed staff means licensed health care professionals who are operating within the scope of their practice and capable of receiving orders. Trained RNs and LPN's are appropriate. The physician, APRN, PA, or LMHP giving the order for the restraint or seclusion must also be available throughout the use of the emergency safety intervention.* *(e)(2) Emergency safety interventions may not exceed 4 hours for residents ages 18 to 21; 2 hour for residents ages 9 to 17; or 1 hour for residents under age 9. Throughout the use of the emergency safety intervention staff should be assessing, monitoring, and re-evaluating the resident so that he or she is released from the restraint or seclusion at the earliest possible time.* *(f) : A licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess psychological and physical wellbeing of residents within 1 hour of the initiation of the emergency safety intervention. A physician, a physician's assistant (PA), an advanced practice registered nurse (APRN) or a trained registered nurse (RN) are qualified to assess physical wellbeing.* *(h) (i) The name and credentials of staff involved in the restraint.* *(j) Consultation with treatment team physician*	(1-4 below): i. The resident's physical and psychological status; ii. The resident's behavior; iii. The appropriateness of the intervention measures; and iv. Any complications resulting from the intervention. 483.358(g)(1) (2) (3) Review a sample of the resident records to ensure: • That the name of the ordering physician or licensed practitioner is clearly documented within the order for each incident of restraint or seclusion. (g)(1) • Confirm that the date and time the order was given was documented for each order for restraint or seclusion and the date and time of the order is consistent with all other documents and logs related to the restraint or seclusion incident. (g)(2) • Verify that each order for restraint or seclusion includes: (g)(3) a. The length of time the intervention may be administered; and b. The specific type of restraint or seclusion to be administered. 483.358(h)(2) Review a sample of resident records to verify that: • The facility documented the start and discontinuation times of the restraint and seclusion; (h)(2) • The 1 hour assessment is documented; (h)(3) • If the assessment included any negative physical or psychological findings, appropriate adjustments or changes were made to the emergency safety intervention. (h)(3) • Documentation included in description of the behavior of the resident which warranted restraint or seclusion; (h)(4) • verify that the names of all staff who were involved in the intervention were documented at some location	documentation begin as with all new orders. Specifically, after a resident has been removed from restraint or seclusion for any amount of time, the next incident of restraint or seclusion may not be considered a continuation of the previous restraint or seclusion order. 483.358(f)(1)-(4) A physician or other licensed practitioner (as recognized by State law and facility policy) must perform a face to face evaluation within 1 hour of the initiation of restraint or seclusion. A telephone call does not fulfill this requirement. The physician or other licensed practitioner must be physically present to evaluate and assess the status of the resident. The assessment ensures the resident's rights, confirms that the restraint or seclusion is necessary and appropriate and allows the practitioner to evaluation the medical status of thee resident. If a resident is released from restraint or seclusion before the physician or other licensed practitioner arrives to perform the assessment, the physician or other licensed practitioner must still conduct the required face to face assessment within one hour after the initiation of the intervention. This face to face assessment must be conducted for all types of restraints (including drugs used as a restraint) and seclusion. 483.358(g)(3) An order for restraint or seclusion is only valid for one individual behavioral incident. Orders for restraint or seclusion may not be extended. If behaviors continue after the end of one order timeframe a separate order is required. 483.358(h) If the resident is still restrained or secluded at the end of a shift, the staff person who witnessed the events that led up to the

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	within the record. (h)(5) 483.358(i) Verify that the facility maintains a separate, cumulative log of all restraint and seclusions that occur in the facility. Each log entry should be dated and timed and include information concerning the interventions that were used and the ultimate outcome of any associated restraint and seclusion. Note any instances where resident record review indicated that an restraint or seclusion occurred but was not entered into the log. 483.358(j) 1. Review the facility policy on verbal orders to determine: a. What timeframe is specified for co-signing verbal orders; and b. Whether this policy is consistent with or more stringent than state and federal requirements for co-signature of verbal orders. 2. Review a sample of resident records to verify that verbal orders are co-signed consistent with state law, facility policy, and/or Interpretive Guidelines.	restraint or seclusion is accountable for providing comprehensive documentation in the record of the events that led up t and the implementation of the restraint or seclusion. After the resident has been removed from restraint or seclusion, the staff that is present during the conclusion of the emergency safety intervention is required to document their observations of the resident throughout the duration of the seclusion or restraint and the discontinuation of the safety intervention. 483.358(h)(3) In those cases where only one hour of restraint or seclusion was ordered and the practitioner performing the assessment feels the restraint or seclusion should continue, a new order is required. 483.358(h)(5) The names of all staff members involved in the emergency safety intervention including that of the physician or licensed practitioner who ordered the emergency safety intervention and the practitioner that performed the 1 hour face to face assessment must be documented. Note: Involved staff include all staff physically participating in the ESI and any staff providing orders or assessments during the ESI 483.358(j) If the ordering physician or other licensed practitioner is not present on the unit at the time the order is given, any verbal order for restraint or seclusion obtained by a registered nurse or other licensed staff should be signed by the physician or licensed practitioner within 48 hours or according to state law.

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§ 483.360 Consultation with treatment team physician		
If a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must— (a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and (b) Document in the resident's record the date and time the team physician was consulted. [66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]	INQUIRES and INDICATORS 483.360(a) Verify that the facility policies require a report to the treatment team physician within 24 hours of an order for restraint or seclusion by an alternate practitioner. 483.360(b) Review a sample of resident records to verify that: a. Documentation of notification of the treatment team physician included in the date and time the physician was notified, the information provided concerning the need for restraint or seclusion, the outcome of the restraint and seclusion	GUIDANCE and INTERPRETATION 483.360(a) The treatment team physician is the physician who is responsible for the management and care of the resident on a day-to-day basis. When an alternate practitioner orders restraint or seclusion in lieu of the treatment team physician he/she has an obligation to inform the treating physician of the events that transpired and led to the order for an emergency safety intervention. They are also responsible for updating the treatment team physician with any complications that may have resulted from the emergency safety intervention and the resident's physical and mental status at the time the report is made. Because the emergency safety intervention/situation and its outcomes will greatly affect the resident's treatment plan, it is important to consult with the treating physician as soon as possible but no more than 24 hours from the time the order was given by the alternate practitioner.
§ 483.362 Monitoring of the resident in and immediately after restraint		
(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. (b) If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse,	INQUIRES and INDICATORS 483.362(a) 1. Review the facility policies to determine how continual assessment and monitoring of resident physical and psychological status during restraint is to be done. The policy should specify: a. Which staff members are responsible for assessing and monitoring the resident	GUIDANCE and INTERPRETATION 483.362(a) "Physically present" should be defined as being in close enough proximity to the resident at all times to be able to verify that the resident is no acute distress from the restraint or seclusion. The staff must be able to assess, at any given moment, the resident's respirations, hear

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must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions. (c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed. [66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001] *(a)(1)(i) All facility direct care staff must complete a KDADS approved training program on the use of emergency safety interventions.* *(a)(1)(ii) Clinical staff are defined as direct care staff or LMHP's, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.* *(c) Licensed practitioners permitted by the state and the facility to evaluate the residents physical and psychological well-being immediately after a resident is removed from a restraint are physicians, a physician's assistant (PA), an advanced practice registered nurse (APRN),a trained-registered nurse (RN).*	2. Review a sample of resident records to verify that during periods of restraint: a. The resident was assessed on a continual basis by the person physically present during the restraint; b. Assessments included observations of the resident's physical and behavioral status at the time of each assessment; and c. Incidences of restraint are charted in the facility restraint and seclusion log. The final assessment made during the restraint should include documentation as to time and circumstances of the release of the restraint. 3. Interview staff to determine their knowledge of: a. How the resident's safety is ensured during an restraint; b. Where staff is physically located when a resident is in restraints; c. How residents are monitored during an restraint; and d. How often residents are monitored during restraint. 4. Observe restraint which occur during the survey process to verify that staff are physically present and monitoring the resident status throughout the entire duration of the restraint. 483.362(b) 1. Review a sample of resident records to verify that: a. There is documentation of the behaviors that justified a new order for continued use of a restraint' b. There is evidence that the physician or licensed practitioner was provided sufficient information concerning the resident's behavior to justify a new order for restraint 483.362(c) Review a sample of resident records to verify that:	and respond to resident calls for assistance and observe changes in resident behavior. "Continually assessing" should be defined as documentation every five minutes of the ongoing assessment of the behavior and physical status of the resident by the staff who are physically present throughout the duration of the restraint or seclusion. 483.362(b) If necessary, prior to the expiration of the original order for restraint, a registered nurse or other licensed staff may telephone the physician or other licensed practitioner, report the results of his/her most recent assessment and obtain further instruction. If the practitioner advises that the ESI continue past the limits of the current order, the expectation is that a new order must be obtained, based upon current behaviors.

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	a. An evaluation of the resident's well being was documented after release from restraint; b. The evaluation was conducted in person; and c. An authorized practitioner performed the evaluation. 1. Check personnel files for training 2. Cross check staff providing interventions are appropriately trained.	
§ 483.364 Monitoring of the resident in and immediately after seclusion		
(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement. (b) A room used for seclusion must— (1) Allow staff full view of the resident in all areas of the room; and (2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets. (c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions. (d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion. [66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001] *(a)(1)(i) All facility direct care staff must complete a KDADS approved training program on the use of emergency safety*	INQUIRES and INDICATORS 483.364(a) 1. Review the facility's policies on seclusion to determine how continual assessment and monitoring of the resident's physical and psychological status during the seclusion is to be done. The policy should specify: a. Which staff members are responsible for assessing and monitoring the resident 2. Review a sample of resident records to verify that during periods of seclusion: a. The resident was assessed on a continual basis by the person physically present during the seclusion; b. Assessment included observation of the resident's physical behavioral status at the time of each assessment; c. Incidences of seclusion are charted in the facility restraint and seclusion log; and d. The facility does not use video monitoring as a substitute for clinical staff. The final assessment made during the seclusion should include documentation as to time and circumstances of the release of the seclusion. 3. Interview staff to determine their knowledge of: a. How resident safety is ensured during an seclusion;	GUIDANCE and INTERPRETATION 483.364 (a) "Physically present" should be defined as being in close enough proximity to the resident at all times to be able to verify that the resident is in no acute distress from the restraint or seclusion. The staff must be able to assess, at any given moment, the resident's respirations, hear and respond to resident calls for assistance, and observe changes in resident behavior. "Continually assessing" should be defined as an assessment at least every five minutes of the behavior and physical status of the resident by the staff who are physically present throughout the duration of the restraint or seclusion.

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interventions. *(a)(1)(ii) Clinical staff is defined as direct care staff or LMHPs, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.* *(d) Licensed practitioners permitted by the state and the facility to evaluate the residents well-being immediately after a resident is removed from a restraint are physicians, a physician's assistant (PA), an advanced practice registered nurse (APRN),and a trained- registered nurse (RN).*	b. The physical location of staff when a resident is in seclusion; c. How residents are monitored during seclusion; d. How often residents are monitored during seclusion; e. What action does staff implement if a resident in seclusion becomes self-injurious, exhibits behaviorally inappropriate reactions such as urinating on the floor or shows signs of physiological illness. 4. Observe any seclusion that occurs during the survey process. Verify that there are staff physically present and monitoring the resident throughout the seclusion. 483.364(b)(1) The facility should indicate the areas of the facility where seclusion is allowed. Locate all designated areas in the facility. Evaluate each room to ensure that it meets the visualization requirements. Review the facility restraint and seclusion log to identify any instances where a room in the facility other than a designated seclusion area was utilized for seclusion. Document if the facility is using areas that are not designated by facility policy. Observe the room to ensure that the room meets the visualization requirements. 483.364(b)(2) Inspect the rooms designated for seclusion by the facility policy to ensure that nothing is in the room that the resident may be injured by or may use to injure him/herself. 483.364(c) Review a sample of resident records to verify that: a. There is documentation of the behaviors that justified a new order for continued use of seclusion; b. There is evidence that the physician or licensed	483.364(b)(1) Any area utilized as a seclusion room must be designed to enable the physically present, continually monitoring staff to be able to visualize the entire body of the resident in the seclusion room. Video monitoring may be used in addition to this room confirguration but may not be used in lieu of the configuration. 483.364(c) If necessary, prior to the expiration of the original order for restraint, a registered nurse or other licensed staff may telephone the physician or other licensed practitioner, report the results of his/her most recent assessment and

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	practitioner was provided sufficient information concerning the resident's behavior to justify a new order for seclusion 483.362(d) Review a sample of resident records to verify that: a. An evaluation of the resident's well being was documented after release from seclusion; b. The evaluation was conducted in person; and c. An authorized practitioner performed the evaluation. 1. Check personnel files for training 2. Cross check staff providing interventions are appropriately trained.	obtain further instruction. If the practitioner advises that the ESI continue past the limits of the current order, the expectation is that a new order must be obtained, based upon current behaviors.
§ 483.366 Notification of parent(s) or legal guardian(s)		
If the resident is a minor as defined in this subpart: (a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. (b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.	INQUIRES and INDICATORS 483.366 (a) 1. Review the facility policy to verify that it addresses: a. What information should be documented in each resident's record regarding facility contact with family or guardian; b. The staff who are responsible (i.e., by title or position) for notifying resident's parent(s) or legal guardian(s) as indicated; c. What documentation should be in the resident record if the parent(s) or legal guardian(s) request a delay in contact concerning initiation of restraint or seclusion; and d. The procedure to be followed when staff is unable to successfully contact the restrained resident's parent(s) or legal guardian(s). 2. Interview staff to determine their knowledge of the facility's policy regarding the contacting of parent(s) or legal guardian(s) after the initiation of each emergency safety situation.	GUIDANCE and INTERPRETATION 483.366(a) Upon admission, the facility should obtain emergency information from the parent(s) or legal guardian(s). In the event a parent or legal guardian cannot be contacted, the facility should have alternate methods for contacting parent(s) or legal guardian(s). The facility's policy should specify what information must be relayed to the parent or legal guardian regarding the initiation of restraint and seclusion. "As soon as possible" is generally considered to be the time of initiation of restraint or seclusion. Although a parent or guardian may request that they not be disturbed during certain periods of time during the day or night, the facility must still notify them but may delay notification to be consistent with their written instructions.

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	483.366 (b) 1. Review a sample of resident records to verify that: a. The facility notifies the parent or guardian of the initiation of restraint or seclusion; b. The facility documents the date and time of the attempted contact; c. The facility documents who they attempted to contact; and d. The facility documents their actual contact.	483.366(b) If the facility is unable to reach the parent or guardian at the time of the restraint or seclusion's initiation, they must continue to try and reach them. The goal should be to communicate with a live person. However, a message will meet the notification standard after the second attempt.
§ 483.368 Application of time out		
(a) A resident in time out must never be physically prevented from leaving the time out area. (b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary). (c) Staff must monitor the resident while he or she is in time out. *(a) If a resident does not stay in time out voluntarily, it is considered seclusion.*	INQUIRES and INDICATORS 483.368(a) 1. Review the facility policy to verify that: a. The facility policy is consistent with the definition of time out as defined in the "Guidance" section of this standard. b. The policy identifies how and by whom time out is implemented and discontinued; and c. The policy states what documentation is required regarding time out and who must do the documentation. 2. Interview staff to verify that they are operating consistently with facility policy concerning: a. When can a resident leave the time out area; b. Types of behaviors that warrant time out; c. Training provided by the facility regarding the use of time out. d. Where time out typically occurs; e. How does staff document this intervention 483.368 (a), (b) and (c) 1. Ensure that the use of time out in the facility is implemented properly and consistently and in a manner that protects the resident's freedom of movement. Time out is a voluntary action and there should be no indication that coercion or intimidation was used by staff.	GUIDANCE and INITERPRETATION 483.368(a) Time out, as defined in this subpart, means a brief voluntary time away from activities for a period, for the purpose of providing the resident an opportunity to regain self-control. Physically preventing the resident from leaving the time out area would be considered restraint or seclusion. 483.368(b) **Exclusionary time out** is defined as the state of being excluded from participation by removal from the environment where an activity or group of individuals is located. **Inclusionary time out** is defined as a state of being included in the environment where an activity or group of individuals is located, but not participating in the activity or with the group. In either situation, whether it be exclusionary or inclusionary, a resident cannot at any time be prevented from leaving the time out area. 483.368(c) In those instances during efforts to use less restrictive measures where the staff requests

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	2. Review resident records containing episodes of the use of staff-suggested time out to verify that staff monitoring was documented. 3. Observe the location of time out episodes. Verify that the locations are consistent with the area specified by the facility policy to be used for time out.	the resident take time out, the staff must monitor the resident throughout the time out episode. Documentation should include time of initiation progression of behaviors during the time out episode, time of ending time out, and the resident's disposition at the end of the time out.
§ 483.370 Post-intervention debriefings		
(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion. (b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of— (1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention; (2) Alternative techniques that might have prevented the use of the restraint or seclusion; (3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and (4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.	INQUIRES and INDICATORS 483.370(a) and (c) 1. Review a sample of resident records to verify that the documentation of both the resident debriefing and the staff debriefing include: a. That a face to face debriefing was held within 24 hours of the conclusion of the restraint or seclusion episode; b. Appropriate staff (and their names) were involved in the face to face debriefing (if one or more of the staff involved in the restraint or seclusion does not attend the face to face, there must be documentation to justify their absence): c. That the resident was present for the debriefing; d. If the resident is a minor, the parents or legal guardians were notified and given an opportunity to participate in the debriefing; e. The meeting discussion includes documentation of how an restraint or seclusion may be prevented in the future based upon information learned from the episode; and f. Any changes to the resident's treatment plan as a result of each debriefing. 2. Interview residents to determine: a. If they were given the opportunity to participate in the debriefing;	GUIDANCE and INTERPRETATION The purpose of the debriefing is to provide both the resident and the staff an opportunity to analyze the events surrounding the emergency safety situation and intervention. It is essential that facilities include all four factors of 483.370(b)(1)-(4) in the debriefing in order to learn from the emergency safety situation and intervention and to provide the resident with a more individualized active treatment plan.

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(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.	b. If they were given the opportunity to actively discuss the emergency safety situation and intervention; and c. Whether strategies to prevent future use of seclusion or restraint were discussed with the resident. 3. Determine if there were any communication barriers for the resident or their parent or guardian during the debriefing. If barriers existed, confirm that the facility made the necessary accommodations. 483.370 Review a sample of resident records to verify: • That a meeting was held within 24 hours among the staff involved in an restraint or seclusion, their supervisor and administrative staff (such as the Unit Director). The discussion of the meeting must address the precipitating factors as well as the actual restraint or seclusion procedure. This meeting does not include the resident or their parents/guardians. (b)(1) • That the staff/supervisory debriefing contained a discussion of non-physical intervention that could have been used prior to the implementation of restraint or seclusion. (b)(2) • That the resident's treatment plan was updated as a result of the staff/supervisory debriefing to include alternate interventions or procedures which should be tried prior to restraint and seclusion in the future. (b)(3) Interview direct care staff to determine: a. How are treatment plan changes documented; and b. Do they know who must attend the two different debriefings 483.370(b)(4) The documentation of the staff/supervisory debriefings must include a discussion of • How this restraint or seclusion impacted the resident's overall progress or treatment;	

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	• Any injuries to the resident or staff which occurred during the restraint or seclusion; • factors contributing to the injury; • procedures that were not followed and contributed to the injury; • measures to be implemented to prevent such injuries in the future; • medical treatment that was required and provided to the resident or staff. Documentation should also verify that injuries at the level of a serious occurrence were reported to the State Medicaid Agency and potentially to the Protective Services Agency as per 483.374(b).	
§ 483.372 Medical treatment for injuries resulting from an emergency safety intervention		
(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention. (b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that— (1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care; (2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and (3) Services are available to each resident 24 hours a day, 7 days a week. (c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention,	INQUIRES and INDICATORS 483.372(a) Verify that the facility has written policies and procedures for emergency medical care of injuries resulting from implementation of safety intervention. 483.372(b) Review any written contracts between the PRTF and the receiving hospital to ensure that the terms of the agreement stipulate that the hospital will accept the resident, provide indicated assessment and treatment, and admit the resident as indicated. In situations where the PRTF is affiliated with an acute care hospital the PRTF should have written Memorandum of Understanding with the parent facility indicating that the acute medical assessment and care will be provided. 483.372(b)(1) 1. Review the facility policy regarding the process for transfer of residents to an acute care hospital. The policy should address the types of medical conditions	GUIDANCE and INTERPRETATION 483.372(a) It is the responsibility of the facility to adequately assess the resident to determine the extent of any injuries obtained during an ESI and provide/secure the appropriate medical care promptly. Staff that are medically trained to provide emergency first aid care and CPR should be available to provide the emergency medical interventions until further follow up emergency care can be provided. 483.372 (a) All injuries shall require appropriate level of medical intervention based on standards of medical practice. 483.372(b)(1) If a resident is determined to need medical care or acute psychiatric care, it is the responsibility of the facility to assure a timely transfer.

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including injuries to staff resulting from that intervention. (d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. *(c) The resident's family and/or custodial case manager shall be notified ASAP adhering to parental preference, no later than 24 hours, of any injuries resulting from an emergency safety intervention.*	or injuries that require transport; 2. Review a sample of resident's records to verify that hospital transfers where conducted in a manner consistent with prompt medical attention and facility policy. 483.372(b)(2) 1. Review the facility policy to ensure it includes what information is required to be provided to the hospital upon resident transfer; 2. Ensure that exchange of information per the facility policy is consistent with state law; 3. Agreements between the PRTF and hospitals should include the required information that should be shared between the two entities; and 4. Interview licensed staff to ensure they are familiar with and understand the policy regarding exchange of information with hospitals. 483.372(b)(3) Written agreements or Memoranda of Understanding between the PRTF and hospitals must state that care will be available 24 hours a day, 7 days a week, including emergent care. 483.372(c) Review the facility restraint and seclusion log. Select a sample of recent restraint and seclusions. From that sample interview the involved client to determine whether he/she suffered any injury during the restraint or seclusion. Verify that the injury was documented in the resident record. If there is no documentation, interview staff members on duty during the restraint or seclusion. Be alert to any patterns of injuries reported by residents but not documented, especially if the restraint or seclusion involve the same staff. 483.372(d) Review a sample of resident records to identify instances where staff injuries occurred during an restraint or seclusion.	483.372(c) The facility should have written policies and procedures that list all the elements that must be included in the documentation of any injury occurring during an ESI. Complete documentation of resident injuries must be included in the resident record. Documentation of staff injuries resulting from emergency safety intervention must be referenced in the associated resident record. However more detailed information concerning the staff injury may be located somewhere other than the resident record. 483.372(d) This discussion may be included in the routine post 24 hour staff debriefing or may be documented separately. Documentation must

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	Follow up with the staff involved to determine if they facility developed a plan to avoid future problems (e.g. procedural changes, provided training…).	address any staff procedures that will be changed as a result of the injury or what additional staff training will be required. Refer to 483.370(b).
§ 483.374 Facility reporting		
(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director. (1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001. (2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency. (b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in §483.352 of this part, and a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility. (2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence. (3) Staff must document in the resident's record that the serious occurrence was reported to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. This	INQUIRES and INDICATORS 483.374(a) The attestation should include as a minimum: 1. The facility name and location; 2. Total number of facility beds; 3. Number of Medicaid residents in the facility; 4. Number of residents for whom the Psych Under 21 is paid for by another state; 5. A list of all states from whom the facility has ever received Medicaid payment for the provision of the Psych Under 21 benefit; 6. A statement certifying that the facility currently meets all of the requirements of Part 483, Subpart G governing the use of restraint and seclusion; 7. A statement that the facility will submit a new attestation of compliance in the event that the facility director is no longer in such position; 8. Name of individual and position of individual signing the attestation; and 9. The date the attestation was signed. 483.347(b)(1) 1. Review the facility policies to determine: a. That "serious occurrence" is defined in a manner that is consistent with this regulation; b. That the policies include procedures that staff must follow in reporting serious occurrences; c. If the facility designates who should report and follow up on serious occurrences; d. If the policy addresses investigation of injuries of unknown origins 2. Interview staff to determine what method the facility uses to report serious occurrences. Ensure that the staff is able to differentiate between what should and	GUIDANCE and INTERPRETATION 483.374(a) KDADS should have a copy of the current facility attestation on file. The surveyor should ensure that there is a current attestation on file for the facility prior to going on site. The surveyor should also verify through the state Medicaid agency that the facility is still operational prior to going onsite. 483.374(b) "Substantial hematoma" should be defined as any hematoma measuring 1% or more of the total body surface area. The resident's palm size may be utilized as a reference for the 1% measurement. 483.374(b)(1) Since PRTF's offer services 24 hours a day, 7 days a week, KDADS interprets a business day as any day of the week; therefore Serious Occurrences are required to be reported no later than 24 hours after the event.

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report should include the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility. (c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office. (1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death. (2) Staff must document in the resident's record that the death was reported to the CMS regional office. [66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001] *(b) All serious injuries defined as any significant impairment of the physical condition of a resident as determined by qualified medical personnel.* *i. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematomas, and injuries to internal organs, whether self-inflicted or inflicted by others.* *ii. All injuries that require medical intervention beyond first aid, including lacerations requiring stitches, substantial hematomas, as well as all death and all suicide attempts are considered serious occurrences and must be reported by no later than close of business the next business day after a serious occurrence to the State Medicaid Agency (Division of Health Care Finance), Department for Aging and Disability Services, applicable child welfare contractor/case manager or JJA case manager, and the Kansas Protective Advocacy System/Disability rights center of Kansas.* *iii. It is the responsibility of the facility to ensure that it reports serious occurrences appropriately.*	should not be reported. 3. During the onsite survey, request a list of all the serious occurrences reported to the state Medicaid agency and the Protection and Advocacy organization within the past year. Observe for patterns of injury that may be associated with action or inaction on the part of the facility. 483.374(b)(2) 1. Review the facility policy to verify that: a. The policy requires parental/legal guardian notification within 24 hours after a serious occurrence; and b. That the policy specifies who should notify the parent/legal guardian. 2. Review a sample of the serious occurrence reports. Verify that notification to parents or guardians was timely, within 24 hours. 483.374(b)(3) Review the resident records for the selected sample above to verify that: a. The occurrence was recorded in the incident and accident report logs kept by the facility; b. The record includes documentation that the occurrence was reported to the State Medicaid Agency and Protection Advocacy organization; c. The documentation includes the name of the person to whom the incident was reported at both agencies; and d. A copy of the actual occurrence report was included in the resident record. 483.374(c)(1)-(2) 1. Review the facility policy to ensure it includes clear instruction for reporting deaths to CMS within the established timeframes. 2. Note any reported deaths by the facility since the last onsite survey. If any deaths occurred since the last onsite survey confirm that the death was reported to	483.374 *(b)(v)* Centers for Medicare and Medicaid Services (CMS) considers Immediate Jeopardy situations to be investigated based upon a predetermined set of triggers established by CMS. **Failure to protect from abuse:** • Serious Occurrence definition: resident's death, a serious injury, or a resident's suicide attempt. Serious injuries are defined as any significant impairment of the physical condition of a resident as determined by a qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematomas, and injuries to internal organs, whether self-inflicted or inflicted by others. • Sexual interactions between staff or residents; e.g., sexual harassment, sexual coercion or sexual assault • Staff striking or roughly handling an individual or resident causing bodily harm

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iv. The facility must investigate any injuries of unknown origin to ensure that a resident is not at risk of additional harm. In addition, if a resident has repeated injuries that are indicative of a pattern, the facility should investigate to ensure tht the resident is not subjected to hostile environment also to take steps to minimize the risk of more injuries. *v. In cases of suspected abuse, neglect, or exploitation of a resident, the facility must follow mandated reporting procedures immediately per K.S.A.38-2223 and K.A.R. 28-4-1209 and amendments thereto.* *(b)(2) The resident's family and agency case manager shall be notified of all reportable incidents* *(b)(3) The facility will document all notifications and retain a serious occurrence report in the residents file.* *(b)(3)(i) The PRTF shall notify KDADS of any natural disaster (e.g. fire, flood, etc.), work stoppage or any significant event-affecting residents of the facility as soon as possible.*	CMS within the established timeframes and documented in the resident's record. 3. During interviews with staff, inquire as to the number of deaths which have occurred at the facility. Confirm for any death they note that the facility followed reporting requirements. 4. If a resident dies outside the facility (for instance, in an acute care hospital) due to injuries which occurred while in the PRTF, the facility must report the death per the reporting requirements. 1. Check personnel files for training on reporting requirements.	(injury) against another resident • Staff yelling, swearing, gesturing or calling an individual derogatory names that results in displays of fear, unwillingness to communicate and recent or sudden changes in behavior by individuals OR Lack of intervention or control (by the facility) to prevent individuals from creating an environment of fear • Bruises around the breast or genital area, or suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising **Failure to prevent neglect:** • Lack of timely assessment of individuals after injury • Lack of supervision for individual that results in a runaway or physical altercations • Failure to carry out doctor's orders • Failure to adequately monitor and intervene for serious medical conditions and individuals with known severe self injurious behavior • Use of chemical/physical restraints **Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed:** • Administration of medication to an individual with a known history of allergic reaction to that medication • Lack of monitoring and identification of potential serious drug interaction, side effects and adverse reactions • Administration of contraindicated medications • Pattern of repeated medication errors without intervention • Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction • Lack of timely and appropriate monitoring required for drug titration

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		KDADS licensing requirements require that a PRTF notify KDADS of any changes in the use of buildings, increasing or decreasing the number of beds, age range, and gender of residents.
§ 483.376 Education and training		
(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of— (1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations; (2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and (3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion. (b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required. (c) Individuals who are qualified by education, training, and experience must provide staff training. (d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations. (e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention. (f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.	INQUIRES and INDICATORS 483.376(a) 1. Review facility training programs, materials, and general facility policies to verify that the content that is to be taught to staff identifies events that are described in (a)(1-3). 2. Observe staff/resident interactions to verify that staff exhibit appropriate (per facility policies and training programs) interactions with residents. 3. Interview staff to determine that they received the required ongoing education and training . Determine whether staff feel that the training they received prepared them adequately to address the concerns of the specific resident population.	GUIDANCE and INTERPRETATION 483.376(a) The facility must attend ongoing training and education activities in the required areas outlined below. It is imperative that the facility identify and provide for the training needs of staff based upon their responsibilities to include direct care staff as well as administrative, clerical, and housekeeping staff. Review the facility documentation in staff files to verify the training is occurring. 483.376(a)(1) The facility must provide educational and hands-on training to staff that assists them in identifying and understanding psychiatric behaviors exhibited by the residents. Educational training is intended to teach concepts and knowledge, such as in an explanation and discussion of various less restrictive interventions that may be used in a given situation. Hands-on training is taught through practical experience, such as watching how a restraint is applied and then applying what is learned through a return demonstration. This training should include the identification of staff roles and behaviors that

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(g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training. (h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency. *(a)(i) The PRTF shall provide written training plan that meets KDADS approval for all staff having direct contact with residents. This training shall include temporary, part-time staff and volunteers, which includes specific training for newly hired staff and for the ongoing competence of all staff, including staff with whom the facility contracts for service. A record of all training must be kept for each staff and volunteer*. *(a)(ii) Prior to working with residents, all staff shall have an orientation to the person's specific duties and responsibilities and the policies and procedures of the facility, including reportable incident reporting, discipline, care and management of children, medication administration, and use of restrictive procedures.* *(a)(iii) Prior to working alone with residents, the director and each full-time, part-time, volunteer and temporary staff person who will have regular and significant direct contact with residents shall be oriented to the policies and procedures of the facility, be familiar with the facilities behavior management system, and have completed a training curriculum approved by the state which includes the following areas:* *A. Mandatory reporting requirements for abuse, neglect and exploitation.* *B. First aid, Heimlich techniques, cardiopulmonary resuscitation and universal precautions.* *C. Crisis intervention, behavior management, and suicide*	483.376(a)(3) 1. Review the facility incident reports related to seclusion and restraint. Ensure that the incident reports identify any first aid/CPR which was needed was provided promptly. 2. Review a sample of staff training files to ensure that training has been provided as required by facility policy and refreshed as required. 483.376(b) 1. Verify that the facility requires all staff who have direct resident care responsibilities to be currently certified in CPR 2. Review a sample of staff training files to verify that the staff is current in CPR training.	affect negative outcomes and the assessment of the impact of the resident's environment contributing to an emergency safety situation. 483.376(a)(2) The facility must provide education and training in the areas of therapeutic, nonphysical intervention skills that will enable them to identify a potential emergency safety situation. Through early identification of such situations, staff can intervene to prevent a situation from escalating to the point where an emergency intervention is necessary. Training methods and skills such as de-escalation, mediation conflict resolution, active listening techniques, verbal and observational methods must be taught through educational and hands-on means. 483.376(a)(3) The facility must provide training and education for all staff in the safe application and use of restraint techniques. This training should include the demonstrated safe application of any restraint devices used by the facility. Training in the techniques of safe use of seclusion should include various methods available in assisting residents into seclusion rooms. Training should also include the identification of signs and symptoms of physiological and/or psychological distress in a resident during an ESI and staff responses to the identification of resident distress to include first aid, CPR, and removal of physical barriers impacting on the resident's safe care. 483.376(b) The facility must ensure that all staff that have direct resident care responsibilities receive certification training in the use of CPR for all age categories as recommended by the guidelines from the American Heart Association. Continuing recertification requirements should be included in the facility training plans.

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prevention. *D. Health and other special issues affecting the population.* *E. Establish a zero-tolerance standard for sexual assault and misconduct for all staff.* *F. Develop and implement standards for sexual assault detection and prevention*	483.376(c) 1. Review the personnel records for in house trainers to verify that their education and certification credentials are current and relevant to the topics they teach. 2. Review contractual agreements to verify that the facility maintains evidence of educational and certification credentials for any contracted staff utilized to teach staff. 483.376(d) Verify through training and personnel documents that the actual demonstration of techniques and successful demonstration of techniques were part of the education and training provided to the staff. 483.376(e) Review a sample of restraint and seclusions that have recently occurred in the facility. Check the training records for all staff involved in these restraint and seclusions to verify that they met the criteria above. 483.376(f) 1. Review a sample of staff personnel files to verify that staff have demonstrated their competence on a six month basis. 2. Review a sample of personnel files to verify that staff are recertified in CPR on an annual basis. 1. Check trainer personnel files for state approved training (MANDT, TCI, CPI, MAB or PIP, along with another training for holds).	483.376(c) The facility has the responsibility for assuring the credentials of their training staff. The staff trainers/instructors must be educated, trained, and experienced in the areas of expertise in which they teach. Trained staff may be either employed by the facility in staff positions or services may be on a contractual basis. If the training services are provided under contractual agreements, review the procedure for evaluation of the services provided to the facility. 483.376(d) As part of the staff training program for managing safety situations, there must be experiential (hands-on) opportunities provided to the staff. Training scenarios should be included in training sessions and emphasize the important techniques taught and any remediation training provided. Trainer observations of these exercises must be documented. 483.376 (f) Demonstration of competencies on a semiannual basis shall consist of supervisory observation and documentation of abilities by the facility.
Utilization Review (UR)		

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In accordance with 42 C.F.R. 456 Subpart D relating to Utilization Control of Mental Hospitals, all Medicaid PRTF services shall have procedures that provide for review of each resident's need for the services. For the Utilization Review (UR), each PRTF shall perform on-going evaluations of the necessity and appropriateness of PRTF services for each resident. The UR shall include a review of the appropriateness of the admission, individual plan of care, length of stay and discharge plan. *(a) Each facility shall have in place continuous performance improvement processes that focus on outcomes of care, treatment, and services. These processes shall include those intended to effectively reduce factors that contribute to unanticipated adverse events and/or outcomes.* (b) *One or more employees of the KDADS/JJA may be assigned to provide technical assistance to the PRTF or to assist the PRTF in developing a performance improvement program or other similar responsibilities. Each PRTF shall cooperate with those agencies efforts and with that agencies monitoring of the PRTF ongoing compliance with the requirements of these standards. This cooperation shall include providing that agency with reasonable access to all of the facilities and administrative records of the licensee and to all clinical records and treatment or service activities of the PRTF*.	INDICATORS 1. Review UR procedures 2. Check documentation that UR has occurred Including: - Appropriateness of admission 3. Individual plan of care 4. Length of stay 5. Discharge plan	
785-1 Documentation/Resident Records		
(a) ALL NOTES MUST BE LEGIBLE AND CORRECTIONS MUST BE MADE SO NOT TO ALTER CONTENT. (b)Each resident's record shall contain the following: 1. The name, sex, admission date, birth date and Social Security Number. 2. The race, height, weight, color of hair, color of eyes and identifying marks.	INDICATORS 1. Provide checklist for these sections	

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3. Language or means of communication spoken and understood by the resident and the primary language used by the resident's family, if other than English. 4. The name, address and telephone number of the person to be contacted in the event of an emergency. 5. Health records. 6. Dental, vision, and hearing records. 7. Health and safety assessments. 8. Current and Past Individual Plans of Care. 9. Consent to treatment forms. 10. Admission and placement information. 11. Signed notification of rights, grievance procedures, including the right to notify KDADS and applicable consent to treatment protections. 12. Education records. 13. Past plan of cares. 14. Current and past PRTF psychiatric evaluations. 15. Special consultations or assessments completed or requested as applicable. 16. Copies of Certification and Re-Certification of need. 17. Progress notes that document the resident's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions. 18. Progress notes must include summaries of individual plan of care reviews and special consultations regarding all aspects of the resident's complete daily program. 19. Documentation of the resident's progress toward meeting treatment goals. 20. Documentation of the family's participation in the treatment and discharge planning including copies provided to guardians 21. Documentation of community service providers'		

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participation in the treatment and discharge planning. 22. All medications and regular medication reviews. Clinical rationale shall be clearly documented for each medication. All changes in medication must be documented in the medication orders. Records documenting administration of all medications indicating dosage, actual administration of the medication, responsible staff administering, and signature of the responsible staff person. 23. Documentation of outcomes and reviews following therapeutic leave. 24. Relevant records from other agencies and systems.		
785-2 Clinical Documentation		
Clinical Documentation: (a)The following must be included in the resident's clinical record: (1) Extent of the resident history and exam must be documented along with a comprehensive plan of care and subsequent reviews. Individual plans of care must follow A KDADS approved format. (2) Progress note for every goal directed service provided which shall include: (i) Date, time, and description of each service delivered and by who (name, designation of profession or Para profession). (ii) Identification of goals addressed, interventions used and resident's response to service. (iii) Progress on stated goals (3) Documentation to support plan of care reviews and discharge planning. (4) Documentation supporting "special" consultations or clinical supervision, which applies directly to the identified resident. (5) Documentation of the family's / legal guardian's participation in the planning and treatment. (6) Documentation indicating regular medication reviews including the current and past psychotropic medications. Clinical rational for each medication	INDICATORS 1. Review clinical records	

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shall be clearly documented. All changes in medication must be documented in the medication orders. Records documenting administration of all prescribed medications indicating dosage, actual administration of medication, responsible staff administering, and signature of responsible staff person. (7) Documentation of all incidents of seclusion, restraint, or restrictive intervention. (8) Relevant records from other agencies and systems including but not limited to: i. Initial Screens for Level of Care and Re-screens for continued stay ii. Local Education Agency – Individual education plans iii. Pertinent clinical documentation of services provided outside the facility (9) Pertinent past and present medical history including diagnosis and the approximate date of diagnosis. (b) The following criteria apply when developing the clinical record (1) The resident record shall be legible and **stand on its own**. (2) The date and reason for every service must be included. (3) Documentation must support the level of care provided in the PRTF. (4) Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp, which reflects results of the exam for each of the systems identified on the rubber stamp. (5) Check marks are not accepted. (6) Records must be created **at the time the service is provided**. (c) The following questions should be asked to ensure appropriate documentation exists to support the level of		

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service billed (1) Is the reason for the treatment documented in the resident record? (2) Are all services that were provided documented? (3) Does the resident record clearly explain why support services, procedures, supplies and medications were or were not provided? (4) Is the assessment of the resident's condition apparent in the record? (5) Does documentation contain information on the resident's progress and results of treatment? (6) Does the resident record include a plan for treatment? (7) Does information in the resident record provide medical rationale for the services? (8) Does information in the resident record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services on behalf of the facility? Is there documentation of timely referrals? (d) Recordkeeping responsibilities rest with the provider.		
785-3 Medication Documentation		
(a) All medication, including nonprescription medication, shall be given only in accordance with label directions, unless ordered differently by a physician, or a physician's assistant operating under written protocol as authorized by a physician, or an advanced registered nurse practitioner as authorized by a responsible physician and operating within their scope of practice. A record shall be kept in the resident's record documenting the following: (1) The name of the person who gave the medication; (2) The name of the medication; (3) The dosage;	INDICATORS 1. Review p/p 2. Review medication log (in or out of chart) 3. Check signatures 4. Check meds in file against meds in cabinet 5. Check physician's orders against MAR.	

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(4) The date and time it was given (5) Any change in the resident's behavior, response to the medication, or adverse reactions (6) Any change in the administration of the medication from the instructions on the label for a notation about each missed dose. (b) Each record must be signed by the individual who was responsible for administering the medication.		
785-4 Claim/Record Storage Requirements		
(a) K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (b) Providers who submit claims via computerized systems (i.e., tape) must maintain these records in a manner which is retrievable. If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers (a) to keep such records as necessary to disclose fully the extent of services rendered to beneficiaries, and; (b) to furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider. (c) Providing medical records to the Kansas Medical Assistance Program or its designee is not a billable charge. (d) Clinical records must be retained according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements.	INDICATORS 1. Tour the facility to identify where records are stored 2. Review P/P	
785-5 Responsibilities of the physician and/or their designee		

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(a) Regular and ongoing contact with all residents and more frequent contact for those residents on medication. (b) Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the resident's individual plan of care. (c) Face-to-face or phone contact with the resident's family as needed. (d) Contact as appropriate with external, community agencies, and natural supports important to the resident's life. (e) Perform and prepare formal, written psychiatric evaluations as needed. (f) Coordinate and/or advise facility staff on medical matters including the prescription and monitoring of psychotropic and other medication. (g) Order the use of seclusion or restraint per CMS regulations. (h)Telemedicine is allowed as long as residents are seen face-to-face by licensed, board eligible, or board certified physicians or their designees who are operating within their scope of practice under protocol for their initial medical evaluation.	INDICATORS 1. Review clinical record for physician progress notes (every resident on psychotropic meds need to be seen at least every 30 days). 2. Review p/p	The use of telemedicine for the medication check would apply to APRNs as they are providing the full medication review under the collaborative practice agreement with the physician. Telemedicine process is referenced in the collaborative practice agreement between the APRN and the MD if they are using such a process.
785-6 Delegation of Nursing Tasks or Procedures		
(a) Each registered professional nurse who delegates nursing tasks or procedures to a designated unlicensed person in the PRTF shall comply with the following requirements: (a) Each registered professional nurse shall perform the following: (1) Assess each resident's nursing care	INDICATORS 1. Check RN personnel file 2. Check procedure for delegation/protocol of nurses 3. Check nurse job description for compliance w/ (a) & (h) 4. Review orientation, instruction, evaluation and competency	

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needs; (2) Formulate a plan of care before delegating any nursing task or procedure to an unlicensed person; and (3) Formulate a plan of nursing care for each resident who has one or more long-term or chronic health conditions requiring nursing interventions. (b) The selected nursing task or procedure to be delegated shall be one that a reasonable and prudent nurse would determine to be within the scope of sound nursing judgment and that can be performed properly and safely by an unlicensed person. (c) Any designated unlicensed person may perform basic caretaking tasks or procedures such as bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercise (excluding occupational therapy and physical therapy procedures), toileting (including diapering and toilet training), and hand washing without delegation. After assessment and providing the needed training to a designated unlicensed person, a nurse may delegate specialized caretaking tasks such as catherization, ostomy care, preparation and administration of gastrostomy tube feedings, care of skin with damaged integrity or potential for this damage, administration of medications, and performance of other nursing procedures as selected by the registered professional nurse. (d) The selected nursing task or procedure shall be one that does not require the designated unlicensed person to exercise nursing judgment or intervention. (e) When an anticipated health crisis that is identified in a nursing care plan occurs, the unlicensed person may provide immediate care for which instruction has been provided. (f) The designated unlicensed person to whom the nursing task or procedure is delegated shall be	of delegated tasks. 5. Review plan for delegating nurse's absence.	

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adequately identified by name in writing for each delegated task or procedure. (g) The registered professional nurse shall orient and instruct unlicensed persons in the performance of the nursing task or procedure. The registered professional nurse shall document in writing the unlicensed person's demonstration of the competency necessary to perform the delegated task or procedure. The designated unlicensed person shall co-sign the documentation indicating the person's concurrence with this competency evaluation. (h) The registered professional nurse shall meet these requirements: (1) Be accountable and responsible for the delegated nursing task or procedure; (2) participate in joint evaluations of the services rendered as needed; (3) record services performed; and (4) adequately supervise the performance of the delegated nursing task or procedure by assessing the appropriate factors before deciding to delegate which include the following: The health status and mental and physical stability of the resident receiving the nursing care, the complexity of the task or procedure to be delegated, the training and competency of the unlicensed person to whom the task or procedure is to be delegated, and the proximity and availability of the registered professional nurse to the designated unlicensed person when the selected nursing task or procedure will be performed. The supervising registered professional nurse may designate whether or not the nursing task or procedure is one that may be delegated or supervised by a licensed practical nurse. Each delegating registered professional nurse shall have a plan to provide nursing care when the delegating nurse is absent.		

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785-7 Supervision of Delegated Tasks or Procedures		
(a) Each registered professional or licensed practical nurse shall supervise all nursing tasks or procedures delegated to a designated unlicensed person in the PRTF setting in accordance with the following conditions. The registered professional nurse shall determine the degree of supervision required after an assessment of appropriate factors, including the following: (1) The health status and mental and physical stability of the resident receiving the nursing care; (2) the complexity of the task or procedure to be delegated; (3) the training and competency of the unlicensed person to whom the task or procedure is to be delegated; and (4) the proximity and availability of the registered professional nurse to the designated unlicensed person when the selected nursing task or procedure will be performed. (b) The supervising registered professional nurse may designate whether or not the nursing task or procedure is one that may be delegated or supervised by a licensed practical nurse. (c) Each delegating registered professional nurse shall have a plan to provide nursing care when the delegating nurse is absent.	INDICATORS 1. Review p/p 2. Check nurse job description for compliance	
785-8 Medication		
(a) A physician, physician's assistant, or an advanced registered nurse practitioner pursuant to a written protocol as authorized by a responsible physician may prescribe medication. Each protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the PA or APRN is authorized to prescribe. (b)The rationale for each medication and any changes in medication must be clearly documented in the resident's	INDICATORS 1. Review p/p 2. Review written protocols 3. Review clinical records for clinical rationale 4. Check personnel file for licensure of medical staff	

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medical record. (c) A physician, physician's assistant (PA), or advanced practice registered nurse (APRN) permitted by the state must see each resident on psychotropic medications at least every thirty days, with progress and clinical status documented in writing. (d) The clinical rationale for each medication must be clearly documented on the resident's discharge summary or final evaluation. (e) When medication is deemed necessary, families and custodial case manger should be informed of the most effective treatment options available as well as possible side effects and the positive and negative outcomes associated with each medication.		
785-9 Medication Storage		
(a) The medicine cabinet shall be located in an accessible, supervised area. The cabinet shall be kept locked. Medication taken internally shall be kept separate from other medications. All unused medication shall be safely discarded.	INDICATORS 1. Tour the facility to identify where meds are stored 2. Ask how medication is safely discarded	
785-10 Medication Administration		
(a) All medications shall be administered by a designated staff member qualified to administer medications. Prescription medication shall be given from a pharmacy container labeled with the following: (1) The resident's name; (2) The name of the medication; (3) The dosage and the dosage intervals; (4) The name of the prescribing physician; and (5) The date the prescription was filled. (b) Any changes of prescription or directions for administering a prescription medication shall be authorized, in writing, by a physician with documentation placed in the resident's record. (c) Each PRTF shall ensure that all medications are prescribed by one of the following medical practitioners:	INDICATORS 1. Review p/p 2. Review written protocols 3. Review clinical records for clinical rationale 4. Cross check sample of meds for compliance w/(1)-(5) 5. Check personnel file for training on med administration 6. Check personnel file for licensure of medical staff	

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(1) A physician; (2) A physician's assistant operating under a written protocol as authorized by a responsible physician; or (3) An advanced practice registered nurse operating under a written protocol as authorized by a responsible physician and operating within their scope of practice. (d) Each PRTF shall develop and implement policies, procedures, and clinical protocols for the administration of prescription and nonprescription medication. If medication is administered to a resident, each PRTF shall designate staff members to administer the medication. Before administering medication, each designated staff member must be delegated the authority to do so by a registered nurse as allowed under the Nurse Practice Act.		
785-11 Staffing Requirements		
(a) The PRFT must be staffed appropriately to meet the needs of all the resident's in their care. The facility must also ensure there are an adequate number of multidisciplinary staffs to carry out the goals and objectives of the facility, and to ensure the delivery of individualized treatment to each resident as detailed in their program description. (b) Minimum Staffing Level Each PRTF shall meet the following minimum staff requirements: (1) The governing body of each PRTF shall designate a head of the facility or administrator who is responsible for the day-to-day operations of the facility. (2) A written daily staff schedule shall be developed and followed. The staff schedule shall meet all of the following requirements: (i) The schedule shall provide for adequate staff to directly supervise and interact with the residents at all times, to implement each resident's individual plan for care, and to	INDICATORS 1. Check personnel records 2. Review staff orientation 3. Review p/p manual 4. Ask for copy of daily schedule 5. Ask for list of professional consultants 6. Ask if auxillary staff are used to augment staffing ratio. If yes, then check credentials of those staff 7. Compare staffing ratios to the census to determine adequate staffing 8. Check # LMHPs. Are there enough to meet requirements of active treatment? 9. Check gender of staff against residents on random sample of shift summaries. 10. Check for a facility drivers list and ensure that all approved facility drivers have valid driver's license and clear driving record. 11. Ask how staff know who is in charge. 12. Observe if staffing requirements are been met	

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provide for each resident's physical, social, emotional, and educational needs. (ii) The schedule shall provide for a minimum ratio of one direct care staff member on active duty to seven residents during waking hours and one direct care staff member on active duty to ten residents during sleeping hours. (iii) At least one direct care staff member of the same sex as the resident shall be present, awake, and available to the resident at all times. If both male and female residents are present in the PRTF, at least one male and one female direct care staff member shall be present, awake, and available. (3) Additional staff shall be available in the facility on all shifts to supplement the staff-to-resident ratio, to provide immediate assistance in case of an emergency and to periodically check on the status of the residents. (4) Resident's shall remain in sight or sound observation range of staff at all times. The minimum ratio of direct care staff shall be immediately available in a connecting area to the sleeping rooms. (5) Alternate qualified direct care staff members shall be provided for the relief of the regular staff members on a one-to-one basis and in compliance with the staffing pattern as required in number 2 above. (6) Electronic supervision shall not replace the direct care staffing requirements. (7) Auxiliary staff members shall be available as needed. The auxiliary staff shall include food service, clerical, and maintenance personnel. Auxiliary staff members shall not be included in meeting the minimum ratio of direct care staff to resident's served unless they have been properly trained as direct care staff.		785-11 (4) *Definitions:* **Sight:** to be positioned within range of the resident to ensure constant visibility. **Sound:** to remain within a distance of the resident to ensure that any identified noise or vocal utterance can be heard. Prolonged silence by a resident does not constitute as keeping the resident within sound. **Increased Risk Precaution** – An observational level that begins following an assessment (including the youth's history) indicating a risk for suicide, self-harm, harm to others, and/or elopement, or other behaviors indicating a need for increased supervision, The resident shall remain on this level of precaution until the facility staff can determine the youth's safety can be maintained at a routine level of sight or sound observation. Examples include, but not limited to, verbalizing intent to injure self or others, attempted elopement or elopement history, continuous non-compliance, violent history (including sexual behaviors and acting out).

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(8) Professional consultant services shall be available, to the extent necessary, to meet the needs of the resident's served. Professional consultants shall include physicians, dentists, nurses, clergy, social workers, psychologists, psychiatrists, teachers, and dieticians. (9) A volunteer shall not be used as a substitute for a direct care staff member, but shall augment the services provided by the staff. (10) A staff person designated to be in charge of the PRTF shall be on-site at all times when a resident is in care. Procedures shall be in place to ensure that all staff members know who is in charge. (c) Licensed Mental Health Professionals shall be available to ensure that the program can meet the stated active treatment as described in the PRTF's service description. At least one licensed mental health professional must be on-call during all hours the residents are sleeping to assist in emergencies.		**Severe Risk Precaution** - A status requiring one-on-one supervision following a risk assessment indicating that a resident is: (a) actively suicidal either by threatening or engaging in suicidal behavior/gestures, (b) actively harmful to self or others, (c) actively attempting to elope. The resident shall remain on this level of precaution until the facility staff can determine the youth's safety can be maintained at a lower level of sight or sound observation. **Staggered intervals -** intervals that are randomly performed to ensure that they are unpredictable to avoid resident(s) from anticipating the event. *Resident(s) in bedroom when awake with bedroom door open* **General population** – Resident(s) must remain within sight of staff OR staff must keep resident(s) within sound at all times. When a resident is being supervised by sound only, safety shall be verified by sight in 15 minute staggered intervals. **Increased Risk Precaution** – Resident must be within sight of staff at all times. **Severe Risk Precaution** – Resident must be within sight and within 5 to 10 feet of staff at all times. *Resident(s) in restroom* **General population** – For instances when 1 resident is in the restroom, the resident must remain within sight of staff OR staff must keep the resident within sound at all times. When a resident is being supervised by sound only, safety shall be verified verbally or by sight every 5 minutes. When more than 1 resident is in the restroom staff must be positioned inside the restroom. **Increased Risk Precaution** – For instances when 1 resident is in the restroom, the resident must

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		remain within sight of staff OR staff must keep the resident within sound at all times with staff positioned so that a direct visual can be accomplished immediately. Main restroom door must be at least ajar. When a resident is being supervised by sound only, safety shall be verified verbally or by sight every 5 minutes. When more than 1 resident is in the restroom staff must be positioned inside the restroom. **Severe Risk Precaution** – Staff must positioned in the restroom and maintain a portion of the resident's body within constant sight. *Privacy situations (i.e. changing clothes, etc.)* **General population** - When a resident is in a room alone, the resident must remain within sight of staff OR staff must keep the resident within sound at all times. When a resident is being supervised by sound only, safety shall be verified verbally or by sight every 5 minutes. **Increased Risk Precaution** – When a resident is in a room alone, the resident must remain within sight of staff OR staff must keep the resident within sound at all times. Main door must be at least ajar. When a resident is being supervised by sound only, safety shall be verified verbally or by sight every 5 minutes. **Severe Risk Precaution** - Staff must be located in the same room as the resident, but allowed to turn away from the resident to assure privacy. Resident must be within 5 to 10 feet of staff at all times. *Resident's sleeping* **General population and Increased Risk Precaution** – Residents must be within sound at all times and staff shall visually see a portion of the resident's body in 15 minute staggered intervals while residents are sleeping **Severe Risk Precaution** - Resident must be within sight and within 5 to 10 feet of staff at all times.

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785-12 Education		
(a) PRTF must ensure residents receive a free and appropriate education accredited by the Kansas State Board of education.	INDICATORS 1. Ask how education is provided.	
785-13 Discipline		
(a) Discipline that is humiliating, frightening, or physically harmful to the resident shall not be used at any time. Each resident shall be protected against all forms of neglect, exploitation, or degrading forms of discipline. No resident shall be isolated or confined in any dark space. Electronic monitoring or an audio communication system shall not replace the required presence of a direct care staff. (b) Corporal punishment shall not be used. (c) Under no circumstances shall any youth be deprived of meals, clothing, sleep, medical services, exercise, correspondence, parental contact, or legal assistance for disciplinary purposes. (d) Under no circumstance shall any youth be allowed to supervise or to administer discipline to another youth. (e). The use of Tasers, pepper spray, OC spray or any other similar devises used as an intervention or restraint is prohibited.	INDICATORS 1. Review p/p 2. Review clinical files, s/r logs, variance reports and progress notes. 3. Tour facility and view time out and seclusion rooms. 4. Review phone contact logs, visitor logs.	
785-14 Family Participation		
(a) The PRTF shall ensure that the resident's family is given the opportunity to participate as full partners in the planning for delivery of services to the resident. Mutual respect between the facility staff and the family and inclusion of the family in all planning and decision-making are critical to successful treatment. (b) The facility shall document all efforts to involve the	INDICATORS 1. Review p/p 2. Check clinical record 3. Ask to see visitation area 4. Check resident files for visiting logs and phone logs. 5. Tour the facility to view the designated area on campus for family visitation	

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resident's family in service planning and delivery. (c) The facility shall ensure that the family is allowed to visit the resident frequently in the facility. (d) The facility shall also ensure that the resident's identified family is able to communicate with the resident by telephone. In the rare circumstances that such communication or visits are not deemed therapeutic, the facility must document the clinical reasons for denying visits or phone calls and shall address these clinical issues in treatment planning and services. The facility must have at least one designated area on-campus for family visitation.		
785-15 Confidentiality		
(a) Facilities must comply with all applicable state and federal confidentiality laws	INDICATORS 1. Review p/p	
Absenteeism Policy		
(a) A resident shall be considered present at the facility for an entire day if the resident is at the facility at 11:59 pm. The facility should take a resident specific census at this time and ensure the facilities business manager has a record of which residents are present in the facility on any given day and can accurately track absentee days for each resident. PRTF's will be reimbursed for absent days as follows: (b) **Visitation Days:** When indicated in the child's plan of care (within the total number of days approved for the child's stay), a maximum of 7 days per visit will be paid at the contracted per diem rate. The frequency, duration, and location of the visits must be a part of the child's individual case plan developed by the facility prior to the visitation. An approved visitation plan must be documented in the child's official record at the facility. (c) If a resident is absent from the facility for a short time due to circumstances needing the residents' immediate attention	INDICATORS 1. Review p/p 2. Check daily census 3. Compare visitation logs with treatment plan.	

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(deaths, weddings, personal business), or the resident leaves the facility without permission. The facility can be reimbursed for up to five days per year at the contracted per diem rate unless the resident's placement is terminated sooner by the resident's guardian in conjunction with the PRTF.		
Emergency Exception Screen		
A resident can be admitted to a PRTF upon acceptance by the facility using the Emergency Exception Screen. The admission screen must be completed by the LMHP certifying need, within 48 hours of admission. The LMHP will certify that this is an exception screen and that the CBST plan has not yet been completed. The CBST will convene within 7 days of admission and determine if the resident needs can be met by the PRTF or should they be diverted to community-based services. If the certification determines that the resident needs can best be served in the community, then the resident must be moved from the PRTF. The placing agency will be responsible for payment after such determination.	INDICATORS 1. Review Exception screen and CBST completed w/in 7 days of screen.	
Unconditional Release from a Psychiatric Residential Treatment Facility		
An individual who is under age 22 and has been receiving inpatient psychiatric services in a Psychiatric Residential Treatment Facility (PRTF) is considered to be a resident in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22. An unconditional release will only occur under the following conditions: 1. PRTF Goals met/achieved, youth discharged successfully from PRTF. 2. PRTF Goals not met/achieved, youth transferred to other IMD (other PRTF or State Psychiatric Hospital) 3. PRTF Goals not met/achieved, family/youth or guardian choice to discontinue services. 4. Youth placed in a correctional facility or removed from treatment and placed for longer than 72 hours while awaiting a court hearing. 5. Youth runs away from the facility and is gone for 7 consecutive calendar days with the facility having no knowledge of when the youth may return.		

Standard	Inquiries and Indicators	Guidance and Interpretations
6. The youth is receiving inpatient medical treatment in a hospital. 7. The youth has died.		
Measurable outcomes		
All Psychiatric Residential Treatment Facility providers must meet the outcome standards, and be incompliance with data collection, and reporting; as stated by Social and Rehabilitative Services of Kansas, Disability and Behavioral Health Services, Mental Health.		
Additional requirements		
(1) A psychiatric residential treatment facility must meet the requirements of the standards of state certification and licensure, to include substance abuse licensure if providing those services, and national accreditation by The Joint Commission, the Counsel on Accreditation of Services for Family and Children (COA), The Commission on Accreditation or Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the state		

CMS TAG #'s and the Standard that it relates back too

TAG #	Standard
N-001	441.151
N-002	483.356 (a)
N-003	483.356 (a)(1)
N-004	483.356 (a)(2)

N-005	483.356 (a)(3)
N-006	483.356 (a)(3)(i)
N-007	483.356 (a)(3)(ii)
N-008	483.356 (a)(4)
N-009	483.356 (b)
N-0010	483.356 (c)(1)
N-0011	483.356 (c)(2)
N-0012	483.356 (c)(3)
N-0013	483.356 (c)(4)
N-0014	483.356 (d)
N-0015	483.358 (a)
N-0016	483.358 (b)
N-0017	483.358 (c)
N-0018	483.358 (d)
N-0019	483.358 (e)
N-0020	483.358 (f)
N-0021	483.358 (g)
N-0022	483.358 (g)(1)
N-0023	483.358 (g)(2)
N-0024	483.358 (g)(3)
N-0025	483.358 (h)
N-0026	483.358 (h)(1)
N-0027	483.358 (h)(2)
N-0028	483.358 (h)(3)
N-0029	483.358 (h)(4)
N-0030	483.358 (h)(5)
N-0031	483.358 (i)
N-0032	483.358 (j)
N-0033	483.360 (a)
N-0034	483.360 (b)
N-0035	483.362 (a)
N-0036	483.362 (b)
N-0037	483.362 (c)
N-0038	483.364 (a)
N-0039	483.364 (b)(1)

N-0040	483.364 (b)(2)
N-0041	483.364 (c)
N-0042	483.364 (d)
N-0043	483.366 (a)
N-0044	483.366 (b)
N-0045	483.368 (a)
N-0046	483.368 (b)
N-0047	483.368 (c)
N-0048	483.370 (a)
N-0049	483.370 (b)(1)
N-0050	483.370 (b)(2)
N-0051	483.370 (b)(3)
N-0052	483.370 (b)(4)
N-0053	483.370 (c)
N-0054	483.372 (a)
N-0055	483.372 (b)
N-0056	483.372 (b)(1)
N-0057	483.372 (b)(2)
N-0058	483.372 (b)(3)
N-0059	483.372 (c)
N-0060	483.372 (d)
N-0061	483.374 (a)
N-0062	483.374 (a)(1-2)
N-0063	483.374 (b)(1)
N-0064	483.374 (b)(2)
N-0065	483.374 (b)(3)
N-0066	483.374 (c)
N-0067	483.376 (a)
N-0068	483.376 (a)(1)
N-0069	483.376 (a)(2)
N-0070	483.376 (a)(3)
N-0071	483.376 (b)
N-0072	483.376 (c)
N-0073	483.376 (d)
N-0074	483.376 (e)

N-0075	483.376 (f)
N-0076	483.376 (g)
N-0077	483.376 (h)