

Psychiatric Residential Treatment Facility
Service Standards Manual
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Department of Social and Rehabilitation Services



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Overview

The purpose of these draft standards is to define the minimum programmatic requirements that must be met by any organization approved or seeking SRS approval as a psychiatric residential treatment facility (PRTF).

A PRTF provides comprehensive mental health treatment to children and adolescents who, due to mental illness, substance abuse, or severe emotional disturbance, are in need of treatment that can most effectively be provided in a psychiatric residential treatment facility. All other ambulatory care resources available in the community have been identified, and if not accessed, determined to not meet the immediate treatment needs of the youth. PRTF programs are designed to offer a short term, intense, focused treatment program to promote a successful return of the child or adolescent to the community. Specific outcomes of the mental health services include the resident returning to the family or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary. The residential treatment facility is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the resident including those residents identified with emotional and behavioral issues.

The following Center for Medicaid Services (CMS) regulations were considered critical in developing the attached set of draft regulations for psychiatric residential facilities: 42 CFR §441.151 through §441.182 of Subpart D of the Federal code.

DEFINITIONS

Absent day: If a resident is not at the facility at the evening census taken at 11:59 pm the resident is considered absent for that day. Therefore, the PRTF may not bill for that day unless the absence has been pre-approved as outlined and within the limits of the State's absentee (reserve day) policy.

CBST (Community-Based Service Team): an individualized team established to access and integrate community resources to meet mental health needs in the least restrictive environment. The CBST is comprised of the resident (as appropriate), a responsible family member/guardian, a knowledgeable representative from the Community Mental Health Center (CMHC), other clinicians, the custodial case manager, and any other individuals considered to be helpful in determining how to best help the youth.

Centers for Medicare and Medicaid Services (CMS): is the agency of the Federal Department of Health and Human Services which is responsible for the administration of the Medicaid program.

Certification/Recertification of need: is the assessment and documentation that certifies medical necessity for psychiatric residential treatment services. (See 42 C.F.R.441.152)

Direct Care Staff: All direct care staff must meet the following requirements: Be 21 years of age or older and at least three years older than the oldest resident and have a high school diploma or its equivalent. Direct care staff are appropriately trained and responsible for basic interactive care such as supervision, daily living care and mentoring of the residents and assisting in the implementation of the plan of care that is within their scope of practice.

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 calls for an emergency safety intervention (restraint or seclusion) as defined in this section.

Family: Legally recognized birth, adoptive or foster parents, grandparents, siblings, other relatives, and legal custodians.

Hospital Leave: is an absence from the facility for more than 24 consecutive hours due to the resident receiving acute inpatient treatment in a hospital, including treatment in a psychiatric unit of a hospital, or a state psychiatric hospital. If the PRTF is unable to plan for return of the resident and continue continuity of care planning because it is unsure when the resident may

return from the hospital the resident should be discharged. Under no circumstances shall the PRTF bill for more than five resident days when the resident is in the hospital.

Licensed Mental Health Professional (LMHP): is an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently, such as: Licensed Psychologists, Licensed Clinical Marriage and Family Therapists, Licensed Clinical Professional Counselors, Licensed Specialist Clinical Social Workers, or Licensed Clinical Psychotherapists.

A LMHP also includes individuals licensed to practice under supervision or direction, such as: Licensed Marriage and Family Therapists, Licensed Professional Counselors, Licensed Masters Social Workers, or Licensed Masters Level Psychologists. Supervision or direction must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician.

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.

Medical Mechanical restraint: Mechanical interventions ordered by a physician used for the assistance of healing or stabilization of physical health.

Medical necessity criteria of a PRTF:

- A substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
- The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- All other ambulatory care resources available in the community have been identified and if not accessed, determined to not meet the immediate treatment needs of the youth.

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.

PRTF Liaison: a designated representative of the responsible community mental health center who collaborates with the PRTF and treatment team to assist with treatment, crisis, and discharge planning.

Psychiatric Residential Treatment Facility (PRTF): is a facility that provides comprehensive inpatient mental health treatment and/or substance abuse services for residents with severe emotional disturbances, substance abuse, and or mental illness that meets State and Federal participation requirements, and is accredited by one of the following accrediting organizations:

1. Council on Accreditation of Rehabilitation Facilities (CARF);
2. Council on Accreditation of Services for Families and Children (COA);
3. Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or;
4. an accrediting body approved by the Kansas Health Policy Authority (KHPA), Kansas Department of Social and Rehabilitation Services (SRS) and the Kansas Juvenile Justice Authority (JJA).

Resident: Any child or youth age six and twenty-two years old, accepted for care and treatment in a PRTF.

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. Seclusion also includes restricting a resident in a locked room, and isolating the resident from any personal contact. The term "locked room" includes any type of door locking device such as a key lock, spring lock, bolt lock, foot pressure lock, physically holding the door closed, or preventing the individual from leaving the room. Seclusion does not include the appropriate use of a time-out room. Locking an individual in a bedroom during sleeping hours is considered seclusion.

Serious occurrence: means any significant incident or an impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, sexual assault, death, suicide attempts, 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, safety and well-being, and who are employed by the facility on a full-time, part-time, or contract basis.

Time out/Restrictive Intervention: 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.

Treatment definitions:

- **Active treatment:** means the implementation and supporting documentation of services outlined in a plan of care developed by a treatment team facilitated by the PRTF. It includes assessment, treatment, crisis prevention and discharge planning. Treatment, overseen by a PRTF physician, is designed to achieve the goal of the resident's successful transition back to the community at the earliest possible time. Treatment reviews address and encourage the therapeutic alliance, collaboration on tasks and consensus on goals from staff, resident, resident's family, and community partners.
- **Individual plan of care:** is the written treatment plan developed specifically to address the needs of each resident to improve his/her condition to the extent that inpatient care is no longer indicated. (See 42 C.F.R. 441.155).
- **Treatment team:** as described by federal regulations and state standards is responsible for developing and reviewing the individual plan of care and is comprised of PRTF service providers, resident, resident's family, Community Mental Health Center representative (CMHC) as designated liaison and other community partners. The PRTF service provider facilitates the treatment and treatment team.

PROGRAM DESCRIPTION STANDARDS

- A. A written program description must guide the agency's operations and delivery of services. Each PRTF is required to develop its own policies, procedures and program description to implement the requirements in this document. The program description must be on file for review by any federal or state agency and the facilities accrediting body during site visits and must be submitted annually on January 1 of each year to the Department of Social and Rehabilitation Services and the Juvenile Justice Authority.
- B. The program description will include the facility location, legal ownership, an administration table of organization, the philosophy, vision and mission of the program and explain in detail how the facility will meet the requirements in this document. The description will include detail regarding the population served by the PRTF, including the number of residents served, age groups, and other relevant characteristics of the population. (This information can be located in different documents and kept together in a file to be readily accessible during any site visit.)
- C. If providing substance abuse treatment services on site, the PRTF must be licensed by Addiction and Prevention Services (AAPS) to provide said services employing AAPS certified substance abuse counselors. If sub-contracting substance abuse treatment services, the provider used must be AAPS certified to do so. The activities included in the service must be intended to achieve identified treatment plan goals or objectives and be designed to achieve the resident's discharge from inpatient status at the earliest possible time. Services provided must be in accordance with 42CFR 441.154-441.156

FEDERAL REGULATIONS AND STATE STANDARDS

This document contains language that is Federal Regulation and state standards. Federal language is in normal text. Language that is specific to Kansas PRTF's are in *italics* directly under that particular Federal Regulation. The additional requirement section is specific to state standards.

42 CFR §441 Subpart D—Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs

§441.151 General requirements.

(a) Inpatient psychiatric services for individuals under age 21 must be:

- (1) Provided under the direction of a physician;
- (2) Provided by—
 - (i) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
 - (ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.
- (3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following—
 - (i) The date the individual no longer requires the services; or
 - (ii) The date the individual reaches 22; and
- (4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with §441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in §483.352 of this chapter must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

[66 FR 7160, Jan. 22, 2001]

(1) Referenced above: Under the direction of a physician means: Under the direction of a physician licensed and board eligible or board certified in the state where the PRTF is located. These physicians may be employed by or contracted with the PRTF.

The physician must provide for the clinical oversight of all services provided by the PRTF. A physician who is licensed and board eligible or a board certified psychiatrist (or a physician who is not a psychiatrist BUT is working in conjunction with a psychologist consistent with 441.156) must be available to oversee the medical needs of the resident including medication management, plan of care development, and can order seclusion and restraint consistent with CFR 42 subpart G of part 483.

§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 the treatment needs of the recipient;
- (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(b) The certification specified in this section and in §441.153 satisfies the utilization control requirement for physician certification in §§456.60, 456.160, and 456.360 of this subchapter. [43 FR 45229, Sept. 29, 1978, as amended at 61 FR 38398, July 24, 1996]

(a) Referenced above: Certification and recertification of the need for services is defined in the Kansas definitions section of this document. The LMHP certifying and re-certifying the need for services must be independent of the facility.

§441.153 Team certifying need for services.

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

(a) For an individual who is a recipient when admitted to a facility or program, certification must be made by an independent team that—

- (1) Includes a physician;
- (2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- (3) Has knowledge of the individual's situation.

(b) For an individual who applies for Medicaid while in the facility of program, the certification must be—

- (1) Made by the team responsible for the plan of care as specified in §441.156; and
- (2) Cover any period before application for which claims are made.

(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (§441.156) within 14 days after admission.

(a)(1) Referenced above: The team responsible for the certification and recertification of services will be the LMHP certifier in conjunction with the Community-Based Services Team (CBST). This must include a face-to-face assessment by an independent LMHP. Recertification must occur within 90 days of admission and within every 60 days thereafter.

§441.154 Active treatment

Inpatient psychiatric services must involve “active treatment”, which means implementation of a professionally developed and supervised individual plan of care, described in §441.155 that is—

- (a) Developed and implemented no later than 14 days after admission; and
- (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

Active treatment will begin immediately upon admission with the information provided by the LMHP doing the certification of need, CBST recommendations and assessments performed by the PRTF. This forms the basis for establishing the immediate plan of care and criteria for discharge.

Active treatment includes ongoing family involvement in the planning for and delivery of services. In active treatment, programming is individualized to the needs of each resident and the family to maximize individual functioning in activities of daily living, education, and vocational preparation.

The PRTF is expected to appropriately treat a resident, document the delivery and response to treatment, and provide or obtain all services the resident needs while a resident of the facility. Services provided by the PRTF must be built on the competencies of the resident and the family, while addressing specific needs (e.g., culture, treatment history, family relationships, etc.) It is expected that therapeutic services are provided at a time that is conducive for the involvement of the youth and family. Specific expectations include, at a minimum, the following, all of which must be provided as needed and documented in the resident's record:

During all waking hours, residents of the PRTF shall be engaged in active treatment, this includes:

Engagement services and activities, including the following:

- *Engaging the resident in a purposeful, supportive, and helping relationship;*
- *Eliciting the residents and resident's family choices concerning basic needs, including determining what supports the resident needs, what productive activities the resident desires to engage in, and what leisure activities the resident desires to participate in; and*
- *Understanding the residents personal history and either satisfaction or dissatisfaction with services and treatments, including medications, that have been provided to or prescribed in the past.*

Strengths assessment services and activities, including the following:

- *Identifying and assessing the residents wants and needs, the residents aspirations for the future, the resources that are or might be available to that resident and their family, the sources of motivation available to the resident, and the strengths and capabilities the resident possesses;*
- *Identifying and researching what educational and vocational, and social resources are or might be available to the resident and might facilitate that resident's treatment, and*
- *Identifying, researching, and understanding the cultural factors that might have affected or that might affect the residents experience with receiving treatment and other services, the effects that these factors might have on the treatment process, and the ways in which these factors might be best used to support the resident's treatment.*

Goal-planning services and activities, including the following:

- *Helping the resident to identify, organize, and prioritize the residents and resident's family's personal goals and objectives with regard to treatment, education and training, and community involvement;*
- *Assisting and supporting the resident in choosing and pursuing activities consistent with achieving those goals and objectives at a pace consistent with that residents capabilities, and motivation;*
- *Teaching the resident goal-setting and problem-solving skills independent living skills, social, and self management skills;*

- *Identifying critical stressors that negatively effect the resident’s mental status and those interventions, coping strategies, and supportive resources that have been successful or helpful in addressing or relieving those stressors in the past; and*
- *Develop relapse prevention strategies, including wrap-around plans and advance directives, which the resident may utilize;*

Advocacy services and activities, including the following:

- *Coordinating the treatment and supportive efforts for the resident.*
- *Advocating for the resident, as appropriate, in developing goals and objectives within the residents individualized treatment plan during the course of that residents treatment, and assisting in acquiring the resources necessary for achieving those goals and objectives*

§441.155 Individual plan of care.

(a) “Individual plan of care” means a written plan developed for each recipient in accordance with §§456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary.

(b) The plan of care must—

- (1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;
- (2) Be developed by a team of professionals specified under §441.156 in consultation with the recipient; and his parents, legal guardians, or others in whose care he will be released after discharge;
- (3) State treatment objectives;
- (4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
- (5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.

(c) The plan must be reviewed every 30 days by the team specified in §441.156 to—

- (1) Determine that services being provided are or were required on an inpatient basis, and
- (2) Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

(d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for—

- (1) Recertification under §§456.60(b), 456.160(b), and 456.360(b) of this subchapter; and
- (2) Establishment and periodic review of the plan of care under §§456.80, 456.180, and 456.380 of this subchapter.

[43 FR 45229, Sept. 29, 1978, as amended at 46 FR 48560, Oct. 1, 1981; 61 FR 38398, July 24, 1996]

(a) Referenced above: Each resident must have a written individual plan of care, which is goal-oriented and specific, describing the services to be provided. The initial individual plan of care must be based upon input from the CBST, treatment team and any other needs which have been identified as specified in (42 CFR 441.156) and be implemented no later than 14 days after admission or 24 hours after returning from an inpatient hospitalization or unexcused leave of absence from the facility. (See 42 C.F.R.441.154).

(c) referenced above: The treatment team must review the plan of care within thirty days and subsequent reviews within 30 days thereafter, evidenced through documentation which meets state and federal requirements. The treatment plan and subsequent reviews support the continued need for PRTF services and is evidenced by the resident's LMHP signature at the PRTF, physician's signature, resident's signature, family's member signature and a list of members who participated in each review. If any required member of the team does not participate, there must be documentation of reasonable efforts by the PRTF to enlist participation from treatment team members.

(d)(1) Referenced above: Does not satisfy the requirement for independent re-certification of need as specified in the Kansas Definition, which specifies re-certification must be done by a Licensed Mental Health Professional independent of the facility in consultation with the CBST team. Independent re-certification of need will be satisfied through the face-to-face assessment and CBST review which is completed 90 days after admission and every 60 days thereafter as specified in 441.153.

§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 recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- (2) Assessing the potential resources of the recipient's family;
- (3) Setting treatment objectives; and
- (4) Prescribing therapeutic modalities to achieve the plan's objectives.

(c) The team must include, as a minimum, either—

- (1) A Board-eligible or Board-certified psychiatrist;
- (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(d) The team must also include one of the following:

- (1) A psychiatric social worker.
- (2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.
- (3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.
- (4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

c(3) Referenced above: Certification by the state means licensed by the state.

(a) Referenced above: The treatment team must include the resident, resident's family, and the Community Mental Health Center (CMHC) representative or designated liaison and LMHP.

§ 483.356 Protection of residents.

- (a) Restraint and seclusion policy for the protection of residents.
- (1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
 - (2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
 - (3) Restraint or seclusion must not result in harm or injury to the resident and must be used only—
 - (i) To ensure the safety of the resident or others during an emergency safety situation; and
 - (ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired.
 - (4) Restraint and seclusion must not be used simultaneously.

(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

- (c) Notification of facility policy. At admission, the facility must—
- (1) Inform both the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program;
 - (2) Communicate its restraint and seclusion policy in a language that the resident, or his or her parent(s) or legal guardian(s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators;
 - (3) Obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and
 - (4) Provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

(d) Contact information. The facility's policy must provide contact information, including the phone number and mailing address, for the appropriate State Protection and Advocacy organization.

(d) Referenced above: The Kansas State Protection and Advocacy Organization is the Disability Rights Center of Kansas (DRC). Formerly known as the Kansas Advocacy & Protective Services (KAPS).

*Disability Rights Center of Kansas (DRC)
635 S.W. Harrison Street, Suite 100
Topeka, Kansas 66603-3726
Voice: 785-273-9661
Toll free Voice: 1-877-776-1541
Toll free TDD: 1-877-335-3725
Fax: 785-273-9414*

(a) (1) Referenced above: the use of restraint or seclusion should be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others. The facility shall demonstrate effective treatment approaches and alternatives to the use of restraint and/or seclusion.

A written plan to address the limited use of restraint and/or seclusion shall be developed by the PRTF and be available at the request of the Department of Social and Rehabilitation Services, the Juvenile Justice Authority, or the Kansas Health Policy Authority.

The facility policy should address all requirements set forth by the CMS conditions of participation to ensure the protection of residents, which include:

- a. ensuring safety both during and after seclusion and restraint;*
- b. specifying the required elements of an order for restraint;*
- c. identifying the staff who are responsible for the continual assessment of a resident during restraint as well as defining the minimal physical and psychological elements that must be assessed;*
- d. Use of mechanical and/or chemical restraints, and standing orders for the facility of “drugs used as a restraint” are prohibited in PRTF’s.*
- e. The guidelines and prohibitions regarding the use of restraint or seclusion relate to psychiatric, mental health, or behavioral health related actions. They do not relate to any physical health related, medical direction or order from a physician treating a youth for physical health issues. Mechanical interventions ordered by a physician assist and promote the essential healing or stabilization of a physical health issue are not governed by these guidelines and prohibitions.*

§ 483.358 Orders for the use of restraint or seclusion.

(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under age 21 be provided under the direction of a physician.

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

(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.

(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(e) Each order for restraint or seclusion must:

- (1) Be limited to no longer than the duration of the emergency safety situation; and
- (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9.

(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to—

- (1) The resident's physical and psychological status;
- (2) The resident's behavior;
- (3) The appropriateness of the intervention measures; and
- (4) Any complications resulting from the intervention.

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

- (1) The name of the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion;
- (2) The date and time the order was obtained; and
- (3) The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use.

(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

- (1) Each order for restraint or seclusion as required in paragraph (g) of this section.
- (2) The time the emergency safety intervention actually began and ended.
- (3) The time and results of the 1-hour assessment required in paragraph (f) of this section.
- (4) The emergency safety situation that required the resident to be restrained or put in seclusion.
- (5) The name of staff involved in the emergency safety intervention.

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

(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28116, May 22, 2001]

(a) Referenced above: Other than a physician, the only licensed practitioner permitted by the state to order seclusion or restraint is a physician's assistant (PA) working under protocol, or an advanced registered nurse practitioner (ARNP) working under protocol, a PhD psychologist, or the head of the treatment facility or their designee who must be a physician, PA, ARNP, or a LMHP as defined in the definitions section of this document and the state Medicaid Plan.

(c) Referenced above: See the definition of licensed practitioner permitted by the State in (a) above.

- (d) *Referenced above: Licensed staff means licensed health care professionals who are operating within the scope of their practice and capable of receiving orders. Trained RNs and LPN's are appropriate. The physician, ARNP, PA, or LMHP giving the order for the restraint or seclusion must also be available throughout the use of the emergency safety intervention.*
- (e)(2) *Referenced above: Emergency safety interventions may not exceed 4 hours for residents ages 18 to 21; 2 hour for residents ages 9 to 17; or 1 hour for residents under age 9. Throughout the use of the emergency safety intervention staff should be assessing, monitoring, and re-evaluating the resident so that he or she is released from the restraint or seclusion at the earliest possible time.*
- (f) *Referenced above: A licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess psychological and physical well being of residents within 1 hour of the initiation of the emergency safety intervention. A physician, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP) or a trained registered nurse (RN) are qualified to assess physical wellbeing. .*
- (h) (i) *Referenced above: The name and credentials of staff involved in the restraint.*
(ii) *Referenced above: Consultation with treatment team physician*

§ 483.360 Consultation with treatment team physician.

If a physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion orders the use of restraint or seclusion, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of restraint or seclusion must—

- (a) Consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion; and
- (b) Document in the resident's record the date and time the team physician was consulted.
[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

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

- (a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.
- (b) If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.
- (c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

(a) Referenced above: All facility direct care staff must complete an SRS approved training program on the use of emergency safety interventions.

Clinical staff is defined as direct care staff or LMHP's, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have also been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.

(c) Referenced above: Licensed practitioners permitted by the state and the facility to evaluate the residents physical and psychological well-being immediately after a resident is removed from a restraint are physicians, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP), a trained- registered nurse (RN).

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

(a) Clinical staff, trained in the use of emergency safety interventions, must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement.

(b) A room used for seclusion must—

- (1) Allow staff full view of the resident in all areas of the room; and
- (2) Be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

(c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

(a) Referenced above: All facility direct care staff must complete an SRS approved training program on the use of emergency safety interventions.

Clinical staff is defined as direct care staff or LMHPs, who have been appropriately trained as described in (a) on the use of emergency safety interventions, and who have also been trained how to appropriately monitor residents in seclusion and restraint. Facility policies and procedures should specify who is clinically trained and appropriate to monitor residents in emergency interventions.

(d) Referenced above: Licensed practitioners permitted by the state and the facility to evaluate the residents well-being immediately after a resident is removed from a restraint are

physicians, a physician's assistant (PA), an advanced registered nurse practitioner (ARNP), and a trained- registered nurse (RN).

§ 483.366 Notification of parent(s) or legal guardian(s).

If the resident is a minor as defined in this subpart:

(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

(b) The facility must document in the resident's record that the parent(s) or legal guardian(s) has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the notification.

§ 483.368 Application of time out.

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

(b) Time out may take place away from the area of activity or from other residents, such as in the resident's room (exclusionary), or in the area of activity or other residents (inclusionary).

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

(a)Referenced above: if a resident does not stay in time out voluntarily, it is considered seclusion.

§ 483.370 Post-intervention debriefings.

(a) Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.

(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of—

- (1) The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
- (2) Alternative techniques that might have prevented the use of the restraint or seclusion;
- (3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
- (4) The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation the names of staff who were present for the debriefing, names of staff that were excused from the debriefing, and any changes to the resident's treatment plan that result from the debriefings.

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

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

(b) The psychiatric residential treatment facility must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonably ensure that—

- (1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
- (2) Medical and other information needed for care of the resident in light of such a transfer, will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
- (3) Services are available to each resident 24 hours a day, 7 days a week.

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

(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

(c) Reference above, The resident's family or custodial case manger shall be notified of any injuries resulting from an emergency safety intervention.

§ 483.374 Facility reporting.

(a) Attestation of facility compliance. Each psychiatric residential treatment facility that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS's standards governing the use of restraint and seclusion. This attestation must be signed by the facility director.

- (1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the State Medicaid agency by July 21, 2001.
- (2) A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.

(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in §483.352 of this part, and a resident's suicide attempt.

- (1) Staff must report any serious occurrence involving a resident to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. by no later than close of business the next business day after a serious occurrence. The report must include the name of the resident involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.
- (2) In the case of a minor, the facility must notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence.

(3) Staff must document in the resident's record that the serious occurrence was reported to the State Medicaid agency, the State-designated Protection and Advocacy system, and the licensing agency. This report should include the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services (CMS) regional office.

(1) Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.

(2) Staff must document in the resident's record that the death was reported to the CMS regional office.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28117, May 22, 2001]

(b)Referenced above: The facility must report each serious occurrence within 24 hours of the event to the State Medicaid agency (the Kansas Health Policy Authority), Department of Social and Rehabilitation Services Mental Health, applicable Child welfare contractor/case manager or JJA case manager, the Kansas Protective Advocacy System/Disability Right Center of Kansas and KDHE. If the serious occurrence involves abuse, neglect or exploitation, you must follow mandated reporting requirements

All serious occurrences that require medical intervention are to be reported, regardless of whether it was 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 occurrence that a resident experiences, but only those that are serious in nature. 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 also to take steps to minimize the risk of more injuries. The facility should also train all employees on the requirement to report suspected abuse or neglect to the appropriate state authorities immediately.

The resident's family or custodial case manager shall be notified of all investigations.

§ 483.376 Education and training.

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

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

(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and

(3) The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in residents who are restrained or in seclusion.

- (b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.
- (c) Individuals who are qualified by education, training, and experience must provide staff training.
- (d) Staff training must include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.
- (e) Staff must be trained and demonstrate competency before participating in an emergency safety intervention.
- (f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis.
- (g) The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
- (h) All training programs and materials used by the facility must be available for review by CMS, the State Medicaid agency, and the State survey agency.

UTILIZATION REVIEW (UR)

In accordance with 42 C.F.R. 456 Subpart D relating to Utilization Control of Mental Hospitals, all Medicaid PRTF services shall have procedures that provide for review of each resident's need for the services. For the Utilization Review (UR), each PRTF shall perform on-going evaluations of the necessity and appropriateness of PRTF services for each resident. The UR shall include a review of the appropriateness of the admission, individual plan of care, length of stay and discharge plan.

ADDITIONAL STANDARDS

Documentation/Resident Records:

ALL NOTES MUST BE LEGIBLE AND CORRECTIONS MUST BE MADE SO NOT TO ALTER CONTENT.

Each resident's record shall contain the following:

Personal information, including:

1. The name, sex, admission date, birth date and Social Security Number.
2. The race, height, weight, color of hair, color of eyes and identifying marks.
3. Language or means of communication spoken and understood by the resident and the primary language used by the resident's family, if other than English.
4. The name, address and telephone number of the person to be contacted in the event of an emergency.
5. Health records.
6. Dental, vision, and hearing records.
7. Health and safety assessments.
8. Current and Past Individual Plans of Care.
9. Consent to treatment forms.
10. Admission and placement information.
11. Signed notification of rights, grievance procedures and applicable consent to treatment protections.
12. Education records.
13. Past treatment plans.
14. Current and past PRTF psychiatric evaluations.
15. Special consultations or assessments completed or requested as applicable.
16. Copies of Certification and Re-Certification of need.
17. Progress notes that document the resident's participation in individual therapy, group therapy, family therapy, and other therapeutic interventions.
18. Progress notes must include summaries of individual plan of care reviews and special consultations regarding all aspects of the resident's complete daily program.
19. Documentation of the resident's progress toward meeting treatment goals.
20. Documentation of the family's participation in the treatment and discharge planning including copies provided to guardians
21. Documentation of community service providers' participation in the treatment and discharge planning.
22. All medications and regular medication reviews. Clinical rationale shall be clearly documented for each medication. All changes in medication must be documented in the medication orders. Records documenting administration of all medications indicating

dosage, actual administration of the medication, responsible staff administering, and signature of the responsible staff person.

23. Documentation of outcomes and reviews following therapeutic leave.

24. Relevant records from other agencies and systems.

Clinical Documentation:

The following must be included in the resident's clinical record:

1. Extent of the patient history and exam must be documented along with a comprehensive treatment plan and subsequent reviews. Individual plans of care must follow an SRS approved format.
2. Progress note for every goal directed service provided which shall include:
 - Date, time, and description of each service delivered and by who (name, designation of profession or Para profession).
 - Identification of goals addressed, interventions used and resident's response to service.
 - Progress on stated goals
3. Documentation to support treatment plan reviews and discharge planning.
4. Documentation supporting "special" consultations or clinical supervision, which applies directly to the identified resident.
5. Documentation of the family's / legal guardian's participation in the planning and treatment.
6. Documentation indicating regular medication reviews including the current and past psychotropic medications. Clinical rationale for each medication shall be clearly documented. All changes in medication must be documented in the medication orders. Records documenting administration of all prescribed medications indicating dosage, actual administration of medication, responsible staff administering, and signature of responsible staff person.
7. Documentation of all incidents of seclusion, restraint, or restrictive intervention.
8. Relevant records from other agencies and systems including but not limited to:
 - Initial Screens for Level of Care and Re-screens for continued stay
 - Local Education Agency – Individual education plans
 - Pertinent clinical documentation of services provided outside the facility
9. Pertinent past and present medical history including diagnosis and the approximate date of diagnosis.

The following criteria apply when developing the clinical record:

1. The resident record shall be legible and **stand on its own**.
2. The date and reason for every service must be included.
3. Documentation must support the level of care provided in the PRTF.
4. Assessments documented merely using a rubber stamp are not accepted unless there is documentation to the side of the stamp, which reflects results of the exam for each of the systems identified on the rubber stamp.
5. Check marks are not accepted.
6. Records must be created **at the time the service is provided**.

The following questions should be asked to ensure appropriate documentation exists to support the level of service billed:

1. Is the reason for the treatment documented in the resident record?
2. Are all services that were provided documented?
3. Does the resident record clearly explain why support services, procedures, supplies and medications were or were not provided?

4. Is the assessment of the resident's condition apparent in the record?
5. Does documentation contain information on the resident's progress and results of treatment?
6. Does the resident record include a plan for treatment?
7. Does information in the resident record provide medical rationale for the services?
8. Does information in the resident record appropriately reflect the care provided in the case where another health care professional must assume care or perform necessary medical services on behalf of the facility? Is there documentation of timely referrals?

Recordkeeping responsibilities rest with the provider.

Medication Documentation:

All medication, including nonprescription medication, shall be given only in accordance with label directions, unless ordered differently by a physician, or a physician's assistant operating under written protocol as authorized by a physician, or an advanced registered nurse practitioner as authorized by a responsible physician and operating within their scope of practice. A record shall be kept in the resident's record documenting the following:

- (1) The name of the person who gave the medication;
- (2) The name of the medication;
- (3) The dosage;
- (4) The date and time it was given
- (5) Any change in the resident's behavior, response to the medication, or adverse reactions
- (6) Any change in the administration of the medication from the instructions on the label for a notation about each missed dose.

Each record must be signed by the individual who was responsible for administering the medication.

Claim/Record Storage Requirements

K.S.A. 21-3849 – Upon submitting a claim for or upon receiving payment for goods, services, items, facilities or accommodations under the Medicaid program, a person shall not destroy or conceal any records for five years after the date on which payment was received, if payment was received, or for five years after the date on which the claim was submitted, if the payment was not received. (This requirement includes primary care case management and Lock-In referrals.) This requirement applies to both record availability for manual invoicing and computer generated invoicing.

Providers who submit claims via computerized systems (i.e., tape) must maintain these records in a manner which is retrievable as follows: A hard copy printout or readable copies from microfilm and microfiche. If the required records are retained on machine-readable media (i.e., tape), a hard copy of the record must be made available when requested.

If these storage requirements are in question, please review Section 1902 (a) (27), (A) and (B) of the Federal Social Security Act which requires providers (a) to keep such records as necessary to disclose fully the extent of services rendered to beneficiaries, and; (b) to furnish upon request by the state agency or secretary of Health and Human Services information on payment claimed by the provider.

Providing medical records to the Kansas Medical Assistance Program or its designee is not a billable charge.

Clinical records must be retained according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requirements.

Responsibilities of the physician and/or their designee:

1. Regular and ongoing contact with all residents and more frequent contact for those residents on medication.
2. Regular and ongoing contact with treatment staff to formulate and monitor the implementation of the resident's individual plan of care.
3. Face-to-face or phone contact with the resident's family as needed.
4. Contact as appropriate with external, community agencies, and natural supports important to the resident's life.
5. Perform and prepare formal, written psychiatric evaluations as needed.
6. Coordinate and/or advise facility staff on medical matters including the prescription and monitoring of psychotropic and other medication.
7. Order the use of seclusion or restraint per CMS regulations.

Telemedicine is allowed as long as residents are seen face-to-face by licensed, board eligible, or board certified physicians or their designees who are operating within their scope of practice under protocol for their initial medical evaluation.

Delegation of Nursing Tasks or Procedures:

Each registered professional nurse who delegates nursing tasks or procedures to a designated unlicensed person in the PRTF shall comply with the following requirements:

- (a) Each registered professional nurse shall perform the following:
 - (1) Assess each resident's nursing care needs;
 - (2) Formulate a plan of care before delegating any nursing task or procedure to an unlicensed person; and
 - (3) Formulate a plan of nursing care for each resident who has one or more long-term or chronic health conditions requiring nursing interventions.
- (b) The selected nursing task or procedure to be delegated shall be one that a reasonable and prudent nurse would determine to be within the scope of sound nursing judgment and that can be performed properly and safely by an unlicensed person.
- (c) Any designated unlicensed person may perform basic caretaking tasks or procedures such as bathing, dressing, grooming, routine dental, hair and skin care, preparation of food for oral feeding, exercise (excluding occupational therapy and physical therapy procedures), toileting (including diapering and toilet training), and hand washing without delegation. After assessment and providing the needed training to a designated unlicensed person, a nurse may delegate specialized caretaking tasks such as catherization, ostomy care, preparation and administration of gastrostomy tube feedings, care of skin with damaged integrity or potential for this damage, administration of medications, and performance of other nursing procedures as selected by the registered professional nurse.

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

Supervision of delegated tasks or procedures:

Each registered professional or licensed practical nurse shall supervise all nursing tasks or procedures delegated to a designated unlicensed person in the PRTF setting in accordance with the following conditions.

- (a) The registered professional nurse shall determine the degree of supervision required after an assessment of appropriate factors, including the following:
 - (1) The health status and mental and physical stability of the resident receiving the nursing care;
 - (2) the complexity of the task or procedure to be delegated;
 - (3) the training and competency of the unlicensed person to whom the task or procedure is to be delegated; and
 - (4) the proximity and availability of the registered professional nurse to the

designated unlicensed person when the selected nursing task or procedure will be performed.

- (b) The supervising registered professional nurse may designate whether or not the nursing task or procedure is one that may be delegated or supervised by a licensed practical nurse.
- (c) Each delegating registered professional nurse shall have a plan to provide nursing care when the delegating nurse is absent.

Medication:

A physician, physician's assistant, or an advanced registered nurse practitioner pursuant to a written protocol as authorized by a responsible physician may prescribe medication. Each protocol shall contain a precise and detailed medical plan of care for each classification of disease or injury for which the PA or ARNP is authorized to prescribe. The rationale for each medication and any changes in medication must be clearly documented in the resident's medical record. A physician, physician's assistant (PA), or advanced registered nurse practitioner (ARNP) permitted by the state must see each resident on psychotropic medications at least every thirty days, with progress and clinical status documented in writing. The clinical rationale for each medication must be clearly documented on the resident's discharge summary or final evaluation. When medication is deemed necessary, families and custodial case manager should be informed of the most effective treatment options available as well as possible side effects and the positive and negative outcomes associated with each medication.

Medication Storage

The medicine cabinet shall be located in an accessible, supervised area. The cabinet shall be kept locked. Medication taken internally shall be kept separate from other medications. All unused medication shall be safely discarded.

Medication Administration:

All medications shall be administered by a designated staff member qualified to administer medications. Prescription medication shall be given from a pharmacy container labeled with the following:

- (1) The resident's name;
- (2) The name of the medication;
- (3) The dosage and the dosage intervals;
- (4) The name of the prescribing physician; and
- (5) The date the prescription was filled.

Any changes of prescription or directions for administering a prescription medication shall be authorized, in writing, by a physician with documentation placed in the resident's record.

Each PRTF shall ensure that all medications are prescribed by one of the following medical practitioners:

- (1) A physician;
- (2) a physician's assistant operating under a written protocol as authorized by a responsible physician; or
- (3) An advanced registered nurse practitioner operating under a written protocol as authorized by a responsible physician and operating within their scope of practice.

Each PRTF shall develop and implement policies, procedures, and clinical protocols for the administration of prescription and nonprescription medication. If medication is administered to a resident, each PRTF shall designate staff members to administer the medication. Before administering medication, each designated staff member shall receive training in medication administration approved by KDHE.

Staffing Requirements:

A. The PRFT must be staffed appropriately to meet the needs of all the resident's in their care. The facility must also ensure there are an adequate number of multidisciplinary staffs to carry out the goals and objectives of the facility, and to ensure the delivery of individualized treatment to each resident as detailed in their program description.

B. Each prospective employee responsible for providing direct care to residents must meet all KDHE physical health requirements for licensure of the facility. If a facility employee will be driving residents in the course of their employment the employees driving record should be checked for moving violations.

C. Minimum Staffing Level

Each PRTF shall meet the following minimum staff requirements:

- (1) The governing body of each PRTF shall designate a head of the facility or administrator who is responsible for the day-to-day operations of the facility.
- (2) A written daily staff schedule shall be developed and followed. The staff schedule shall meet all of the following requirements:
 - (a) The schedule shall provide for adequate staff to directly supervise and interact with the residents at all times, to implement each resident's individual plan for care, and to provide for each resident's physical, social, emotional, and educational needs.
 - (b) The schedule shall provide for a minimum ratio of one direct care staff member on active duty to seven residents during waking hours and one direct care staff member on active duty to ten residents during sleeping hours.
 - (c) At least one direct care staff member of the same sex as the resident shall be present, awake, and available to the resident at all times. If both male and female residents are present in the PRTF, at least one male and one female direct care staff member shall be present, awake, and available.
- (3) Additional staff shall be available in the facility on all shifts to supplement the staff-to-resident ratio, to provide immediate assistance in case of an emergency and to periodically check on the status of the residents.
- (4) Resident's shall remain in sight sound observation range of staff at all times. The minimum ratio of direct care staff shall be immediately available in a connecting area to the sleeping rooms.
- (5) Alternate qualified direct care staff members shall be provided for the relief of the regular staff members on a one-to-one basis and in compliance with the staffing pattern as required in number 2 above.
- (6) Electronic supervision shall not replace the direct care staffing requirements.
- (7) Auxiliary staff members shall be available as needed. The auxiliary staff shall include food service, clerical, and maintenance personnel. Auxiliary staff

- members shall not be included in meeting the minimum ratio of direct care staff to resident's served unless they have been properly trained as direct care staff.
- (8) Professional consultant services shall be available, to the extent necessary, to meet the needs of the resident's served. Professional consultants shall include physicians, dentists, nurses, clergy, social workers, psychologists, psychiatrists, teachers, and dieticians.
 - (9) A volunteer shall not be used as a substitute for a direct care staff member, but shall augment the services provided by the staff.
 - (10) A staff person designated to be in charge of the PRTF shall be on-site at all times when a resident is in care. Procedures shall be in place to ensure that all staff members know who is in charge.

Licensed Mental Health Professionals shall be available to ensure that the program can meet the stated active treatment as described in the PRTF's service description. At least one licensed mental health professional must be on-call during all hours the residents are sleeping to assist in emergencies.

Staff Training:

- A. The PRTF shall provide written training plan that meets SRS approval for all staff having direct contact with residents. This training shall include temporary and part-time staff and volunteers which includes specific training for newly hired staff and for the ongoing competence of all staff, including staff with whom the facility contracts for service. A record of all training must be kept for each staff member.
- B. Prior to working with residents, all staff shall have an orientation to the person's specific duties and responsibilities and the policies and procedures of the facility, including reportable incident reporting, discipline, care and management of children, medication administration, and use of restrictive procedures.
 1. Prior to working alone with residents, the director and each full-time, part-time and temporary staff person who will have regular and significant direct contact with residents shall be oriented to the policies and procedures of the facility, be familiar with the facilities behavior management system, and have completed a training curriculum approved by the state which includes the following areas:
 - a. Mandatory reporting requirements for abuse, neglect and exploitation.
 - b. First aid, Heimlich techniques, cardiopulmonary resuscitation and universal precautions.
 - c. Crisis intervention, behavior management, and suicide prevention.
 - d. Health and other special issues affecting the population.
 - e. Establish a zero-tolerance standard for sexual assault and misconduct for all staff.
 - f. Develop and implement standards for sexual assault detection and prevention.
 - g. Training to staff and residents shall be provided to increase the awareness of a safe reporting mechanism creating an environment that discourages sexual aggression and misconduct.
 - h. Training of core values and basic knowledge needed in the delivery of mental health services and in working effectively with families as partners.

Education:

PRTF must ensure residents receive a free and appropriate education accredited by the Kansas State Board of education.

Discipline:

- (1) Discipline that is humiliating, frightening, or physically harmful to the resident shall not be used at any time. Each resident shall be protected against all forms of neglect, exploitation, or degrading forms of discipline. No resident shall be isolated or confined in any dark space. Electronic monitoring or an audio communication system shall not replace the required presence of a direct care staff.
- (2) Corporal punishment shall not be used.
- (3) Under no circumstances shall any youth be deprived of meals, clothing, sleep, medical services, exercise, correspondence, parental contact, or legal assistance for disciplinary purposes.
- (4) Under no circumstance shall any youth be allowed to supervise or to administer discipline to another youth.
- (5) The use of tazers, pepper spray, OC spray or any other similar devices used as an intervention or restraint is prohibited.

Family Participation:

The PRTF shall ensure that the resident's family is given the opportunity to participate as full partners in the planning for delivery of services to the resident. Mutual respect between the facility staff and the family and inclusion of the family in all planning and decision-making are critical to successful treatment.

The facility shall document all efforts to involve the resident's family in service planning and delivery. The facility shall ensure that the family is allowed to visit the resident frequently in the facility. The facility shall also ensure that the resident's identified family is able to communicate with the resident by telephone. In the rare circumstances that such communication or visits are not deemed therapeutic, the facility must document the clinical reasons for denying visits or phone calls and shall address these clinical issues in treatment planning and services. The facility must have at least one designated area on-campus for family visitation.

Confidentiality:

Facilities must comply with all applicable state and federal confidentiality laws.

Absenteeism Policy:

A resident shall be considered present at the facility for an entire day if the resident is at the facility at 11:59 pm. The facility should take a resident specific census at this time and ensure the facilities business manager has a record of which residents are present in the facility on any given day and can accurately track absentee days for each resident. PRTF's will be reimbursed for absent days as follows:

Visitation Days: When indicated in the child's treatment plan (within the total number of days approved for the child's stay), a maximum of 7 days per visit will be paid at the contracted per diem rate. The frequency, duration, and location of the visits must be a part of the child's individual case plan developed by the facility prior to the visitation. An approved visitation plan must be documented in the child's official record at the facility.

If a resident is absent from the facility for a short time due to circumstances needing the residents' immediate attention (deaths, weddings, personal business), or the resident leaves the facility without permission, the facility can be reimbursed for up to five days per year at the contracted per diem rate unless the resident's placement is terminated sooner by the resident's guardian in conjunction with the PRTF.

Discharge Planning:

Discharge planning for the resident shall begin as soon as possible upon admission to the PRTF. This process should include the CMHC staff where the youth will be discharging to if determined, the treatment team and other facility staff, and the resident and their legal guardian when possible. The CMHC and the legal guardian should remain in contact with the facility treatment team to assist in any transitional discharge planning. Discharge criteria will be established when writing the treatment plan..

Prior to discharge the PRTF shall submit documents related to the resident's care in Their facility to any mental health providers who will be providing aftercare. The key components on this document shall include:

- Medical needs including allergies
- Medication; dosage; reason for medication; prescriber
- Discharge diagnosis
- Prevention plan to address symptoms of harm to self/others
- Any other essential recommendations
- Appointments with after discharge service providers-date, time, place
- Contact information for internal providers
- Contact information for CMHC/PRTF Liaisons
- CMHC crisis line number
- Education contact number from PRTF.

For any resident receiving or who has received psychotropic medication during their PRTF stay the clinical rationale for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge will also be clearly stated on the discharge summary. Residents on psychotropic medications must leave the facility with a prescription written for at least a 30-day supply of medication. The resident should also leave the facility with a minimum of three-day's worth of prescription medication when applicable. The expectation is that the PRTF will receive notification 10 days before the child must leave the PRTF to ensure proper discharge planning. If the discharge must occur prior to a 10 day notification, it is the custodial case manager's responsibility to ensure proper persons are notified of the residents pending discharge, including discharge date and assisting with appointment setting in the community. The PRTF must ensure proper identification of individuals who pick up the resident upon discharge.

Emergency Exception Screen:

A resident can be admitted to a PRTF upon acceptance by the facility using the Emergency Exception Screen. The admission screen must be completed by the LMHP certifying need, within 48 hours of admission. The LMHP will certify that this is an exception screen and that the CBST plan has not yet been completed. The CBST will convene within 7 days of admission and determine if the resident needs can be met by the PRTF or should they be diverted to community based services. If the certification determines that the resident's needs can best be served in the community, then the resident must be moved from the PRTF. The placing agency will be responsible for payment after such determination.

Appeal Procedures:

Certification/Recertification Appeal Procedure:

If the facility physician disagrees with the screening determination and believes the resident needs to be certified or recertified to receive PRTF services, the facility physician may request an appeal review in writing to the Consortium. To request an appeal review of an initial certification, contact the Consortium at 1-800-466-2222 within fifteen (15) working days from the date of the screening. A psychiatrist will conduct an appeal review within two working days of the request pending receipt of appropriate documentation. To request an appeal review of a recertification, contact the Consortium at 1-800-466-2222 within five (5) working days from the date of rescreening. A psychiatrist will conduct an appeal review within two working days of the request pending receipt of appropriate documentation.

Screening decisions will be provided to the beneficiary or legal guardian in writing, and will include a notice concerning the right to a fair hearing. Beneficiary or legal guardian has the right to a fair hearing process, and must make a written request, received within 30 days from the date of the notice of action. An additional (3) days shall be allowed if the notice is mailed.

The Consortium shall assume responsibility for presenting their case in the fair hearing process and will provide to the beneficiary and the legal guardian copies of the pre-admission screening case records to be utilized in the fair hearing process. SRS reserves the right to conduct an administrative review of all fair hearings.

Changing of Standards:

The services described in the manual are funded by federal and state dollars. Rules and regulations governing the programs are subject to change. From time to time it will be necessary for the state to revise rules and regulations and eligibility requirements in accordance with statutory provisions when such changes are necessitated by budgetary limitations or other circumstances. When changing of standards, SRS will elicit feed back from identified internal and external stakeholders.

Unconditional Release from a Psychiatric Residential Treatment Facility

An individual who is under age 22 and has been receiving inpatient psychiatric services in a Psychiatric Residential Treatment Facility (PRTF) is considered to be a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

An unconditional release will only occur under the following conditions:

- 1) PRTF Goals met/achieved, youth discharged successfully from PRTF.
- 2) PRTF Goals not met/achieved, youth transferred to other IMD (other PRTF or State Psychiatric Hospital)
- 3) PRTF Goals not met/achieved, family/youth or guardian choice to discontinue services.
- 4) Youth placed in a correctional facility or removed from treatment and placed for longer than 72 hours while awaiting a court hearing.
- 5) Youth runs away from the facility and is gone for 7 consecutive calendar days with the facility having no knowledge of when the youth may return.
- 6) The youth is receiving inpatient medical treatment in a hospital.
- 7) The youth has died.

Measurable outcomes:

All Psychiatric Residential Treatment Facility providers must meet the outcome standards, and be in compliance with data collection, and reporting; as stated by Social and Rehabilitative Services of Kansas, Division of Health Care Policy Mental Health.

Additional requirements:

- A. Prior to enrollment with the Kansas Medical Assistance Program (KMAP) as a PRTF to receive Medicaid reimbursement, each PRTF must be licensed by KDHE and have a provider agreement with SRS and/ or JJA. Providers may hold a provider agreement with either SRS or JJA if they plan to only serve one population. If PRTF's intend to serve both populations they will need to hold a provider agreement with both SRS and JJA.
- B. A psychiatric residential treatment facility must meet the requirements of the standards of state certification and licensure, to include substance abuse licensure if providing those services, and national accreditation by the Joint Commission on Accreditation healthcare Organizations (JACHO), the Counsel on Accreditation of Services for Family and Children (COA), The Commission on Accreditation or Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the state
- C. One or more employees of the SRS/JJA/KDHE may be assigned to provide technical assistance to the PRTF or to assist the PRTF in developing a performance improvement program or other similar responsibilities. Each PRTF shall cooperate with those agencies efforts and with that agencies monitoring of the FRTF ongoing compliance with the requirements of these standards. This cooperation shall include providing that agency with reasonable access to all of the facilities and administrative records of the licensee and to all clinical records and treatment or service activities of the PRTF.

ATTACHMENT A
Kansas State Medicaid Plan Definition
Of a Psychiatric Residential Treatment Facility (PRTF)

These programs are intended to provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, substance abuse diagnosis, and/or a mental health diagnosis with a co-occurring disorder (i.e. substance related disorders, mental retardation/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues). Such services are provided in consideration of a child's developmental stage.

Services must be provided in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the recipient's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR 441.154 - 441.156.

Recipients of these services must be assessed by a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility, utilizing an assessment consistent with state law, regulation and policy. Utilizing this assessment a Community Based Services Team (CBST) which complies with the requirement of 42 CFR 441.153 must certify in writing the medical necessity of this level of care in accordance with the criteria and requirements outlined in 42 CFR 441.152. In addition, the need for this level of care will be evidenced by:

- a substantial risk of harm to self or others, or a child who is so unable to care for his or her own physical health and safety as to create a danger to their life; and
- the services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed; and
- all other ambulatory care resources available in the community have been identified and if not accessed determined to not meet the immediate treatment needs of the youth.

After admission, a Licensed Mental Health Practitioner (LMHP) or physician who is independent of the treating facility must re-certify in writing the need for this continued level of care on a regularly scheduled basis as defined by state law, regulation, and/or policy.

Services furnished in a psychiatric residential treatment facility must satisfy all requirements in subpart G of 42 CFR 483 governing the use of restraint and seclusion.

Provider Qualifications:

Providers of Inpatient Psychiatric Services for Individuals under the age of 21 must meet all general requirements for participation as specified in 42 CFR 441.151.

Additionally, a psychiatric residential treatment facility must meet the requirements and standards of state certification and licensure, and national accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for

Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

Services must be under the direction of a physician and all staff must meet applicable licensure and certification requirements and adhere to scope of practice definitions of state licensure boards.

Limitations:

An individual under age 22 who has been receiving this service is considered a resident of the PRTF until he is unconditionally released or, if earlier, the date he reaches age 22.

Reserve days, for periods of absence from a PRTF, will be reimbursed to providers with prior approval.

ATTACHMENT B
**Psychiatric Residential Treatment:
Grievance Process**

Whenever a resident/family, legal guardian or other involved party has concerns or disagreements about psychiatric residential treatment or related issues, follow these steps in sequence:

- 1. Initiate open discussion with the concerned parties closest to the problem, attempting to find resolution. This includes taking the concerns to a supervisory level if needed to attempt resolution.**

If the concerns are not resolved satisfactorily or if it is the resident's / family's preference at any point in the process:

- 2. Contact the assigned SRS – Mental Health Field Representative. A listing of contact information for the MH Field Staff can be found at:
<http://www.srskansas.org/hcp/MHSIP/QEStaffListing.htm>**

If the concerns are not resolved satisfactorily or if it is the resident's / family's preference at any point in the process:

- 3. Contact central office SRS-Mental Health at 785-296-7272, ask for the MH Outcomes Manager.**

Or by contacting:

Department of Social and Rehabilitation Services
Division of Health Care Policy – Mental Health
Docking State Office Bldg., 10th Fl. North
Topeka, KS 66612

- a. Once information from all parties is gathered, the MH Outcomes Manager will assist in problem resolution through collaboration with state agency representatives and community partners as needed. Options will be identified and considered.*
 - b. The identified parties will engage in problem resolution and/or policy development and /or prevention planning for the future.*
 - c. Any issues requiring decision making from SRS management will be provided to the SRS-Director of Mental Health who will assist or refer to SRS Leadership as needed.*
- 4. If the resident / family wishes to appeal a decision or request a fair hearing, they should submit a request for an appeal within 30 days of the notice to:**

**The Kansas Department of Administration
Office of Administrative Hearings,
1020 S. Kansas Avenue,
Topeka, KS 66612**

RIGHT TO REQUEST A FAIR HEARING:

You have the right to ask for a fair hearing if you do not agree with the State Department of Social and Rehabilitation Services (SRS) or the State Department of Administration (KDA) decision made regarding your case. At the hearing, you can explain why you do not agree. A household member, lawyer, friend, relative, advocate, or any other person you want may speak for you at the hearing. For medical assistance, you have the right to a hearing if your request has been received before the date the decision becomes effective. Your medical assistance may continue at the current level while a hearing is being made. Any benefits you receive while waiting on the decision may be recovered if the decision is not in your favor. If you are dissatisfied with a fair hearing decision, you may request further review of the decision.

To request a fair hearing, you must file a written request with the Office of Administrative Hearings, 1020 S. Kansas Avenue, Topeka, KS 66612 within 30 days of the written notice. If the notice of denial was mailed to you, K.S.A. 77-531 allows you an additional three days to file a Fair Hearing request.

CIVIL RIGHTS PROVISION:

No person shall, on basis of age, race, color, sex, handicap, religious creed, national origin, or political belief, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity of the State Department of Social and Rehabilitation Services or the State Department of Administration. If you feel that you have been discriminated against you may file a complaint in writing to SRS or KDA, to the State of Kansas Human Right Commission Landon State Office Bldg., 900 SW Jackson Street, Suite 568 South Topeka, Kansas 66612-1258, or to the United States Commission on Civil Rights, Central Regional Office, Suite 908, 400 State Avenue, Kansas City, Kansas 66101