



Newsletter

*Published by the
N.J. Dept. of Human Services,
Div. of Medical Assistance & Health Services*

Volume 11 No. 64

July 2001

TO: JCAHO Accredited Residential Treatment Centers -- **For Action**
Health Care Maintenance Organizations – **For Information Only**

SUBJECT: **Restraint and Seclusion Procedures for Medicaid, NJ
FamilyCare and Children's System of Care Initiative (CSOCI)
Providers**

EFFECTIVE: **July 21, 2001**

PURPOSE:

1. To inform providers of the Condition of Participation related to the use of restraint and seclusion in residential psychiatric treatment facilities (PRTF) providing services to Medicaid/NJ FamilyCare or CSOCI beneficiaries under the age of 21; and
2. To provide the attestation form that the providers must file with the Division by July 21, 2001

BACKGROUND: On January 22, 2001, the Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), published an interim final rule in the Federal Register detailing the requirements related to the use of restraints and seclusion in Medicaid-funded PRTFs providing services to beneficiaries under age 21. An amendment and clarification of this rule was published in the Federal Register by CMS/HCFA on May 22, 2001, which included a requirement that the facilities attest, in writing, their compliance with the requirements, to their State Medicaid Agency.

ACTION: Effective **July 21, 2001** all providers are required to provide to the state Medicaid agency an attestation that they meet all the requirements of the Condition of Participation described in 42 CFR 483, subpart G.

Attached is a Summary of the interim final rule with interpretative text provided as needed. Also attached is an Attestation Certification as well as an Attachment to the Attestation Certification.

Each Psychiatric Residential Treatment Facility is required by the interim final rule to attest, in writing, that the facility is in compliance with the standards set forth by the rule and return the Certification to their State Medicaid Agency by July 21, 2001.

As you are aware, we forwarded to you this entire package by e-mail or fax on Monday, July 16, 2001. We are requesting that you fax a copy of your Attestation Certification and the Attachment to the Attestation Certification to: Constance Thomas, Administrator, Bureau of Policy, Division of Medical Assistance and Health Services by the end of the day July 21, 2001. The fax number is 609-631-4955. A hard copy of the Attestation Certification and the Attachment to the Attestation Certification should be sent to Gregory Danese, Division of Medical Assistance and Health Services, PO Box 712, Mail Code #9, Trenton, NJ 08625-0712 and post marked no later than July 27, 2001.

Please review the Attestation Certification and the Attachment to the Attestation Certification carefully. As you can see, we are asking that the Chief Executive Officer, or designee, sign the Attestation Certification. We are also asking the Attachment to the Attestation Certification be filled out and faxed to us as well. **If you are unable to sign the Attestation Certification because you do not meet all the requirements**, please fill out the Attachment to the Attestation Certification indicating what requirements you do not meet and provide us with your plan to meet the requirements. Please fax and mail the Attachment in the same manner and timeframes as required for the Attestation Certification as described above. Once you have completed your compliance plan, please notify us immediately and send us your Attestation Certification.

Out of state providers who are enrolled as psychiatric residential treatment facilities (PRTF) that are not enrolled in their State Medicaid Agency as a PRTF are required to file their attestation with this Division. Out of state providers who are enrolled as psychiatric residential treatment facilities with their State Medicaid Agency are required to file a copy of their attestation with this Division.

The original of this attestation must be filed with the State, and a photocopy should be maintained on file in the facility itself.

The Division understands that this is short notice and we are committed to helping providers understand and comply with the new Federal requirements. New guidelines and requirements are being communicated to the Division and we will share any additional information received, as it becomes available. Thank you for your patience and anticipated cooperation.

If you have any questions concerning this Newsletter, please contact the Office of Utilization Management at (609) 588-2721.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")**

FEDERAL REQUIREMENTS FOR THE USE OF RESTRAINT AND SECLUSION

I. GENERAL PRINCIPLES

1. Each resident has the right to be free from restraint and seclusion of any form except to protect the safety of the resident and staff.
2. Restraint and seclusion are considered emergency safety interventions and are to be used in emergency situations solely to ensure the safety of facility residents or staff.
3. Restraint and seclusion are never to be ordered or used as a means of coercion, discipline, retaliation, or for the convenience of the staff members.

Example: Restraining an individual until he or she complies with prescribed medication or therapy sessions, or placing an individual in seclusion as a consequence of a rule infraction such as refusing chores or breaking curfew.

4. Choice of restraint and seclusion is limited to the least restrictive intervention that can be performed safely and is appropriate to the severity of the behavior, and the resident's age, developmental status, size, gender, physical, medical and psychiatric condition and personal history (including any history of physical or sexual abuse.)
5. The restraint or seclusion must terminate once the emergency safety situation has expired, even if the order for restraint and seclusion has not expired.

II. DEFINITIONS

"Drug used as a restraint" means any drug that meets all of the following conditions:

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

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

"Emergency safety situation" means unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs, that calls for an emergency safety intervention because non-restraining interventions have not worked to deescalate the situation.

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

“Minor” means a minor person as defined under State law and includes a resident who has been declared legally incompetent by the applicable State court.

“Personal restraint” means the application of physical force without the use of any device, for the purpose of restricting the free movement of a resident’s body. Personal restraint does not include briefly holding, without undue force, a resident in order to calm or comfort the resident, or holding a resident’s hand or arm to safely escort a resident from one area to another.

“Restraint” means a personal hold of any duration, a mechanical restraint, or a drug used as a restraint. Restraint does not include briefly holding, without undue force, a resident in order to calm or comfort the resident or holding a resident’s hand or arm to safely escort him or her from one area to another.

“Seclusion” means involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. **A "time out" intervention is not seclusion.** During a time out, the resident is not physically restricted from leaving the area and the time out can be accomplished either in the presence of other residents (inclusionary) or away from other residents (exclusionary). These interventions are to be utilized to calm a resident and defuse a situation prior to using the more restrictive methods of restraint or seclusion.

III. COMMUNICATION OF PATIENT RIGHTS

All beneficiaries shall be informed of all facility policies related to the use of restraint or seclusion upon admission to the facility. In the case of a resident who is under the age of 18, the resident's parent or legal guardian shall be informed of the policy.

The policy shall be explained verbally and provided in writing in a language that the resident and/or their legal guardian understand, including American Sign Language if appropriate.

The written policies must include the phone number and mailing address of the state’s Protection and Advocacy agency. **In New Jersey**, this address is NJ Protection and Advocacy, 210 South Broad Street, 3rd floor, Trenton, NJ 08608. The phone number is (609) 292-9742 or 1-800-922-7233 (for use in NJ only). **Out-of-state** facilities should follow the directions of their State Medicaid program.

The resident or the resident's legal guardian must sign an acknowledgement that this policy was provided to them and that they understand the policy. This written and signed acknowledgement shall be placed in the resident’s file.

IV. STAFF TRAINING AND CERTIFICATION

All staff members of the facility are required to be trained in:

- Techniques to identify staff and resident behaviors, events and environmental factors that may trigger the need for the use of emergency safety interventions;

- The use of non-physical and non-restraining intervention skills, such as deescalation, mediation, conflict resolution, active listening, and verbal and observational methods to prevent emergency safety situations; and
- Safe and appropriate restraint and seclusion techniques, including the ability to respond to signs of physical distress in residents who are being restrained or in seclusion, including adult and child cardiopulmonary resuscitation (CPR).

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

Staff must demonstrate their competencies in the safe use of restraint and seclusion before they can participate in an emergency safety intervention and then every six months thereafter. Competency or certification in CPR must be demonstrated and documented annually. Administrators shall provide additional training as indicated to ensure staff proficiency.

The facility must document the completion of all training and competency demonstrations in the employee's personnel record, including the date of the training and the name(s) of the persons certifying the completion of the training.

All training programs and materials must be available for review by

- the Center for Medicare and Medicaid Services (CMS),
- the New Jersey Division of Medical Assistance and Health Services or its agents, (for both in-state and out-of-state agencies); and
- the state survey agency, which is the New Jersey Department of Health and Senior Services for the New Jersey facilities.

V. APPROPRIATE TIMELINES FOR THE USE OF RESTRAINT OR SECLUSION TECHNIQUES

Restraint and seclusion are only to be used in emergency situations. These techniques are intended to be used for a limited time period, and only to ensure the safety of the patient and other people in the immediate area.

EXAMPLE: A patient in an inpatient psychiatric facility has become agitated beyond the point of being calmed by non-restraining interventions. The individual is actively trying to physically harm either himself or other people in the area. In this situation, the use of restraint may be ordered to ensure that the agitated individual does not physically harm either himself or another patient or staff person in the area.

As soon as the resident and the situation are stabilized, the use of the restraint or seclusion is to cease immediately. The following time limits for the use of either restraint or seclusion are the maximum time limits allowed.

- Not to exceed a total of 4 hours for beneficiaries ages 18-21

- Not to exceed a total of 2 hours for beneficiaries ages 9-17
- Not to exceed a total of 1 hour for beneficiaries under the age of 9

Restraint and seclusion are never to be ordered or used simultaneously.

VI. ORDERING THE USE RESTRAINT OR SECLUSION

Mechanical restraint, drug restraint, or seclusion

An order for mechanical or drug restraint or seclusion cannot be written as a standing order or on an as needed (PRN) basis. Each order must be limited to no longer than necessary to resolve the emergency safety situation.

The patient's treatment team physician must order this use of mechanical or drug restraint or seclusion. If someone other than the treatment team physician orders the mechanical or drug restraint or seclusion, the treatment team physician must be contacted as soon as reasonably possible and informed that the order was placed.

- For in-state facilities, if the treatment team physician is unavailable, a physician, advance practice nurse, or physician's assistant must order the use of a restraint or seclusion. In-state facilities may use on-call staff, per diem staff, consultants or other methods of pooling coverage in order to meet this requirement.
- Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.

The order placed must be for the least restrictive intervention that is the most likely to be effective in resolving the situation based on consultation with staff.

The ordering practitioner must provide written orders whenever possible, but may provide verbal orders over the phone under the following conditions:

- For in-state facilities, the verbal order must be received by an advanced practice nurse, registered nurse, or physician's assistant (Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.);
- The order must be received while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends.
- The practitioner giving the order must be available to the staff, at least by telephone, for consultation throughout the entire period of the intervention; and
- The practitioner must, as soon as possible, document, sign and date the verbal order, and the circumstances requiring the order.

The documentation of each order must include the licensed practitioner's name and title, the date and time the order was obtained, and the emergency safety intervention ordered including the length of time authorized for its use.

Personal restraint

An order for personal restraint cannot be written as a standing order or on an as needed (PRN) basis. Each order must be limited to no longer than necessary to resolve the emergency safety situation.

The patient's treatment team physician must order this use of personal restraint. If someone other than the treatment team physician orders the personal restraint, the treatment team physician must be contacted as soon as reasonably possible and informed that the order was placed.

- If the treatment team physician is unavailable, then for in-state facilities, a licensed member of the child's treatment team who is not precluded by regulation from ordering a personal restraint and who is permitted by the facility to order a personal restraint, must order the use of a personal restraint. In-state facilities may use on-call staff in order to meet this requirement.
- Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.

The order placed must be for the least restrictive intervention that is the most likely to be effective in resolving the situation based on consultation with staff.

The ordering practitioner must provide written orders whenever possible, but may provide verbal orders over the phone under the following conditions:

- For in-state facilities, a member of the treatment team who is not precluded from receiving such an order and who is permitted by the facility to receive the order must receive the verbal order. (Out-of-state facilities must follow the state Medicaid program requirements of the state in which they are located.);
- The order must be received while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends;
- The practitioner giving the order must be available to the staff, at a minimum by telephone, for consultation throughout the entire period of the intervention; and
- The practitioner must document, sign and date the verbal order, and the circumstances requiring the order, as soon as possible after the order is placed.

Each order must include the licensed practitioner's name and title, the date and time the order was obtained, and the emergency safety intervention ordered including the length of time authorized for its use.

VII. MONITORING DURING THE EMERGENCY SAFETY INTERVENTION

Restraint:

1. **Clinical staff** who have been trained in the appropriate use of restraints must be physically present in order to continually assess and monitor the physical and psychological well-being of the resident being restrained throughout the duration of the intervention.
2. If the restraint continues beyond the time limit specified in the order given by the appropriate practitioner, staff who have been authorized to receive the order as indicated above should contact the practitioner who initiated the order for further instructions.
3. For in-state facilities, a **physician, advance practice nurse, registered nurse or physician's assistant or other licensed practitioner trained in the use of emergency safety intervention and who are not precluded by regulation to conduct an assessment**, must make a face-to-face assessment of the physical and psychological well being of the individual being restrained within one hour of the initiation of the restraint. (Out-of-state facilities must follow their state Medicaid requirements on who is authorized to do such an assessment).
 - Facilities may need to use more than one individual in order to assure that both parts of the assessment are completed.
4. The one-hour assessment must include, but is not limited to:
 - The resident's physical and psychological status, including the resident's behavior;
 - The appropriateness of the intervention; and
 - Any complications from the use of the intervention.

Seclusion:

1. **Clinical staff** who have been trained in the appropriate use of seclusion must be continually monitoring the resident who has been placed in seclusion. The staff person must be physically present in the room or immediately outside the seclusion room to ensure the safety of the resident. Video monitoring does not meet this requirement.
2. If the restraint continues beyond the time limit specified in the order given by the appropriate practitioner, staff who have been authorized to receive the order as indicated above should contact the practitioner who initiated the order for further instructions.
3. For in-state facilities, a **physician, advance practice nurse, registered nurse or physician's assistant or other licensed practitioner trained in the use of emergency safety intervention and not precluded by regulation to conduct an assessment**, must make a face-to-face assessment of the physical and psychological well being of the individual being restrained within one hour of the initiation of the restraint. (Out-of-state facilities must follow their state Medicaid requirements on who is authorized to do such an assessment.)
 - Facilities may need to use more than one individual in order to assure that both parts of the assessment are completed. For example, a registered nurse may conduct the

physical assessment but a licensed clinical social worker might conduct the psychological assessment, if deemed appropriate by the facility.

4. The one-hour assessment must include, but is not limited to:

- The resident's physical and psychological status, including the resident's behavior;
- The appropriateness of the intervention; and
- Any complications from the use of the intervention.

VIII. NOTIFICATION OF THE PARENT(S) OR LEGAL GUARDIAN(S)

The facility must notify the parent(s) or legal guardian(s) of the resident as soon as possible after the initiation of the intervention. Documentation must be included in the resident's file, and must include the name of individual notified, the date and time of the notification and the signature and title of the staff member providing the notification.

IX. AFTER THE EMERGENCY SAFETY INTERVENTION

Immediately after the drug or mechanical restraint or seclusion is over, for in-state facilities, a **physician, advance nurse practitioner, registered nurse, physician's assistant** who is trained in the use of emergency safety interventions shall evaluate the physical and mental condition of the resident. Staff may use on call staff to perform either or both parts of the assessment as long as they assure the assessment is completed timely. (Out-of-state facilities must follow the requirements of their state's Medicaid program on who must perform this assessment.)

Immediately after the personal restraint is over, for in-state facilities, **licensed staff** who are not precluded from making an evaluation of the well-being of the child, and who are trained in the use of emergency safety interventions, shall evaluate the well-being of the resident. Staff may use more than one staff member to perform both parts of the assessment as long as they assure the assessment is completed timely. (Out-of-state facilities must follow the requirements of their state's Medicaid program on who must perform this assessment.)

For all emergency safety interventions, staff must document the intervention by the end of the shift in which the emergency safety intervention ended. Documentation must include, at a minimum:

- ✓ The name of the physician who gave the order;
- ✓ The date and time that the order was given;
- ✓ The type of intervention ordered, including length of time the intervention was ordered for;
- ✓ The actual time of the initiation and termination of the intervention;
- ✓ The time and results of all assessments performed during or after the intervention;

- ✓ The emergency safety situation that required the use of the intervention; and
- ✓ The name, title and credentials of all staff involved in the intervention.

If the practitioner ordering the intervention is not the resident's treatment team physician, the ordering practitioner, or the professional receiving the order, must consult with the resident's treatment team physician as soon as possible to advise the physician of the intervention. Documentation of the date and time the treatment team physician was consulted must be included in the resident's record.

X. MEDICAL TREATMENT FOR INJURIES RESULTING FROM USE OF RESTRAINT OR SECLUSION

Staff must immediately obtain medical treatment from qualified medical personnel for treatment of any injury sustained as a result of an emergency safety intervention.

The facility must have affiliations or written transfer agreements in effect with the closest hospitals in the area that can provide needed treatment to the child. If possible, the facility should use Medicaid-participating hospitals.

The agreements or affiliations must ensure that:

- A resident will be admitted to the hospital when a transfer is necessary for medical or acute psychiatric care;
- Medical and other information needed for the care of the child that is allowed to be exchanged in accordance with a state's medical privacy law will be exchanged between the two facilities; and
- Services are available 24 hours a day, 7 days a week.

All injuries to the resident and the staff that occurred as a result of the safety intervention must be recorded in the resident's record.

XI. DEBRIEFINGS

As soon as reasonably possible, but no later than 24 hours after the incident, the **staff members and residents** involved in the incident shall have a face-to-face discussion. This discussion may include other staff members and/or the resident's legal guardians, as deemed appropriate by the facility. If the presence of a particular staff member would jeopardize the well being of the resident, then that staff person may be excused from this discussion by administrative staff.

- The discussion must provide both the resident and staff an opportunity to discuss the circumstances resulting in the intervention, and strategies to be used by the staff, resident or others to prevent the future use of an intervention.

Within 24 hours after the use of a restraint or seclusion, all staff involved in the emergency safety intervention and appropriate **facility administrative and supervisory clinical staff** must conduct a debriefing to:

- Identify the factors that led to the use of the intervention;
- Identify alternative interventions that could have been used to prevent the intervention;
- Identify the procedures, if any, that staff are to implement to prevent any reoccurrence of the use of restraint or seclusion;
- Identify the outcome of the intervention, including any injuries that may have resulted in the use of the intervention.

Staff must document in the resident's record that both debriefings took place, and include

- The names of the staff who were present;
- The names of the staff who were excluded;
- The date and time of the debriefing;
- The resident's attendance and level of participation in the debriefing; and
- Any changes made to the resident's treatment plan as a result of the debriefing.

If there is an injury to a resident or staff member as a result of the use of restraint or seclusion, the staff member(s) involved with the intervention must meet with supervisory staff and evaluate the circumstances that resulted in the injury, in order to develop a plan to prevent future injuries.

XII. SERIOUS INJURY, SUICIDE ATTEMPT, OR DEATH OF A RESIDENT

1. For both the in-state and out-of-state providers, in the event of serious injury, suicide attempt or death of a resident, the provider must continue to report each occurrence to the Department's Division of Youth and Family Services (DYFS) or the Division of Mental Health Services (DMHS) using the current reporting methodology. For those providers who do currently report such incidents to either DYFS or DMHS, the report must be sent to the Office of Utilization Management, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712.
2. Reports of such incidents must also be sent to the state-designated Protection and Advocacy agency. For in-state providers, this address is NJ Protection and Advocacy, 210 South Broad Street, 3rd floor, Trenton, NJ 08608. The phone number is (609) 292-9742 or 1-800-922-7233 (for use in NJ only). Out-of-state facilities should follow the directions of their State Medicaid program on where to report these incidents.
3. If the resident is a minor (under age 18), the parents or legal guardians must be notified as soon as reasonably possible, but no later than 24 hours after the incident.

4. Reports must be submitted as soon as possible, but no later than the next business day.
5. The staff must document in the resident's record that the serious incident was reported to State Medicaid agency, the State-designated Protection and Advocacy agency and the family, as applicable. Documentation should include the date and time of the reporting, as well as the name of the individual making the report and the name of the person to whom the incident was reported.
6. A copy of the report that was sent to the Medicaid agency and the State-designated Protection and Advocacy agency must be retained in the resident's record, as well as in the facility's incident and accident reporting log.
7. In the event of the death of a child, the facility must also report the incident to the regional office of the Center for Medicare and Medicaid Service (CMS). This includes the demise of any child, whether as the result of use of restraint or seclusion or any other activity, including but not limited to, the result of an accident or a suicide attempt. The report must be filed as soon as reasonably possible, but no later than the close of business on the next business day after the incident.

- New Jersey and New York providers must send the report to:

Lois Suntzenich
New York Regional Office
Center for Medicare and Medicaid Service
Room 38-100
Federal Building
26 Federal Plaza
New York, New York 10278

- Other out-of-state providers should use the address provided to them by their state Medicaid agency.

8. All reports of the incident must include:

- ✓ Name of the resident;
- ✓ Description of the occurrence;
- ✓ Name, street address, and telephone number of the facility; and
- ✓ Any other information the PRTF is able to provide regarding the death/occurrence.

NOTE: All incidents and all notifications must be recorded in the child's record as soon as possible, but no later than 24 hours after the incident occurs.

ATTESTATION CERTIFICATION

Page 1 of 2

I, the undersigned, certify that I am the Chief Executive Officer, or designee, of _____, a Psychiatric Residential Treatment Facility (PRTF), which provides inpatient psychiatric services to Medicaid/NJ FamilyCare/Children's System of Care Initiative (CSOCI) beneficiaries under the age of 21.

Based upon my personal knowledge and belief, I attest that the responses on the attached Attachment to the Attestation Certification are true and correct, and that _____ currently meets, and will continue to meet, the attached requirements for the use of restraints and seclusion in PRTFs providing services to individuals under the age of 21. I agree that if the facility fails to meet any of these requirements, I will notify the Division of Medical Assistance and Health Services immediately.

I understand that the Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), or its authorized representative, has the right to conduct an on-site survey at any time to validate whether the statements made on the attached list of requirements are true. I understand that any falsification, omission, or concealment of material fact in the attached document(s) may subject each of us to civil or criminal liability.

I agree that the facility will submit a new attestation to the Division of Medical Assistance and Health Services or the appropriate state Medicaid Agency, if there is a change in the individuals serving as Chief Executive Officer.

I agree that the facility will notify the applicable State Medicaid agency if the facility, to the best of our knowledge, no longer complies with the requirements related to restraint and seclusion.

Address of the facility: _____

Telephone number: _____

New Jersey Medicaid Provider Number: _____

ATTESTATION CERTIFICATION

Page 2 of 2

Chief Executive Officer

Name (please print) _____

Signature _____

Title _____

Date _____

ATTACHMENT TO THE ATTESTATION CERTIFICATION

The _____ meets the following Conditions of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21 as defined in 42 CFR Subpart G: §§483.350 – 483.376.

Yes No Has in place policies which define emergency safety interventions i.e., the use of restraint and/or seclusion, consistent with the definitions at 42 CFR 483.352;

If "No" describe compliance plan (include target dates):

Yes No Have in place policies consistent with 42 CFR 483. 356 which protect the safety and rights of individuals, including notification of the individual or their parent/legal guardian;

If "No" describe compliance plan (include target dates):

Yes No Have the resources available and the procedures consistent with 42 CFR 483.358 in place related to ordering, and receiving the order for, the use of restraints and/or seclusion and the appropriate timeframes for the use of these interventions;

If "No" describe compliance plan (include target dates):

Yes No Have policies and procedures in place consistent with 42 CFR 483.360 related to consulting with the individual's treatment team physician when ordering the use of restraints and/or seclusion;

If "No" describe compliance plan (include target dates):

ATTACHMENT TO ATTESTATION CERTIFICATION

Yes No Has in place procedures consistent with 42 CFR 483.362, for the monitoring and assessment of beneficiaries who are in restraint and immediately after the use of restraint;

If "No" describe compliance plan (include target dates): _____

Yes No Has in place procedures consistent with 42 CFR 483.364, for the monitoring and assessment of beneficiaries who are in seclusion and immediately after the use of seclusion;

If "No" describe compliance plan (include target dates): _____

Yes No Has in place a procedure consistent with 42 CFR 483.366, to notify a beneficiary's parent(s) or legal guardian(s) when restraint or seclusion are used with that beneficiary;

If "No" describe compliance plan (include target dates): _____

Yes No Has in place a procedure consistent with 42 CFR 483.370 regarding the debriefing of all individuals involved in the use of the restraint or seclusion;

If "No" describe compliance plan (include target dates): _____

ATTACHMENT TO ATTESTATION CERTIFICATION

Yes No Has a plan in place regarding medical treatment for injuries resulting from the use of restraint or seclusion consistent with 42 CFR 483.372;

If "No" describe compliance plan (include target dates): _____

Yes No Has in place a procedure consistent with 42 CFR 483.374 and all applicable State statutes and rules for reporting all deaths and serious injuries or occurrences to the appropriate parties;

If "No" describe compliance plan (include target dates): _____

Yes No Has in place policies consistent with 42 CFR 483.376 related to the training and certification of the staff involved in the use of emergency safety interventions

If "No" describe compliance plan (include target dates): _____

Identifying Information

Name of Facility: _____

Address of the facility: _____

Telephone number: _____

New Jersey Medicaid Provider Number: _____

Name of Chief Executive Officer: _____