DRAFT Psychiatric Residential Treatment Facilities (PRTF) Certification Standards

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I. INTRODUCTION

The purpose of these Psychiatric Residential Treatment Facility (PRTF) Certification Standards is to outline the standards and requirements that must be met by any organization approved or seeking approval to be certified and enrolled as a Medicaid certified PRTF for beneficiaries under the age of twenty-one (21). Specific state and federal requirements for PRTFs are contained in the PRTF Certification Standards below. To become a Medicaid provider certified as a PRTF, the Facility must attest to meeting the PRTF Conditions of Participation (CoP) found within the Code of Federal Regulations (CFR) at 42 C.F.R. Part 483 Part G, and attest that all its residents meet the Certification of Need requirements contained in 42 C.F.R. Part 441, Subpart D: Inpatient Psychiatric Services for Individuals under Age 21 in Psychiatric Facilities or Programs.

A PRTF is certified to receive Medicaid reimbursement for the provision of comprehensive behavioral health treatment to residents who, due to mental illness or severe emotional disturbance, need active treatment that can only be provided in an inpatient hospital level of care psychiatric residential treatment Facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated.

Failure to comply with any certification, licensing, fiscal, or legal requirements may result in sanction for the Facility. The Executive Office of Health and Human Services EOHHS may request that a corrective action plan be submitted, and immediate action be taken to ameliorate deficiencies. Sanctions may include, but are not limited to, placing a hold on new admissions, or placing a license on probationary status, closure of an operational unit or reduction in the total number of beds, or suspension or revocation of certification or disenrollment from the Rhode Island Medicaid program.

II. FACILITY STANDARDS

Psychiatric Residential Treatment Facilities (“Facility” or “facilities”) shall meet all applicable State and federal requirements. All PRTF’s are subject to the additional certification requirements contained in these certification standards. In addition, all facilities are subject to federal regulations governing restraint and seclusion.

The Facility shall have a physical location in Rhode Island that is welcoming, safe, publicly accessible and complies with all Americans with Disabilities (ADA) guidelines.

Facilities shall provide the following attestations, documents and/or written policies and/or protocols:

Qualification Compliance

The Facility shall provide a list of all current and relevant organizational certifications, accreditations, licenses, and other regulatory compliance acknowledgements that indicate the expiration dates for any/all of these qualifications as well as a description of how the Facility plans for continued compliance with these qualifications.

The Facility shall maintain and comply with the terms of all licenses, permits and other governmental approvals necessary for the lawful provision of the services detailed in these certification standards. The Facility will notify DCYF and EOHHS promptly if any such license, permit, or other governmental approval is denied, revoked, suspended, or placed in any form of provisional status.

Notification Requirements

The Facility shall notify EOHHS, DCYF, the Rhode Island Department of Health (RIDOH) - as the State Survey Agency - and Disability Rights Rhode Island (DRRI) the State's Protection and Advocacy System within five (5) days with details pertaining to the following:

A. Changes to the ownership, control, or business address of the Facility, including, without limitation, any merger or consolidation to which the Facility is a party.
B. Any occurrence that could materially impair the ability of the Facility to carry out its duties and obligations set forth in these certification standards. Including, but not limited to, the arrest of an employee.
C. Any material litigation, administrative proceedings, or investigations in which the organization or any of its principals, partners, associates, sub-facilities, or support staff are currently involved.
D. Identify and address any conflicts of interest that may arise as a result of business activities or ventures by the organization or associates of the organization, employees, or sub-facilities as a result of any individual's status as a member of the board of directors of any organization likely to interact with EOHHS and/or DCYF..

The Facility shall notify EOHHS, DCYF, RIDOH and DRRI State Protection and Advocacy System promptly regarding any complaint, claim, suit, or criminal or administrative proceeding made or charged against the Facility regarding the services provided under this set of certification standards. For the purposes of this requirement, "promptly" will be defined as within the applicable Rhode Island statutory requirements, and if no applicable statutory requirement, then in no more than twenty-four (24) hours.

Compliance with State Laws and Federal Regulations

The Facility shall, always, comply with all applicable federal, state and local laws, ordinances, rules and regulations.

The facility shall attest in writing that it is following federal regulations pertaining to Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs (42 CFR Part 441 Subpart D). This attestation shall be signed by the Facility director.

The Facility shall attest in writing that it is following federal standards governing the use of restraint and seclusion (42 CFR 483.358). The attestation shall be signed by the Facility director.

On-Site Monitoring, Evaluation, and Inspection

The Facility agrees to permit on-site monitoring, evaluation, and inspection of all activities by officials of EOHHS, RIDOH (as the state survey agency), DCYF and DRRI as the State Protection and Advocacy System or designees of these agencies, and where appropriate, the federal government. On site monitoring and/or visits must take place at any time as it relates to compliance with certification, licensing, and fiscal requirements.

Self-Contained Campus

The physical structure of the Facility shall include a campus-based, residential Facility with a full, onsite accredited school that can deliver independent educational services, including special education services and supports, for all residents within an integrated treatment milieu on the campus. As part of the self-contained campus, the Facility shall have recreational space, such as a gym or other facilities, that can be used year-round. All residents shall have access to a full kitchen and food served seven (7) days a week.

Least Restrictive Environment

The Facility shall ensure that the physical site shall be a home-like environment that focuses on the needs and interests of the individual. The Facility shall provide the least restrictive environment that promotes independence and provides a safe, predictable, nurturing environment while assuring the residents' health and safety.

Condition of Physical Site

The Facility shall be updated and in a good living condition, and the physical site must meet all requisite RIDOH (as the State Survey Agency) and Medicaid standards. All buildings shall meet any and all applicable state and local building and zoning requirements.

Accreditation

The Facility shall provide the documentation that demonstrates compliance with the following federal accreditation requirement:

A. For facilities that are psychiatric hospitals, either a state survey determining if the hospital meets the requirements per federal regulations or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.
B. For facilities that are not a hospital, 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 Youth, or by any other accrediting organization with comparable standards that is recognized by the State.

Rate and Financial Reimbursement

The Facility shall comply with the cost-based payment methodology in the Rhode Island Medicaid Sate Plan, approved by CMS in the PRTF State Plan Amendment 21-0007.

The Facility shall submit to EOHHS and DCYF a copy of its most recent audited financial statements within nine (9) months of close of the facility's fiscal year. The annual financial audit must comply with Generally Accepted Accounting Principles (GAAP) and in accordance with Generally Accepting Auditing Standards (GAAS).

All non-profit PRTFs must annually send EOHHS and DCYF a copy of their most recently filed IRS Form 990 within nine (9) months of close of the facility's fiscal year.

The Facility shall fully cooperate with EOHHS in the annual development of the cost-based payment methodology and shall provide EOHHS access to all requested financial records. The facility further agrees to provide to EOHHS and DCYF any additional supporting financial and statistical information within ten (10) business days of EOHHS or DCYF request.

Service Provision Eligibility

The Facility shall ensure that services are provided only to residents who meet the following conditions:

A. Provided before the individual reaches age twenty-one (21); and
B. Certified in writing by the independent team under the direction of a physician to be the necessary level of care in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with Sec. 441.152.

Education

The Facility shall convene or initiate an educational meeting or, if the resident has been identified as having an educational disability, an Individual Educational Plan (IEP) team meeting within twenty-one (21) days of the resident's admission and provide notice to the DCYF caseworker, legal guardian, or education advocate, and to the local education agency (LEA).

The Facility shall ensure that all residents have access to extracurricular and social activities as required by state and federal law, including but not limited to the Preventing Sex Trafficking and Strengthening Families Act of 2014, McKinney-Vento Homeless Assistance Act, Individuals with Disabilities Education Act (IDEA), and in accordance with the school stability provisions of the Fostering Connections to Success and Increasing Adoptions Act of 2008 and the Every Student Succeeds Act of 2015 (ESSA).

The Facility shall make all efforts to maintain continuous involvement with the LEA and continuity with the sending LEA, high school portfolio and graduation credit requirements are necessary. The Facility will work with the LEA to develop a transition plan for all children with an IEP.

Use of Hardware Secure and Locked/Unlocked Status

The Facility shall describe and provide the related policy documents regarding:

A. Whether the Facility is locked or unlocked;
B. Whether the Facility is hardware secure or not hardware secure; and
C. A description of the rationale for being hardware secure or not hardware secure.

Certification of Need

The Facility shall ensure that for a resident who is a recipient of Medicaid when admitted to the Facility, the certification of need is made by an independent team that:

A. Includes a physician;
B. Has competence in diagnosis and treatment of mental illness, preferably in child/adolescent psychiatry; and
C. Has knowledge of the individual's situation and clinical needs.

The Facility shall ensure that for a resident who applies for Medicaid while in the Facility, the certification shall:

A. Be made by the independent team responsible for the plan of care as specified in 42 CFR § 441.156, and
B. Cover any period before the application for which claims are made.

The Facility shall ensure that for emergency admissions, the certification for admission:

A. Is made by the independent team responsible for the plan of care (Sec. 441.156)
B. is completed within fourteen (14) days after admission.

The Facility shall ensure that the independent team certifies that -

A. Ambulatory care resources available in the community do not meet the treatment needs of the referred Medicaid beneficiary.

B. Proper treatment of the referred Medicaid beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
C. 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.

The Facility shall ensure that certification and recertification of the need for inpatient care complies with the following:

A. A physician has certified for each applicant or recipient that inpatient services in a hospital are or were needed.
B. The certification was made at the time of admission or if an individual applies for assistance while in a hospital before the Medicaid agency authorizes payment.
C. The physician recertifies for each applicant or recipient that inpatient services are needed.
D. Recertification is made at least every sixty (60) days after certification.

The Facility shall ensure that information pertaining to the composition of the independent team conducting the certification of need and the information used to make certification of need determination is available upon request by EOHHS, DCYF, RIDOH and/or DRRI as the State Protection and Advocacy System.

Culturally and Linguistically Appropriate Services (CLAS)

The Facility shall be culturally and linguistically competent by demonstrating a defined and organized set of values and principles that address behavior, attitudes, services, policies, and structures to enable providers to work effectively with families of various racial/ethnic backgrounds, cultures, and linguistic preferences.

The Facility shall demonstrate expertise and willingness to care for residents and families from varied cultural and socio-economic backgrounds, including but not limited to residents identifying as LGBTQIA.

The Facility shall affirm a commitment to recruit and hire qualified staff with a demonstrated ability to meet the cultural needs of the residents in their care.

The Facility shall comply with the most up to date CLAS standards.

Treatment Model

The Facility shall provide comprehensive and intensive treatment, medical and psychiatric care, and onsite educational services for residents with intense clinical needs using a comprehensive model of care.

The Facility shall ensure that a strength-based and trauma informed model of care is evident in the policies, procedures, interventions, and milieu-based programming.

The Facility shall ensure that treatment and support interventions have a strong focus on strategies to address significant trauma, reduce symptomology and increase youth capacity for self- control and self-regulation, with a focus on four (4) major areas that research has found has the most long-term positive impact:

A. Short-term crisis stabilization
B. Intensive clinical services F
C. Engagement and work with the family and natural supports
D. Ensuring comprehensive family and community supports post-residential

The Facility shall provide evidence-based programs and practices and shall have policies and procedures in place to ensure fidelity to the evidence-based programs and practices utilized by the Facility.

The Facility shall provide training, supervision, and quality assurance and quality improvement strategies to monitor fidelity to evidence-based practices and track related outcomes.

The Facilities programming shall be reflective of family-driven and youth-guided care, cultural and linguistic competence, clinical excellence and quality standards, accessibility, community involvement and transition planning (between settings and from youth to adulthood).

Engagement of Family/Caregivers/Guardians in Resident Treatment

The Facility shall actively engage family/caregivers and address family/caregiver needs throughout the resident's course of treatment and for residents without clear permanency options or family involvement, that the treatment team is cultivating family connections (however "family" is defined by a resident) and that this is included as a goal in the resident's treatment plan.

The Facility shall ensure that family members/caregivers are educated about their resident's treatment, the significance of the family/caregiver roles in treatment, and the range of information, education, skill-building, and peer and other supports that will be provided to families/caregivers.

Individual, group and family therapy by master's level clinicians shall be provided weekly or more frequently, as is clinically necessary.

Referrals, Decisions & Admissions

The Facility shall accept referrals made by DCYF and other referral sources for all Medicaid enrolled residents.

The Facility shall maintain a "no reject, no eject" policy; no resident shall be refused services or discharged from service due to their previous history or reluctance to engage in the program.

The Facility shall provide EOHHS and DCYF a written rationale should the Facility assert its unable to meet the needs of a referred resident.

The Facility shall provide detailed written dispositions for referrals within the time requirements specified by EOHHS and DCYF.

The Facility shall accept admissions of a resident when EOHHS and/or DCYF determines that it is an emergency situation.

The Facility maintains continuous "24/7" and 365/6-day per year admission availability and shall ensure that EOHHS and DCYF are provided with 24/7 emergency contact information.

Individual Plan of Care

The Facility shall provide "active treatment", which means implementation of a professionally developed and supervised individual plan of care.

The Facility shall ensure that a physician establishes a written plan of care for each resident before submission of authorization for payment.

The Facility will ensure that the initial plan of care is developed and implemented no later than fourteen (14) days after admission.

The Facility shall ensure that that the plan of care includes:

A. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
B. A description of the functional level of the individual;
C. Objectives
D. Any orders for:
    1. Medications
    2. Treatments
    3. Restorative and rehabilitative services
    4. Activities
    5. Therapies
    6. Social Services
    7. Diet
E. Special procedures recommended for the health and safety of the resident;
F. Plans for continuing care, including review and modification to the plan of care; and
G. Plans for discharge.

The Facility shall ensure that the plan of care is:

A. Based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the resident's situation and reflects the need for inpatient psychiatric care.
B. Developed by a team of professionals and in consultation with the recipient and their parents, legal guardians, or others in whose care they will be released after discharge
C. State treatment objectives.
D. Prescribe an integrated program of therapies, activities, and experience designed to meet the objectives.
E. 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 resident's family, school, and community upon discharge.
F. Designed to achieve the recipient’s discharge from inpatient status at the earliest possible time.

The Facility will ensure that the plan is reviewed every thirty (30) days by the physician and other personnel involved in the resident’s care to:

A. Determine that services being provided are or were required on an inpatient basis; and
B. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

The Facility shall utilize the CANS and OHIO Scales for Youth and ensure initial CANS certification and yearly CANS re-certification is completed by the staff administering the assessment.

Transition Planning and Discharge

The Facility shall begin transition planning residents immediately after admission and individual treatment plans shall specify measurable goals and objectives, which when met indicate that the resident is ready for transition to a less restrictive setting.

The Facility, when a resident is absent from the Facility due to medical or behavioral health reasons, including hospital stay; elopement; or other causes, shall ensure that the resident is taken back into the Facility and not deny return to the Facility after any absence without a planned discharge.

The Facility shall not discharge a resident from their program without a specific discharge plan and shall not unilaterally discharge a resident in an unplanned manner.

The Facility shall make all efforts to transition a resident to a family setting; if unable to transition to a family setting, the resident will be stepdown to an appropriate alternative setting.

The Facility shall participate in discharge planning and implementation activities with the assigned DCYF staff members as appropriate, regarding the resident's transition.

The Facility shall complete a written discharge summary no less than fifteen days (15) prior to discharge that shall include:

A. the resident's recent progress and status reports;
B. education,
C. medical and mental health information;
D. and identifies post-discharge services, including provider/treatment team information and relevant appointment dates. It is the Facility's responsibility to define the resident's needs. The Facility shall not make recommendations for a specific program. The written discharge summary will be completed no less than fifteen days (15) prior to discharge.

The Facility shall provide the written discharge to the DCYF caseworker, the resident and the resident's family/caregiver.

Personnel Policy

The Facility shall have policies that address how the Facility selects, screens, hires, and trains personnel. This policy shall at minimum provide for and describe a:

A. Governance structure;
B. Criteria and procedures for employee performance reviews;
C. Orientation procedure for new staff;
D. Process for initial and ongoing training designed to ensure that staff shall have the necessary range of knowledge, skills, and abilities to provide high quality care;
E. Method for conducting employee screening and background checks as mandated by State and federal law;
F. Method for verifying staff qualifications;
G. How supervision is provided including accessibility of supervisors, review of client records, ongoing feedback between the supervisor and staff, and frequency of performance evaluations of case managers

Smoking Policy

The Facility shall have a smoking policy that at a minimum prevents staff from smoking in the presence of participants.

Grievance Policy

This policy shall outline how the Facility will respond to resident (and their parents/legal guardians) grievances that involve the Facility and/or staff and communicate information about resident grievances to EOHHS and DCYF. This policy shall discuss at a minimum:

A. Methods for ensuring residents are informed of their right to report a grievance.
B. Process to review, report, investigate, and respond to grievances, and associated timelines.
C. Approach to trend analyses and addressing issues identified.

In addition, the Facility shall have a policy which outlines the facilities response to employee grievances. This policy shall discuss at a minimum the acceptance and resolution of grievances brought by employees as a result of facilities management practices.

Emergency Management Plan

The Facility shall comply with all applicable Federal, State and local emergency preparedness requirements.

The Facility shall have an emergency preparedness program that contains all elements cited in 42 CFR § 441.184. These elements include the following:

A. *Emergency plan*. The Facility shall develop and maintain an emergency preparedness plan that shall be reviewed and updated at least every two (2) years.
B. *Policies and procedures*. The Facility shall develop and implement emergency preparedness policies and procedures, based on the emergency plan, risk assessment and the communication plan. The policies and procedures shall be reviewed and updated at least every two (2) years.
C. *Communication plan.* The Facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every two (2) years.
D. *Training.* The facility shall develop and maintain an emergency preparedness training program that is based on the emergency plan, risk assessment and the communication plan. The training and testing program shall be reviewed and updated at least every two (2) years.
E. *Testing*. The Facility shall conduct exercised to test the emergency plan twice per year.

Resident Record Policy

The policy shall include:

A. The procedure governing the use, storage, and removal of resident records;
B. The conditions for release of information contained in the resident record;
C. The requirements of authorization in writing by the resident or parent(s)/legal guardian(s) for release of information;
D. The maintenance of all records relating to the delivery and documentation of PRTF services for a minimum of seven (7) years and the maintenance of all financial records for a period of seven (7) years; and
E. Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

F. Maintenance of original copies of the initial clinical assessment, updates of the initial clinical assessment, treatment plans, progress notes, medical/psychiatric information, discharge summary and aftercare plans.
G. Inclusion in the resident record information from third parties, educational records, collateral information/reports, and any additional annual paperwork.

Sexual Assault Detection and Prevention

The facility shall have standards for sexual assault detection and prevention that are:

A. Integrated into onboarding and ongoing training of all staff and volunteers;
B. Available to residents;
C. Available to each residents' family/caregivers;
D. Subject to a documented process for review and updates on a regular cadence and/or upon a reported incident of sexual assault at the facility and/or involving a resident while they are in the facilities care.

III. STAFFING STANDARDS

Treatment Team

The Facility will ensure that the treatment team shall include, at a minimum, the following:

A. A board-eligible or board-certified psychiatrist
B. A clinical psychologist who has a doctoral degree
C. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases
D. A licensed clinician with a relevant Master's degree
E. A psychiatric social worker
F. A registered nurse with specialized training or one year's experience in treating mentally ill individuals
G. An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating individuals with mental illness.

Background Checks

The Facility shall be responsible for ensuring that all persons who are offered employment, volunteers and consultants in positions with supervisory or disciplinary power over a resident or involve routine contact with undergo statewide and nationwide criminal record background checks, including sex offender registry checks.

The Facility owner/operator shall attest in writing that any employees, volunteers and/or consultants who did not undergo a state and national background check, including the owner/operator, has no supervisory or disciplinary power over or routine contact with residents.

The Facility shall be responsible for ensuring that a statewide criminal record background check is completed for each employee, volunteer and/or consultant who has supervisory or disciplinary power over or routine contact with every three (3) years at the time of re-certification.

The Facility shall be responsible for ensuring that Nationwide background checks are completed, at minimum, before the date of hire and are recommended to be redone every five (5) years of consistent employment thereafter.

The Facility shall pay for any expense associated with the criminal record background checks.

Minimum Staffing

The Facility shall ensure that a sufficient quantity of qualified staff members are employed.

Facility staffing standards shall include direct care, nursing, and psychiatric professionals.

The Facility shall ensure that staffing ratios comply with the requirements established by EOHHS.

The Facility shall develop and follow a written daily staff schedule that meets the following requirements:

A. Provides for adequate qualified staff to directly supervise and interact with residents at all times'.
B. Allows for the implementation each resident's individual plan for care, including any residents that require "one-on-one" coverage or "constant supervision".
C. Provides for a minimum ratio of one (1) direct care staff member on active duty to three residents during waking hours and one direct care staff member on active duty to six (6) residents during sleeping hours.

The Facility shall ensure that additional qualified staff are available 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.

The Facility shall adequately staff and have related policies and procedures in place to ensure that residents are sound observation range of staff at all times.

The Facility shall not replace the direct care staffing requirements with electronic supervision.

The Facility shall make available auxiliary staff member as needed. 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 unless they are properly trained as direct care staff.

The Facility shall designate for each shift a staff person that oversees the Facility and is available on-site at all times during the designated shift. Procedures shall be in place to ensure that all staff members know who the staff person designed to be in charge is for each shift.

A clinician shall be available to residents and staff via an on-call system 24/7.

An RN shall be available to agency staff 24/7 via an on-call system, and the medical doctor/psychiatrist shall be available 24/7 to the RN.

Training Requirements

The Facility shall provide a written training plan for 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 services.

Prior to working with residents, all staff shall have an orientation to the staff person's specific duties and responsibilities and the policies and procedures of the Facility, including reportable incident reporting, behavioral management, resident care, and use of restrictive interventions.

Prior to working alone with residents, the Facility director and each full-time, part-time and temporary staff person who will have regular and significant direct contact with residents shall complete training in the following areas:

Mandatory reporting requirements for abuse, neglect, and exploitation

- First Aid, Heimlich techniques, cardiopulmonary resuscitation, and universal precautions
- Crisis intervention, behavior management, and suicide prevention
- Health and other special issues affecting the population
- The zero-tolerance standard for sexual assault and misconduct for all staff

The Facility shall require staff to have ongoing education, training, and demonstrated knowledge on a semiannual basis of:

A. Techniques to identify staff and residents' behaviors, events and environmental factors that may trigger emergency safety situations,
B. 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;
C. 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.

The Facility shall require staff to have an annual validation of CPR skills and Community First Responder (nasal naloxone administration) and biannual competency validation for emergency safety intervention skills for all direct care staff.

The Facility shall ensure that individuals who are providing training are qualified by education, training, and experience.

Staff training shall include training exercises in which staff members successfully demonstrate in practice the techniques they have learned for managing emergency safety situations.

The Facility shall ensure that staff are trained and demonstrate competency before participating in an emergency safety intervention.

The Facility shall document in the staff personnel records that the training and demonstration of competency were successfully completed.

Documentation of training shall include the date training was completed and the name of persons certifying the completion of training.

All training programs and materials used by the Facility shall be available for review by CMS, DCYF, EOHHS, RIDOH and DRRI the State Protection and Advocacy System and any other entity serving as the state survey agency.

IV. RESTRAINT AND SECLUSION

Use of Restraint and Seclusion

The Facility shall comply with federal regulations governing restraint and seclusion pertaining to psychiatric rehabilitative treatment facilities.

The Facility shall ensure the following:

A. Restraint and seclusion are not used as a means of coercion, discipline convenience, or retaliation.
B. Restraint and seclusion orders are not to be written as a standing order or on an as needed basis.
C. Restraint and seclusions are used only during an emergency safety intervention until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint and seclusion order has not expired.
D. Restraint and seclusions are not used simultaneously.
E. Emergency safety interventions are 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.

Orders for Restraint and Seclusion

Orders for restraint or seclusion shall only be provided by a physician or other licensed practitioner who is trained in the use of emergency safety interventions.

Orders shall be written so that only the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff is authorized.

If the order for restraint or seclusion is verbal, the verbal order shall be received by a licensed staff while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.

The verbal order shall be verified in written form in the resident's record signed by the physician within 24 hours of the initiation of the restraint and/or seclusion.

The physician shall be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

The Facility shall ensure that each order for restraint or seclusion has the following limits related to duration:

A. Limited to no longer than the duration for the emergency safety situation;
B. Limited to four (4) hours or less for residents ages eighteen (18) through twenty-one (21);
C. Limited to two (2) hours or less for residents ages nine (9) through seventeen (17); and
D. Limited to one (1) hour or less for residents under the age of nine (9).

Each order for restraint or seclusion shall include:

The name of the ordering physician

A. The date and time the order was obtained; and
B. The emergency safety intervention ordered including the length of time for which the physician authorized its use.

Documentation of Restraint and Seclusion

Staff members shall document the intervention in the resident's record.

Documentation shall be completed by the end of the shift in which the intervention occurred. If the intervention does not end during the shift in which it began, documentation shall be completed during the shift in which it ends.

Documentation of the intervention shall include the following:

A. The order for the restraint or seclusion;
B. The time the emergency safety intervention began and ended;
C. The time and results of the 1-hour assessment required in standards related to the use of restraint and seclusion;
D. The emergency situation, and any precipitation events that led to the emergency situation that required the resident to be restrained or put in seclusion; and
E. the name of staff members involved in the emergency safety intervention.

The Facility shall maintain a record of each emergency safety situation, the intervention used, and their outcomes.

The facility shall ensure that every restraint or seclusion is reported to EOHHS and DRRI as a Serious Occurrence.

Consultation with Treatment Team Physician

The physician shall contact the resident's treatment team physician (unless the ordering physician is the resident's team physician).

The physician shall 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 secluded and document in the resident's case record the date and time that the team physician was consulted.

Monitoring of the Resident in and Immediately after Restraint

Within one (1) hour of the initiation of the emergency safety intervention, a physician shall assess the physical and psychological wellbeing of residents conducts a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to:

A. The resident's physical and psychological status;
B. The resident's behavior;
C. The appropriateness of the intervention measures; and
D. Any complications resulting from the intervention.

Clinical staff trained in the use of emergency safety interventions shall be physically present and continually assessing and monitoring the physical and psychological wellbeing of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

If the emergency safety situation continues beyond the time limit of the order for the use of restraint, licensed staff shall immediately contact the ordering physician to receive further instructions.

A physician or other licensed practitioner who is permitted by the state and the Facility to evaluate the resident's wellbeing and is trained in the use of emergency safety interventions shall evaluate the resident's wellbeing immediately after the restraint is removed.

Monitoring of the Resident in and Immediately after Seclusion

Clinical staff who are trained in the use of emergency safety interventions shall be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological wellbeing of the resident in seclusion.

The room used for seclusion shall:

A. Allow staff full view of the resident in all areas of the room and
B. Provide an environment that is free of potentially hazardous conditions, such as unprotected light fixtures and electrical outlets.

If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a licensed staff shall immediately contact the ordering physician.

A physician or other licensed practitioner who is permitted by the state and the Facility to evaluate the resident's wellbeing and is trained in the use of emergency safety interventions shall evaluate the resident's wellbeing immediately after the resident is removed from seclusion.

Notification of Parent(s) or Legal Guardian(s)

The Facility shall, at the time of admission to the Facility the incoming resident and, in the case of a minor, the resident's parent(s) or legal guardian(s), are informed of the Facility's policy regarding the use of restraint and seclusion during an emergency safety intervention that may occur while the resident is in the program.

The Facility shall communicate the use of restraint and seclusion policy in a language that the resident and their parent(s) or legal guardian(s) understands (including American Sign Language), and, when necessary, provide interpreters or translators.

The Facility shall obtain an acknowledgement in writing from the resident, and, in the case of a minor, from the parent(s) or legal guardian(s) that they were informed of the Facility's policy on the use of restraint or seclusion during an emergency safety situation and that this acknowledgement is filed in the resident’s record with a copy provided to the resident or the parent(s) or legal guardian(s).

The Facility shall provide the resident and, in the case of a minor, the parent(s) or legal guardian(s), the contact information for the state’s Office of Protection and Advocacy including phone number and mailing address.

If the resident is a minor, the Facility shall notify the parent(s) or legal guardian(s) of a resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.

The Facility shall document in the resident's record that the parent or legal guardian, if the resident is a minor, has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing notification.

Application of Time Out

Staff shall not prevent a resident from leaving the time out area.

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

Staff shall monitor the resident while they are in time out.

Post-Intervention Debriefings

Within twenty-four (24) hours after the use of restraint or seclusion, the staff involved in an emergency safety intervention shall have a face-to-face discussion with the resident.

The discussion shall include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. (Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the Facility.)

The Facility shall conduct such a discussion in a language that is understood by the resident's parent(s) or legal guardian(s).

The discussion shall provide both the resident and the staff with the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, resident, or others that could prevent the future use of restraint or seclusion.

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

A. The emergency safety situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention;
B. Alternative techniques that might have prevented the use of the restraint or seclusion;
C. the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
D. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.

Staff shall document in the resident's record that both debriefing sessions took place and shall include in that documentation the full 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.

Medical Treatment for Injuries Resulting from an Emergency Safety Intervention

Staff shall immediately obtain medical treatment from qualified medical personnel for a resident injured because of an emergency safety intervention.

The Facility shall have affiliations or written transfer agreements in effect with one (1) or more hospitals approved for participation under the Medicaid program that reasonably ensure that:

A. 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.
B. The Facility ensures that medical and other information needed for care of the resident following such a transfer will be exchanged between the institutions in accordance with state medical privacy law, including information needed to determine whether the appropriate care can be provided in a less restrictive setting.
C. Services are available to each resident twenty-four (24) hours a day, seven (7) days a week.

Staff shall document in the resident's record all injuries that occurred as a result of an emergency safety intervention, including injuries to staff resulting from that intervention.

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

Serious Occurrence

The Facility shall report each serious occurrence to EOHHS, DCYF and DRRI the State Protection and Advocacy System no later than close of business on the next business day after the serious occurrence.

The Facility is required to report each serious occurrence to EOHHS, DCYF and DRRI the State Protection and Advocacy System no later than close of business on the next business day after the serious occurrence.

The Facility shall report at least the following serious occurrence using the EOHHS serious occurrence reporting forms:

A. A resident’s death.
B. Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflected by someone else.
C. A resident’s suicide attempt or suicidal gesture regardless of staff assessment of intent.
D. Any incidences of abuse and neglect
E. A pattern of injuries to a resident,
F. Elopement (leaving or attempting to leave the Facility without permission)
G. Physical altercations (between residents and/or including staff)
H. Police response to the facility, including any arrests made (residents and/or staff)
I. The use of restraint and/or seclusion with the physician’s order.
J. A resident being sent to an emergency department of a psychiatric evaluation

The Facility shall utilize the EOHHS serious occurrence reporting form in reporting a serious occurrence:

A. The name, address, and phone number of the facility
B. Date of the incident
C. The name of the resident involved;
D. The name of the resident’s parent/guardian;

E. The resident's date of birth;
F. The resident's home jurisdiction;
G. The resident's date of admission;
H. The referral source (agency or individual who referred resident to the facility);
I. A description of the occurrence and nature of injury as applicable;
J. Individuals notified of the serious occurrence;
K. The full name and title of the facility staff member submitting the report
L. The full name and title of any staff involved and/or who witnessed the incident; and
M. A statement regarding the facilities response to the serious occurrence, including but not limited to:
    1. that staff were suspended;
    2. an investigation was initiated; and
    3. the status of any resident who was injured or attempted to self-injury.

The Facility shall, in the case of a minor, notify the resident's parent(s) or legal guardian(s) as soon as possible and in no case later those twenty-four (24) hours after the serious occurrence.

The Facility shall ensure that staff document in the resident's record that the serious occurrence was reported to EOHHS, DCYF and DRRI the State Protection and Advocacy System, including the name of the person to whom the incident was reported.

The Facility shall maintain a copy of each serious occurrence report in the resident's record as well as in the incident and accident report logs kept by the Facility.

The Facility shall report the death of any resident to the Centers for Medicare and Medicaid Services (CMS) regional office in additional to the agencies who are required to receive any serious occurrence report.

The Facility shall 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 and shall document in the resident's record that the death was reported to the CMS regional office.

V. REPORTING AND PERFORMANCE STANDARDS

Reporting Standards

In addition to the reporting specific to serious occurrences detailed in the above section, the following monthly reporting shall be completed by the Facility:

A. Resident census including out of state placements and average length of stay
B. Status reports including but not limited to progress toward treatment goals and anticipated duration of services
C. Total number of resident elopements and number of residents who eloped
D. Number of serious occurrences
E. Number of emergency room visits and number of residents who were seen in the emergency room
F. Number of hospitalizations and number of residents who were hospitalized

Performance Standards

The Facility shall cooperate in and comply with quality improvement programs including, but not limited to, case review, site review, quality improvement forums, and Medicaid reviews.

The Facility shall, for the term of these certification standards, submit all claims, service utilization management, clinical case management and quality improvement data requested by EOHHS and DCYF.

The Facility shall complete and provide EOHHS and DCYF with any assessments required by EOHHS, as the single state Medicaid agency, and DCYF, as the children's mental health authority, in a time period designated by either agency.

The Facility shall ensure compliance with the following clinical practice standards:

A. Completion of initial clinical assessments and treatment plans within fourteen (14) days of admission.
B. Completion of a comprehensive bio-psychosocial assessment and treatment plan within thirty (30) days.
C. Completion of progress reports quarterly and as requested by the State.
D. Completion of clinical progress notes within twenty-four (24) hours of each individual, family or group session.
E. Completion of milieu DAP notes before the end of each shift.

The Facility shall ensure that internally, all resident records are audited for completeness and correctness on a quarterly basis using a EOHHS approved Medicaid Audit form and that any incomplete or incorrect documentation shall be ameliorated by the clinician within ten (10) days.

The Facility shall allow DCYF, EOHHS, RIDOH, the State Advocacy Organization and/or CMS to audit records at any time.

VI. CERTIFICATION PROCESS

Certification Period

RI EOHHS certification periods include:

A. Initial certification: One (1) year following the initial certification date, unless sooner suspended or revoked.
B. Recertification: Three (3) years following the date of renewal, unless sooner suspended or revoked.

Certification Process

A. The initial certification process applies to new facilities who are not certified to provide PRTF. The recertification process applies to entities who currently maintain an active PRTF certificate.
B. Applicants shall apply for initial certification or recertification using the Application for Certification included in Appendix A (to be released when certification standards are final). The Application for Certification must be submitted forty-five (45) calendar days prior to the date of renewal.
C. The State will convene a PRTF Application Review Committee to evaluate applications. A periodic review process will be established by the State, depending on the submission of applications.

D. Prior to technical review, submitted applications will be reviewed for completeness and for compliance with core expectations. Incomplete applications will be returned without further review.
E. Initial certification will be effective on the date specified by EOHHS once EOHHS determines that the PRTF Facility is in compliance with these certification standards and other applicable laws and regulations.

Issuance and Transfer or Assignment of Certificate

Upon receipt of a completed application for a certificate, EOHHS shall issue a certificate if the Facility meets the requirements of the standards included herein. A certificate issued hereunder shall be the property of the state and loaned to such certified agency. Each certificate shall be issued only for the premises and persons named in the application and shall not be transferable or assignable except with the written approval of EOHHS.

Change of Ownership, Operation, or Location

A. When a change of ownership or operation or location of a PRTF is planned or when discontinuation of services is contemplated, EOHHS shall be given written notice ninety (90) calendar days in advance of any proposed changes in location, name, or ownership of the PRTF, or PRTF agency closure.
B. A certificate shall immediately become void and shall be returned to EOHHS when operation of a PRTF is discontinued or when any changes in ownership occur.
C. When there is a change in ownership or in the operation or control of the PRTF, EOHHS reserves the right to extend the expiration date of such certificate, allowing the facility to operate under the same certificate which applied to the prior certificate holder for such time as shall be required for the processing of a new application or reassignment of consumers, not to exceed six (6) weeks.

Denial, Suspension or Revocation of Certificate or Curtailment of Activities

EOHHS is authorized to deny, suspend or revoke the certificate or curtail activities of any PRTF that receives State or federal funding and:

A. Has failed to comply with EOHHS rules and regulations;
B. Has failed to comply with the standards herein;
C. Has offered or provided services to participants outside of the scope of its certificate; or
D. Has jeopardized the health and safety of any participant;
E. Has been excluded from the Medicaid Program by and State or Federal agency.