

EXHIBIT 355

Probes and Procedures for Appendix J, Part II- Interpretive Guidelines- Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

Governing Body Probes and Procedures

W102 Compliance Principles §483.410

The Condition of Participation of Governing Body is met when each of the other Conditions of Participation are also met.

The Condition of Participation is not met when:

- One or more of the other 7 conditions of participation have first been determined to be not met, and the governing body has failed to take action that identifies and resolves systemic problems of a serious and recurrent nature; or
- The facility has been denied any license or approval required by Federal, State, or local law by the authority having jurisdiction for that law.

W103 §483.410(a)

W104 §483.410(a)(1)

When Condition level deficiencies (other than the Governing Body Condition) are repeated and pervasive patterns of Standard level deficiencies are cited, the actions of the Governing Body should be reviewed to determine whether adequate direction has been provided by that body.

Interview the administrator or review the minutes of governing body meetings, if available, to determine whether or not the governing body identified and addressed the cited problem.

Example: Surveyor notes that staff have been trained, but are not implementing programs or are being inappropriately deployed (e.g., there are enough staff but they are assigned to duties like record keeping which prevents them from delivering needed services). There is documentation to confirm the Governing Body was aware of these problems, but were not addressing the concerns. This indicates a failure of the governing body to exercise operating direction over the facility.

W105 §483.410(a)(2)

W106 §483.410(a)(3)

W107 §483.410(b)

W108 §483.410(b)

W109 §483.410(b)

W110 §483.410(c)(1)

W111 §483.410(c)(1)

W112 §483.410(c)(2)

W113 §483.410(c)(3)

W114 §483.410(c)(4)

W115 §483.410(c)(5)

W116 §483.410(c)(6)

W117 §483.410(d)(1)

W118 §483.410(d)(2)

W119 §483.410(d)(2)

W120 §483.410(d)(3):

Is there evidence of shared communication, program planning and implementation, and problem solving?

Is there a relationship among the objectives, data, techniques, etc., within the programs or services delivered? Does the facility periodically observe services that are provided by the outside resource?

W121 §483.410(d)(4)

W101 §483.410(e)

Client Protections Probes and Procedures

W122 Compliance Principles §483.420

The Condition of Participation of Client Protections is met when:

- Clients are free from abuse and neglect;
- Clients are free from unnecessary drugs and restraints; and
- Individual freedoms are promoted (e.g., clients have choice and opportunities in their money management, community involvement, interpersonal relationships, daily routines, etc.).

The Condition of Participation of Client Protections is not met when:

- Clients have been abused, neglected or otherwise mistreated and the facility has not taken steps to protect clients and prevent reoccurrence;
- Clients are subjected to the use of drugs or restraints without justification; or
- Individual freedoms are denied or restricted without justification (e.g. systemic lack of privacy, of freedom of access to the community or to other clients, in use of personal possessions and money, etc.).

W123 §483.420(a)(1)

Evaluate the level of client understanding of his or her rights through interview and observation. When speaking with clients, families or guardians, determine if the facility communicated the client rights before or at admission. If clients and/or families do not understand their rights, review the facility's methodology for communicating this information.

Interview staff to determine their knowledge of client rights.

How does the facility determine if a client can or cannot understand his/her rights? How does the facility inform staff, clients, parents and/or guardians, or non-English speaking clients of rights (e.g. use of printed materials, specialized programs to inform deaf and/or blind clients, informal conferences)?

To what extent has the question of advocacy been raised if clients do not have family members? Or if clients have family members who do not wish to have contact made with them? Or if the client does not want the family to participate in decision making?

What manner of assistance is provided once a decision is made that a client has a need for advocacy, guardianship, or protective services?

W124 §483.420(a)(2)

If the client, family or guardian indicates that they are not promptly informed of the above or are not informed fully, review the documentation in the client record to determine whether the facility made any attempts to notify, whether contact was made with the correct person (family member or guardian) and what information was provided.

How does the facility inform the client/parent/guardian of the client's condition, and of other significant events (e.g. through written correspondence, phone calls, informal conferences, in native language, in a timely manner)?

Is there correspondence in the record informing the appropriate guardian of the client's condition? Is there evidence of informed consent when needed?

Are alternative treatment procedures made available for those who refuse specific treatment?

What kinds of treatments do clients refuse (if any)? Why? How does the facility respond to refusals?

How does the facility ensure that the concept of informed consent has been taught to clients, including the ramifications of refusal of treatment?

Is there evidence that appropriate people are informed of benefits and risks of treatments, including psychoactive drugs?

What does the facility do when clients show consistent patterns of refusal of treatments or programs?

W125 §483.420(a)(3)

During observations of client programs and during interviews with the clients, their families and/or guardians, confirm that the facility encourages and facilitates clients in the exercise of their rights (facility rights and constitutional rights).

During staff interviews confirm that the staff are familiar with client rights and are able to articulate how the rights are encouraged or protected through individual program plans and group activities.

Observe for any failure to allow a client to exercise his or her rights due to either mobility, sensory or communication barriers. It is expected that clients will have free access to all areas of the facility.

How are clients prepared to exercise their rights?

Are provisions made for all clients to assert their rights including those with mobility, sensory and communication impairments?

Can staff explain individual rights and how they facilitate individual exercise of rights?

Do clients use advocacy systems?

Are there established individual grievance procedures?

Are advocates given access to the client and his/her records, as appropriate, consistent with the Developmental Disabilities Assistance and Bill of Rights Act, as amended?

Are rights that are modified or limited specific, general, or blanket? Are they reviewed to ensure continued appropriateness to the client?

What ways show that clients assert their rights (e.g. do they vote, self-advocate, participate in self-governance council, participate in citizenship training, participate in community political activities)?

What type of complaints do individuals report (if any) and how well does the facility respond?

When interviewing individuals, do they describe situations which demonstrate the exercising of their rights?

On what basis does the facility accept, or not accept, a client's informed choice?

In what manner is due process ensured? How does the team fit into this process?

W126 §483.420(a)(4)

During surveyor observations note any client who is of the chronological age to utilize money management and exhibits the skills necessary to be on a formal money management program. Through observation and interview, determine the extent of any financial management program in which the client is involved. Review the client's comprehensive functional assessment (CFA) to confirm that the program is consistent with the findings of the assessment. The IPP must include measurable, individualized objectives to meet the various training goals consistent with the findings of the CFA and the IDT determination. The programs and strategies used to meet objectives should be detailed, understandable, and readily available for review and updating by staff in order to ensure a client's progress toward self-determination, choice, and independence. Such programs and strategies used to meet objectives may be established through documentation.

If the client is not on a formal money management program, the surveyor must review the IDT evaluation to determine whether the team addressed the results of the CFA and the identification of skills which can be cross-utilized in training programs. If this cannot be confirmed through documentation, a citation may be written.

How many clients does the facility report manage their own funds?

Through interview and observation of staff and clients served, are there clients who are able to manage their own money with assistance, if needed?

Are clients allowed to spend funds as they choose? Are there spending opportunities? Do they have cash?

Does staff make financial decisions for use of individual funds which the facility reports are managed by the client?

Does staff work closely with particular clients to participate in decisions about spending their money?

For those clients who manage their financial affairs, are they knowledgeable of their income source and amount?

What evidence is manifest by clients that they know what to do with personal finances? To what extent do clients know how to conduct bank transactions?

How are clients paid? Cash? Check? Vouchers? Tokens?

W127 §483.420(a)(5)

During observations on the living units and the work/training areas, observe for any clients who are exhibiting functional regression although all relevant factors such as medical, change in family situation, etc. have been ruled out. Compare these clients to the facility list of incidents and/or accidents to determine if they have sustained injuries or accidents. Observe the living and work environments of these clients to evaluate the amount of supervision provided. Interview the client, the staff and/or the client's family as indicated.

During observations in the living/training/work areas, observe for clients who appear fearful, suspicious, timid, shaking when approached, avoiding eye contact, overly obedient. Review the number of incidents/accidents recorded for the client observed exhibiting that behavior, and note the amount of staff supervision provided to the client. Interview the client, staff and/or client's family as indicated.

In addition, interview the facility staff to determine their level of understanding as to what constitutes abuse, how incidents are to be reported and specific client needs for additional protection.

If there is evidence that supports an Immediate Jeopardy determination, refer to Appendix Q. If it is determined that the facility has/had knowledge of abuse by a staff member or punishment imposed by a staff member and failed to comply with the requirements of 483.420 (d) (1) (iii), 483.420 (d) (2), 483.420 (d) (3) and 483,420 (d) (4) the clients at the facility should be considered to be at risk and an immediate jeopardy determination should be made.

Are there patterns of staff conduct which may be punitive, abusive, retributive, and counterproductive or a substitute for programming towards self-control?

Is there a systematic pattern of incident reports which suggest or allege abuse?

How is the facility organized to prevent abuse (e.g., investigative systems, abuse management, and analysis of incident and injury patterns, client/parent/guardian ombudsman systems)?

Cross-reference W150 for more probes.

W128 §483.420(a)(6)

During observations in the living/training/work areas note behaviors such as:

- Clients exhibiting excessive drowsiness during waking hours;
- Clients exhibiting excessive inactivity;
- Clients exhibiting symptoms of extra pyramidal symptoms (EPS) and
- Clients repetitively pacing.

Review the client's record to evaluate whether the client is receiving a drug, a dosage of a drug or frequency of a drug which is not consistent with their diagnosis, laboratory results and IPP as developed by the IDT.

Is there evidence of substitutions of one form of restrictive procedures for another (e.g. as drug usage is reduced)? Is there widespread increase in the use of time-out and restraint procedures and vice versa?

Does the active treatment plan address drug use, physical restraint and/or time-out modification?

Are clients receiving any drugs for which there are no substantiated uses or active monitoring to support their use? How long is use of a psychoactive drug allowed to continue without improvement to the client? What criteria must be satisfied before a psychiatric consultation is requested?

Cross reference W295 and W311 for more probes.

W129 §483.420(a)(7)

During observations in the living areas, notice whether clients have and utilize places to go to be alone and are they allowed to do so? For example, are clients allowed to go to their room alone? Allowed to go to a quiet private area? What measures are taken by the staff to intervene when another client does not respect the privacy of a client? If the use of private areas is not observed during the survey, interview the staff and clients to confirm that areas for privacy are provided and used. Interview clients and staff to verify that the specified areas for privacy are routinely available (and accessible) to all residents, including those who utilize wheelchairs and other adaptive equipment.

Do clients actually seek out and utilize opportunities for privacy?

Do clients actually have places to go to be alone and are they allowed to do so? For example, are clients allowed to go to their room alone? Allowed to go to a quiet private area, or do staff routinely "herd" clients preventing opportunities for privacy?

Are these rights afforded to less-disabled clients only?

Are clients taught "private area" behavior and responsibilities?

What do you see staff do when clients are not mindful of their or other's privacy?

To what extent are clients talked about in the presence of other clients?

W130 §483.420(a)(7)

During observations note any areas which compromise privacy such as multiple showers, more than one sink in a bathroom, no doors on toilet stalls, bathroom doors propped open during hygiene, failure by the staff to either close doors or draw privacy curtains during medical examinations and treatments. Confirm that the level of assistance provided is consistent with the current individual program plan.

Observe staff providing assistance to the clients during toileting, bathing, and other personal hygiene activities. Staff should assist, giving utmost attention to the client's privacy.

To what extent have accommodations been made so that clients with physical disabilities, who otherwise would be independent, can perform basic personal hygiene activities without staff present?

How does staff preserve personal privacy of clients when visitors are present?

W131 and W132 §483.420(a)(8)

Are clients assigned to bathe, toilet or feed other clients?

Is each client who provides work for the facility allowed to refuse to work for the facility?

Are there individual payment records? If a client makes less than the prevailing wage, can that person's individual production or performance record be retrieved?

If time studies were conducted, did the facility measure the same skills as performed by persons who are not disabled?

Are household tasks assigned and changed equitably?

Do clients have reasonable responsibilities, to the extent possible, for keeping their own private areas of living unit clean and neat?

Are clients coerced to work for staff in order to gain privileges?

Are clients trained to perform services for the facility for reinforcers or tokens rather than pay?

Do clients work the same job everyday without pay?

W133 §483.420(a)(9)

If a guardian overrides certain wishes of the client, verify whether the restriction(s) have a negative impact on the client's active treatment goals for more independent functioning and whether the restriction(s) could prevent the facility from meeting the overall needs of the client.

Does the facility provide clients with the opportunity to form individual relationships with others including opportunities to experience personal relationships both within and outside the facility?

What pattern of freedom of movement do you see at the facility? Do most clients move freely? Few?

On what basis is freedom of movement restricted? How often is this restriction re-evaluated? Is this dealt with programmatically in the individual program plan for each client?

W134 §483.420(a)(9)

During observations and interview, confirm that clients are encouraged to communicate with families or friends via letter or e-mail and that privacy is provided for these activities. During

interviews with families, inquire as to the amount of communication the family receives from the client.

How do clients send and receive mail?

Does staff assist clients who are unable to open and read mail themselves? Is writing assistance provided?

W135 §483.420(a)(10)

W136 §483.420(a)(11)

Clients should also be allowed to decline participation in either social or religious activities. During observations and interviews verify that this right is supported.

Are all activities agency-centered or sponsored?

Are religious preferences known and honored?

What is the level of client participation (relevant to level of individual functioning):

- Fully independent?
- Staff assisted/client participation?
- Total staff assistance?

Are the clients allowed to participate independently in activities commensurate with their level of functioning and interest?

What is the facility's system to facilitate a client's participation?

What does the facility do to draw out non-participating clients to the point that the client makes his/her own active choice to participate or not?

Does the facility arrange for clients to participate in community integrated activities individually or in small groups (3 or less) at least part of the time?

Does the facility arrange age and interest appropriate outside activities for clients with the community (e.g. recreation centers, churches, and social clubs)?

W137 §483.420(a)(12)

Determine whether the failure of a client to achieve functional, adaptive skills, or to have opportunities to make informed choices, or to achieve any positive outcomes is a result of the constant use of materials or participation in activities that are age-inappropriate.

Are clients dressed in their own clean, neat and attractive clothing?

Is it of the correct size and in good condition?

Is clothing appropriate for the weather and type of activity?

To what extent is there a pattern of slacks that are too long or too short? Are cords and pins used to keep pants up instead of belts?

To what extent does the facility provide items of lesser quality or provide only one type of a particular item?

Is there clothing for a variety of activities (e.g. clothing for church, casual social functions, sport events)?

Do colors, styles, and designs match and conform to community standards?

Are clients assisted in clothes selection, room decoration and other forms of self-expression?

Are clients satisfied with the access to and choice of the kinds and numbers of personal possessions they have?

How frequently during the course of the day do you observe clients using their personal possessions?

Are clients' personal decorative possessions displayed?

Are client possessions protected?

To what extent is there a pattern of individual loss, due to theft or destruction by others? What does the facility do to prevent loss? Is it successful?

W138 §483.420(a)(12)

During observations and interviews request that the client identify his/her personal clothes storage and personal possession storage.

To what extent are items of clothing such as pajamas, underwear, and socks, considered "stock" items as opposed to belonging to clients?

W139 §483.420(a)(13)

During the entrance conference determine whether any married couples currently reside in the facility. If so, interview the couples to verify that the facility permits co-habitation.

W140 §483.420(b)(1)(i)

Review the accounting records for each client in the survey sample for whom the facility manages personal funds to ensure a full accounting on a monthly basis of the client's personal funds entrusted to the facility and to verify that the funds are spent only for the individual client of the account. Interview the clients to verify the extent of their use of their personal funds.

W141 §483.420(b)(1)(ii)

W142 §483.420(b)(2)

W143 §483.420(c)(1)

Are families contacted for involvement in planning services/treatments for clients?

On a routine basis, what kinds of activities, information, and problems get communicated?

How does the facility develop and maintain active family/guardian participation?

Does the facility respond to the wishes of non-adjudicated adult clients who do not wish their family's involvement?

Does information in the client record correlate with information provided families?

Are parents and guardians allowed to talk to direct care and service providers?

What is the facility's basis for denying participation by the parents or guardians?

Is there a pattern to the denials or to the reasons stated?

How does the facility explain the meaning of "active treatment" to parents and guardians?

To what extent are families informed of how to reinforce training and/or the maintenance of skills while clients are with them?

What efforts has the facility made to accommodate scheduling problems for interdisciplinary team (IDT) or other meetings of families?

W144 §483.420(c)(2)

During family or guardian interviews, validate the quality and frequency of the communications between the facility and families or guardians. If the family or guardian indicates that the facility does not communicate with them, review the documentation in the client record regarding communications that have occurred.

How does the facility communicate with families and friends of those served?

Is there a pattern of lag time between contact and response which suggest responses are not timely?

W145 §483.420(c)(3)

During interviews with clients and families or guardians inquire as to the visiting policies. If restrictions are voiced, review the associated client record to further review the restriction.

Is there a systematic pattern of unreasonable restrictions on visitors in terms of when they can come, where they can go on the facility's property and to whom they can speak?

W146 §483.420(c)(4)

During interviews with families or guardians inquire as to the areas of the facility they have visited and whether they have ever been restricted from an area. If they have been restricted ask for specific details and the rationale given by the facility.

Is there a pattern to the types of restricted locations?

Is there evidence such as "no admittance" signs or policies against visitors in any of these areas?

W147 §483.420(c)(5)

During interviews with the clients and families/guardians, verify that facility assists with and encourages outside trips and vacations.

What is the frequency of these outings? What types of outings?

Are outings age-appropriate?

How does the facility provide choice in outings?

Can clients choose not to participate?

W148 §483.420(c)(6)

The facility must be able to produce evidence that emails or telephone notifications actually occurred.

Are family members/guardians informed of incidents/alleged abuse?

Are telephone numbers and addresses for parents and guardians kept and periodically updated?

What is the time frame for notification?

W149 §483.420(d)(1)

During interviews with staff, determine their knowledge level of what constitutes abuse, neglect or mistreatment by a staff member and how such instances are reported. During interviews with families and guardians, inquire as to any concerns they may have with staff treatment of the client. During observations, observe closely staff interactions with the clients.

Verify that the facility's policies and procedures address:

- 1) Screening potential employees for a history of abuse, neglect or mistreatment;
- 2) Staff and client training related to abuse and abuse prohibition practices;
- 3) How and to whom clients, family and staff should report concerns;
- 4) Identification of suspicious bruising and injury occurrences, patterns, and trends that may constitute abuse or neglect;
- 5) Injuries of unknown source;
- 6) How investigative procedures may vary for different types of incidents;
- 7) Procedures to protect clients from harm during an investigation of mistreatment, neglect or abuse; and
- 8) Reporting in accordance with State laws.

Refer to W186 because there is often a relationship between the adequacy of facility staffing and staff treatment of clients.

Is there a pattern among incidents of alleged abuse, accidents, behavior programs, psychoactive drug use, staff training, and adequacy of staffing levels that may suggest possible mistreatment, neglect or abuse of clients?

How does the facility monitor staff treatment of clients to ensure that the requirements are not being violated?

W150 §483.420(d)(1)(i)

If there is evidence that supports an Immediate Jeopardy determination, refer to Appendix Q for additional guidance. If it is determined that the facility has/had knowledge of abuse by a staff member or punishment imposed by a staff member and failed to comply with the requirements of 483.420 (d) (1) (iii), 483.420 (d) (2) 483.420 (d) (3) and 483.420 (d) (4), the clients at the facility are considered to be at risk and an immediate jeopardy should be issued.

Determine whether or not the perpetrator is still working at the facility and where they are working. Determine whether the perpetrator is working directly with the client or other clients.

Can staff define what constitutes abuse and punishment?

Are programs or policies "masks" for punitive, abusive controls?

How does the facility actively promote respect for clients?

How do staff members set acceptable behavioral limits for clients?

Does group punishment occur?

Does demeaning, belittling or degrading punishment occur?

Does staff speak loudly, harshly? In negative, punishing terms? With threats, coercion?

Cross-reference W127 for definitions and additional probes.

W151 §483.420(d)(1)(ii)

Observe meals during the survey. Note any instances where a client does not get the entire meal or the same portions as other clients. Note instances where second helpings are denied. Note instances where snacks are computed into the daily caloric intake for the client but are denied as punishment for behaviors. Interview the staff to determine the cause of these restrictions and confirm in the client record that such restrictions are necessary for the health of the client and have been approved by the specially constituted committee.

Note instances where water or other liquids are restricted for a client. Interview the staff to learn the rationale for the restriction and review the client record to determine that any restriction is medical in nature.

W152 §483.420(d)(1)(iii)

How does the facility screen employees for previous convictions?

Who are the facility's new hires? Has the facility implemented its system in such a fashion to ensure that W152 has been achieved?

W153 §483.420(d)(2)

How many alleged violations have been reported this year? Last year?

What mechanisms are in place to ensure prompt detection, reporting, and appropriate follow-up?

W154 and W155 §483.420(d)(3)

After you review reports of investigation, do you identify a pattern to the depth, thoroughness, conclusions and actions taken that suggest:

- Comprehensive and responsive investigations?
- Well conducted but negated or altered reports?
- Shallow or routinized investigations?

W156 §483.420(d)(4)

If a report of known or suspected abuse or neglect involves the acts or omissions of the administrator, how has the provider arranged for an unbiased review of the allegation (such as, an authority outside of the facility investigating the report and, if necessary, taking appropriate corrective action)?

W157 §483.420(d)(4)

The surveyor will need to evaluate the documented facts of the situation and the corrective actions taken by the facility and make a determination regarding the appropriateness of the facility's actions.

After investigations have been completed, how many alleged violations culminated in progressive discipline actions? Staff discharges?

As a result of the facility's investigations, is there a pattern of reduction of allegations?

Facility Staffing Probes and Procedures

W158 Compliance Principles §483.430

The Condition of Participation of Facility Staffing is met when:

- The Condition of Participation of Active Treatment is met (e.g. there are sufficient numbers of competent, trained staff to provide active treatment); and
- The Condition of Participation of Client Protections is met (e.g. there are sufficient numbers of competent, trained staff to protect clients' health and safety).

The Condition of Participation of Facility Staffing is not met when:

- The Condition of Participation of Active Treatment has first been determined to be not met and the lack of active treatment has resulted from insufficient numbers of staff or lack of trained, knowledgeable staff to design and carry out client's programs; or

The Condition of Participation of Client Protections has first been determined to be not met and the lack of client protection has resulted from insufficient numbers of competent, trained staff to protect the health and safety of clients.

W159 §483.430(a)

Verify that there are sufficient numbers of QIDPs to:

- observe clients,
- review data and progress, and
- revise programs based on client need and progress.

Verify the monitoring by QIDPs to ensure:

- consistent communication among external and internal programs and disciplines;
- individual program plans are designed in accordance with the CFA;
- each individual program is implemented consistent with the written active treatment plan;
- that any conflicts between programmatic, medical, dietary, and vocational aspects of the client's assessment and program are resolved;
- follow-up occurs for any recommendation for services, equipment or programs; and
- that adequate environmental supports (e.g. accessibility to front door, kitchen sink, clothes closet, washing machine and assistive devices) are present and in good working order to promote independence.

The determination that the number of QIDPs is adequate rests with the ability of the facility to provide the services described above in an effective manner.

Are the QIDP functions actually being carried out, or is paperwork simply reviewed?

Are timely modifications of unsuccessful programs or development of programs for unaddressed, but significant needs made or ensured by the QIDP function?

Are program areas visited and are performance and problems of clients discussed?

Does the plan flow from only the original diagnosis/assessment? Does it take into consideration interim progress on plans and activities?

Does the QIDP make recommendations and requests on behalf of clients? How does the facility respond?

W160 §483.430(a)(1)

W161 §483.430(a)(2)(i)

W162 §483.430(a)(2)(ii)

W163 §483.430(a)(2)(iii)

W164 §483.430(b)(1)

W165 §483.430(b)(1)

W166 §483.430(b)(1)

Look for evidence that paraprofessional and non-professional staff implement programs in a manner consistent with the clients IPP.

W167 §483.430(b)(2)

Review the client's IPP to identify the professional interventions needed to meet their goals and objectives.

Are these services available when they are most beneficial for the client?

Are these people available to staff on other shifts? Weekend staff?

Is professional staff available to monitor the implementation of individual programs if necessary?

W168 §483.430(b)(3)

W169 §483.430(b)(4)

W170 §483.430(b)(5)

How does the facility verify that its professionals meet State licensing requirements?

W171 §483.430(b)(5)(i)

Surveyor verifies occupational therapist has a degree, national certification, and State licensure, if applicable.

W172 §483.430(b)(5)(ii)

Surveyor verifies occupational therapy assistant has a degree, national certification, and State licensure, if applicable.

W173 §483.430(b)(5)(iii)

Surveyor verifies physical therapist has a degree, national certification, and State licensure, if applicable.

W174 §483.430(b)(5)(iv)

Surveyor verifies physical therapy assistant has a degree, national certification, and State licensure, if applicable.

W175 §483.430(b)(5)(v)

W176 §483.430(b)(5)(vi)

W177 §483.430(b)(5)(vii)

W178 §483.430(b)(5)(viii)

W179 §483.430(b)(5)(ix)

W180 §483.430(b)(5)(x)

W181 §483.430(b)(5)(xi)

Surveyor verifies the dietician has a degree, national registration, and State licensure, if applicable.

W182 §483.430(c)(1)

After observing client or volunteer activities done with clients served, can you determine whether or not those same services should and could have been provided reasonably by the facility, in the absence of those clients or volunteers?

Are clients served assigned to bathe, toilet, and feed or supervise other clients served in the absence of hired staff?

W183 §483.430(c)(2)

Are there incidences of aggression, assault, or clients leaving the building at night, without immediate detection?

W184 §483.430(c)(3)

In instances where one staff person is on duty and there is an increased number of injuries or unplanned client absences or a failure of staff to provide needed services promptly, investigate whether the clients involved did not meet 483.430 (c)(3)(i)-(iii) for asleep staff or whether staff have failed to respond to situations which could have been anticipated.

W185 §483.430(c)(4)

Is there observational or other evidence to suggest that clients are being neglected (e.g. demonstrate need for toileting, changing, active treatment interventions) while staff do laundry, housekeeping, cooking or serving household tasks?

W186(1) §483.430(d)(1)

In making this determination, clearly identify if the unmet need is the result of insufficient numbers of staff or ineffective deployment of staff.

W186(2) §483.430(d)(2)

W187 §483.430(d)(3)

W188 §483.430(d)(4)

Day program staff should be able to provide surveyors with the number of the responsible staff member who is available by telephone while clients are out in the community.

W189(1) §483.430(e)(1)

Is there an observed systemic lack of appropriate interactions and interventions with clients?
Does interview of staff and review of in-service records confirm little or no training activities?

Does new staff receive orientation to the facility and the clients with whom they are to work?

W189(2) §483.430(e)(2)

Does the staff training program reflect the basic needs of the clients served within the program?

Does observation of staff interactions with clients reveal that staff knows how to alter their own behaviors to match needs and learning styles of clients served?

W190 §483.430(e)(2)

W191 §483.430(e)(2)

W192 §483.430(e)(2)

W193 §483.430(e)(3)

During various times of the day, observe staff interactions with clients to see if the specific interventions, techniques and strategies to change inappropriate behavior outlined in the sampled client's program plans are consistently and correctly implemented.

If this standard is not met, evaluate W169 for professional staff involvement in staff training.

W194 §483.430(e)(4)

Observation and interview verify whether staff is competent and knowledgeable about the needs, programs, and progress of each sampled client with whom they are assigned to work.

Active Treatment Probes and Procedures

W195 Compliance Principles §483.440

The Condition of Participation of Active Treatment Services is met when:

- Clients have developed increased skills and independence in functional life areas (e.g., communication, socialization, toileting, bathing, household tasks, use of community, etc.);
- In the presence of degenerative or other limiting conditions, clients' functioning is maintained to the maximum extent possible;
- Clients receive continuous, competent training, supervision and support which promotes skills and independence; and
- Clients need continuous, competent training, supervision and support in order to function on a daily basis.

The Condition of Participation of Active Treatment Services is not met when:

- Clients functional abilities have decreased or have not improved and the facility has failed to identify barriers and implement a plan to minimize or overcome barriers;
- Clients are not involved in activities which address their individualized priority needs;
- Clients do not have opportunities to practice new or existing skills and to make choices in their daily routines; or
- Clients are able to function independently without continuous training, supervision and support by the staff.

W196 §483.440(a)(1)

When the standard of active treatment (W196) is not met, the condition of participation at W195 must be cited as not met as well.

How does the facility address the active treatment needs of clients along their full life span?

As you conduct each observation, determine:

- Is the activity scheduled or planned?
- Are materials present to implement the activity?
- Are they used?
- Are all clients present involved or engaged in the activity?
- Are the activity and materials age-appropriate, adaptive and functional?
- Are new skills and behaviors being taught or reinforced?
- Are all clients reinforced and prompted frequently?
- Are all staff verbally and physically involved?
- Are there sufficient staff for the activity?

- Are interactions characterized by a "mentor/friend" tone? Does the activity relate directly to specific objectives and needs? Does staff demonstrate the skills necessary to train or reinforce training on the IPP objectives?
- Are clients observed to engage in aggression, self-injurious behavior or self-stimulatory behavior (e.g. finger flicking)? If so, does staff intervene as per the IPP?

W197 §483.440(a)(2)

W198 §483.440(b)(1)

W199 §483.440(b)(2)

W200 §483.440(b)(3)

W201 §483.440(b)(4)(i)

Can you identify a pattern of transfer or discharge that occurs suddenly and that cannot be accounted for on an emergency basis?

What are the facility's criteria for emergency transfer or discharge, and what are the procedures?

Do parents/family members/friends/advocates/guardians participate with the client in the transfer/discharge decision-making process?

Does the reason for transfer/discharge given by the client and/or family correspond with what is reported in the record?

W202 §483.440(b)(4)(ii)

What do clients who are being considered for transfer/discharge (and/or parents, etc.) report about their participation in the process (if any)?

Does the IPP reflect objectives preparing the client for transfer or community placement?

How are client and family views recognized by facility staff? How do they deal with them?

W203 and W204 §483.440(b)(5)(i)

W205 §483.440(b)(5)(ii)

Verify that the plan includes all that is required to facilitate a smooth transition to a new environment.

W206 §483.440(c)(1)

Where clients' needs are identified on the CFA and are not addressed on the IPP, determine if appropriate professional program staff participated in the (IDT) process and why the need is currently not being addressed formally.

Do the plans from client to client have a predictable sameness about them?

Does the plan flow from only original diagnosis/assessment? Does it take into consideration interim progress or emergent needs?

Does the team create an integrated plan or is the plan a "stapling together" of individual pieces with little or no discussion as to how pieces relate/impact on each other? Are conflicts seen among various pieces of the plan? Refer to W120.

When prepackaged programs are used, are needed individual adaptations tailored to the needs, and functional skills of a client?

W207, W208 and W209 §483.440(c)(2)

Question routine, unscheduled absences by relevant team members and evaluate the impact on the IPP.

Does the facility have a working means of gathering all needed data for IPP sessions?

Are the views of staff not present at the team meeting incorporated in the plan?

Are clients/parents/guardians provided with information prior to a meeting which will be used at the meeting to make decisions?

Does the scheduling of the program planning meeting take into account the schedules of day programs and the availability of family?

If unable to attend, does someone review the results of meetings and act on areas of question, dispute?

If clients served do not attend IPP meetings, what reasons does staff give to explain their absence?

How does staff prepare clients to participate in IDT meetings?

Does the facility respect client wishes for additional representatives on the IDT, such as friends or advocates?

W210 §483.440(c)(3)

If during observations and interviews of a client admitted to the facility within the past six (6) months, it is noted that a client's current programs do not correspond with what are observed to be his/her abilities/needs, review the client's CFA to determine whether a re-assessment was conducted within 30 days after admission.

W211 §483.440(c)(3)

W212 §483.440(c)(3)(i) See below

W213 §483.440(c)(3)(ii) See below

W214 §483.440(c)(3)(iii) See below

§483.440(c)(3)(i)--(iii):

Do assessments interpret the significance of the results in terms of the clients' functional daily life needs or do they simply describe diagnoses, test performances or clinical impressions?

Do assessments merely report scores or functioning age levels or in the absence of strengths/needs lists, are the skills necessary to support those determinations identified within the assessment?

Do the strengths and needs identified by the facility correspond to what you see clients do or not do during observations?

Does the assessment reflect how the environment could be changed to support the person?

W215 §483.440(c)(3)(iv)

Do assessments conclude whether or not "hands-on" therapy conducted by professionals is indicated, and if an individual problem still exists, does the assessment recommend how the team should deal with the problem?

Is there a pattern of client need areas not addressed in clients' IPP objectives that correspond to the absence of those professional service areas at the facility?

W216 through W225 §483.440(c)(3)(v)(1) through (10)

For all domains, do assessments describe what clients can and cannot do in terms of skills needed within the context of their daily lives?

Is the assessment based on:

- Actual performance of the client against objectified criteria?
- Reports by staff/parents/guardians?
- Observed performance in a variety of settings?
- Simple checklists?

Are assessments individualized?

Are assessments conducted in appropriate environments?

W221 §483.440(c)(3)(v)(6)

During observations, note any client who exhibits questionable hearing loss. Interview the client and direct care staff to determine if there is a loss, and if so, what measures have been taken to address the loss.

Review the client record to ensure that evaluation of hearing was included in the CFA and corresponds with the observations of the client.

W226 §483.440(c)(4)

W227 §483.440(c)(4)

Validate that needs identified on assessment result in the development and implementation of objectives to meet those needs.

Surveyors should review any situation where a client is of the chronological age to perform money management at some level and is observed to have the above referenced skills but is not on a formal money management program. The decision to implement a money management training objective should not be based solely upon developmental level or physical disability.

Is there a predominant pattern of staff-oriented objectives rather than learner-oriented objectives?

Is there repetition and predictability of programming across clients?

W228 §483.440(c)(4)

W229 §483.440(c)(4)(i)

W230 §483.440(c)(4)(ii)

W231 §483.440(c)(4)(iii)

W232 §483.440(c)(4)(iv)

Are chosen objectives the most direct means for resolving identified needs?

Do programs and strategies have a relationship to needs identified and objectives chosen?

W233 §483.440(c)(4)(v)

W234 §483.440(c)(5)(i)

W235 §483.440(c)(5)(ii)

W236 §483.440(c)(5)(iii)

W237 §483.440(c)(5)(iv)

Data which shows no improvement over long periods of time without intervention by the IDT or QIDP should be discussed with the QIDP.

Confirm during interviews that the designated QIDP is familiar with the recording of data and the analysis of the data collected.

W238 §483.440(c)(5)(v)

W239 §483.440(c)(5)(vi)

During client observations, interview, and record review, note any behaviors which appear to be interfering with training programs. Interview the QIDP and review IDT notes to determine whether such behaviors have been addressed. Verify the team has added a replacement behavior to the plan and that the QIDP is monitoring the success of learning that replacement behavior.

W240 §483.440(c)(6)(i)

If clients are observed in need of glasses, hearing aids, or other assistive devices, review the plan to determine if these needs were identified.

W241 §483.440(c)(6)(ii)

W242 §483.440(c)(6)(iii)

Surveyors should investigate any use of temporary mechanical supports such as towels or sheets. Surveyors should also look closely at the use of mechanical supports to ensure that the supports are not in fact restraints.

Is evidence of "developmental incapability" based on client performance, medical evidence, historical efforts at training; or is it based on "opinions" of staff (in the absence of performance data)? Does the activity prepare clients to function more independently or does it merely train the client to adapt to his/her particular facility (e.g. large institutional living)?

Do staff direct their activities toward the acquisition of clients to learn increasingly complex skills or does staff accept that clients will not or cannot grow and change?

W243, W244 and W245 §483.440(c)(6)(iv)

W246 §483.440(c)(6)(v)

Question any program directing that the client remain on continuous bed rest without legitimate medical justification.

For those for whom out-of-bed activity is a threat to their health and safety, look for:

- Clients and staff engaged in activities to increase sensory stimulation; and
- Equipment designed to promote increasing the client's sensory stimulation.

Is equipment available to provide access to community activities?

Are mobility devices available and used as needed by clients?

W247 §483.440(c)(6)(vi)

Determine if the facility accommodates the client's interests, needs, abilities, and preferences. For example, determine whether a group activity has been adapted for the clients as needed and whether it meets each client's needs/preferences. Interview staff to determine how activities facilitate or impede client choice.

Interviews clients about the choices they are provided and if their choices are honored.

W248 §483.440(c)(7)

W249 §483.440(d)(1)

During observations, determine whether:

- 1) Active treatment activities are integrated into the normal daily routines;
- 2) Clients are observed performing scheduled active treatment activities;
- 3) There are appropriate and sufficiently trained staff to implement the IPP objectives; and
- 4) The classroom, therapy or activity environments are conducive to learning with limited distractions, noise levels or other behavioral obstacles to learning.

Does the activity schedule and the content of the activities relate directly to the strengths, needs and objectives in the IPP for each client or are the activities/content "make work," generalized, non-developmental time fillers?

Can staff describe how activities relate to strengths, needs and IPP objectives?

Are active treatment activities integrated into a "normal daily rhythm"?

Are clients observed performing scheduled active treatment activities?

Is there sufficient and appropriate staff to implement IPPs?

Is training on priority objectives implemented at discrete time intervals exclusively, or is training implemented as the client's needs emerge during the course of the day, as well?

Is there a consistent discernible pattern of evidence that staff implement, practice, reinforce, and otherwise carry out strategies to achieve individual objectives?

At any point in time are IPP interventions observable during staff and client interactions, in formal and informal settings alike, throughout the individual's living experience?

Does the classroom, therapy or activity environment lend itself to the learning experience or are distractions, noise levels, or other individual behaviors obstacles to individual learning?

W250 §483.440(d)(2)

Investigate any pattern of staff action or scheduling which results routinely in all or the majority of clients engaging in the same activity (such as everyone goes to the park or the movies at the same time) or routine at the same time (such as showers or tooth brushing).

While the facility should have access to and be aware of the client's schedule from their day program, there is no requirement that this schedule and the residential schedule be merged into one document.

W251 §483.440(d)(3)

Do staff assigned to work with the client encourage him or her to perform activities of daily living with maximum independence? Is development and reinforcement of these skills implemented regularly?

Is there evidence that each discipline working with the client integrates, as appropriate, other disciplines' objectives and techniques? (For example, do direct care staff implement manual communications systems? Does the O.T. implement behavior management programs, if needed by the client, during O.T. training sessions?)

Are informal daily activities designed to promote choice, self-management, skill enhancement or reinforcement?

W252 §483.440(e)(1)

Do the data collected on an individual basis vary according to the nature of the task, or are data collected the same way for all clients on all tasks?

Do the data collected yield information relevant to making program decisions?

Are the data collected on objectives implemented outside the agency also reviewed and analyzed to justify change in the objectives?

Is there a correlation between recorded data and observed individual performance?

W253 §483.440(e)(2)

Is there a discernible pattern indicating that the facility routinely fails to detect the need to change individual programs?

Does the facility record unusual episodes and other incidents that suggest the staff needs to respond with a changing program or other special attention?

W254 §483.440(e)(2)

W255 through W258 §483.440(f)(1)(i) to (iv)

During review of data collection in association with the observation of active treatment programs, interview the direct support staff and QIDP regarding any client who has completed his/her objective. Determine whether the QIDP has reviewed the data and recommended appropriate adjustments to the program.

Is the QIDP actually monitoring individual programs, or does the QIDP simply review paperwork? See also W159.

Are timely modifications of unsuccessful programs or development of programs for unaddressed, but significant needs made or ensured by the QIDP?

Does the QIDP routinely visit program areas and discuss performance and problems of clients?

Is there evidence that collected data are systematically recorded, analyzed, and used to make changes in programs?

Can the QIDP describe the programs implemented with clients for whom they are responsible or do they need to go to the record for this information?

W259 §483.440(f)(2)

W260 §483.440(f)(2)

During the annual IPP review, verify that the IDT considers new prioritization the addition of objectives and the deletion of objectives based upon the performance data provided to the team. There should be a logical relationship between goals and objectives from year to year.

Does the annual review result in actual changes in the individual's programs, or is it a "rubber stamp" duplication of the prior year's plan?

Does the facility respond routinely to the need for change in an individual's program or does an individual's program tend to be changed only once a year or on a time periodic basis (e.g. every quarter or six months)?

Is there a logical relationship among goals and objectives from year to year or are objectives established in a fragmented, unrelated pattern from year to year?

Can the reason for changes, deletions, or additions to IPP objectives be identified?

W261 §483.440(f)(3)

W262 §483.440(f)(3)(i)

For each client in the sample who has a behavior management program with restrictive/aversive techniques and or drugs to manage behavior, assure that the specially constituted committee has reviewed and approved the plan. Does the committee generally approve whatever staff recommends without substantive review?

Does the committee generally approve whatever staff recommends without substantive review?

Does the committee require that less restrictive means be demonstrated to be ineffective?

What is the length of time from program submission to committee review?

Do you discern a pattern of committee involvement in the ongoing monitoring of approved programs? Does the committee seek changes, if indicated?

If staff assigned to the committee(s) is also members of the particular client's interdisciplinary team, does that staff member abstain from approving formally the client's program?

W263 §483.440(f)(3)(ii)

During interviews with family members, ask specifically what information the facility provided to them before they were asked to sign the consent.

Verify whether or not consent was obtained in accordance with law.

W264 §483.440(f)(3)(iii)

W265 §483.440(f)(4)

Verify that committee recommendations have been addressed by the facility.

Client Behavior Probes and Procedures

W266 Compliance principles §483.450

The Condition of Participation of Client Behavior and Facility Practices are met when:

- Individual programs and activities regularly include use of positive techniques, teaching strategies, and supports. Efforts are made to reduce and eliminate use of restrictive techniques with positive results;
- Restrictive techniques are used only when warranted by the severity of the behavior, and result in desired behavioral outcomes.

OR

The Condition of Participation for client Behavior and Facility Staffing is not met when;

- Individual programs and activities do not regularly include the implementation of positive techniques, supports, and teaching strategies.
- Staff does not teach and reinforce appropriate behaviors such as communication skills, social skills, coping skills, independence and choice making skills and leisure skills.
- When restrictive techniques are used when not warranted by the severity of the behavior or result in undesirable behavioral outcomes.

Restrictive interventions are used without first documenting attempts of less restrictive or more positive measures.

W267 §483.450(a)(1)

W268 §483.450(a)(1)(i)

W269 §483.450(a)(1)(i)

Observations which indicate that client choice is encouraged include, but not limited to:

- Formal and informal programs include choice;
- Choice is incorporated into everyday activities of daily living;
- Appropriate and purposeful activities and materials known to be preferred by the individual are available; and
- Alternatives are available for clients who do not choose to participate in a planned activity.

If observations do not verify client choice is provided and encouraged, review policies and procedures to determine whether the policies fail to address choice and self-management or whether staff are not promoting client choice, self-determination and self-management, in accordance with the facility policy and procedures.

W270 §483.450(a)(1)(iii)

W271 §483.450(a)(1)(iv)

W272 §483.450(a)(2)

W273 §483.450(a)(3)

W274 and W275 §483.450(b)(1)

W276 §483.450(b)(1)(i)

W277 §483.450(b)(1)(ii)

The surveyor should assess the use of emergency restrictive interventions to assure that the facility could not have reasonably anticipated the behavior, and verify that the team has reviewed the individual program plan for its adequate attention to the problem precipitating the emergency measure.

W278 §483.450(b)(1)(iii)

Do clients observed with behavior problems (e.g., aggression, withdrawal, stereotypical, self-abusive) have individually designed behavior programs?

Does the "maladaptive" behavior ever occur as an "appropriate" response given the client's circumstances?

How has the staff tried to determine what the client is trying to accomplish or communicate by displaying the maladaptive behavior? How do they respond to the behavior and the need being communicated?

Was the possibility addressed that the inappropriate behaviors might be an expression of a mental disorder? Was a medical and/or psychiatric consultation obtained, especially if a treatment program was unsuccessful for a reasonable length of time?

Is there consistent positive reinforcement procedures used with clients? What specific client behaviors do staff report they are to reinforce or are observed to be reinforcing?

Would environmental alterations alone reduce or eliminate the maladaptive behavior? Does the team consider attempting environmental changes before instituting a more restrictive program to control inappropriate behavior?

Is there evidence of interventions to change the conditions which lead to inappropriate behavior?

W279 §483.450(b)(1)(iv)(A)

W280 §483.450(b)(1)(iv)(B)

W281 §483.450(b)(1)(iv)(C)

W282 §483.450(b)(1)(iv)(D)

W283 §483.450(b)(1)(iv)(E)

W284 §483.450(b)(1)(iv)(F)

W285 §483.450(b)(2)

Verify through observation and record reviews that:

- 1) for each behavior intervention there was adequate staff present to implement the intervention safely and still meet the needs of the other clients present;
- 2) staff follow approved facility procedures when implementing behavior interventions and these interventions are consistent with the approved IPP for the client; and
- 3) client rights were protected (to be released from restraints once calm, to be free from verbal abuse from staff during the event, to be treated with dignity during the event).

What mechanism does the facility use to ensure that approval does not extend longer than warranted?

To what extent is the special review committee involved in monitoring?

Do the procedures deny requisite human needs, such as sleep, shelter, bedding, or use of bathroom facilities?

Are rights denied in the absence of the required consent and approvals?

Are drugs used to manage inappropriate behavior monitored for unfavorable side effects?

W286 §483.450(b)(3)

How commonly are these techniques used? What types of problems are they used for?

Do these techniques continue to be implemented and/or authorized regardless of client success on individual program plan objectives?

Are restraints, time-out rooms or drugs used for environmental deficiencies (e.g. lack of staff, program structure)?

W287 §483.450(b)(3)

Are the behaviors listed as problematic occurring only in certain situations, such as in living areas and on weekends, possibly indicative of understaffing? Are the problematic behaviors occurring during day programs, possibly indicative of inappropriate placement?

Is there a systematic pattern showing restrictive technique usage occurring more frequently in units where staffing is not optimal? Where there is frequent staff turnover?

Is usage tied directly to a carefully approved behavior reduction program? Or, is it in practice, a means of locking clients at the convenience of staff or in the absence of effective programming?

W288 §483.450(b)(3)

Does the program to control inappropriate behavior actually address the problems identified, or is it a behavior control/punishment program that does not result in desired behavior outcomes?

W289 §483.450(b)(4)

Are behavior programs demonstrably implemented in formal and informal settings alike as per the individual program plan?

Is there a complete description of the behavior occurring and evidence to show that as inappropriate behaviors diminish, desired, appropriate behaviors increase?

Does the facility change the program as client behavior indicates?

What specific appropriate behaviors are being taught, improved, supported or substituted for the maladaptive behavior?

W290 §483.450(b)(5)

Is there a pattern of restrictive techniques used in tandem (e.g. a client is released from time-out, but is then put in another type of restraining device)?

Is there a long term pattern of usage without discernible gains in client progress?

Do client records contain "approved" programs incorporating restrictive techniques, yet there is:

- Only episodic frequency of the maladaptive behavior?
- Relatively rare usage of the restrictive technique?
- No previously tried and implemented positive strategies showing lack of success?

W291 §483.450(c)(1)

Verify whether or not anyone standing or lying in any position, in any part of the time-out room (including all four corners) can be seen.

What reasons cause clients to be placed in time-out rooms most frequently? Is there a pattern of time-out usage? What is it?

On the average, how long are clients placed in "time-out rooms"? Is time-out room usage extended on a routine basis?

Does the frequency of time-out room usage indicate that isolation is more reinforcing to the client than the environment?

Are there plans to move to less restrictive means of modifying the behavior?

Is criterion clearly specified for use/discontinuance of time-out rooms? What does staff do with clients after they leave time-out rooms?

Is usage directly tied to a carefully approved behavior reduction program or is it in practice a means of locking clients at the convenience of staff or in the absence of effective programming?

How does staff monitor clients in time-out rooms? What does staff do if a client in a time-out room screams? Engages in self-abuse? Becomes incontinent? Shows signs of medical illness?

W292 §483.450(c)(2)

Review documentation in client records and conduct interviews with staff to confirm that clients are placed in time out rooms for no longer than one hour.

W293 §483.450(c)(3)

W294 §483.450(c)(4)

Can staff show how long and frequently time-out has been used?

Can staff describe what environmental variables contributed to each time-out usage?

W295 §483.450(d)(1)(i)

What is the reason for the restraint? Does the individual program plan identify the type of restraint to be used? Does the severity of the behavior justify its usage?

Does the facility consider factors other than the client in determining causes for need for restraints (e.g. other clients, staff, building noise, sufficiency of program structure)?

Are there clear, performance-based linkages between use of restraints in practice and behavior programs that use restraints? Or are restraints used in ways and at times other than prescribed in the client's program?

W296 §483.450(d)(1)(ii)

Is there a systematic pattern of incidents being called "emergencies" in order to apply restraints without use of an approved program?

Are repeated emergency applications of restraints followed up with development of systematic behavior management programs? Is use of an emergency application documented and reviewed by the QIDP or designee with appropriate follow-up?

W297 §483.450(d)(1)(iii)

What does staff do to prepare clients for medical or dental examinations in order to reduce the need for physical or mechanical restraints?

Have other options such as desensitization training, behavior shaping, intensive positive reinforcement, environmental changes, etc. been tried?

Are clients routinely restrained before medical or dental examinations?

W298 §483.450(d)(2)(i)

W299 §483.450(d)(2)(ii)

W300 §483.450(d)(3)

W301, W302 and W303 §483.450(d)(4)

Is there a pattern that clients are placed in restraints repeatedly for two (2) hour consecutive applications during the entire restraint authorization period?

Does the team decide whether constant or frequent monitoring is helpful or contraindicated for a client? On what basis is this decision made?

When staff applies restraints do they demonstrate proper usage per each client's program? Is the use of restraints well documented to present a clear picture of the events prior to, during, and following its use? Is this information reviewed by the IDT and addressed?

W303 §483.450(d)(4)

Verify the client's status was documented in the client's record each time the client was checked by staff while in restraint.

In addition to observations of any physical restraint in use at the time of the survey, review the client's record for documentation of the methods of application utilized and the response of the client to the restraint. Observation and/or documentation should confirm that the staff responds quickly to any client discomfort. To the extent possible, normal range of motion should be maintained by the client while in restraint.

W304 and W305 §483.450(d)(5)

Is there documentation in a client's record regarding contraindications, if any, to certain types of restraints?

How will the client's safety be ensured?

How does staff decide which type of restraint to use for a particular client?

W306 §483.450(d)(6)

W307 §483.450(d)(6)

W308 and W309 §483.450(d)(7)

For what reason does staff use barred enclosures?

How long do clients remain in these devices?

What other interventions have been tried?

Is use of these enclosures incorporated into individually designed plans, aimed at elimination of the behavior causing the need?

W310 §483.450(e)(1)

Are clients who receive medications lethargic and inactive during the day? If so:

- How long has the client been on medication?
- How long have the overt behaviors of lethargy and inactivity been noticed?
- Have there been any attempts to taper the medication down?

Is there evidence that the medication helps to facilitate the client's participation in his/her individual program plan objectives?

W311 §483.450(e)(2)

W312 §483.450(e)(2)

Note any instances in the survey sample and/or drug review where clients are receiving drugs for behavior control. Look for evidence that:

- 1) the facility tried explored and tried alternate measures before resorting to the use of the drug;
- 2) the drug is ordered for specific behaviors or DSM diagnoses;
- 3) that the inappropriate behaviors are being monitored ;
- 4) the IDT was involved in the decision to use the behavior management drug;
- 5) the use of the drug is incorporated into the IPP; and
- 6) there is a comprehensive behavior management plan in place which includes efforts to reduce or eliminate the targeted behaviors.

Is there documentation that alternative interventions have been considered and tried where appropriate?

Is there a pattern of prescription of the same drug used for many clients, regardless of the problem?

Is the overall rate of psychotropic medication usage appropriate to the nature of the population served (e.g. in relation to case mix)?

Is there evidence that the client can be and is placed on psychotropic medications without a full review and the protection processes of these requirements?

Is there an identifiable working mechanism to reduce or eliminate the need for psychotropic drug use on each affected client? Are data collected so that the effect of drug usage can be assessed?

Does the physician, psychologist, pharmacist, nurse, and other program and health staff work together to reduce psychotropic drug utilization?

Are drug reduction plans actually implemented as indicated by reaching criteria in the behavior management programs?

W313 §483.450(e)(3)

W314 §483.450(e)(4)(i)

W315 §483.450(e)(4)(i)

Determine what strategies (staffing, programmatic, environmental, staffing) the facility has put in place to help the client successfully reduce or withdraw from the drugs used to control behaviors. In the case of psychiatric medications, it may not be indicated to do any withdrawal of medication, as a therapeutic range must be maintained. If the IDT is not reducing a medication due to a therapeutic range, there should be documentation that this is the effective therapeutic range for the client and reasons why it would be detrimental for the client to be outside of the range. How does the physician monitor usage of drugs prescribed and is this monitoring and decision-making for drug usage a part of the team process or is it done in isolation by the medical staff? Is there sufficient time for the physician to review the clients with the team?

What do staff report about the medications the client receives? Their purpose? Side effects? What would they do if side effects suddenly appeared (e.g. extrapyramidal side effects in a person on anti-psychotic drugs)?

Is there evidence that the effects of the therapeutic intervention are being assessed and modified in light of the presence or absence of the desired response? In light of the emergence of side effects?

W316 §483.450(e)(4)(ii)

W317 §483.450(e)(4)(ii)

Is staff aware of possible withdrawal symptoms, and are plans developed to assist the client through these periods of stress?

Is drug therapy prescribed for an indefinite period of time?

Healthcare services Probes and Procedures

W318 Compliance principles §483.460

The Condition of Participation of Health Care Services is met when:

- Clients receive preventative services and prompt treatment for acute and chronic health conditions; and
- Clients' health is improved or maintained unless the deterioration is due to a documented clinical condition for which deterioration or lack of improvement is an accepted prognosis.

The Condition of Participation of Health Care Services is not met when clients do not receive adequate health care monitoring and services, including appropriate and timely follow-up, based upon their individualized need for service.

W319 §483.460(a)(1)

W320 and W321 §483.460(a)(2)

W322 §483.460(a)(3)

Are referrals made to other specialists when appropriate? Are referrals followed up?

Are women provided with gynecological services?

Are clients referred to neurologists, if they have poor seizure control over a long period of time?
A noted toxicity of seizure medications?

Are clients with apparent mental illness (e.g., depression, psychosis, obsessive/compulsive disorder) referred to specialists for proper diagnosis and treatment?

W323 §483.460(a)(3)(i)

Do assessments of vision and hearing include acuity measures, as well as physiological measures, as appropriate?

W324 §483.460(a)(3)(ii)

W325 §483.460(a)(3)(iii)

Has physician justification been provided when the physician determines that a standard laboratory test is not necessary for the client?

W326 §483.460(a)(3)(iii)

W327 §483.460(a)(3)(iv)

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

The current recommendations of the Center for Disease Control and Prevention, Guidelines for Preventing the Transmission of Tuberculosis in Health Care Facilities, (most recent edition) should be followed by the facility. The current guidelines may be accessed at Centers for Disease Control (CDC).

W328 §483.460(a)(4)

W329 §483.460(b)(1)

W330 §483.460(b)(2)

W331 §483.460(c)

W332 §483.460(c)(1)

W333 §483.460(c)(2)

W334 §483.460(c)(3)(i)

An example of a body system review is foot care, and appropriate questions to ask in ascertaining the status of foot care would be:

- Is there evidence of abnormal swelling?
- Is skin supple?
- Are there signs of skin cracking or breaking?
- Are ulcers present?
- Is fungus present?
- Are there signs of ingrown nails?
- Are nails painful when pressed?
- Is there dampness between toes?

W335 §483.460(c)(3)(ii)

W336 §483.460(c)(3)(iii)

W337 §483.460(c)(3)(iv)

W338 §483.460(c)(3)(v)

What is the feedback mechanism to the physician?

Is there a traceable relationship between facility staff and physicians that result in timely changes in clients' health care?

W339 §483.460(c)(4)

Is skin integrity maintained and breakdown prevented?

Are measures used to prevent skin breakdown (e.g. padding pressure points, use of emollients)?

W340 §483.460(c)(5)(i)

W341 §483.460(c)(5)(ii)

W342 §483.460(c)(5)(iii)

W343 §483.460(d)(1)

If there are fewer than ten (10) nurses employed by the facility, verify current licensure for all the nurses employed. If there are more than ten (10) nurses employed, select a sample of ten (10) nurses. Verify current licensure for all nurses in this sample.

W344 §483.460(d)(2)

W345 §483.460(d)(3)

W346 §483.460(d)(4)

W347 §483.460(d)(5)

W348 §483.460(e)(1)

W349 §483.460(e)(2)

W350 §483.460(e)(3)

During observations, verify that staff observe the clients during oral hygiene programs, provide prompts to the clients as indicated, and intervene when necessary. If staff is not following the IPP, interview the staff to determine what training they received to assist clients with oral hygiene programs.

W351 §483.460(f)(1)

W352 and W353 §483.460(f)(2)

W354 §483.460(f)(3)

W355 §483.460(g)(1)

W356 §483.460(g)(2)

During observations, interview and record review, verify that clients receive dental services as needed. These services include periodic examination, cleanings, prompt treatment of infections, screenings for oral cancer, treatment of injuries, extractions, restorations and pain control.

Are clients' dental needs neglected until there is pain or other emergency?

Do examinations indicate that services were furnished, rather than notes indicating that the client was "unable to be examined" or "as best as can be determined?"

W357 and W358 §483.460(h)(1)

W359 and W360 §483.460(h)(2)

W361 §483.460(i)

W362 §483.460(j)(1)

Does this review look at the client's response to the drug?

W363 §483.460(j)(2)

W364 §483.460(j)(3)

W365 §483.460(j)(4)

W366 §483.460(j)(5)

W367 §483.460(k)

During the drug pass observations, verify that the facility utilizes an administration system that identifies each drug up to the point of administration.

W368 §483.460(k)(1)

W369 §483.460(k)(2)

W370 §483.460(k)(3)

W371 §483.460(k)(4)

During drug passes, observe whether clients are offered the opportunity to participate consistent with their functional skill level and verify that the programs are being carried out consistently and in accordance with the written objective. For clients not in need of formal self-administration programs who are not provided opportunities to participate in administration process, cite a deficiency at §483.440(c)(6)(vi).

If, as a result of observations and interviews, there are any concerns as to why a client is not on a formal program, the surveyor should review the associated assessments and interdisciplinary discussions. During this review look for evidence that the IDT documented a justification as to why the client was not appropriate for a formal self-administration program and that the justification provided was based on an evaluation of the results of an accurate, current, valid assessment.

Is there a pattern of refusal to allow self-medication?

How is the health and safety of clients assured during training for self-medication?

W372 §483.460(k)(5)

W373 §483.460(k)(6)

Is there a pattern that all clients self-medicate whether they can demonstrate the skill or not?

W374 §483.460(k)(7)

W375 and W376 §483.460(k)(8)

W377 through W381 §483.460(l)(1)

W382, W383 and W384 §483.460(l)(2)

W385 §483.460(l)(3)

W386 §483.460(l)(4)

W387 §483.460(l)(5)

W388 §483.460(m)(1)(i)

W389 §483.460(m)(1)(ii)

W390 §483.460(m)(2)(i)

W391 §483.460(m)(2)(ii)

W392 §483.460(m)(3)

W393 §483.460(n)(1)

W394 §483.460(n)(2)

Physical Environment Probes and Procedures

W406 Compliance Principles §483.470

The Condition of Participation of Physical Environment is met when:

The environment promotes the health and safety, independence and learning of the clients who reside there.

The Condition of Participation of Physical Environment is not met when:

- Environmental conditions interfere with learning and independence (e.g. lack of appropriate assistive devices, accessible bathrooms and closets, house or water temperatures, etc.) to such an extent that the Condition of Participation for Active Treatment is not met.
- Clients are at risk to health and safety due to environmental conditions.

- Poor infection control practices are observed and there is a high rate of infections or communicable diseases among the clients residing in the facility.

W407 §483.470(a)(1)

W408 §483.470(a)(2) and (3)

W409 §483.470(b)(1)(i)

W410 §483.470(b)(1)(ii)

W411 §483.470(b)(1)(iii)

W412 and W413 §483.470(b)(1)(iv)

W414 §483.470(b)(1)(v)

W415 §483.470(b)(2)

W416 §483.470(b)(3)

If the medical risk of a client is so potentially life threatening that the client requires continuous unobstructed surveillance during sleeping hours to ensure his or her health and safety, the surveyors should validate a 24-hour on duty staffing pattern in this situation.

(See also W344, W333, and W183).

W417 §483.470(b)(4)(i)

Is there a pattern of placing adults with physical disabilities in cribs?

W418 §483.470(b)(4)(ii)

W419 §483.470(b)(4)(iii)

W420 and W421 §483.470(b)(4)(iv)

W422 §483.470(c)(1)

W423 §483.470(c)(2)

Investigate other storage spaces if all client personal belongings are not in their room.

W424 §483.470(d)(1)

Verify that if delays occur that there are no negative impacts on the clients.

W425 §483.470(d)(2)

W426 §483.470(d)(3)

If water is above 110 degrees F, do clients demonstrate ability to self-regulate water temperature?

Is there a pattern of excluding clients from the opportunity to learn how to regulate water temperature?

W427 §483.470(e)(1)(i)

W428 §483.470(e)(1)(ii)

How is ventilation provided?

How does the facility regulate room temperatures and ventilation?

Is there proper ventilation in individual bathrooms and shower areas?

W429 §483.470(e)(2)(i)

Interview staff to determine how they handle regulating temperatures and promoting comfortable and healthy environments.

How often do temperatures depart from normal comfort ranges?

W430 §483.470(e)(2)(ii)

Observe heating apparatus to verify that not exposed elements exist which could pose a burn risk to clients.

W431 §483.470(f)(1)

If incident reports reveal frequent falls with injuries, interview clients identified in the incidents reports and staff to verify whether the falls resulted from non-slip resistant floor surfaces.

W432 §483.470(f)(2)

W433 §483.470(f)(3)

During observations, verify whether clients are inhibited from free movement about the facility due to floor coverings such as rugs.

W434 §483.470(f)(3)

W435 §483.470(g)(1)

Is there sufficient space and adaptive equipment so that clients in wheelchairs can go outside regularly and participate in recreational events?

W436 §483.470(g)(2)

If a repair necessitates the client go without an item for more than a day, the facility must demonstrate the steps taken to minimize the negative effect on the client.

If clients are resistive to their training program for their assistive equipment, interview staff and verify in the client's IPP the interventions the facility has implemented to:

- engage the client in the appropriate training; or
- assist the client to make an informed decision about whether or not to use the aid.

Interview staff about:

- what provisions are made for repairs of prostheses and assistive technology devices,
- timeliness of repairs, and
- whether the needed prostheses and assistive technology devices are in good repair and are properly fitted.

Verify that temporary replacements for assistive technology are available during equipment repair periods.

What provisions are made for repairs of prostheses and assistive technology devices? Are repairs timely? Are needed prostheses and assistive technology devices in good repair and proper fit? Are loaners available during repair periods?

How does the facility address the use of special devices with clients who are resistive of their use?

W437 §483.470(g)(3)

W438 §483.470(h)(1)

Review the facility's emergency plans for fire, severe weather, and missing clients. Verify that the emergency plans address those types of emergencies relevant to the facility, its geographic location and the needs of the clients served.

Interview staff regarding emergency exit plans. Determine whether or not staff are familiar with the facilities' §483.470(f)(2) policies and procedures.

W439 §483.470(h)(2)

Review facility policies and procedures for the most recent date of change. Verify the emergency plans have been updated if conditions affecting the clients have changed.

Review staff training records to confirm staff have received training in emergency procedures. Verify that staff has been trained on the most recent version of the emergency plans and procedures.

W440 and W441 §483.470(i)(1)

W442 §483.470(i)(1)(i)

W443 §483.470(i)(1)(ii)

W444 §483.470(i)(1)(iii)

W445 §483.470(i)(2)(i)

W446 §483.470(i)(2)(ii)

W447 §483.470(i)(2)(iii)

What problems and corrective actions do fire drill reports identify?

W448 §483.470(i)(2)(iv)

W449 §483.470(i)(1)(iii)

W450 §483.470(i)(1)(v)

W451 §483.470(i)(3)

If the FSES/BC is used, validate the rating of clients as part of the sampling process. If significant discrepancies are noted from what staff report and what evidence can be ascertained about client behavior, conduct an in-depth investigation into the ratings of all clients in conjunction with the LSC surveyor.

LSC/no tag §483.470(j)

W452 §483.470(k)(1)

W453 §483.470(k)(2)

W454 §483.470(l)(1)

W455 §483.470(l)(1)

Verify through observation that staff have access to proper hand washing facilities.

W456 §483.470(l)(2)

In instances of infection control problem are there patterns to suggest:

- Staff is not practicing established techniques?
- Problems are not being analyzed to result in corrective action?
- There is aggressive resolution to problems identified that leads overall to a reduction in the number of infection control problems?

Is there evidence of clients contracting infections or communicable diseases that can be attributed to poor infection control practices?

W457 §483.470(1)(3)

W458 §483.470(1)(4)

Dietary Services Probes and Procedures

W459 Compliance Principles §483.480

The Condition of Participation of Dietary Services is met when:

- The clients maintain body weights and lab levels considered acceptable for their age, height, body type and clinical condition or are receiving services and supports to assist them to do so; and
- Clients participate in normalized dining experiences appropriate to their functional abilities (e.g. using knives, family style meals, going to restaurants, etc.) and are being taught skills to do so.

The Condition of Participation of Dietary Services is not met when:

- Clients experience excessive weight loss or gain, abnormal lab levels, or deterioration in health as a result of an inadequate diet; or
- Clients do not receive training and supports which enable them to eat as independently and in as normalized manner as possible.

W460 §483.480(a)(1)

Within the context of the characteristics of the clients who reside in the facility, is there a pattern of excessive usage of "food allergy," weight gain and/or reduction diets which may indicate an unnecessary and non-normalizing emphasis on special diets?

When food consistency modifications are necessary, is there evidence of periodic efforts to upgrade the food consistency for clients?

Are weight reduction diets generally coordinated with plans for exercise?

Is the diet order followed as prescribed?

Are between meal snacks provided as needed?

Are desired weight range goals maintained or supported with the calories and nutrients provided?

How does the facility assure that menus are nutritionally adequate and varied?

- Recent significant weight gain or loss?

- Fever/infection?
- Diarrhea? Chronic disease?
- Chewing and swallowing problems?
- Chronic blood loss?
- Excessive use of laxatives?
- Abnormal laboratory values?

Are the staff aware of and do they respond to any potential adverse food/drug interactions?

Have fiber and fluids been increased in the diet of clients on anticonvulsants and tranquilizers to decrease likelihood of constipation? If not, why?

W461 §483.480(a)(2)

W462 §483.480(a)(3)

W463 §483.480(a)(4)

During observations, note clients who are eating modified or specialized diets and verify the diets are prescribed based upon information presented by the IDT that includes a dietitian and a physician.

Is the dietitian involved in reviewing information about clients and gathering additional information, such as laboratory reports and drugs prescribed that might affect food intake?

Have the modified and special diet orders been reviewed for their appropriateness and effectiveness? How has the client's response to the diet been considered?

W464 §483.480(a)(4)

W465 §483.480(a)(5)

If food is withheld during a meal, is food of comparable nutritive value to the withheld menu item provided?

Are the primary reinforcers used with clients consistent with the diet intended for those clients?

Are the types of food used as primary reinforcers consistent with other IPP objectives or needs (e.g. if the client is learning to use finger foods, are “finger food” types of reinforcers (like grapes) used?) Refer to W151.

W466 §483.480(a)(6)

W467 §483.480(b)(1)

W468 §483.480(b)(1)

Interviews should verify whether the times are acceptable to the clients and conducive to the recreational, employment, and programmatic schedules.

Are mealtimes, including snack times, sufficiently flexible to allow the client opportunities to participate in a variety of activities in and out of the facility?

Are snacks consistent with the client's intended diet?

Are snacks routinely provided to all clients?

W469 and W470 §483.480(b)(1)(i)

W471 §483.480(b)(1)(ii)

W472 §483.480(b)(2)(i)

W473 §483.480(b)(2)(ii)

Carrying a thermometer vs. asking for one. What should a surveyor do?

Are hot foods held at not less than 140 degrees F. and served promptly (e.g. within 15 minutes of being removed from temperature control devices)? Are cold foods held and served at 45 degrees F.?

Do you observe clients eating within 15 minutes from the time of service (time the food was taken out of temperature control devices)?

Is there a pattern of food-related illnesses, resulting from inappropriate temperature control?

W474 §483.480(b)(2)(iii)

Observe clients during meals for signs of choking, coughing, chewing difficulties, swallowing difficulties, etc. as these may be indications of food not served in the proper consistency for the client's developmental level.

Observe to assure that foods are sufficiently moist for ease of chewing and swallowing.

For clients who have great physical difficulty in eating and swallowing, and must be fed, observe for:

- Staff use of appropriate swallowing stimulation techniques as indicated;
- Proper tongue thrust reduction techniques as indicated;
- Staff use of proper food and liquid thickening agents to facilitate easier eating and swallowing as indicated and ordered;
- Separation of pureed foods from other foods in order to allow the clients to enjoy foods separately;
- Positioning of food so that the client can see his or her meal; and
- Appropriate client positioning (refer 483.480(d)(5)).

On what basis does the facility decide to modify the texture of a client's diet? Is there specific justification for a pureed diet?

When food consistency modifications are necessary, is there evidence of periodic efforts to upgrade the food consistency for clients?

Are foods sufficiently moist for ease of chewing and swallowing?

Is pureed food of a consistency that is appropriate for the client's eating and swallowing ability and not in liquid ("watery") consistency?

For clients who have great physical difficulty in eating and swallowing, and must be fed:

- Do staff use appropriate swallowing stimulation techniques?
- Proper tongue thrust reduction techniques?
- Do staff use proper food and liquid thickening agents to facilitate easier eating and swallowing?
- Are pureed foods mixed with other foods and fed to clients? Or do clients get to enjoy the tastes of various foods fed to them?
- Is the food positioned so that the client is permitted to see his or her meal?
- Is the client positioned appropriately?

W475 §483.480(b)(2)(iv)

W476 §483.480(b)(3)

Verify through observation that food remaining on the client's dishes after meals is not saved unless the client requests that the food be saved for him or her to be eaten later in the day.

Is food remaining on the client's dishes saved or reused after the meal is completed?

W477 §483.480(c)(1)(i)

Are menus available for those clients who can read?

W478 §483.480(c)(1)(ii)

Interview clients about their ability to participate in the selection of menu items to determine how their food choices are honored.

Interview staff to determine what procedure they follow to ensure that equal substitutions within food groups are made when food not available or client does not want to eat a particular food.

Review the weekly menu for specific "name" of the food and drink item e.g., orange juice instead of just juice, green beans instead of the word vegetable.

If observations of meal and snack times do not provide evidence that clients are receiving foods from a variety of food groups, investigate further by:

- Interviewing staff regarding the client's modified or specially prescribed diet;
- Interviewing staff to determine how the facility assures that menus are well-balanced; and
- Verifying through record review the modified or specially- prescribed diet in the client's record.

Do clients participate in the selection of menu items, to the maximum extent possible?

Are substitutions made within the same food group (e.g. meat for another source of protein)?
Vegetable for another item similar in nutritional value?

Are clients allowed to substitute menu items with their own choices (even though seemingly void in variety (e.g. a client wishes to consume pizza 3 times per week, or on consecutive days) provided that the items contain the nutritive value comparable to the planned items on the menu?

Do menus specify the "name" of the juice, vegetable, or starch (e.g. orange juice, green beans, rice)?

W479 §483.480(c)(1)(iii)

Do menus reflect variety for the season of the year (e.g., fresh fruits in summer)?

W480 §483.480(c)(1)(iv)

Is there evidence that sufficient food exists to yield the portion sizes indicated on the menu?

W481 §483.480(c)(2)

Are substitutions noted when intended menu items are not served?

W482 §483.480(d)(1)

Is the dining room a pleasant environment in which to eat? Is there a pattern of clients eating their meals in bedrooms or other non-eating areas?

What is the rationale for prohibiting a client from eating in a dining area? Has eating in a dining area ever been tried with the client before? What happened? Are periodic attempts to get such clients to eat in a dining area, continued?

W483 §483.480(d)(2)

When dining observations identify clients eating in wheelchairs, interview staff to determine the reason why they are not seated in chairs at the table.

Do clients eat together with others at the same table?

Are clients in wheelchairs positioned correctly and included in dining groupings of their peers without physical disabilities? Or do all clients in wheelchairs eat together or are they located around the edges of dining areas?

Are clients in wheelchairs lined up to eat?

Do clients in wheelchairs routinely eat at table? Or do they eat on their lap trays or hospital bed trays?

On what basis does the facility determine if a client in a wheelchair needs to eat the meal in the wheelchair rather than transferring to a regular chair?

W484 §483.480(d)(3)

Observe clients and verify in the record that clients are provided with adapted furniture and equipment as identified by the IDT at each meal.

Are condiments, napkins and appropriate eating utensils provided? Are clients trained to use them?

Is there a pattern of staff allowing clients to use any piece of adapted equipment, regardless of the client's need for that equipment?

Is the height of the dining table sufficient so that a client in a wheelchair can sit in the wheelchair at the table, if needed?

W485 §483.480(d)(4)

If you see this is an indicator of inadequate staff: staff not present, staff more engaged in meal service than in supervision of the dining experience, clients engaging in maladaptive behavior without staff available to intervene.

W486 §483.480(d)(4)

W487 §483.480(d)(4)

Interview staff regarding the availability of extra portions.

W488 §483.480(d)(4)

During dining observations, surveyors should observe staff use the appropriate level of prompting, cueing, physical assistance etc. to assure clients are using or developing the skills needed for independent eating.

Determine to what extent clients are exposed to out-of-the-home dining environments available to the general public (e.g. restaurants, fast-food establishments, picnics, parties, cafeterias, etc.).

Is the client encouraged, permitted and reinforced for being as independent as possible during meals?

Does staff demonstrate skills and techniques which promote socialization?

Do facility staff enable clients who are eating dependent, when appropriate, to move from tube-feeding, or blended, ground, pureed, etc., to the next level of food size, texture, or otherwise greater levels of independent eating?

How does staff address the problem of clients who consistently show a lack of interest in eating?

Is family style dining made available to clients who are able to participate?

Are clients allowed to dine out at places like fast food restaurants during mealtime? Is it part of the client's IPP?

How does staff deal with clients who exhibit maladaptive behavior during mealtime? Is it part of the client's IPP?

Are clients rushed through their meals?

Is there a pattern of eating programs not being implemented on short staffed days? Short staffed meals? In the presence of staff?

Is the food to be eaten, located at a distance and level from the client, such that the client can eat with maximum independence?

Is the client taught to use the most normal, least stigmatizing clothing protectors during mealtimes?

Do clients take turns participating in setting their own tables? Serving their own meals? Preparing meals? Shopping for and putting food away?

W489 §483.480(d)(5)

For clients who have great physical difficulty in eating or swallowing and must be fed, is the client positioned in the upright position appropriate to the client's needs?