



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C 17-28-PRTF

DATE: May 19, 2017

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs)

Memorandum Summary

- During the recent PRTF training courses many questions were received from attendees regarding survey expectations in applying the PRTF Condition of Participation (CoP) and regulatory requirements.
- **PRTF FAQs:** Attached is a list of the questions we received and our responses which are provided to support surveyor consistency nationwide.

Background

The PRTF FAQ document was compiled from questions which were submitted by the State Agency or Regional Office surveyors either during or after PRTF basic surveyor training classes. The aim of this FAQ is to promote national consistency in the application of the PRTF requirements; assist in surveyor understanding of the PRTF program nuances; and to clarify any misunderstanding that may have occurred as the result of class presentations. This FAQ is not intended to replace or supersede the Centers for Medicare & Medicaid Services (CMS) PRTF related policies or regulations.

Contact: For questions about this memorandum or the FAQ list contact Peter Ajuonuma peter.ajuonuma@cms.hhs.gov or Donald Howard donald.howard@cms.hhs.gov.

Effective Date: Immediately. This document should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment- PRTF Frequently Asked Questions

cc: Survey and Certification Regional Office Management



2017

Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQ)

**Division of Continuing Care Providers
Centers for Medicare and Medicaid Services (CMS)**

Psychiatric Residential Treatment Facilities (PRTF) FAQ

General Topics

1. Question: How often should a PRTF attestation statement be done?

Answer: Per section § 483.374(a) (1), a facility enrolling as a Medicaid provider must meet the attestation requirement at the time it executes a provider agreement with the Medicaid agency. No further attestation is required.

2. Question: Since statutory definitions of adulthood differ from State to State, for those States where the adult age starts at age 18, may individuals who are above 18 years receive services in a PRTF? Can the State limit the age for PRTF treatment, or do all children have benefits until age 21?

Answer: Yes. The age limit imposed by the regulation for the PRTF benefit is 21 years of age. Refer to § 441.151(a) (3).

3. Question: What is the average length of stay or maximum treatment period for PRTF residents?

Answer: There are no available data on average length of stay. PRTF regulations do not specify any length of stay limitation.

4. Question: Some timeframes within the PRTF regulation are "immediately" or "as soon as possible." What is the expected or acceptable time limit estimation of these time frames?

Answer: The term "immediately" as associated with medical treatment for injury is defined as *without any delay*. The PRTF develops and follows policies for the length of time for co-signing a verbal order for restraint or seclusion. This time frame should be consistent with current standards of practice and/or State law which is generally between 48-72 hours.

5. Question: What is the youngest age a child can utilize a PRTF services? Do all States have the same entry/age regulation?

Answer: The regulations do not specify a minimum age limit for PRTF treatment. The maximum age is 21 years. Refer to § 441.151(a)(3).

6. Question: Must PRTF residents be discharged when they reach age 22, even if they still require psychiatric services? Should there be provisions for referrals to adult services otherwise?

Answer: A resident may receive PRTF services past age 21 years, if the need for the services is indicated and appropriately justified. However, the resident must be discharged to an adult psychiatric facility before their 22nd birthday. PRTFs should not admit any resident after the age of 21 years. Refer to § 441.151(a)(3).

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7. Question: Does the contact information for the protection and advocacy agency have to be posted in the facility or just be in the written policy for review upon admission?

Answer: The contact information for the State's Advocacy and Protection agency does not have to be posted on the unit. The facility must provide the contact information upon admission to the resident and/or resident's representative. Refer to § 483.356(d).

8. Question: Is there any requirement that serious occurrence and incident reports must be made part of the resident's medical records?

Answer: Staff must document, in the resident's record, all serious occurrences including injuries that occur as a result of an emergency safety intervention. Staff must also document in the resident's record that the serious occurrence was reported to both the State Medicaid Agency (SMA) and the State designated Protection and Advocacy agency. The report to the Protection and Advocacy agency must include the name of resident; description of the occurrence; name and street address and telephone number of the facility. A copy of the report must be maintained in the resident's record. However if a facility uses a Quality Assurance (QA) tool for internal evaluation of the incident, there is no requirement that the QA tool has to be in the resident's record. Refer to §§ 483.372(c) & 483.374(b).

9. Question: Are PRTFs required to document all occurrences of time-out interventions?

Answer: All time-out interventions must be monitored and documented, to describe how the resident responds to behavior management intervention, and how he/she interacts within the milieu. Refer to § 483.368(c) and the Interpretive Guideline.

10. Question: Please clarify the distinctions between the roles and responsibilities of Medicare and Medicaid agencies.

Answer: Medicaid is a joint State and federal program that provides health coverage to low income individuals and families. Medicaid health benefits can vary from State to State depending on which services are included in the State Plan. Medicaid eligibility criteria can also vary from State to State. The SMA oversees the administration of PRTF services to Medicaid beneficiaries. State Survey Agencies (SA) perform surveys of PRTFs on behalf of the SMA. See SOM section 2832E.1.

Medicare is a federally administered program for the aged and disabled.

11. Question: Is it appropriate for a facility to be a PRTF if the sole purpose is for Substance Abuse Treatment? Also can there be adults on the physical unit that houses youth who are receiving PRTF services or does the entire unit have to be for the youth?

Answer: Substance abuse is considered a psychiatric diagnosis. There is no prohibition against a PRTF serving only substance abuse residents.

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All residents on a PRTF unit should be 21 years or younger, and there is no regulation that requires separation of the population by age category. Refer to § 441.151(a).

12. Question: Are PRTF's in each State supposed to be uniform in treatment?

Answer: All certified PRTFs are subject to the same regulatory requirements. Although, they may provide a variety of services based on their unique resident population needs or State laws.

13. Question: When a State does not provide PRTF services and refers one of its residents to another State to receive PRTF service, is it the resident's home State or the State where that person is receiving services that would be responsible for payment?

Answer: It is the SMA of the resident's state of residence that is responsible for reimbursing the out of state PRTF for the services the resident receives. See SOM section 2832E.1.

14. Question: Is PRTF coverage available for dual diagnoses, for instance when a resident has schizophrenia and intellectual disability?

Answer: Yes. The resident with an intellectual disability, who is under the age of 21 years, may receive services in the PRTF if they have a psychiatric diagnosis that requires PRTF placement.

Restraint and Seclusion

15. Question: Is there a time frame for face-to-face interaction of the physician and the resident regarding restraint?

Answer: The face-to-face assessment must be performed within one hour of initiating the restraint or seclusion intervention. If the ordering physician is not available to perform the assessment, any available licensed healthcare provider may complete the face-to-face assessment. Refer to § 483.358(f).

16. Question: If the resident has the right to be free from restraint or seclusion does that mean you could never use restraint or seclusion even as last resort.

Answer: The regulation at § 483.356(a)(1) provides that each resident has the right to be free from restraint or seclusion, or any form, used as a means of coercion, discipline, convenience, or retaliation. The regulation does not prohibit the use of restraint or seclusion, but does restrict any form of the intervention that is used as a punishment. The intent of this regulation is to ensure that restraint or seclusion is used as an intervention of last resort, to protect the residents in emergency safety situations.

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17. Question: Are there Special Review Committees for review of the use of psychotropic medication as restraints in PRTFs, like there are in Intermediate Care facilities for Individual with Intellectual Disabilities (ICF/IID)?

Answer: There is no requirement in the PRTF CoP for a special review committee for use of psychotropic medications.

18. Question: Tell us about enclosure beds in regards to use of restraint/seclusion.

Answer: While there is no PRTF regulation which specifically prohibits the use of an enclosed bed as a restraint, due to the high activity level and diagnostic characteristics of PRTF residents, using an enclosed bed in a PRTF is a safety risk that can result in injury to both staff and residents.

19. Question: Must the door to an enclosure be locked in order to consider an intervention as seclusion?

Answer: Seclusion is defined as an involuntary confinement of a resident alone in a room, or an area, from which the resident is physically prevented from leaving. A locked door is not the only measure that makes an intervention seclusion. Refer to SOM section 2830B.

20. Question: If the spit guards are considered restraints, then can spit guards and a restraint chair be used together?

Answer: A "spit guard" is not considered a restraint but as personal protection equipment used for infection prevention. Therefore, a spit guard and restraint chair could be used at the same time. Refer to § 483.356(a)(4).

21. Question: Any weight limits on a restraint chair?

Answer: All restraint equipment, including a restraint chair, must be appropriate for the size and weight of the resident.

22. Question: It is my experience that staff will use an intervention but call it something else like "zoning." Is zoning to the quiet room where a resident cannot come out considered as seclusion?

Answer: Any time a resident is confined to an area alone and prevented from exiting it is seclusion.

23. Question: Given the statement that a resident has the right to be free from restraint or seclusion, would this mean that the use restraint or seclusion violates the resident's right?

Answer: The regulation at § 483.356(a)(1) provides that 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. The regulation does not prohibit the use of restraint or seclusion, as an intervention

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of last resort, to protect the residents in an emergency safety situation.

24. Question: Is post restraint assessment the same thing as a face-to-face assessment?

Answer: The face-to-face assessment occurs within one hour of initiation of restraint or seclusion. It must occur, even if the resident is still in restraint or seclusion. Refer to § 483.358(f). A Post restraint or seclusion assessment occurs after the end of the intervention. It includes a comprehensive assessment of the resident's physical and psychological well-being, as well as any injury assessment that resulted from the restraint or seclusion intervention. Refer to § 483.362(c).

25. Question: Since PRTF tags N0188 and N0189 require that two separate post-intervention debriefings be completed; can these debriefings be combined or completed simultaneously?

Answer: The debriefings in N0188 and N0189 cannot be combined. The post intervention debriefing referenced in N0188 is the initial post intervention debriefing when staff who participated in the intervention meet with the resident or resident's representative to re-evaluate the intervention to see what improvement can be effected in the future. Refer to § 483.370(a). N0189 refers to the system evaluation debriefing where the management meets with staff to evaluate the intervention for the purpose of improving the system and education of the staff. Refer to § 483.370(b).

26. Question: If the licensed professional has an hour to do the face-to-face assessment, what happens when the seclusion ends early (and the resident is calm), before the hour is up. Then no assessment is done or documented?

Answer: Even if the restraint or seclusion lasts for only five minutes, the licensed healthcare provider, who gave the Emergency Safety Intervention (ESI) order, or another healthcare provider who is licensed in the State, must perform the face-to-face within one hour of initiation of the intervention. Refer to § 483.358(f).

27. Question: What is a time out? What are the benefits of using a time out in behavior management?

Answer: Time out means the removal of a resident from stimuli for a period of time to a designated area from which the resident is not physically prevented from leaving. This procedure is used for the purpose of providing the resident an opportunity to regain self-control. Time out is a less restrictive behavior management intervention that helps in decreasing agitating stimuli, and assists in de-escalation of disruptive behavior, without the use of restraint or seclusion. Refer to §483.352.

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28. Question: When a resident voluntarily takes a timeout in the seclusion room, is it considered seclusion?

Answer: A voluntary timeout is not considered seclusion. Refer to § 483.368(a).

29. Question: Is the facility required to monitor a resident during a voluntary time out?

Answer: Yes, a resident may request a voluntary time out and if it is granted, the staff must monitor the resident while he/she is in time out. Refer to § 483.368(c).

30. Question: Does a resident have to voluntarily go to time out? Can staff assistance or coercion be used to get a resident into a time out?

Answer: There is no requirement that a resident voluntarily go to time out. Staff should first suggest or encourage a resident to take a time out away from agitating stimuli. If this is unsuccessful, the resident may be compelled to take the time out and taken away from the stimuli involuntarily. If placed into an area from which the resident cannot exit voluntarily it would be considered seclusion.

31. Question: Must a facility have a designated room where residents take time out?

Answer: No. Time out may occur in any location of the facility where the agitating stimuli is reduced, such as the resident's room or a separate area of the activity room. Refer to § 483.368(b). The goal of a time out is to decrease stimuli and prevent further escalation of anxiety, agitation, or disruptive behavior.

32. Question: Can a facility have a policy that they will not use restraints and seclusions interventions?

Answer: No. A PRTF facility must establish a policy for the use of restraint and seclusion. It is not likely that a facility will be able avoid the use of all restraint or seclusion. Therefore it is critical that a policy for safe use be in place and that staff are familiar with and trained on the policies.

33. Question: Does restraint include chemical restraint?

Answer: Yes. The use of medication may be considered a chemical restraint when it is not a standard treatment for the resident's medical or psychiatric condition and is administered to manage a resident's behavior with the temporary effect of restricting the resident's freedom of movement. Refer to §483.352.

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34. Question: If a patient is given an intramuscular Ativan for agitation, which was ordered to be given as needed (PRN) on his/her medication administration record, can it be considered as a chemical restraint?

Answer: When a medication is given in response to a resident's aggressive behavior, in order to restrict the resident's movement or prevent the resident from acting out violently, then it would be a chemical restraint. Refer to §483.352.

35. Question: Are frequency of assessments during seclusion or restraints determined by facility policies or is there an established time?

Answer: Clinical staff, trained in the use of emergency safety intervention, must continually assess, monitor, and evaluate the physical and psychological well-being of the resident in restraint or seclusion. Although the PRTF regulations do not stipulate the exact time interval for assessments, the Interpretive Guideline defines "continually assessing" as observing, measuring and evaluating at all times and documenting ongoing assessment of the behavior and physical status of the resident by the staff. The PRTF staff must be physically present throughout the duration of the restraint or seclusion. Refer to the Interpretive Guidelines at §483.362(a) and §483.364(a).

36. Question: Can a PRTF meet the requirement for continuous monitoring by using only a video monitoring device, to monitor a resident in restraint or seclusion, from a remote location?

Answer: No. Video monitoring does not meet the requirement for continuous monitoring during restraint or seclusion intervention. Per the regulation, clinical staff trained in the use of emergency safety intervention, must be physically present or immediately outside the seclusion room, and must be continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Refer to §§ 483.362(a) and 483.364(a)

37. Question: If medication is considered a restraint, is the patient going to need to be monitored?

Answer: Yes. Every resident must be continuously monitored during any form of restraint or seclusion intervention. Refer to §483.362(a) and §483.364(a).

38. Question: If a verbal order for restraint or seclusion is not signed by the ordering physician. Do we cite the facility for deficiency under tag N0143?

Answer: Yes. Refer to §483.358(d).

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39. Question: Under what situation can the use of as needed (PRN) medication be regarded as chemical restraint?

Answer: PRN medications are pre-ordered for the treatment of a resident's psychiatric condition. When a medication is ordered PRN as a part of the routine medication regimen to help an agitated resident gain control of his/her behavior, it is not considered as a chemical restraint. However, any one-time order received for the administration of a psychotropic medication, above the normal dosage the patient usually receives, in response to a behavioral incident, would be considered a chemical restraint. Refer to §483.352.

40. Question: If a resident is self-injurious in seclusion, shouldn't seclusion cease?

Answer: Yes.

41. Question: Do orders for restraint or seclusion have to come before the emergency situation?

Answer: An order for restraint or seclusion may be given during or immediately after the emergency safety situation arises. An order for restraint or seclusion may not be given in advance as a routine or as a PRN order in anticipation of an emergency situation.

42. Question: Must the physician order for restraint or seclusion show the time the intervention started or time the order was given?

Answer: The physician order for restraint or seclusion must include the date and time the order was given. The physician should include in the order the duration approved including the actual time the intervention was initiated. The Refer to §483.358(g)(2).

43. Question: Is there a timeframe the order for restraint or seclusion must be obtained?

Answer: An order for restraint or seclusion must be received during or immediately after an emergency safety intervention is initiated. Refer to §483.358(e).

44. Question: If staff stands in front of an open door to physically prevent the resident from coming out of the room, does that constitute seclusion?

Answer: Yes. Preventing a resident from exiting the area at will is considered seclusion if the resident is alone in the room.

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45. Question: When a registered nurse uses a form to document restraint or seclusion intervention according to facility documentation policy, is it okay if there is no documentation on a progress note?

Answer: Documentation on a separate form which contains all necessary assessment and intervention details is acceptable as long as the documentation is ultimately made part of the resident's record.

46. Question: When a resident voluntarily takes a time out in an unlocked seclusion room after receiving as-needed (PRN) medication for agitation, does it count as simultaneous use of chemical restraint and seclusion?

Answer: This scenario is neither seclusion nor a restraint. The PRN medication the resident received was ordered by his/her physician in advance for symptoms of agitation. Used in this manner the medication is intended to assist the resident to regain control rather than as a chemical restraint. If the resident was prevented from leaving the seclusion room at will, however, it would be considered seclusion.

47. Question: Can we consider seclusion room walls that feel like rough sand paper as an environmental safety hazard?

Answer: No. There is no indication that a rough wall can pose an extraordinary safety risk to PRTF residents.

48. Question: What is the time frame limitation for the use of a time-out intervention?

Answer: The regulation does not set a time limit for the use of time-out. However, the individual facility should have a written policy to address the time limit for time-out.

49. Question: What is the difference between a mechanical restraint and a personal restraint?

Answer: Mechanical restraint means any device attached or adjacent to the resident's body, that he/she cannot easily remove, which restricts his/her freedom of movement or normal access to his/her body. A personal restraint means an application of physical force without the use of any device, for the purpose of restraining the free movement of the resident's body.

50. Question: Facilities often utilize a fill-in form for documenting restraint or seclusion intervention. Should we cite the facility for deficient documentation if the form does not reflect adequate documentation? For instance, when the debriefing form does not contain the names of staff that participated in the emergency safety intervention?

Answer: As long as the information required during a restraint or seclusion incident is contained within the medical record, there is no requirement as to what information must appear on what

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forms. If the documentation is not sufficient, the facility may receive a citation at §483.370(c), tag N0193.

51. Question: Under what circumstances should a surveyor cite a PRTF for resident abuse due to lack of evidence of less restrictive interventions being used prior to initiation of restraint/seclusion intervention? Under what tag can this deficiency be cited?

Answer: It would be expected that staff are trained to use the least restrictive intervention consistent with the individual treatment plan. However, there could be situations where immediate and more restrictive interventions are necessary to protect resident safety. This would not be considered resident abuse if the situation required a more restrictive intervention immediately. Instances where the staff automatically use the highest level of intervention for the purpose of retaliation, coercion, punishment or convenience would be considered resident abuse. Refer to §483.376(a).

Treatment Team and Resident's Plan of Care

52. Question: Does the treatment plan need to be updated once an ESI occurs, and how soon should it be updated?

Answer: The treatment plan does not have to be updated after each ESI. The treatment plan should be reviewed and updated at least every 30 day by the treatment team. Refer to §441.155(c).

53. Question: Would a resident with acute psychosis and suicidal ideation be appropriate for PRTF admission?

Answer: The level of acuity and the condition of the residents admitted to a particular PRTF is determined by the structure and resources of the particular facility. While some facilities are equipped to treat acute psychiatric exacerbation, others may admit residents only after they have been stabilized.

54. Question: Who certifies the resident's need for PRTF treatment?

Answer: The treatment team will complete the PRTF certification of need for services. The team must include at a minimum: a psychiatrist; a psychologist; and a physician. The team must also include one of the professionals listed in §441.156(d).

55. Question: Where would you cite deficiency, if a resident's active treatment plan does not address the resident's medical problems such as asthma or seizure disorder?

Answer: Any deficiencies related to the treatment plan content should be cited at §441.155 (tags N0108-N0113).

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56. Question: Is the parent/guardian participation in care planning.?

Answer: The participation of parents/legal guardians/representatives in treatment planning is required for minors (as defined per State Law) and those clients that have legal guardians. Refer to §441.155(b)(2).

Medical Treatment for Residents

57. Question: What does EPSDT stand for, and what does it include? Who performs the EPSDT screening?

Answer: The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. The screening is done by various Medicaid providers.

58. Question: Does each State use the EPSDT? If so would that screening be in the resident record?

Answer: EPSDT is a part of each state Medicaid plan. The PRTF survey process does not include a review of EPSDT documentation.

59. Question: What constitutes serious injury from restraint/seclusion?

Answer: A serious injury is defined in the PRTF regulations as any significant impairment of the physical condition of the resident as determined by qualified medical personnel. Serious injury may include, but is not limited to: burns; laceration; bone fractures; substantial hematoma; and injuries of internal organ. Refer to 42 CFR §483.352.

60. Question: In the event of an emergency, you will have EMS transport to the nearest emergency hospital and agreements aren't something necessary for acute care treatment based in today's world especially in urban/suburban areas. Are you really referring to hospitals with mental health emergency services as that is very different?

Answer: The PRTF must show evidence of affiliation or a written agreement with one or more hospitals for the admission of their residents for acute medical or psychiatric care. In the case of a medical or psychiatric emergency, the EMS transport will follow its own policies regarding which hospital to which the resident will be transported. Refer to §483.372(b).

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61. Question: Regarding the requirement for a PRTF to have a written transfer agreement with a hospital, can we assume that as long as a PRTF can reasonably affiliate with an acute care hospital in the area, a written agreement is not necessary?

Answer: Affiliation means the PRTF is a part of the formal organizational structure of a hospital which can be substantiated by hospital organizational charts. Absent this affiliation a written agreement would be required.

62. Question: Can a physician admitting privilege with a psychiatric hospital or acute care hospital meet the requirement for the PRTF transfer agreement with a hospital?

Answer: No. The admitting privilege of an individual physician cannot substitute for the requirement for a transfer agreement with a hospital or acute care facility.

Facility Notification and Reporting

63. Question: Is there a specific time frame for notifying parents or legal guardians of the use of restraint or seclusion intervention, other than as soon as possible?

Answer: The regulation requires that the parents or legal representatives be informed as soon as possible. Facilities may specify time limits for this notification in their restraint and seclusion policy document. However, in most cases, the requirement for “as soon as possible” is generally construed to mean the next business day or not more than 48 hours. Refer to §483.366.

64. Question: What is the Regional Office (R.O.) supposed to do with the death reports?

Answer: The CMS RO reviews the circumstances of all deaths reported and communicates with the applicable State Survey Agency regarding their recommendation for any investigation.

65. Question: Can a parent/guardian "opt out" of notification of restraint when the resident is admitted?

Answer: The parent or guardian may not opt out of the post ESI notification requirement.

Staffing, Education and Training

66. Question: Does “licensed provider” also include a licensed Social worker?

Answer: The PRTF regulations refer to licensed practitioners who are permitted by the State to order restraint and seclusion or to evaluate the resident’s wellbeing post restraint and/or seclusion. Social workers are not usually included in these State permissions as they do not have

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the medical expertise to do the evaluations and are not usually allowed to order treatments or medications.

67. Question: Does the requirement for annual Cardiopulmonary Resuscitation (CPR) competency validation require a hands on return demonstration under PRTF regulatory requirement?

Answer: Yes. Staff must demonstrate competency in the use of CPR on an annual basis. Certification in the use of CPR, including periodic recertification, is required. Refer to §483.376.

68. Question: How many employee records need to be reviewed for education and training?

Answer: A sample of up to 25 percent but not less than ten staff should be reviewed, and should include all categories of staff.

69. Question: May a licensed social worker receive a verbal doctor's order for medication or emergency safety intervention?

Answer: No. Verbal orders for medication, restraint or seclusion must be received and transcribed by licensed nurses. The level of nursing staff certification and training required to receive the verbal order may differ by State law. Refer to § 483.358(d).

70. Question: Who are the Licensed Independent Practitioners (LIPs)?

Answer: LIPs are individuals, other than physicians, who are licensed to treat patients. They include clinical psychologists, nurse practitioners, physician assistants, and clinical social workers. The responsibilities and scope of practice for each individual LIP may vary from State to State, based on individual Practice Acts or State laws.

71. Question: Can a physician assistant or an advanced practice RN do the face-to-face?

Answer: Yes. Depending on what the State law allows. LIPs, including advanced practice registered nurses, can perform face-to-face assessments.

72. Question: If multiple staff are involved in the emergency safety intervention, must all the staff participate in debriefing?

Answer: As much as possible, all staff who participated in the intervention should be involved in debriefing. If a staff member is excused, it must be documented why the staff member was excused.

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73. Question: Is this annual requirement for CPR training related to CPR certification or just the competency demonstration? Currently CPR certifications are for 2 year.

Answer: The PRTF regulations require an annual validation of CPR skills and bi-annual competency validation for emergency safety intervention skills for all direct care staff. This means that the facility must show evidence of validating its staff CPR competency on an annual basis. This does not mean that staff need to renew their CPR certification every year.

74. Question: Regarding the requirement for the PRTF CoP, is there any requirement that the facility must have RN coverage on each unit at all times?

Answer: The regulation does not specify RN staffing at all times for each unit and there is no requirement for a particular number of nursing staff on each facility or unit. However, the PRTF must ensure there is sufficient RNs coverage to perform RN duties, such as nursing assessment during emergency safety intervention, and treatment for injuries.

75. Question: For the purpose of meeting the CoP requirement for physician services, can a PRTF use telemedicine to meet its psychiatrist or physician coverage need?

Answer: Telemedicine may not be used for a face-to-face assessment.

76. Question: If a staff member initiates an ESI and then goes on vacation, can the staff be exempted from participating during the debriefing?

Answer: A staff may be excused from the ESI debriefing if circumstances make it impossible for the staff to participate. Such an excuse must be documented on the debriefing document. See answer on 72 above.

77. Question: Do Physicians and other LIPs need CPR certification?

Answer: Yes. All direct care staff including all clinicians must have basic CPR certification. Higher cardio pulmonary certification, such as advanced cardiac life support or advanced cardiovascular life support (ACLS) may fulfill the CPR requirement.

Survey Process

78. Question: As a surveyor, am I required to sit in on or observe a post-intervention debriefing?

Answer: A surveyor is not required to directly observe a post intervention debriefing. Surveyors review the resident records to ensure that the intervention was safe and appropriately performed. However, if the surveyor is invited by the facility to observe post intervention debriefing, they may observe.

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79. Question: Is there any guidance on how to conduct resident interviews?

Answer: The information on resident interviews is contained in the SOM at Section 2833C (4e), Task 5.

80. Question: During a revisit, does the surveyor look at twelve months records prior to the day of the survey or since the day of the last survey?

Answer: Since the last survey.

81. Question: What is the difference between a complaint survey of a PRTF and a complaint survey of other provider types?

Answer: There are no differences in complaint investigation procedures.

82. Question: When a State's Protection and Advocacy agency conducts an investigation on their own, what information can we share with them?

Answer: The State Survey Agency can share unredacted ASPEN Complaint Tracking System (ACTS) data and survey report forms with the State Protection and Advocacy Agency upon receipt of a request. The SA may not share any information regarding the upcoming survey schedule except in situations of joint survey activity.

83. Question: How often do PRTFs need to be surveyed?

Answer: PRTFs are to be surveyed a minimum of every five years.

84. Question: If we are to survey 20 percent of our PRTF facilities each year, and one closes, should we "pull" one from next year to meet the 20 percent for this year?

Answer: If a facility is not due for survey, it is not necessary to pull one forward to make up the 20 percent, unless the SA elects to do so. The maximum survey interval for PRTF is five years and as long as the intervals are maintained, it is not necessary to survey 20 percent of all PRTF surveys in a year.

85. Question: If a facility has a complaint survey, can the complaint survey take the place of every 5 years recertification survey?

Answer: If the complaint survey included a review of all the requirements it can count as a recertification survey. However, if the complaint survey is focused and did not review all requirements, it cannot be counted as a recertification survey.

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86. Question: There was mention that “the sample selected should also include the names of the facility's attending physician. Can you tell me where that is within the SOM Task 1 that requires the listing of a physician or is this particular to a specific State?

Answer: It is not a requirement that the sample include the name of the attending physician. The Basic PRTF Training course has been revised.

87. Question: If information is received after the exit date of a survey, but before deficiencies are written, will the exit date change depending on when the latest information was received.

Answer: No the exit date remains the same.

88. Question: Is there a different complaint survey process for PRTF?

Answer: The complaint investigation process for PRTF is the same as other provider types. See Chapter 5 of the SOM.

89. Question: Is there any recommendation for a better technique for documenting observations since it is sometimes challenging to remember the details of all the facts if one waits later to complete the documentation.

Answer: Sometimes it is difficult to document observation on the spot due to sensitivity of the population. While the best practice is not to take notes during the observation, it is permissible for the surveyor to make notes if necessary or indicated. There are no special techniques for unobtrusive note taking. Simply record the observations that you need to record.

90. Question: If a minor is a ward of the State, from whom should the surveyor obtain permission before interviewing the resident?

Answer: Residents who are wards of the State usually have court appointed legal guardians/representatives. However, surveyors do not have to obtain permission before interviewing a PRTF resident. The resident's admission and treatment consent covers the consent for survey, because the survey is an effort to validate the quality and effectiveness of the treatment the resident is receiving.

91. Question: If you cannot interview your assigned resident would you substitute another resident and then add them to the sample?

Answer: Yes.

92. Question: Should a surveyor review both State and federal regulations during the same survey?

Answer: The PRTF survey should be based on federal regulations.

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93. Question: Is the sample selection for a complaint survey the same as the sample selection for an initial survey or recertification?

Answer: The complaint investigation does not have to follow the survey sample size. Resident records other than the resident involved in the complaint should be selected with the initial emphasis on the resident associated with the complaint. Then expand the investigation if the complaint allegations are confirmed.

94. Question: How can a surveyor determine if the resident could have received services on an outpatient basis as opposed to admission to the PRTF?

Answer: The surveyor does not review eligibility for inpatient care. The surveyor would simply check to ensure that the certification of the need for services by the physician is in the record (42 CFR 441.152).

95. Question: Are there tags where a surveyor can cite for deficiencies of state specific regulations? If so, then wouldn't the surveyor be doing State survey functions instead?

Answer: There are no PRTF regulations for compliance with State and local laws. The surveyor surveys using federal regulations.

96. Question: Are surveyors required to check water temperature as part of environmental safety requirement?

Answer: There are no federal regulations covering water temperature with regard to PRTFs. If there are State licensure regulations for PRTFs this finding may be referred to the appropriate agency for follow-up.

97. Question: What tag would you cite if you identified an issue with the facility infection control or environmental sanitation or should the surveyor make a referral to the State licensing authority?

Answer: There are no infection control specific requirements under the PRTF requirements.

98. Question: Do the milieu and resident observation include observing how frequent staff exits the unit to take breaks?

Answer: No. The focus of the survey is adequate staff coverage and not monitoring staff break time unless the breaks are clearly impacting program outcomes or resident safety.

99. Question: Do Immediate Jeopardy requirement apply to PRTF? If yes, under what regulation or tag number can it be cited?

Answer: Immediate jeopardy (IJ) guidelines, under Appendix Q of the SOM, apply to all certified Medicare/Medicaid entities including PRTFs. The IJ is documented at the applicable

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regulation. IJs are most likely to occur in PRTFs at the CoP for restraint and seclusion (42 CFR 483.365 *General requirements for psychiatric residential treatment facilities.* `

100. Question: When a client appears to be excessively sedated would the surveyor investigate the possibility of chemical restraint or resident neglect?

Answer: Excessive sedation may be an indication of many medical and non-medical issues such as lack of sleep, diabetic hypoglycemia, or excessive medication. When the surveyor notices a resident that is extremely drowsy they should question the medical staff regarding the resident's condition. If the excessive drowsiness is from a non-routine medication administered for management of aggressive/disruptive behavior, this should be treated as and meet the requirements of a restraint according to the regulation.

For more information or clarification about PRTF survey and certification questions, contact:

Peter Ajuonuma, JD, MSHA, MBA, NE-BC, RN.

CMS, CCSQ/SCG/DCCP

Phone: (410) 786-3580

Peter.ajuonuma@cms.hhs.gov

OR

Donald Howard, MSW

CMS, CCSQ/SCG/DCCP

Phone: (410) 786-6764

Donald.howard@cms.hhs.gov