

State Operations Manual
Appendix N-Psychiatric Residential Treatment Facilities
(PRTF) Interpretive Guidance

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(Rev. 131, Issued: 1-16-15)

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A psychiatric residential treatment facility must meet the requirements in §441.151 through §441.182 of this chapter

§441.151 Beneficiary and Accreditation 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 that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or a hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in part 482 of this chapter, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(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 of Accreditation 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 services immediately before he or she reached age 21, before the earlier of the following-

- (i) The date the individual no longer requires 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.

§441.152 -Certification of need for services.

- (a) A team specified in 441.154 must certify that-*
 - (1) Ambulatory care resources available in the community do not meet treatment needs of the beneficiary;*
 - (2) Proper treatment of the beneficiary'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 beneficiary's condition or prevent further regression so that the services will no longer be needed.*
- (b) [Paragraph applies to utilization control requirement for physicians – Not to be surveyed by SA – for review of facility]*

§441.153 - The team certifying need for services.

Certification under §441.152 must be made by terms specified as follows:

- (a) For an individual who is a beneficiary 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 child psychiatry, and*
 - (3) Has knowledge of the individual's situation.*
- (b) For an individual who applies for Medicaid while in the facility or 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.*
- (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.*

§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 beneficiary's discharge from in patient status at the*

earliest possible time.

§441.155 - Individual plan of care.

(a) “Individual plan of care” means a written plan developed for each beneficiary 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 beneficiary’s situation, and reflects the need for inpatient psychiatric care;

(2) Be developed by a team of professional specified under §441.156 in consultation with the beneficiary; 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 beneficiary’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 the services being provided are or were required on an inpatient basis, and

(2) Recommend changes in the plan as indicated by the beneficiary’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 – [paragraph and subparagraphs

(1) and (2) relevant for utilization control hospitals only]

§441.156 Team developing individual plan of 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 beneficiary’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(2) Assessing the potential resources of the beneficiary’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.

§441.180 and §441.182 – Maintenance of Effort – Requirements of SMA.

§483.356/ Protection of Residents.

§483.356(a)/ Restraint and seclusion policy for the protection of residents

§483.356(a)(1)/ Each resident has the right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

§483.356(a)(2)/ An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

§483.356(a)(3)/ Restraint or seclusion must not result in harm or injury to the resident and must be used only-

§483.356(a)(3)(i)/ To ensure the safety of the resident or others during an emergency safety situation; and

§483.356(a)(3)(ii)/ Until the emergency 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.

§483.356(a)(4)/ Restraint and seclusion must not be used simultaneously

§483.356(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).

§483.356(c)/ Notification of facility policy. At admission, the facility must:

§483.356(c)(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;

§483.356(c)(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;

§483.356(c)(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

§483.356(c)(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).

§483.356(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.

§483.358/ Orders for use of restraint or seclusion.

§483.358(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 beneficiaries under age 21 are provided under the direction of a physician.

§483.358(b)/ If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

§483.358(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.

§483.358(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.

§483.358(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.*

§483.358(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.

§483.358(g) Each order for restraint or seclusion must include-

§483.358(g)(1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

§483.358(g)(2) The date and time the order was obtained; and

§483.358(g)(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.

§483.358(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:

§483.358(h)(1) Each order for restraint or seclusion as required in paragraph (g) of this section.

§483.358(h)(2) The time the emergency safety intervention actually began and ended.

§483.358(h)(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.

§483.358(h)(4) The emergency safety situation that required the resident to be restrained or put in seclusion.

§483.358(h)(5) The name of staff involved in the emergency safety intervention.

§483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

§483.358(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.

§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—

§483.360(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 Protection of Residents-Each resident has the right to be free from restraint and seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.

§483.360(b) Document in the resident's record the date and time the team

physician was consulted.

§483.362/ Monitoring of the resident in and immediately after restraint.

§483.362(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.

§483.362(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, 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.

§483.362(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.

§483.364/ Monitoring of the resident in and immediately after seclusion.

§483.364(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.

§483.364(b)/ A room used for seclusion must—

§483.364(b)(1)/ Allow staff full view of the resident in all areas of the room; and

§483.364(b)(2)/ Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

§483.364(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.

§483.364(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.

§483.366/ Notification of parent(s) or legal guardian(s). If the resident is a minor as defined in this subpart:

§483.366(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.

§483.366(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.

§483.368/ Application of time out

§483.368(a)/ A resident in time out must never be physically prevented from leaving the time out area.

§483.368(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 of other residents (inclusionary)?

§483.368(c)/ Staff must monitor the resident while he or she is in time out.

§483.370/ Post intervention debriefings.

§483.370(a)/ Within 24 hours after the use of the 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.

§483.370(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 –

§483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention;

§483.370(b)(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

§483.370(b)(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

§483.370(b)(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

§483.370(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, the names of staff who were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

§483.372/ Medical Treatment for injuries resulting from an emergency safety intervention.

§483.372(a)/ Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety

intervention.

§483.372(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—

§483.372(b)(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;

§483.372(b)(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

§483.372(b)(3)/ Services are available to each resident 24 hours a day, 7 days a week.

§483.372(c)/ Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

§483.372(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.

§483.374/ Facility Reporting

§483.374(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' standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

§483.374(a)(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.

§483.374(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 section §483.352 of this part, and a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system 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.

§483.374(b)(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.

§483.374(b)(3)/ Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including 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.

§483.374(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 and 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.

§483.376/Education and Training

§483.376(a)/ The facility must require staff to have ongoing education, training, and demonstrated knowledge of –

§483.376(a)(1)/ Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

§483.376(a)(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

§483.376(a)(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.

§483.376(b)/ Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

§483.376(c)/ Individuals who are qualified by education, training and experience must provide staff training.

§483.376(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.

§483.376(e)/ Staff must be trained and demonstrate competency before participating in an emergency safety situation.

§483.376(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.

§483.376(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.

§483.376(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.

Regulation

N0100

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Subpart G: Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

Interpretive Guidelines Subpart G

Surveyors must make a determination regarding the compliance or non-compliance of the overall Condition of Participation under Subpart G at the end of each facility survey. A determination of non-compliance may be based upon either patterns of performance or isolated instances with real or potential harm for residents. Deficiencies cited in the following areas:

Section 483.354 General requirements for psychiatric residential treatment facilities

Section 483.356 Protection of Residents;

Section 483.358 Orders for the use of restraint or seclusion;

Section 483.372 Medicaid treatment for injuries resulting from an emergency safety intervention,

Section 483.374 Facility Reporting and/or

Section 483.376 Education and Training

Surveyors should consider the seriousness and significance of the aggregate findings in the survey areas when determining any non-compliance at a Condition level. If the determination is made that the facility is out of compliance with the Condition of Participation, the surveyor must make this finding at N-0100. The determination must include a list of the N tag findings which resulted in the Condition non-compliance to be made.

§483.350 Basis and Scope

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

(a) Statutory basis. Sections 1905(a)(16) and (h) of the Act provide that inpatient psychiatric services for individuals under age 21 include only inpatient services that are provided in an institution (or distinct part thereof) that is a psychiatric hospital as defined in section 1861(f) of the Act or in another inpatient setting that the Secretary has specified in regulations. Additionally, the Children's Health Act of 2000 (Pub. L. 106-310) imposes procedural reporting and training requirements regarding the use of restraints and involuntary seclusion in facilities, specifically including facilities that provide inpatient psychiatric services for children under the age of 21 as defined by sections 1905(a)(16) and (h) of the Act.

(b) Scope. This subpart imposes requirements regarding the use of restraint or seclusion in psychiatric residential treatment facilities, that are not hospitals, providing inpatient psychiatric services to individuals under age 21.

§483.352 Definitions

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

For purposes of this subpart, the following definitions apply:

Drug used as a restraint means any drug that—

- (1) Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others;*
- (2) Has the temporary effect of restricting the resident's freedom of movement; and*
- (3) Is not a standard treatment for the resident's medical or psychiatric condition.*

Emergency safety intervention means the use of restraint or seclusion as an immediate response to an emergency safety situation.

Emergency safety situation means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention as defined in this section.

Mechanical restraint means any device attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

Minor means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.

Personal restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another.

Psychiatric Residential Treatment Facility means a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.

Restraint means a “personal restraint,” “mechanical restraint”, or “drug used as a restraint” as defined in this section.

Seclusion means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

Staff means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

Time out means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control.

N0101-N0119

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§483.354 General requirements for psychiatric residential treatment facilities.

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§483.354 A psychiatric residential treatment facility must meet the requirements in §441.151 through §441.182 of this chapter.

Interpretive Guidelines §483.354

Surveyors should reference guidelines for requirements §441.151 through §441.182 in the ASPEN system.

§483.356 Protection of Residents.

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

N0125

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a) Restraint and seclusion policy for the protection of residents.

Interpretive Guidelines § 483.356(a)

The use of restraint and seclusion as described in this Condition of Participation (COP) applies to all residents of the Psychiatric Residential Treatment Facilities (PRTFs) (i.e., children and individuals under the age of 21).

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 a minimum, the facility's procedures regarding all the requirements as set forth in this COP.

N0126

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a)(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.

Interpretive Guidelines § 483.356(a)(1)

Restraint or seclusion, including drugs/medications used as restraint, is not to be used as 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 purpose of controlling behavior.*
- 2. Coercion – (depriving the resident of the exercise of his/her free will by the use or threat of physical or emotional 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 number of trained staff or programming.*
- 4. Retaliation- Staff or facility practice must never use restraint or seclusion as a means to retaliate against a resident for any reason. The frequent use of emergency safety interventions 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.*

N0127

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a)(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.

Interpretive Guidelines § 483.356(a)(2)

The use of restraint or seclusion must not be a planned or anticipated intervention. Active treatment does not include the routine use of restraint and seclusion. There should not be a specific plan in place for restraints and seclusion but the facility must have policies on the process if action is necessary and have facility procedures in place for implementation. In order to ensure a resident receives active treatment and is free from

abuse, it is necessary that a physician or other licensed practitioners' order be given for each single instance of restraint or seclusion (as indicated by individual state law).

N0128

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§483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only—

Interpretive Guidelines § 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 back or chest of the individual);*
- 2. Restraints that restrict the resident's ability to communicate during an emergency safety intervention.*

N0129

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a)(3)(i) To ensure the safety of the resident or others during an emergency safety situation; and

Interpretive Guidelines § 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 a reaction to an 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.

N0130

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a)(3)(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.*

Interpretive Guidelines § 483.356(a)(3)(ii)

The resident in restraint or seclusion should be evaluated on a continual basis (see N-0165 and N-0166 for continual monitoring criteria) and ended at the earliest possible time based on the assessment and evaluation of the resident's condition.

Restraint or seclusion intervention must be discontinued if the safety situation has ceased and the safety of the resident and others can be ensured, even when the physician order for the restraint or seclusion has not expired. For example, if a resident has recovered from their unanticipated maladaptive behavior in 2-hours instead of the maximum 4-hour time frame specified in the order, it is the expectation that the resident is released from restraint or seclusion at the 2-hour point. The facility policy for restraints and seclusion should outline the criteria for discontinuing ESI interventions.

N0131

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(a)(4) *Restraint and seclusion must not be used simultaneously.*

Interpretive Guidelines § 483.356(a)(4)

The facility must not utilize restraint, including drugs/medications used as restraint at the same time as utilizing seclusion.

There may be isolated instances where both physical and psychopharmacological restraints are required during one emergency safety situation. In addition, the risk(s) associated with any drug/medication used as a restraint must be weighed against the type and severity of the behavior the resident is exhibiting. 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.

N0132

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(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).

Interpretive Guidelines § 483.356(b)

Review 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)*

N0133

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(c) Notification of facility policy. At admission, the facility must—

§483.356(c)(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;

Interpretive Guidelines § 483.356(c)(1)

Under subpart 483.352(3), “Minor” means a minor as defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.” The facility must ensure 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.

N0134

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(c)(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;

Interpretive Guidelines § 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.

N0135

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(c)(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

Interpretive Guidelines § 483.356(c)(3)

See Interpretive Guidance for §483.356(c)(1).

N0136

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(c)(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).

Interpretive Guidelines § 483.356(c)(4)

See Interpretive Guidance for §483.356(c)(1).

N0137

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.356(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.

Interpretive Guidelines § 483.356(d)

This written 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.

§483.358 Orders for the use of restraint or seclusion

N0140

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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 beneficiaries under age 21 are provided under the direction of a physician.

Interpretive Guidelines § 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 frequency of training required for these practitioners in the area of emergency safety interventions. Reference §483.376 Education and Training, tags N-0214-N-0224 below

N0141

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion.

Interpretive Guidelines § 483.358(b)

The treatment team 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 as soon as possible from the time the order was given by the alternate practitioner and in a signed written form in the resident's record.

N0142

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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.

Interpretive Guidelines § 483.358(c)

The restraint or seclusion used must be appropriate for both the resident and the situation. The treatment plan should address any contraindications or inappropriate interventions for the resident. A medication that is not being used as a standard treatment for the resident's medical or psychiatric condition that results in controlling the resident's behavior and/or in restricting his or her freedom of movement is considered a restraint.

Example: Staff use of physical restraint hold for a resident who is verbally abusive and/or escalating without having utilized other non-physical de-escalation techniques would be considered as not appropriate or not least restrictive. Verbal de-escalation techniques and decrease in physical environmental stimuli would be considered least restrictive. Use of any physical intervention would be considered counter therapeutic, and potentially traumatic, for victims of physical or sexual abuse.

The residents' treatment plan should indicate the least restrictive interventions to help the resident and treatment staff in the case of emergency situations where an unanticipated behavior requires immediate protection of the individual or others. Documentation in the residents medical record should detail the less restrictive measures utilized prior to the application of the restraint or seclusion.

Staff should document interventions that have been attempted prior to implementing seclusion or restraint. The effectiveness or ineffectiveness of 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.

N0143

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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.

Interpretive Guidelines § 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 for restraint or seclusion. The verbal order can only be received by a registered nurse or other licensed staff. If the facility identifies "other licensed staff" this should conform to state law. The policy should also include the timeframe in which a physician or other licensed practitioner must co-sign the verbal order.

N0144

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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.**

Interpretive Guidelines § 483.358(e)

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 time frames 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 restraint 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 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.

N0145

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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 wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing 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.**

Interpretive Guidelines § 483.358(f)

A physician or other licensed practitioner (as recognized by State law and facility policy) such as registered nurses, physician's assistants or nurse practitioners, if it is within the scope of their discipline and licensure, must perform an in person face-to-face evaluation of the resident within one-hour of the initiation of restraint or seclusion. A telephone call or other electronic communication 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 evaluate the medical status of the resident.

If a resident is released from restraint or seclusion before the physician or other licensed practitioner arrives to perform the face-to-face 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/medications used as a restraint) and seclusion.

N0146

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(g) Each order for restraint or seclusion must include—

§483.358(g)(1)The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;

Interpretive Guidelines § 483.358(g)(1)

Each order for restraint and seclusion, an order is required regardless of the expected length of time the restraint or seclusion will be used, the type of emergency safety intervention used, or where the emergency safety intervention takes place. The ordering practitioner does not need to be physically present to give the order. However, a licensed practitioner must be available for staff consultation at least by telephone, throughout the entire period of the emergency safety intervention, reference §483.358(d).

Documentation (resident medical record and appropriate logs) must have evidence of all aspects of circumstances, date, time and both licensed and non-licensed staff involved in the emergency safety intervention.

Ensure that the person writing the restraint or seclusion order is appropriately licensed and possesses required qualifications as established by the regulation or relevant state law.

N0147

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(g)(2) The date and time the order was obtained; and

Interpretive Guidelines § 483.358(g)(2)

The date and time of the restraint or seclusion order must match with the date and time of the restraint or seclusion intervention.

N0148

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(g)(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.

Interpretive Guidelines § 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.

N0149

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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:

Interpretive Guidelines § 483.358(h)

Relevant and appropriate staff must fully document the events leading up to, during and after the implementation of restraint or seclusion as specified by §483.358(h)(1-5). This includes documentation of the time in which the emergency safety situation/intervention began, the request and receipt of any practitioner orders for intervention, a complete description of the emergency safety situation, the results of the 1 hour face-to-face assessment, and the names of all staff that were involved with the restraint and seclusion.

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 restraint or seclusion is accountable for providing comprehensive documentation in the record of the events that led up to 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.

N0150

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(h)(1) Each order for restraint or seclusion as required in paragraph (g) of this section.

Interpretive Guidelines § 483.358(h)(1)

”As stated in §483.358(g), Each Order for restraint or seclusion must include-“ through §483.358(g)(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” and associated Guidance.

N0151

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(h)(2) The time the emergency safety intervention actually began and ended.

N0152

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(h)(3) The time and results of the 1-hour assessment required in paragraph (f) of this section.

Interpretive Guidelines § 483.358(h)(3)

In addition to the information required at N-0145, the assessment should include whether or not the physician or other licensed practitioner advised continuation of the emergency safety intervention or termination of the emergency safety intervention and the documentation justifying the decision. 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.

N0153

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(h)(4) The emergency safety situation that required the resident to be restrained or put in seclusion.

N0154

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(h)(5) The name of staff involved in the emergency safety intervention.

Interpretive Guidelines § 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 who performed the one hour face-to-face assessment must be documented

NOTE: Involved staff includes all staff physically participating in the ESI and any staff providing orders or assessments during the ESI.

N0155

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.

Interpretive Guidelines § 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.

N0156

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.358(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.

Interpretive Guidelines § 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 in accordance with applicable state law.

N0160

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§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—

§483.360(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

Interpretive Guidelines § 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 treatment team physician of the events that transpired and led to the order for an emergency safety intervention and in a signed written form in the resident's record.

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 may greatly affect the resident's treatment plan, it is important to consult with the treatment team physician, as soon as possible from the time the order was given by the alternate practitioner

N0161

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.360(b) Document in the resident's record the date and time the team physician was consulted.

Interpretive Guidelines § 483.360(b)

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

§483.362 Monitoring of the resident in and immediately after Restraint

N0165

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.362(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.

Interpretive Guidelines § 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 and respond to resident calls for assistance and observe changes in resident behavior.

“Continually assessing” should be defined as observing, measuring and evaluating at all times and documentation every 5 minutes of the ongoing assessment of the behavior and physical status of the resident by the staff members who are physically present throughout the duration of the restraint or seclusion.

N0166

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.362(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, 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.

Interpretive Guidelines § 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.

There must be documentation in the resident record of the behaviors which justified a new order for restraint.

N0167

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.362(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.

Interpretive Guidelines § 483.362(c)

This assessment is conducted in person (i.e., face-to-face). Consistent with state law and facility policy, physicians or other licensed practitioners such as registered nurses, physician’s assistants or nurse practitioners may perform this assessment of the resident’s physical and psychological status if it is within the scope of their discipline and licensure.

§483.364 Monitoring of the resident in and immediately after seclusion.

N0170

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.364(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.

Interpretive Guidelines § 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 observing, measuring and evaluating at all times and documentation every 5 minutes of the ongoing assessment of the behavior and physical status of the resident by the staff that are physically present throughout the duration of the restraint or seclusion.

N0171

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.364(b) A room used for seclusion must—

(1) Allow staff full view of the resident in all areas of the room; and

Interpretive Guidelines § 483.364(b)(1)

Any area utilized as a seclusion room must be designed to enable the staff to be physically present, continually monitor and visualize the entire body of the resident in the seclusion room. Video monitoring may be used in addition to this room configuration but cannot be used in lieu of physical monitoring.

N0172

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.364(b)(2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

Interpretive Guidelines § 483.364(b)(2)

Unprotected lights fixtures and electrical outlets are only two examples of potentially hazardous conditions and are not all-inclusive.

N0173

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.364 (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.

Interpretive Guidelines § 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 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.

There must be documentation in the resident record of the behaviors which justified a new order for restraint.

N0174

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.364(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.

Interpretive Guidelines § 483.364(d)

This assessment is conducted in person (i.e., face-to-face). Consistent with state law, physicians or other licensed practitioners such as registered nurses, physician's assistants or nurse practitioners may perform this assessment of the resident's physical and psychological status.

N0178

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

***§483.366 Notification of parent(s) or legal guardian(s).
If the resident is a minor as defined in this subpart:***

§483.366(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.

Interpretive Guidelines § 483.366(a)

Upon admission, the facility should obtain emergency contact information from the parent(s) or legal guardian(s). In the event that a parent or legal guardian cannot be contacted, the facility should have alternate methods for contacting parent(s) or legal guardian(s). Determine if the facility has a system of updating resident's contact information for each new admission or for residents who have been admitted for long periods of time.

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 from 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.

N0179

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.366(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.

Interpretive Guidelines § 483.366(b)

If the facility is unable to reach the parent or guardian at the time the restraint or seclusion is initiated, they must continue to try to 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

N0183

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.368(a) A resident in time out must never be physically prevented from leaving the time out area.

Interpretive Guidelines § 483.368(a)

Time out, as defined in this subpart, means the restriction of a resident for a period of time to a designated area from which the resident is not physically prevented from leaving, for the purpose of providing the resident an opportunity to regain self-control. Staff physically preventing the resident from leaving the time out area would be considered seclusion.

The definitions we have employed for “mechanical restraint” and “personal restraint” are modeled on the hospital definition of “restraint” codified in § 482.13(e)(1)(i). In this rule, we distinguish between “personal” and “mechanical” restraint to clarify that mechanical restraint means any device attached or adjacent to a person’s body, while personal restraint means the application of physical force on a person’s body without the use of any device.

N0184

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.368(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 of other residents (inclusionary).*

Interpretive Guidelines § 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.

N0185

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.368(c) *Staff must monitor the resident while he or she is in time out.*

Interpretive Guidelines § 483.368(c)

In those instances during efforts to use less restrictive measures where the staff requests that the resident take a 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 time out.

§483.370 *Post intervention debriefings*

N0188

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(a) Within 24 hours after the use of the 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 wellbeing 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 and 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.

Interpretive Guidelines § 483.370(a)

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 their debriefing, as well as review the emergency safety situation and intervention, in order to improve the resident's treatment plan.

Review of sample 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.*

N0189

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(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 –

§483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention;

Interpretive Guidelines § 483.370(b)(1)

See Interpretive Guidance for § 483.370(a)

N0190

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(b)(2) Alternative techniques that might have prevented the use of the restraint or seclusion;

Interpretive Guidelines § 483.370(b)(2)

See Interpretive Guidance for § 483.370(a)

N0191

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(b)(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and

Interpretive Guidelines § 483.370(b)(3)

See Interpretive Guidance for § 483.370(a)

N0192

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(b)(4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

Interpretive Guidelines § 483.370(b)(4)

See Interpretive Guidance for § 483.370(a)

N0193

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.370(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, the names of staff who were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

Interpretive Guidelines § 483.370(c)

See Interpretive Guidance for § 483.370(a)

§483.372 Medical Treatment for injuries resulting from an emergency safety intervention.

N0196

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.

Interpretive Guidelines § 483.372(a)

It is the responsibility of the facility to adequately assess the resident to determine the extent of any injuries sustained during an ESI and provide/secure the appropriate medical care promptly. Staff that is medically trained to provide emergency care and CPR should be available onsite, to provide the emergency medical interventions until further follow up emergency care can be provided.

N0197

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(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—

Interpretive Guidelines § 483.372(b)

The facility must have written arrangements with one or more hospitals to receive residents in the case of an emergency.

N0198

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(b)(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;

Interpretive Guidelines § 483.372(b)(1)

If a resident is deemed to need medical care or acute psychiatric care, it is the responsibility of the facility to assure a timely transfer based on the urgent or emergent nature of symptom or injury presentation.

N0199

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(b)(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

Interpretive Guidelines § 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.*

N0200

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(b)(3) Services are available to each resident 24 hours a day, 7 days a week.

Interpretive Guidelines § 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.

N0201

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(c) Staff must document in the resident's record, all injuries that occur as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

Interpretive Guidelines § 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.

N0202

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.372(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.

Interpretive Guidelines § 483.372(d)

This discussion may be included in the staff debriefing or may be documented separately. Documentation must address any staff procedures that will be changed as a result of the injury or what additional staff training will be required. Refer to N-0189, N-0190, N-0191, N-0192.

§483.374 Facility reporting

N0205

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(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' standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

Interpretive Guidelines § 483.374(a)

The State Survey Agency 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.

N0206

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(a)(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.

Interpretive Guidelines § 483.374(a)(1)-(2)

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.*

N0207

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(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 section §483.352 of this part, and a resident's suicide attempt.***

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system 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.

Interpretive Guidelines § 483.374(b)(1)

“Serious injury”, as defined in §483.352, means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else. Serious injuries also include incidences of abuse and neglect.

All serious injuries that require medical intervention are to be reported, regardless of whether they were associated with the use of restraint or seclusion. It is the responsibility of the facility to ensure that it reports serious occurrences appropriately.

The facility need not report every injury that a resident experiences, but only those that are substantial in nature. For instance, a small bruise on a thigh, which occurred as a result of running into a table, or abrasions as a result of a fall, may not be appropriate to report. It is the expectation that a facility investigate any injuries of unknown origin to ensure that a resident is not being harmed. In addition, if a resident has repeated injuries that are indicative of a pattern the facility should investigate to ensure that the resident is not subjected to a hostile environment and take steps to minimize the risk of more injuries.

Deficiencies cited at 42 CFR 483.374 (b) involving a failure to report serious injuries resulting from abuse or neglect have greater probability of rising to an immediate jeopardy level finding. Immediate jeopardy procedures are outlined in Appendix Q of the State Operations Manual.

N0208

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(b)(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.

Interpretive Guidelines § 483.374(b)(2)

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.*

Review a sample of the serious occurrence reports. Verify that notification to parents or guardians was timely, within 24 hours.

Survey procedures and probes

1. Review policy to determine:

That the policy requires parental/ legal guardian notification within 24 hours after a serious occurrence.

That the policy specifies who should notify the parent/ legal guardian and what information should be given.

Documentation of notification is recorded in the resident's chart.

2. Review documentation of serious occurrences to determine if notification to parents or guardians was timely, within 24 hours.

N0209

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including 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.

Interpretive Guidelines § 483.374(b)(3)

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*

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 should not be reported.

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.

N0210

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.374(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 and 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.

Interpretive Guidelines § 483.374(c)

Review the facility policies to determine:

- a. The policy requires notification to the CMS RO no later than COB of the next business day after residents death, and*
- b. The policy should specify who should notify the CMS RO.*

§483.376 Education and Training

N0214

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of –

Interpretive Guidelines § 483.376(a)

The facility staff must attend ongoing training and education activities in the required areas outlined below (N-0215-N-0218). 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 that the training is occurring.

N0215

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(a)(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

Interpretive Guidelines § 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 was learned through a return demonstration. This training should include the identification of staff roles and behaviors that affect negative outcomes and the assessment of the impact of the resident's environment contributing to an emergency safety situation.

N0216

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(a)(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

Interpretive Guidelines § 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.

The facility must also include training on the correct application of time out and how to monitor a resident in time out.

N0217

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(a)(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.

Interpretive Guidelines § 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 utilized by the facility. Training in the techniques of the 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 CPR, and removal of physical barriers impacting on the resident's safe care.

N0218

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.

Interpretive Guidelines § 483.376(b)

The facility must ensure that all staff that has direct resident care responsibilities receive certification training in the use of cardiopulmonary resuscitation (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.

N0219

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(c) Individuals who are qualified by education, training and experience must provide staff training.

Interpretive Guidelines § 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.

N0220

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(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.

Interpretive Guidelines § 483.376(d)

As part of the staff training program for managing emergency 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.

N0221

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.

Interpretive Guidelines § 483.376(e)

The facility policy must require that all staff must be trained and have documented evidence of demonstrated competency before they may participate in an emergency safety situation.

N0222

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(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.

Interpretive Guidelines § 483.376(f)

- 1. Review a sample of staff personnel files to verify that staff has demonstrated their competence on a six month basis.*
- 2. Review a sample of personnel files to verify that staff is recertified in CPR on an annual basis.*

N0223

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(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.

Interpretive Guidelines § 483.376(g)

The facility must document all successfully completed competency evaluations in the personnel files or training records. This documentation should include the dates the training was completed and the names of the responsible staff that certified the completion of the competency evaluations.

N0224

(Rev. 131; Issued: 01-16-15, Effective: 01-16-15, Implementation: 01-16-15)

§483.376(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.

Interpretive Guidelines § 483.376(h)

The facility training documentation should be easily accessible and must be current.

Transmittals Issued for this Appendix

Rev #	Issue Date	Subject	Impl Date	CR#
R131SOM	01/16/2015	New to State Operations Manual (SOM), Appendix N- Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance	01/16/2015	N/A