CMS Manual System

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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 135 **Date: February 27, 2015**

SUBJECT: Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities revisions. An addition of a New Exhibit to the State Operations Manual (SOM) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Probes and Procedures for Appendix J, Part II – Interpretive Guidelines- Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

I. SUMMARY OF CHANGES: Revisions have been made to the Guidance content of Appendix J, Part II–Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities to reflect current standards of practice. Revisions were made to the W-tags listed on this transmittal form. No guidance revisions were made to W115, W118, W139, W161, W162, W175-W178, W188, W226, W265, W357, W364, W377-W382, W387-W391, W409-W413, W418, W432-W434, W452, W453, or W471. The probes and procedures previously contained under the guidance have been placed into a State Operations Manual (SOM) Exhibit. New exhibit XXX is being added to SOM Appendix J containing surveyor probes and procedures previously in Appendix J, Part II – Interpretive Guidelines for ICF/IID. The probes and procedures provide surveyors with additional clarification, beyond the guidance in Appendix J, in interpreting the regulation text.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 27, 2015
IMPLEMENTATION: April 27, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	Appendix J/W100
R	Appendix J/W101 thru W114
R	Appendix J/W116 thru W117
R	Appendix J/W119 thru W160
R	Appendix J/W163 thru W174
R	Appendix J/W179 thru W187
R	Appendix J/W189 thru W225

R	Appendix J/W227 thru W264
R	Appendix J/W266 thru W356
R	Appendix J/W358 thru W363
R	Appendix J/W365 thru W376
R	Appendix J/W383 thru W386
R	Appendix J/W392 thru W408
R	Appendix J/W414 thru W417
R	Appendix J/W419 thru W431
R	Appendix J/W435 thru W451
R	Appendix J/W454 thru W470
R	Appendix J/W472 thru W489
N	Exhibit 355/Probes and Procedures for Appendix J, Part II – Interpretive Guidelines- Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

W102
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410 Condition of participation: Governing body and management
(a) Standard: Governing body

W103
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(a) The facility must identify an individual or individuals to constitute the governing body of the facility.

Guidance §483.410(a)

If concerns are noted regarding the governing body, written documentation verifies that the facility has designated the individual or individuals to constitute the governing body and their titles.

W104
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.

Guidance §483.410(a)(1)

The governing body develops, monitors, and revises, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety.

Direction by the Governing Body includes areas such as health, safety, sanitation, maintenance and repair, and utilization and management of staff.

Condition level operational deficiencies may be associated with a failure by the Governing Body to exercise general direction of the facility.

W105
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(a)(2) The governing body must set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility.

Guidance §483.410(a)(2)

The policies of the facility must include the qualifications of the administrator, and the qualifications are stated in the job description of the administrator.

W106

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(a)(3) The governing body must appoint the administrator of the facility.

Guidance §483.410(a)(3)

This appointment must be in writing.

(b) Standard: Compliance with Federal, State and local laws

§483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to:

Guidance §483.410(b)

The facility has no final adverse action by a Federal, State, or local authority. Such adverse actions include, but are not limited to fines, limitation on services that may be provided, or loss of licensure.

The facility must be able to provide for review, current licenses and permits as well as applicable reports of inspections by State or local health authorities.

If a situation is identified indicating the provider may not be in compliance with Federal, State, or local law, refer that information to the authority having jurisdiction (AHJ) for follow-up actions. See W107, W108, or W109.

W107

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(b) health,

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

W108

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(b) safety, and

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

W109

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(b) sanitation.

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

(c) Standard: Client Records

W110
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(1) The facility must develop and maintain a record keeping system that includes a separate record for each client and;

W111
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(1) that documents the client's health care, active treatment, social information, and protection of the client's rights.

Guidance §483.410(c)(1)

The structure and content of a client's record must be an accurate, functional representation of the actual experience of the client in the facility.

The record should contain an accurate account of all information relevant to the client's health care, active treatment, social information and protection of the client's rights, such as communications, correspondence, program plans (to include both in-house and outside service programs), progress summaries, activity plans and activity participation, incidents, consent forms and all medical information.

If the records are maintained electronically, the facility staff should be able to access various parts of the record without difficulty. If they are unable to access components of the record upon request, then this may indicate a lack of training by the facility.

W112
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

Guidance §483.410(c)(2)

"Keep confidential" means safeguarding the content of information including video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the client, parent of a minor child, or legal guardian, and consistent with the advocate's right of access. Facility staff and consultants, hired to provide services to the client, sign confidentiality agreements before having access to client records and should have access to

only that portion of information that is necessary to provide effective responsive services to the client.
These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

The facility has in place safeguards to ensure that access to all information regarding clients is limited to those clients designated by Health Insurance Portability and Accountability Act (HIPAA) requirements, the Developmental Disabilities Act, State law and facility policy.

The facility should prevent any instances of unauthorized access or dissemination. For example, the staff is observed to leave the client record (hard copy or electronic version) in the living room of the house when visitors or persons not authorized to access client records are present. Client records must be secured when staff is not present.

The facility must develop and follow procedures for maintaining the confidentiality of client information during transport to medical appointments or to other locations outside the facility.

Confidentiality applies to both central records and information kept at dispersed locations. If there is information considered too confidential to place in the record used by all staff (e.g., identification of the family's financial assets, sensitive medical data), it may be retained in a companion record located in a secure location in the facility with a notation made in the primary record as to the location of confidential information. The facility must ensure that any client information provided to day services programs is maintained confidential.

The sharing of client specific information with members of the "specially constituted committee" required by §483.440(f)(3), who are not affiliated with the agency, does not violate a client's right to have information about him or her kept confidential. The committee must have relevant information to function properly.

Facility confidentiality safeguards include the development and implementation of written policies to assure that members of the specially constituted team maintain confidentiality. Such processes may include signed confidentiality agreements.
These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

W113

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

Guidance §483.410(c)(3)

The facility develops and follows written policies governing the release of client information.

Release of any personally identifiable information does not occur unless consent(s) is obtained prior to the release.

These policies must address at a minimum who must give consent for the release of information from records. The policy and procedures should account for other situations involving the release of client information, such as:

- *who should be notified when records have been released;*
- *procedures to be followed with subpoenas;*
- *time frames for providing requested information; and*
- *information regarding a client's HIV status may not be released without specific consent and may not be in the record if that consent has not been given.*

W114

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

Guidance §483.410(c)(4)

Illegible writing in hard copy records can contribute to communication deficits among staff. Illegible writing which cannot be easily interpreted by facility staff upon surveyor request may constitute a safety issue.

Electronic signatures are acceptable in the electronic record system.

W116

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(c)(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

Guidance §483.410(c)(6)

"Appropriate" means those parts of each client's record are most likely (or known) to be needed by the residential staff to carry out the client's active treatment program in the unit; to alert staff to health risks and other aspects of medical treatment; to support the psychosocial needs of the client; to contact family or emergency contacts, and to provide anything else necessary to the staff's ability to work on behalf of the client.

The staff of the residential living unit has, and can access, all information which is relevant to implementing client program plans, appropriate care of, interaction with, and provision of services for the client.

(d) Standard: Services provided under agreements with outside sources

W117

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(d)(1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

Guidance §483.410(d)(1)

If a service is not provided directly, there must be a written agreement for such services.

Written agreements are required for emergency services such as dentists and pharmacies. For those services that require a visit to a hospital, the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) typically utilizes services from an emergency department of the hospital, thus no written contract is required.

Federal statute (P.L. 94-142) requires all school-aged children to receive a free and appropriate school education. Therefore, a written agreement between ICF/IIDs and public schools is not necessary.

W119

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(d)(2)(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.

W120

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(d)(3) The facility must assure that outside services meet the needs of each client.

Guidance §483.410(d)(3)

Outside services are any services needed by the clients and not provided directly by the facility (hospital visits, dental visits, day program services, etc.).

Programs and services must be coordinated between the facility and the outside service, and foster consistency of implementation across settings of teaching strategies and behavior management.

The facility monitors outside services on an ongoing basis to ensure that services provided are consistent with the needs of each client as identified in the Individual Program Plan (IPP). For example, if the facility is implementing a behavior management or a communication program for the client, it is shared with the outside program and implemented by the outside program (workshop, day program, etc.) and the outside program agrees to incorporate it into their day program. At periodic intervals, the facility staff visit or communicate with the outside program to verify consistency across the two settings.

With outside resources, it is the responsibility of the facility to assure that the services are provided in a safe clean environment, by appropriately qualified professions, and any untoward outcome of services are promptly addressed. If, in spite of attempts by the facility to assure compliance, the outside program does not implement the program for the client, then the facility remains responsible for the lack of active treatment.

W121

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(d)(4) If living quarters are not provided in a facility owned by the ICF/IID, the ICF/IID remains directly responsible for the standards relating to physical environment that are specified in §483.470(a) through (g), (j) and (k).

Guidance §483.410(d)(4)

Even though the facility's premises may be rented from a landlord, the facility must ensure that the requirements for physical environment are met, either through arrangement with the landlord or through the facility's own services.

(e) Standard: Licensure

W101

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.410(e) The facility must be licensed under applicable State and local law.

Guidance §483.410(e)

The facility has a current, valid State license when required under State law.

W122

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420 Condition of participation: Client protections

(a) Standard: Protection of clients' rights

§483.420(a) The facility must ensure the rights of all clients. Therefore the facility must

Guidance §483.420(a)

The facility must ensure the client's rights and does not wait for him or her to claim a right. This obligation exists even when the client is less than fully competent and requires that the facility is actively engaged in activities which result in the protection of the client's rights, advocacy for individual clients who have no family or an inactive family, and training programs for clients and staff on the understanding and protection of client rights.

W123

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

Guidance §483.420(a)(1)

The obligation to inform requires that the facility presents information on rights to the client, his or her family or his or her legal guardian in a manner and form which they can understand. In most instances, family means parent. However, in those instances where parents are deceased or choose not to be active in the client's life and there is another family member who does wish to be active, but is not the legal guardian, this family member should be informed of the client's rights. Printed materials should be provided in understandable terms and provided in the language necessary to ensure understanding. Specialized methods, as indicated, should be provided for communication with clients, families or legal guardians with hearing or vision impairment.

Pro-active assertion of client rights includes, but is not limited to:

- *Signed evidence that the client, his or her family and/or his or her legal guardian have been informed of the client's rights, and*
- *Evidence that the communication of these rights were provided at the client's level of comprehension, and in the language understandable to the client.*

The obligation to inform also requires that the facility make some determination of whether the client and his or her family, or legal guardian understood the rights presented and made additional efforts to communicate the rights if the rights were not understood.

If the facility has written "rules of the facility", these rules must be communicated to the client, their family and or legal guardians at the time of admission and must not be in conflict with any of the rights listed in 42 CFR 483.420 (a) (1-13).

W124

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

Guidance §483.420(a)(2)

Clients, their families or legal guardians are promptly informed of any change in the client's medical or behavioral needs that requires immediate alteration to programmatic or medical intervention. Promptly is defined by the level of severity of the alteration. In each case, they must also be informed of the attendant risks of any recommended treatments or interventions and of their right to refuse treatment, training or services.

If parents or legal guardians wish for other members of the client's family to be informed of such changes, they must put this permission in writing.

The communication of this information must be provided in the manner and language understood by the client or their family or legal guardian (language boards, sign language, etc.).

The term "attendant risks of treatment" describes the risk vs. risk and risk vs. benefit associated with the treatment. These risks include possible side effects, other complications from treatments including medical and drug therapy, unintended consequences of treatment, other behavioral or psychological ramifications arising from treatment, etc.

The facility actively attempts to engage clients who refuse to participate in active treatment. While the regulation recognizes the client's right to refuse treatment, persistent refusal that impacts the health and safety of the client and/or others, or the ability to provide overall active treatment, may result in facility's consideration of alternative placements for the client. It is expected, however, that the facility has assessed the reason for refusal, and developed and implemented all possible interventions to engage the client in active treatment programs prior to referring the client to another therapeutic setting.

A client, his or her family member, or legal guardian who refuses a particular treatment (e.g., a behavior control, seizure control medication or a particular intervention strategy) must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available. The client's preference about alternatives should be elicited and considered in deciding on the course of treatment. If the client, family member, or legal guardian also refuses the alternative treatment, or if no alternative exists to the treatment refused, the facility must consider the effect this refusal may have on other clients, the client himself or herself, and if they can continue to provide services to the client consistent with these regulations.

If the facility is unable to provide services to a client due to consistent refusal to participate, they must weigh all options including an involuntary discharge. Involuntary discharge must be for good cause (see 483.440(b)(4)(i)).

When a client is considered for participation in experimental research the client, his/her family and/or legal guardian must be fully informed of the nature of the experiment (e.g., what medications or physical interventions will be utilized, the length of the research, any possible side effects and how the information from the research will be utilized). Information regarding the possible consequences of participating or not participating must be provided to the client, family member or legal guardian. The written consent of the client, his/her family or legal guardian must be received prior to participation. For a client who is a minor or who has been adjudicated as incompetent, the written informed consent of the parents of the minor or the legal guardian is required. The signed, informed consent documentation must be in compliance with HHS Guidelines for Research Involving Human Subjects. The signed consent must also include a clear discussion of what treatments will be included in the research, the time limits for the research and should clearly inform the client, family member or legal guardian that the client may end participation at any time without fear of recrimination. If the research protocol indicates that clients receive compensation, then clients are compensated per the protocol.

Any research must be reviewed and approved by the Specially Constituted Committee. See W263.

W125

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

Guidance §483.420(a)(3)

To the extent that a client is able, choices are made on his/her own. Each client has autonomy of decision making and choice.

They are free to move about without limitations imposed due to staff preferences or staff convenience.

Clients are not restricted without due cause or due process.

To the extent that the client is able to make decisions for him or herself, it is inappropriate to delegate the person's right to others (e.g. parents, family members, etc.).

The facility has an obligation to assure client health and safety and must balance that obligation with the rights of clients.

If the facility has implemented a restriction, the following should be in place:

- *An assessment supporting the need for the restriction;*
- *An individualized behavior plan to reduce the need for the restriction has been developed and implemented;*
- *A written informed consent for the behavior plan which includes the restriction;*
- *Approval of the Specially Constituted Committee; and*
- *Monitoring by the Committee of the progress of the training program, designed to reduce and eventually eliminate the restriction.*

Clients, families, and legal guardians have the right to register a complaint with the facility and the State Survey Agency. If so, the facility must respond promptly and appropriately. The facility must ensure protection of the client from any form of reprisal or intimidation as a result of a complaint or grievance reported by the client, family, or legal guardian.

Issues involving the exercise of constitutional rights such as voting should be addressed as a component of the IPP when the Interdisciplinary Team (IDT) determines a need for training. Clients who have been adjudged to need guardianship or have been assessed as needing assistance to advocate for themselves should receive assistance or support so they may exercise their rights as citizens of the United States.

W126

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

Guidance §483.420(a)(4)

The regulation is clear that in those cases where a client already possesses the skills necessary to independently manage their own financial affairs, the facility will allow the client to continue to do so. Formal training in financial management must be provided for all other clients in the facility to the extent of their capabilities. The regulation places the responsibility for determining the extent of the client's capabilities in this matter upon an assessment and interdisciplinary process within the facility.

To reach a determination as to whether a money management program is appropriate, the facility IDT uses the comprehensive functional assessment (CFA) to evaluate the ability of each client to participate in such a program. Under 42 C.F.R. 483.440(c)(3), the team evaluation must establish, through documentation, that the IDT considers all of the objective data within the assessment in reaching their determination, especially the identification of client skills which can be used across training programs. Examples of assessment findings that may be considered by the IDT include skills that can be cross-utilized in training programs such as:

1. *Fine motor coordination;*
2. *The ability to make choices;*
3. *The ability to identify preferences; and*
4. *Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)*

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.
The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

W127

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

Guidance §483.420(a)(5)

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. *The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.*
b. *The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.*
c. *The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.*
d. *The facility must act to prevent physical, verbal, sexual or psychological abuse.*

If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

"Threat", for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

"Abuse", for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or

sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unneccesary" if there is evidence the drugs are being used:

- *In excessive dose (duplicate therapy);*
- *For excessive duration;*
- *Not monitored adequately;*
- *Without adequate indications for its use;*
- *With adverse consequences which indicate the dose should be reduced or discontinued; or*
- *Any combination of the reasons listed above.*

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- *The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;*
- *Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;*
- *Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;*
- *Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.*

W129

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

The facility must provide areas within the living area in which the client can have time to be alone, when appropriate, and to have privacy (their conversations cannot be overheard) for personal interactions/activities. There should be a location where the client can meet privately with family and/or friends and a telephone available where he/she can hold private telephone conversations.

Personal privacy for clients also includes the right to have certain personal information about them kept confidential. Staff should not discuss one client in front of others (clients, parents, legal guardians, visitors, etc.) and should not post personal information about clients in areas where other clients, families and the public can read the information.

Video/audio taping or live feed must not be used in place of or for the convenience of staff. The facility may install video/audio equipment for purposes of observing client/staff interactions. Video/audio equipment may only be installed in common areas (in no case may videotaping or live feed be done in bathrooms, bedrooms or areas where private visits are conducted). The clients, families and/or legal guardians of the clients residing in the areas where videotaping or live feed will occur must give informed consent for the installation and must be assured that no personal privacy will be jeopardized. The use of the equipment must be presented at and approved by the specially constituted committee for the facility prior to the installation of video or audio devices.

Motion sensors should not be considered cameras.

W130

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(7) ensure privacy during treatment and care of personal needs;

Guidance §483.420(a)(7)

Clients must be provided privacy during personal hygiene activities (e.g., toileting, bathing, dressing) and during medical/nursing treatments that require exposure of one's body.

People not involved in the care of the client should not be present without their consent while they are being examined or treated.

Whenever possible, the facility should be sensitive to clients' preferences for same sex care in private situations.

W131

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(8) Ensure that clients are not compelled to perform services for the facility and

Guidance §483.420(a)(8)

Clients are not required or expected to be a source of labor for a facility. The client must not be required or expected to do productive work for the facility, other than appropriate care of one's own personal space or shared responsibilities for common areas.

W132

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(8) ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

Guidance §483.420(a)(8)

"Work", as used in the regulation, means any directed activity, or series of related activities which results in a benefit to the economy of the facility or in a contribution to its maintenance, or in the production of a salable product. In deciding whether a particular activity constitutes "work" as defined above, the key determinant is whether the facility would be required to hire additional full or part-time staff (or pay overtime to existing staff) to perform the service the client is asked to perform.

Clients volunteering to do real work that benefits the facility should give informed consent for such practices and understand that by providing employable services they are able to be compensated. This does not preclude a client from helping out a friend or being kind to others. Self-care activities related to the care of one's own person or property are not considered "work" for purposes of compensation.

In general, participation in any household task which promotes greater independent functioning and assists the client to prepare for less restrictive setting (and which the client has not yet learned) is permitted as long as tasks are included in the IPP in written behavioral and measurable terms. This participation must be supervised, and indices of performance should be available. No task may be performed for the convenience of staff (e.g., supervising clients, running personal errands).

"Compensated" means the client is provided with money or other forms of negotiable compensation for work (including work performed in an occupational training program) and such compensation is to be used at the client's discretion.

Prevailing wage refers to the wage paid to non-disabled workers in nearby industry or the surrounding community for essentially the same type, quality and quantity of work or work requiring comparable skills. A client who works in the facility must be paid at least the prevailing minimum wage, unless an appropriate certificate has been obtained by the facility in

accordance with current regulations and guidelines issued under the Fair Labor Standards Act, as amended.

Any client performing "work", as defined above, must be compensated in direct proportion to his or her output. The facility should utilize Department of Labor and/or Department of Vocational Rehabilitation formulas and techniques for determining rate of pay. A client's pay is not dependent on the production of other clients when he or she works in a group.

When the client's active treatment program includes assignment to occupational or vocational training or work, specific work objectives of anticipated progress should be included in the IPP along with reasons for the assignments. If the training of clients on particular occupational activities or functions involves "real work" to be accomplished for the facility, the clients must be compensated based on ability. For example, if in the process of work training activities which involve learning to clean a floor, the floor for a particular building is cleaned and does not require further janitorial cleanup, then the client must be compensated for this activity at the prevailing wage.

W133

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice,

Guidance §483.420(a)(9)

Privacy must be provided for both face-to-face interactions and electronic interactions.

The facility must provide opportunities for the client to communicate, through regular mail, telephone and/or electronic mail and meet in private with persons of their choice (e.g., friends from the community, family members, and advocates). There may be instances where legal guardians override the wishes of the client. In these instances, the facility should be actively working with the legal guardian and the client to reach the maximum agreeable level of interaction for the client.
Space must be provided for clients to receive visitors in reasonable comfort and privacy.

W134

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(9) and to send and receive unopened mail;
Guidance §483.420(a)(9)

Clients must be provided the opportunity to send/receive all types of mail unopened and read the contents themselves if able. If the staff has to open and read mail to the client, this should be done in a private place allowing the client as much participation as possible.

Clients who have their own electronic equipment must be provided the opportunity to send, receive, and read electronic mail with privacy.

W135

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

Guidance §483.420(a)(10)

Any restriction of telephone access must be explained in the IPP with a plan to advance the client's access. For persons with hearing loss who could benefit, Text Telephone (TTY) services or other accommodations should be provided.

As with any other rights restriction, the restriction must be addressed in the IPP, written informed consent obtained, and the plan must be reviewed and approved by the specially constituted committee.

W136

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

Guidance §483.420(a)(11)

Clients should be offered the opportunity to participate in various types of activities in the community (e.g., going to grocery stores, hair salons, restaurants, places of worship, pharmacies, community meetings and events) based on their interests and choices. The facility must make accommodations for physical issues such as hearing impairment and mobility limitations. In addition, clients should be taught the applicable skills to participate in their choice of activities to the fullest extent of their abilities.

It is not acceptable for all client activities to be provided in the facility.
When a client is identified to be on restriction from community integration opportunities, interview clients, families, legal guardians and staff to determine if due process was afforded for this restriction and whether the restriction is included in the IPP.

In the event of a court placement that restricts community access, due process does not apply.

There should be evidence that the facility assists and encourages all clients, regardless of functioning levels, to have input into the decisions on community integration activities. It is not acceptable to require clients to attend unwanted activities due to staffing considerations.

W137

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and

Guidance §483.420(a)(12)

Clients should have personal possessions and clothing which meet their needs, interests and choices.

Clients should have free access to their own possessions and clothing. When considering whether a client has free access to their personal possessions and clothing, ensure that physical limitations have been addressed.

Clients who are unable to access and use personal possessions and clothing appropriately are involved in programs to learn the necessary skills to do so.

In situations where the behavior of one or more clients in a living area prevents free access to personal possessions for each client, the facility must develop IPPs for the client with disruptive behavior. The facility must also ensure that during the implementation of this program plan that none of the other clients have their rights infringed upon. Clients should not be without personal possessions because of the behavior of others with whom they live.

All client possessions, regardless of their apparent value to others are treated with respect for what they may represent to the client. Where those choices include socially stigmatizing materials, the facility should provide learning opportunities to make more socially appropriate choices. The facility should encourage clients to use or display possessions of his or her choice in a culturally normative manner.

If a method for identifying personal effects is used, it should be inconspicuous and in a manner that will assist the client to identify them.

"Appropriate" clothing means a supply of clothing that is sufficient, in good repair, accounts for a variety of occasions and seasons, and appropriate to age, size, gender, and level of activity. Modification or adaptation of clothing fasteners should be considered based on the needs of a client with a physical disability to become more independent.

As appropriate, each client's active treatment program maximizes opportunities for choice and self-direction with regard to choosing and shopping for clothing which enhances his or her appearance, and selecting daily clothing in accordance with age, sex and cultural norms.

Clients are permitted to keep personal clothing and possessions for their use while in the facility. Determine how the facility both ensures the safety of personal possessions while at the same time providing client access to them when the client chooses.

Clients are provided the opportunity, encouraged, and trained to use age-appropriate materials. The term "age-appropriate" refers to anything that reinforces recognition of the client as a person of a certain chronological age. Clients who choose to keep items traditionally used by children such as dolls or model cars are not an automatic citation. There must be evidence the

facility is encouraging the client to use these possessions in a socially appropriate, non-stigmatizing manner. The facility's environment must be furnished with materials and activities that will enhance opportunities for growth.

W138

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(a)(12) ensure that each client is dressed in his or her own clothing each day; and

Guidance §483.420(a)(12)

Clothing such as pajamas, underwear, socks, hats, mittens/gloves, and coats should be the personal property of the client and not considered "stock" items. There should be no communal clothes. If clients are unable to do their own personal laundry the facility must ensure that clothing is properly laundered and returned to the appropriate client.

The staff of the facility should ensure that clients dress appropriately for the season and the occasion by implementing training programs or guidance for the client as indicated.

W140

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(b)(1)(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

Guidance §483.420(b)(1)(i)

All purchases made using client personal funds must be itemized in the accounting record with the exception of pocket money. Pocket money given to the client does not need to be itemized. Pocket money should be considered a nominal amount of five dollars or less at a time. Funds provided by the facility and dispensed to a client as part of a program to train the client in money management, and funds that are not entrusted to the facility (e.g., funds paid directly to the client's representative payee) do not require accounting.

In those instances where a legal guardian or the individual client is in control of their personal funds, no accounting is necessary by the facility.

W141

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(b)(1)(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

Guidance §483.420(b)(1)(ii)

If the facility elects to pool clients' funds in an interest-bearing account, including common trust accounts, it is expected to know the interest separately accrued by each client, as part of its

required accounting of funds. Interest accumulated to a client's account belongs to the client, not the facility.

W142

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(b)(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

Guidance §483.420(b)(2)

Those persons having legal authority to access the accounting records for personal funds such as the client, parent, or legal guardians should be afforded access upon request unless there is documented rationale for withholding the information.

It is not necessary that a facility furnish an annual financial statement to the client, or the client's parent or legal guardian, since the facility is already required to make the financial record available at any time upon request. The client, parent, and/or legal guardian, in turn, is free to choose to make the financial record available to anyone else.

(c) Standard: Communication with clients, parents, and guardians.

§483.420(c) The Facility must –

W143

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

Guidance §483.420(c)(1)

The facility must maintain an on-going effort to communicate with parents, family members and/or legal guardians regarding the implementation of active treatment programs for the client. The facility encourages and engages parents, family members and legal guardians in the continued implementation of active treatment programs even while spending time outside of the facility setting.

"Unobtainable", for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

"Inappropriate", for the purposes of this guideline, means that behavior of the parent or legal guardian could be disruptive or detrimental to the client's program outcome. In this case, determine what the facility has done to bring effective resolution to the problem.

W144
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(2) Answer communications from clients' families and friends promptly and appropriately;

Guidance §483.420(c)(2)

It is reasonable to expect that the facility will provide at least an interim response to inquiries from the client's families and friends within 48 hours.

W145
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

Guidance §483.420(c)(3)

Any limitations on visitors must be implemented as a result of IDT evaluation and discussion and be documented. This documentation should include evidence of approval from the specially constituted committee. Decisions to restrict a visitor for an individual client must be reviewed and re-evaluated each time the IPP is reviewed or at the client's request. Broad restrictions on visitors such as times of the day or certain days of the week are a violation of this requirement.

W146
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

W147
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

Guidance §483.420(c)(5)

The facility should assist and encourage the client to communicate with their families or legal guardians concerning possible outside visits and vacations as frequently as possible. When the client does schedule a trip or vacation, the facility must ensure that all necessary preparation is completed to facilitate the departure.

The facility should not sponsor or allow clients to take a particular type of trip that would

jeopardize their safety or health without consultation with parents/legal guardians and/or the IDT.

W148

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(c)(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

Guidance §483.420(c)(6)

"Significant" incidents or changes in the client's condition include serious injury, unusual seizure activity, hospitalization, serious illness, accident, death, allegations of abuse, neglect, or mistreatment, unauthorized absence, or any notifications the parent or legal guardian's requests.

It is reasonable to expect the facility to contact the family or legal guardian of a client as soon as possible after an incident occurs, but no later than 24 hours after the incident. If notification is done via electronic mail, the facility must request a response from the e-mail recipient to confirm notification. Telephone notification must be accomplished by talking to the person directly. If a message is left, the facility must request a call back to confirm receipt of the notification.

Contact by letter may be utilized as follow up confirmation, but not be the initial, primary or sole mode of communication with the family or legal guardian.

If unable to contact the family or legal guardian, there should be evidence that the facility attempted to reach alternate emergency contacts.

Requests from clients who are their own guardian to limit notifications to their families must be honored.

(d) Standard: Staff treatment of clients.

W149

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

Guidance §483.420(d)(1)

The facility, through implementation of its policies, must set up a structure that screens and trains employees, protects clients and prevents, identifies, investigates and reports abuse, neglect and mistreatment of clients.

The policies must designate who (either by name or title) has the authority to act in the Administrator's absence and take any immediate corrective actions necessary to assure a client's safety such as removing a staff person from direct client contact.

"Mistreatment", for the purposes of this guideline, includes behavior or facility practices that result in any type of client exploitation such as financial, physical, sexual, or criminal. Mistreatment also refers to the use of behavioral management techniques outside of their use as approved by the specially constituted committee and facility policies and procedures.

"Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior may constitute neglect. Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect.

Refer to W127 for definitions of abuse.

W150

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(1)(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

W151

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(1)(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

W152

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(1)(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

Guidance §483.420(d)(1)(iii)

The facility is required to screen potential employees for a prior employment history of child or client abuse, neglect or mistreatment, as well as for any conviction based on those offenses. The abuse, neglect or mistreatment must have been directed toward a child or a client/resident/patient of a health care facility in order for the prohibition of employment to apply.

No one with a conviction or substantiated allegation of child or client abuse, neglect or mistreatment regardless of employment date, is employed by the facility. This requirement also applies to acts of abuse, neglect or mistreatment committed by a current ICF/IID employee outside the jurisdiction of the ICF/IID (e.g., in the community or in another health care facility). The facility must follow state guidelines or requirements for background checks to assure that they make every effort to check new employee's background.

Where the facility has terminated an employee based upon confirmation that abuse, neglect or mistreatment occurred during the employee's performance, and the termination decision was

overturned by either arbitration finding or a court finding, the employee must be returned to a position which does not involve direct contact between that employee and clients of the facility.

A person who abused a resident in a nursing facility, and as a result, is barred from employment in the nursing home setting would also be prohibited from employment in the ICF/IID. While facilities are not required to periodically screen existing employees, if the facility becomes aware that such action has been taken against an employee, the facility is required to prohibit continued employment. This is also true of any conviction in a court of law for child, elder, or client (resident, patient) abuse, neglect or mistreatment. Therefore, conviction for abusing one's own child is also a reason employment would be prohibited.

W153

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

Guidance §483.420(d)(2)

Injuries of unknown source that give rise to a suspicion that they may be the result of abuse or neglect, should be reported immediately.

An injury should be reported as an "injury of unknown source" when:

- *The source of the injury was not witnessed by any person and the source of the injury could not be explained by the client; and*

- *The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.*

It is important to note that members of the ICF/IID population are a mobile population and lead active lives. Therefore, they experience normal day-to-day bumps and minor abrasions as they go about their lives. These minor occurrences which are not of serious consequence to the individual and do not present as a suspicious or repetitive injury (as discussed above) should be recorded by the facility staff once they are aware of them and follow-up should be conducted as indicated. For injuries that do not rise to the level of reportable "injuries of unknown source", the facility should follow its policies and procedures for incident recording, investigation, and tracking.

The facility must immediately report any suspicious injuries of unknown source and all allegations of mistreatment, neglect or abuse to a client residing in the facility regardless of who is the alleged perpetrator (e.g., facility staff, parents, legal guardians, volunteer staff from outside agencies serving the client, neighbors, or other clients, etc.).

If state law requires reporting to an agency or entity other than the administrator, the Centers for Medicare & Medicaid Services (CMS) expects the administrator to be notified as well, in order to ensure facility response to promptly safeguard the client(s).

For the purposes of this regulation "immediately" means there should be no delay between staff awareness of the occurrence and reporting to the administrator or other officials in accordance with State law unless the situation is unstable in which case reporting should occur as soon as the safety of all clients is assured.

W154

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated and

Guidance §483.420(d)(3)

In the absence of any pre-survey information that would indicate the need for a more thorough review of reports of investigation, review 5 percent of the total client investigations for the last three (3) months (but no less than 10).

A thorough investigation includes at a minimum :

- *The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams;*
- *Review of all information;*
- *Resolution of any discrepancies;*
- *Summary of conclusions; and*
- *Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.*

If patterns of possible abuse, mistreatment or neglect are identified, or the incident report logs for the past three (3) months indicate an extremely high incident rate, then a full review of the incidents for the past three (3) months should be completed.

W155

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(3) must prevent further potential abuse while the investigation is in progress.

Guidance §483.420(d)(3)

The facility must take all measures necessary to protect the client, including removal of the staff from working with the client if indicated. See W154.

W156

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and,

Guidance §483.420(d)(4)

Some states require that allegations of abuse must be reported to the police. A police investigation may take longer than five (5) working days. Their investigation does not change the requirement that the facility must complete an internal investigation report of findings within the five day timeframe. When outside authorities are involved, the facility will still be required to complete their investigation within five days to the extent authorized by such entities. "Working days" means Monday through Friday, excluding state and Federal holidays.

W157

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.420(d)(4) if the alleged violation is verified, appropriate corrective action must be taken.

Guidance §483.420(d)(4)

The facility is required to ensure that clients residing in the facility are not subjected to physical, verbal, sexual or psychological abuse or punishment.

Appropriate corrective action is required for findings of abuse, neglect or mistreatment by other clients residing in the facility, staff of outside agencies, parents or any other person, and for injuries to clients resulting from controllable environmental factors.

If the facility receives allegations of abuse, neglect, or mistreatment of a client during out of facility visits with their family, they must report these allegations to the appropriate state authority for investigation. The facility does not have to conduct an internal investigation regarding the alleged violation.

Appropriate corrective action is defined as that action which is reasonably likely to prevent the abuse, neglect, mistreatment or injury from recurring.

This regulation does not require staff termination as the only appropriate corrective action.

The corrective action imposed by the facility is commensurate with the violation.

When a facility is forced to re-hire a staff person, determined by the facility investigation to have been responsible for abuse, neglect, or mistreatment, the facility continues to be responsible for ensuring the health and safety of the clients, and ensures that those staff members do not work directly with clients.

W158

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430 Condition of participation: Facility staffing.
(a) Standard: Qualified intellectual disability professional

W159
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who –

Guidance §483.430(a)

The position of qualified intellectual disability professional (QIDP) is unique to the ICF/IID program. This position can be central to the overall responsiveness and effectiveness of an active treatment program. Whether a supervisory or non-supervisory position, the QIDP is responsible to:

- *Orchestrate all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs;*
- *Effectively coordinate internal and external program services and supports to facilitate the acquisition of client skills and adaptive behaviors; and*
- *Promote competent interactions of residential staff with clients in program implementation and behavior management.*

Breakdowns in the provision of needed services does not automatically equate with deficient practice with QIDP regulations. Non-compliance with QIDP regulations exist where the facility has failed to provide a QIDP or sufficient numbers of QIDPs to effectively perform these required functions or the QIDP(s) has failed to assertively attempt to integrate, coordinate and/or monitor each client's active treatment program.

Elements of integrating, coordinating and monitoring active treatment programs include:

- *Routinely observing clients across settings in program areas to assess effectiveness of program implementation and consistency of training effort to determine effectiveness of IPPs and making timely modifications to facilitate achieving desired skills or goals.*
- *Routinely interacting with program staff across settings to assist in determining the effectiveness and continued relevance of program plans in meeting identified client needs.*
- *Determining the need for program revision based on client performance.*
- *Identifying inconsistencies in training approaches or programs not being implemented as written and facilitating the resolution of these inconsistencies.*
- *Assures follow-up occurs for any recommendation for services, equipment or programs so that needed services and supplies are provided in a timely manner to meet the client's needs.*

The number of QIDPs will vary depending on such factors as the number of clients the facility serves, the complexity of needs manifested by these clients, the number, qualifications and

competencies of additional professional staff members, and whether or not other duties are assigned to the QIDP function.

The QIDP function may not be delegated to other employees even though the QIDP co-signs their work.

W160

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(a)(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

Guidance §483.430(a)(1)

"Experience" means providing professional or direct services, either paid or volunteer, in a setting that serves persons with intellectual disabilities. The experience working directly with persons with intellectual or other developmental disabilities can be obtained prior to or after obtaining the qualifying degree or credentials.

§483.430(a)(2) Is one of the following:

W163

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(a)(2)(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section

Guidance §483.430(a)(2)(iii)

The individual must have at least a bachelor's degree in one of the professions listed in §483.430 (b)(5)(i-xi).

(b) Standard: Professional program services

W164

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430 (b)(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.

Guidance §483.430 (b)(1)

The effectiveness of the active treatment effort is dependent on a facility's assembly of a competent team of professional program staff, with knowledge of contemporary care practices in intellectual disabilities specific to their field of expertise, that work cooperatively as members of an IDT. The facility is responsible for the acquisition of professional staff necessary to provide direct and indirect professional services to meet client needs.

Professional program services are those services that meet the needs identified by a client's CFA that must be provided by a member of a vocation founded upon specialized education/training.

Professional staff services also include on-going monitoring of the effectiveness of programs and plans developed by professional staff but implemented by non -professional staff.

Indirect professional staff services also include on-going, technical support to staff implementing these programs as well as timely assessment of the need for modification of the program with appropriate communication to the QIDP and IDT.

The needs identified in the initial CFA, as required in §483.440(c)(3)(v), should guide the team in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis.

Since such needed professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience, determine if the facility's delivery of professional services is adequate by the extent to which clients' needs are aggressively and competently addressed. Some examples in which professional expertise may overlap include, but are not limited to:

- *Physical development and health: nurse, dietitian, pharmacist.*
- *Nutritional status: nurse, nutritionist or dietitian.*
- *Sensorimotor development: educators, recreation therapists, and occupational therapist, physical therapist.*
- *Affective (emotional) development: special educators, social workers, psychologists, psychiatrists, mental health counselors, rehabilitation counselors, behavior therapists, behavior management specialists, behavior analyst, and medical staff.*
- *Speech and language (communication) development: speech-language pathologists, special educators for people who are deaf or hearing impaired, and medical staff.*
- *Auditory functioning: audiologists (basic or comprehensive audiologic assessment and use of amplification equipment); speech-language pathologists (like audiologists, may perform aural rehabilitation); special educators for clients who are hearing impaired and medical staff.*
- *Cognitive development: teachers (if required by law, e.g., school aged children, or if pursuit of GED is indicated), behavior analysts, psychologists, speech-language pathologists.*
- *Vocational development: occupational therapists, vocational rehabilitation counselors, or other work specialists (if development of specific vocational skills or work placement is indicated).*
- *Social Development: teachers, professional recreation staff, social workers, behavior analysts, psychologists (specialized training needs for social skill development).*
- *Adaptive behaviors or independent living skills: special educators, occupational therapists, behavior analysts, and medical staff.*

W165

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(1) Professional program staff must work directly with clients

Guidance §483.430(b)(1)

Examples of professional staff working directly with clients include: performing professional assessments of clients, provision of direct support and services and periodic monitoring by the professional of the client working on the program. The amount and degree of direct care that professionals must provide will depend on the needs of the client and the ability of other staff to effectively work with clients on a day-to-day basis.

For those services that must be provided by a professional due to either law, licensure or registration, the client receives the services directly from the professional. Professionals may deliver services through the supervision and direction of subordinates where provided by law.

W166

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(1) and with paraprofessional, nonprofessional and other professional program staff who work with clients.

Guidance §483.430(b)(1)

Paraprofessionals are persons in various occupational fields who are trained to assist professionals but are themselves not licensed at the professional level.

Examples of "working with" these other staff may include, but not be limited to:

- *Modeling the correct technique for interacting with clients or implementing a specific program objective.*
- *Designing residential activity programs and teaching staff how to implement them.*
- *Conducting classes on discipline specific topics.*
- *Answering questions of staff related to program implementation or specific behavioral management issues.*
- *Monitoring active treatment areas to identify program implementation or staff-client interaction issues.*

W167

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

Guidance §483.430(b)(2)

There should be sufficient professional staff in the facility to ensure that:

- *needed assessments by professionals are completed timely;*
- *direct professional services are provided when indicated;*
- *clients are receiving interventions as specified in the IPP;*
- *client outcomes are being monitored by the professional;*
- *assessments and outcomes are being communicated to the IDT; and*
- *professional staff are available to consult with team members when needed.*

W168

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

Guidance §483.430(b)(3)

When a professional does an assessment and determines there are client needs which become incorporated into the IPP, with a current prioritized objective, the professional should actively participate on the IDT. This participation may be through written reports or verbally while attending the IPP meeting or participating via telephone or other electronic means, to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs, and to reach decisions as a team, rather than individually, on how best to address those needs.

W169

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

Guidance §483.430(b)(4)

Professional program staff provides various types of training to staff as indicated by the IPP and IDT.

- *Formal training: a specific training done at the time a program is implemented or updated by the professional, with all staff who works with the client.*
- *Informal training: when the professional observes the staff not correctly implementing a program, the professional provides informal guidance on correct implementation.*
- *Training on programs that apply to multiple clients: when a particular program applies to several clients in a facility, a professional may provide training to several staff on a particular topic that applies to multiple clients (such as safe transfer techniques).*

Professional staff of the facility should participate in ongoing training such as conferences and workshops to maintain current standards of practice in the field of intellectual and developmental disabilities as required by their professional licensure or certification.

W170

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:

W171

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(i)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in the state they are practicing in, and are registered or certified nationally as applicable.

W172

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(ii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W173

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W174

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iv)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in State they are practicing in, and are registered or certified nationally as applicable.

W179

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

Guidance §483.430(b)(5)(ix)

If a professional is not nationally registered as a dietician, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

W180

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

Guidance §483.430(b)(5)(x)

Human Services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves. A human services professional works directly with the population being served. Surveyors should see evidence that a human service professional has a bachelor's degree at a minimum.

W181

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(b)(5)(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5)(i) through (x) of this section are not required- -

(A) Except for qualified intellectual disability professionals;

(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and

(C) Unless otherwise specified by State licensure and certification requirements.

Guidance §483.430(b)(5)(xi)

An individual client program may not require that professional staff perform all of the services as outlined by the IPP (e.g. the direct support staff may be trained by the professional to safely and effectively carry out the designed program), however, any specialized therapy must involve evaluation, program development, and re-assessment by the appropriate professional at periodic intervals.

(c) Standard: Facility staffing

W182

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(c)(1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

Guidance §483.430(c)(1)

The facility must have sufficient staff to provide needed care and services without the use of volunteers or enlisting the help of clients residing in the facility to perform the duties normally performed by facility staff.

The facility may not rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services. Volunteers are permissible, but must be in addition to the number of paid staff required to carry out a function. Volunteers should have an orientation to the policies and procedures of the facility and oversight is required by facility staff.

W183

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(c)(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing- -

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

Guidance §483.430(c)(2)

Indicators of staff not being awake in relation to the occurrence of incidents, accidents, and injuries may include, but are not limited to:

- *incidents of unplanned client absences;*
- *untimely reaction to a medical emergency;*
- *injuries from client to client aggression; or*
- *a pattern of injuries of unknown origin.*

If even one client meets 483.430(c)(2)(i-ii) then staff must be awake on a 24-hour basis.

A client has a medical care plan when an acute or chronic occurrence requires clinical assessment and monitoring on a scheduled basis.

W184

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(c)(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing- -

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients.

Guidance §483.430(c)(3)

At all times, there must be at least one staff person on-duty in the facility if even one client is present. For purposes of this provision, "on duty" staff need not be awake during normal sleeping hours, but do need to respond to injuries, illness, and emergencies promptly.

W185

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

Guidance §483.430(c)(4)

Direct care staff should not be performing support services (e.g., making beds, cooking, cleaning, etc.) independently which takes them away from client interaction and teaching. If support services in the house cannot be done jointly as chores between clients, as part of their training program, and the support staff, additional staff should be added to perform the chores. This does not include any staff chores done during client's sleeping hours.

"Support staff" include all personnel hired by the facility that are not either direct care staff or professional staff. For example, support staff includes, but are not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel.

(d) Standard: Direct care residential living unit staff

W186

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Guidance §483.430(d)(1)

"Sufficient" means enough direct care staff to effectively implement the active treatment programs as defined in the IPP, to meet client needs, and to respond to emergencies, illness, or injuries.

Even though minimum ratios are defined at §483.430(d)(3), active treatment may require more staff than the minimums required ratios, therefore compliance should not be based on staffing ratios alone.

§483.430(d)(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

Guidance §483.430(d)(2)

"Direct care staff" are those personnel who are assigned to work directly with the clients providing support during activities of daily living and active treatment programs.

Professional staff who work with clients in a living unit on a periodic basis are not included in direct care staff ratios.

Supervisors of direct care staff can be counted only if they share in the actual work of the direct care of clients on a continuous basis (e.g. take client assignment).

Direct care supervisors whose principle assigned function is to supervise direct care staff may not be included in direct care staff ratios although they may occasionally provide direct services to clients.

Non-direct care staff supervisors whose principle assigned function is to supervise non-direct care staff may not be included in direct care staff ratios.

W187

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2;

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4;

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

Guidance §483.430(d)(3)

At all times on a 24-hour basis the staff to client ratio must be 1 to 3.2, 1 to 4, or 1 to 6.4 based upon the client population.

W189

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Guidance §483.430(e)(1)

Newly employed staff receive a supported orientation program (mentor or ongoing supervision) during their early employment. All staff receive continuing education on such issues as abuse and neglect, handling emergency situations, behavior management, and treating people with respect and dignity, etc.

The primary evidence of an effective staff training program is the observed competent interaction between staff and clients.

§483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients'

W190

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- *developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology use of appropriate materials. and providing informal opportunities to practice skills);*
- *use of adaptive equipment and augmentative communication devices and systems; and*
- *effective recordkeeping procedures.*

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- *use of behavioral principles during interactions between staff and clients;*
- *use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;*
- *use of least restrictive interventions;*
- *use of positive behavior intervention programming; and*
- *training clients in appropriate replacement behaviors.*

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- *signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);*
- *exercise and diet;*
- *first aid;*
- *infection control;*
- *reporting to appropriate healthcare professionals; and*
- *for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.*

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

Inadequate training is evident when staff do not correctly implement behavioral programs, use inappropriate management techniques, cannot explain what intervention is to be used and how it is to be implemented.

W194

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

Guidance §483.430(e)(4)

Staff are observed in various settings during the day correctly and consistently implementing the specific IPPs of the clients with whom they are working.

W195

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440 Condition of participation: Active treatment services

(a) Standard: Active treatment

W196

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward--

(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

Active treatment embodies an individually- tailored series of daily life and living experiences that serve as the primary opportunity for the acquisition, development and expression of functional skills and adaptive behaviors necessary for the client to experience optimal independence and promote purposeful "self-expression".

The uniqueness of each client is a core consideration in the design of active treatment programs. It is expected that individual clients are given the opportunity to provide input into the content of their day-to-day living experiences.

An active treatment program includes the following elements as substantiated through observation, interview and record review:

a) Each client's needs and strengths have been accurately assessed and relevant input has been obtained from team members; (Observations and interviews with the client by the surveyor should be consistent with the current assessment information. Interview the QIDP regarding any needs observed but not addressed through assessment/programming by the facility).

b) Each client's IPP is based on assessed needs and strengths, and addresses major life areas such as personal skills, home living skills, community living skills, employment skills, etc., essential to increasing independence and ensuring rights;

c) Needs identified as a priority are addressed formally and through activities which are relevant and responsive to client need, interest and choice;

d) Active treatment is consistently implemented in all relevant settings both formally and informally as the need arises or opportunities present themselves. It should not be limited to specific periods of time during the day or environments. Each client should receive aggressive and consistent training, treatments and supports in accordance with their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day. Each client has the adaptive equipment and environmental adaptations necessary for him/her to progress toward heightened independence as recommended and contained in their IPP. Active treatment means taking advantage of opportunities for the practice of new skills and the use of other skills during the normal rhythm of each client's day.

e) *Each client's performance related to IPP objectives is accurately and consistently measured and documented and programs are modified on an ongoing basis based on data and major life changes; and*

   i. *Clients with degenerative conditions receive training, treatment and services designed to retain skills and functioning and to prevent further regression to the extent possible.*
   ii. *Clients may need adjustments to their active treatment programs as functional or endurance limitations are identified associated with the aging process. In such cases, there may be more of an emphasis on the retention of skills already attained and reducing the rate of loss of skills, than on the acquisition of new skills.*

In large part, it is this pervasive and continuous reinforcement of "formal" training through "informal" routine daily living experiences and interactions with staff and others that makes active treatment programs effective. Formal settings are those that are planned and specifically structured for training on objectives and interventions. Informal settings are times that are not anticipated or planned but that offer the opportunity for training.

Active treatment programs mirror normal living experiences such as leisure activities and social conversation at the dinner table. It must be clear that active treatment programs are far more than implementation of discreet formal training sessions or programs that are conducted at prescribed times by defined personnel. Learning occurs in the process of the normal rhythm of life and life experiences.

W197

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(a)(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

Guidance §483.440(a)(2)

All active treatment programs must be based upon assessed developmental needs which are prohibiting the client from living in a more independent setting.

Active treatment moves clients to a more independent setting.

- *When a client is in the facility simply for protective oversight and is not in need of training for developmental deficits, this does not constitute active treatment (e.g. a court placement to protect the community or the client from the client's behavior).*
- *Programs that are simply being provided to maintain a client's independence would not be considered active treatment since the client is not actively being trained to live in a more independent setting. If a client already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support and resources that services that only an ICF/IID can provide, they can be considered generally independent.*

For example, a client is admitted to the ICF/IID for the primary purpose of competency determination for a court hearing. This client lived independently prior to admission. The active treatment programs they are receiving are focused on maintaining that independence and do not address specific developmental deficits that inhibit independent living. This would not be considered active treatment.

(b) Standard: Admissions, transfers, and discharge

W198

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

Guidance §483.440(b)(1)

All client admissions must be based upon assessed developmental deficits which are prohibiting the client from living in a more independent setting and which require those intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The individual components of the provision of active treatment include CFA, IPP, program implementation, program documentation, and program monitoring and change. When any of these individual components of active treatment are not in place, resulting in the clients not receiving active treatment, this regulation this not met.

W199

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

Guidance §483.440(b)(2)

Preliminary evaluations should support the need for an admission to an ICF/IID (e.g., deficits in functional skills or adaptive behaviors). The information from the preliminary evaluation must be used by the facility to make an admission decision.

Occasionally, emergency admissions of clients may occur without benefit of a preliminary evaluation having been conducted prior to admission. When situational emergencies necessitate admission before a preliminary evaluation can be conducted, or when pre-admission information is incomplete, the completion of the preliminary admission evaluation within seven (7) calendar days after admission will satisfy compliance with this requirement.

W200

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and

nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

Guidance §483.440(b)(3)

The preliminary evaluation contains specific information useful to determine if the facility can meet the client's needs and if the client can benefit from placement.

The facility makes every reasonable effort to gather all available data to assist in their determination.

Background information would include information that gives insight into the clients' previous living environments and programming efforts.

The assessment must include a consideration as to whether reasonable accommodation as required by the Americans with Disabilities Act would enable the client to benefit from placement in facility.

§483.440(b)(4) If a client is to be either transferred or discharged, the facility must- -

W201

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(4)(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

Guidance §483.440(b)(4)(i)

Transfer or discharge occurs only when the facility cannot meet the client's needs, the client no longer requires an active treatment program in an ICF/IID setting; the individual/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation would be more beneficial to the client.

"Transfer" means the temporary movement of a client to another facility (e.g. another ICF/IID, psychiatric hospital, medical hospital) with the intention of return to the original site.

"Discharge" means the permanent movement of a client to another facility or setting which operates independently from the ICF/IID (e.g. the facility is not under the jurisdiction of the facility's governing body).

Documentation includes evidence of an assessment that evaluated the pros and cons of the transfer or discharge and the rationale for the final decision.

W202

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(4)(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

Guidance §483.440(b)(4)(ii)

The client and their family or the client and their legal guardian are involved in planning for any transfer or discharge and receive the services necessary to assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. If the client has an advocate, the advocate should participate in the decision-making process.

Orderly, planned transfers and discharges usually take place over an extended period of time. The IPP should reflect objectives or interventions which prepare the client for transfer or discharge. Transfers or discharges executed on short timeframes (e.g. less than 30 days) without "good cause" would not comply with the "reasonable" intent of the regulations.

"Reasonable" time is the time required to provide clients and their families with planned steps and established timeframes to facilitate the successful transition. Time frames are modified based on client needs and emergent situations.

Preparation of the client for transfer may include orientation or trial visits to the new location. Staff should take steps to minimize potential anxiety or any behavioral reactions which could result from the client's transfer.

§483.440(b)(5) At the time of the discharge, the facility must-

W203

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(5)(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status

Guidance §483.440(b)(5)(i)

The final summary should be useful for continued services in the client's new setting. The final discharge summary should be entered into the client's record, provide a summary of the client's course of stay in the ICF/IID, provide a final summary of the client's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the client's IPP.

The status should address whether or not a clients' skills have been maintained, deteriorated, or improved during their stay.

W204

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(5)(i) and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

Guidance §483.440(b)(5)(i)

When the client is discharged, the receiving entity (another ICF/IID, waiver home, family home, nursing home, etc.) is provided a copy of the discharge summary. The ICF/IID should obtain written consent to share this information with the persons who will be providing services to the client in the future and their parents/or legal guardians. Sharing the discharge summary with State Agencies as applicable is determined by state requirements.

W205

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(b)(5)(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

Guidance §483.440(b)(5)(ii)

The post discharge plan of care is a component of the discharge summary.

The facility utilizes the information from the discharge summary to prepare the discharge plan of care. The post-discharge plan of care identifies the essential supports and services necessary for the client to successfully adjust to the new living environment and describe necessary coordination of services. It should incorporate the client's preferences. It should identify specific client needs after discharge such as personal care, physical therapy, client/caregiver education needs, and the ability of the client or caregiver to meet those needs after discharge.

(c) Standard: Individual program plan

W206

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to- -

i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

ii) Designing programs that meet the client's needs.

Guidance §483.440(c)(1)

If a need is identified in the CFA, the professional associated with that need will conduct an initial evaluation for the development of the IPP.

The needs identified in the CFA determine the professional, paraprofessional, direct support staff, disciplines or service areas that must participate in the development of the IPP.

W207

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(2) Appropriate facility staff must participate in interdisciplinary team meetings.

Guidance §483.440(c)(2)

While there is no correct number of individuals that comprise the IDT, the team should include appropriate facility staff (professional and paraprofessional staff), that are responsible for designing, developing, and/or implementing the client's IPP and direct support staff who work closely with the clients.

For any prioritized objective, the paraprofessional or professional personnel responsible for the development and monitoring of that program should participate on the team, either through actual attendance or written or verbal input.

Members of the IDT may change as the assessed needs of the client change (e.g. medical issues, nutritional issues, communication needs, fine motor skill needs, gross motor skill needs, social issues or behavioral concerns).

W208

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(2) Participation by other agencies serving the client is encouraged.

Guidance §483.440(c)(2)

The facility must make every effort to coordinate the Individual Education Plan (IEP) from the school or the client's program plan from outside program, work site or workshop with the IPP. This may result in a single document, but there is no requirement for a single combined document. There must be evidence that all applicable plans were coordinated (evidence of discussion across the plans and observation would confirm integration of the IPP across the various settings). The QIDP is responsible for the coordination of the plans.

The facility should communicate changes in the IPP or in the clients' life situation with teachers and workplace representatives either directly or through written communication.

W209

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(2) Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.

Guidance §483.440(c)(2)

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

It is expected that the client will routinely attend team meetings unless their participation is unobtainable. Examples of when client participation is not available include, but are not limited to: 1) the client is away from the facility for medical reasons or hospitalization; or 2) although the facility has documented repeated attempts to engage the client, the client refuses to participate.

If families/legal guardians are unable to attend a program planning meeting, the facility provides them information regarding the meeting outcome and gives them an opportunity to discuss the plan with the facility staff.

"Unobtainable", for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

"Inappropriate", for the purposes of this guideline, means that the parent or legal guardian's behavior is so disruptive or uncooperative that others cannot effectively participate; the client does not wish his or her parent to participate, and the client is competent to make this decision; or there is strong and documented evidence that the parent or legal guardian is not acting on the client's behalf or in the client's best interest. In the case of the latter, determine what the facility has done to bring effective resolution to the problem.

Instances when it is not appropriate for the client, parent or legal guardian, to attend the team discussion are rare. If the client does not attend the meeting, the facility must document the reason for his/her non-participation.

There may also be instances where a parent or legal guardian is considered unobtainable for a team meeting, such as being out of the country. In these instances, the parent or legal guardian should still be notified of the meeting, provided with information concerning the outcome of the meeting and documentation in the client record should describe why the parent or legal guardian could not attend and what information was provided to them.

If the client is an adult who is competent to make decisions and who is not adjudicated, parents may not participate in the process if their participation is opposed by the client.

In the event that a non-adjudicated adult chooses not to have their family involved in the active treatment process, the surveyor should see evidence in the record of efforts made by the facility to understand why the client has declined family participation. If the client continues to decline family involvement after the facility has held discussions with him/her about the importance of this issue, the facility should honor the wishes of the client.

In general, the more involvement and communication among the team members, the client and the parent or legal guardian the more likely the plan will be successful. The facility goal should be to routinely include these parties unless rare circumstances exist.

W210

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.

Guidance §483.440(c)(3)

For new admissions, the CFA is completed within 30 days after admission and is utilized as the basis for the IPP.

New, revised or updated assessments completed within the first 30 days of admission, accurately identify the functional abilities of the client.

"Accurate" assessments refer to assessment data that are current, relevant and valid, and the skills, abilities, and training needs identified by the assessment correspond to the client's actual, observed status. Assessments must be administered with appropriate adaptations such as specialized equipment, use of an interpreter, use of manual communication and tests designed to measure performance in the presence of visual disability.

The content of or format of the assessments or the particular assessment tools which are to be used for the CFA are not specified. Assessments must include identification of those functional life skills in which the client needs to be more independent and those services needed for the client to become more community integrated.

W211

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3) The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must -

Guidance §483.440(c)(3)

During assessment, the client is given opportunities to participate in age-appropriate activities to assess the person's functioning in those activities or settings. For example, the use of baby toys during the assessment of an adult would not be appropriate.

W212

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(i) Identify the presenting problems and disabilities and where possible, their causes;

Guidance §483.440(c)(3)(i)

The CFA includes:

- *all diagnoses and developmental deficits for the client;*
- *the supporting information for each; and*

- *each evaluation should include conclusions and recommendations which go into the development of an active treatment program for the client.*

W213

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(ii) Identify the client's specific developmental strengths;

Guidance §483.440(c)(3)(ii)

The client's identified developmental strengths, preferences, methods of coping/compensation, community use and awareness, friendships and positive attributes and capabilities are clearly described in functional terms in the assessments.

Identified strengths are consistent with the client's observed functional status.

W214

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(iii) Identify the client's specific developmental and behavioral management needs;

Guidance §483.440(c)(3)(iii)

The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture.

"Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or self-injurious behavior).

A functional behavioral assessment is a problem-solving process for evaluating client inappropriate behavior. It relies on a variety of techniques and strategies to identify the purpose of the specific behavior(s) and to help the IDT select interventions to directly address the behavior(s). A functional behavior assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant client-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non-occurrence) of specific behaviors.

The CFA must identify the specific accommodations that address the client's needs to ensure better opportunity for the client's success. The identified accommodations may be assistive technology which can help a person learn, play, complete tasks, get around, communicate, hear or see better, control their own environment and take care of their personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.).

W215

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(iv) Identify the client's needs for services without regard to the actual availability of the services needed; and

Guidance §483.440(c)(3)(iv)

Identification of needed services is based on the CFA.

In the presence of significant developmental deficits, it is not acceptable for the facility to say that a particular professional therapy or treatment is not needed or not available if the CFA identifies a deficit. The assessment must identify the course of specific interventions recommended to meet the client's needs, both through direct professional services and non-professional services. For example, a client's communication skill development may not require the intensive services of a speech-language pathologist however, the direct care staff will need to work with the client and use a pre-determined communication system.

§483.440(c)(3)(v) Include

Guidance §483.440(c)(3)(v)

The CFA should include an assessment of each of the areas listed below. Assessments should include specific information about the person's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

If assessments are done separately by professional disciplines, there should be evidence that the assessments are brought together in an interdisciplinary approach to address the client's various developmental areas.

The CFA must be completed upon admission and annually as indicated. While the assessment may not have the specific titles of the areas listed below, the surveyor must be able to identify information within assessments from each of the areas below.

W216

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) physical development and health,

Guidance §483.440(c)(3)(v)

Physical development and health: This portion of the CFA includes the client's developmental history, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history); a review and summary of all laboratory reports since the last comprehensive evaluation, a summary of all required medical interventions since the last CFA;

skills of the client normally associated with the monitoring and supervision of one's own health status, and administration and/or scheduling of one's own medical treatments. Reports of all specialist consultations should be included in the assessment as indicated by physical examination results.

IDT reviews any current advanced directives that the client may have in place as part of the CFA.

W217

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) nutritional status,

Guidance §483.440(c)(3)(v)

Nutritional status: Nutritional status includes height and weight, the client's eating habits and preferences, favorite foods, determination of appropriateness of diet, adequacy of total food intake, bowel habits, means through which the client receives nutrition (e.g. feeding tube) and the skills associated with eating (including chewing, sucking and swallowing disorders).

W218

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) sensorimotor development,

Guidance §483.440(c)(3)(v)

Sensorimotor development: Sensorimotor development includes the development of perceptual skills that are involved in observing the environment and making sense of it. Identified sensory deficits should be evaluated in conjunction with the impact they will have on the client's life. A sensory deficit in eye contact may not have a detrimental effect on the client's life if it will not hold the client back from further accomplishments or skill acquisitions. Motor development includes those behaviors that primarily involve: muscular, neuromuscular, or physical skills and varying degrees of physical dexterity. Because sensory and motor development are intimately related and because activities in these areas are functionally inseparable, attention to these two aspects of bodily activity is often combined in the concept of sensorimotor development. For those motor areas that are identified by the assessment as limited, the assessment should specify the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status and the extent of time the device is to be used throughout the day.

W219

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) affective development,

Guidance §483.440(c)(3)(v)

Affective (Emotional) development: Affective or emotional development includes the development of behaviors that relate to one's interests, attitudes, values, morals, emotional feelings and emotional expressions.

W220

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) speech and language development

Guidance §483.440(c)(3)(v)

Speech and language (communication) development: One of the most contributable causes of behaviors, frustration by the clients, etc. is lack of effective communication. It is imperative that the CFA identifies how the client communicates, what barriers are present, what services are available and what programs and services will be provided to assist the client to go out into and participate fully in the world. Observed client communication skills match the evaluation results and that training programs are in place to address needs.

Communication development refers to the development of both verbal and nonverbal and receptive and expressive communication skills. Assessment data identify the appropriate intervention strategy to be applied, and which, if any, augmentative or assistive devices will improve communication and functional status. These intervention strategies should provide the client with a viable means of communication which is appropriate to their sensory, cognitive and physical abilities.

W221

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) and auditory functioning,

Guidance §483.440(c)(3)(v)

Auditory functioning: Auditory functioning refers to the extent to which a person can hear, to the maximum use of residual hearing if a hearing loss exists, and whether or not the client will benefit from the use of amplification, including a hearing aid or a program of amplification.

W222

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) cognitive development,

Guidance §483.440(c)(3)(v)

Cognitive development: Cognitive development refers to the development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the client has and those best used by the

trainers. It is critical that the CFA address the individual learning style of the client in order to best direct the way the trainers will teach formal and informal programs.

W223

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) social development,

Guidance §483.440(c)(3)(v)

Social Development: Social development refers to the formation of those self-help, recreation and leisure, and interpersonal skills that enable a client to establish and maintain appropriate roles and fulfilling relationships with others. Assessments may address family supports and relationships, sexual awareness and sexuality, friendships, social awareness, social skills and social interests.

W224

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) adaptive behaviors or independent living skills necessary for the client to be able to function in the community,

Guidance §483.440(c)(3)(v)

Adaptive behaviors or independent living skills: Adaptive behavior refers to the effectiveness or degree with which clients meet the standards of personal independence and social responsibility and community orientation and integration expected of their age and cultural group. Adaptive behaviors are those behaviors that are developed to cope with deficits in order to be able to perform every day skills as independently as possible. Independent living skills include, but are not limited to, such things as food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. Assessment may be performed by anyone trained to do so. Standardized tests are not required. Standardized adaptive behavior scales which identify all or predominantly all "developmental needs" are not sufficient to meet this requirement, but can serve as a basis for screening.

W225

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(3)(v) and as applicable, vocational skills.

Guidance §483.440(c)(3)(v)

Vocational development, "as applicable": Vocational development refers to work interests, work skills, work attitudes, work-related behaviors, and present and future employment options. The determination of whether or not a vocational assessment is "applicable" is typically based on age (adolescents or adults more than likely require this type of assessment). The vocational assessment for each client may address job sampling, job development, on-site job training and long term follow-up, as appropriate to the client and determined by the IDT.

Vocational assessments should describe, for all domains, what clients can and cannot do in terms of skills needed within the context of their daily lives and jobs.
Assessments should be individualized and based on:

- *Actual performance of the client against objective criteria;*
- *Reports by staff/parents/legal guardians; and*
- *Observed performance in a variety of settings.*

W227

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4) that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section,

Guidance §483.440(c)(4)

Objectives are developed for those needs that are identified by the CFA and which are considered to be most likely to improve the client's ability to independently function in his/her daily life, as determined by the IDT.

There is a clear link between the specific objectives and the functional assessment data and recommendations.

Objectives are developed for those needs that are observed to most likely impact the client's ability to function in daily life. Training objectives should be developed to address client needs rather than staff oriented objectives.

Clients are expected to have training objectives in the areas of activities of daily living, based on the client's assessed needs and as prioritized by the IDT. If clients have eyeglasses, dentures and/or other assistive devices it is expected that the team considers objectives, based upon the assessment of client needs, addressing the care and use of such devices. However, in the area of programs to teach the clients' money management it is not expected that every client will automatically have a formal training objective to participate in such a program. The decision to prioritize such a program and to what level the program is developed is decided by the IDT based upon the results of the CFA and in consideration of such factors as, transferable skills, the ability to make choices, the ability to identify preferences and cognitive abilities such as attention span and an understanding of the principle of cause and effect.

Similarly, the decision to prioritize and develop a training objective for a client to participate in a self-administration program for medications must be made by the IDT and be based upon information from the CFA. Formal self administration programs should not be confused with informal efforts to include the client in the administration process such as allowing them to hold a glass of water, identify the box where his/her medications are stored or put a pill into their own mouth themselves under the supervision of a person who is qualified to administer medications.

W228

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4) and the planned sequence for dealing with those objectives.

Guidance §483.440(c)(4)

The objectives identified in W227 are organized in a logical sequence, determined by the team that will assist the client toward the attainment of skills resulting in greater self-choice, independence, and community integration. The logical sequencing of objectives means there is a completion of one objective that serves as the building block for the next with relevance to the client's functional status. Where objectives are logically ordered but do not have relevance to the client's functional status, refer to 483.440(c)(4).

If the IPP is organized in a logical sequence, this requirement is met. For example, if the long term goal is to travel independently in the community, the objective sequencing may involve training the client to recognize traffic signs, cross the street safely, and to obtain help when needed if lost or an emergency arises.

These objectives must –

W229

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4)(i) Be stated separately, in terms of a single behavioral outcome;

Guidance §483.440(c)(4)(i)

Each objective clearly states one expected learning result.

"Single" behavioral outcome means that there is a separate objective assigned for each discrete behavior that the team intends the client to learn. For example, "Mary will bake a cake and clean the oven" are two separate behaviors and, therefore, should be stated in two separate objectives. Completion of the morning hygiene routine includes programs for performance of face washing, tooth brushing and hair combing which are three separate objectives; however, the behavioral outcome for each would be the same (e.g. completion of the morning hygiene routine).

W230

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4)(ii) Be assigned projected completion dates;

Guidance §483.440(c)(4)(ii)

Completion dates are based on the client's rate of learning.

Completion dates are assigned to each objective on which the client is currently working.

Completion dates are individualized (e.g. not all the same for all clients and all objectives).

The "projected date of completion" for an IPP objective is not the same as a "review" date. For each objective assigned a priority, the team should assign a projected date (month and year) by which it believes the client will have learned the new skill, based on all of the assessment data. This date triggers the team to evaluate continuously whether or not the client's progress or learning curve is sufficient to warrant a revision to the training program.

W231

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4)(iii) Be expressed in behavioral terms that provide measurable indices of performance;

Guidance §483.440(c)(4)(iii)

The desired learning outcome is stated in a manner which enables all staff working with the client to consistently identify the target behavior and to clearly identify when it is being displayed.

The objective is stated in a manner which permits it to be measured with quantifiable data.

"Behavioral" terms include only those behaviors which are "client" rather than staff oriented and those that any person would agree can be seen or heard. Determine if all staff who work with the client can define the exact same outcome on which to measure the client's performance.

"Measurable indices of performance" are the quantifiable criteria to use in determining successful achievement of the objective. Quantifiable criteria include various measurements of intensity and duration. For example, "Client X will walk ten feet, with the use of her tripod walker, on each of five (5) consecutive days."

W232

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4)(iv) Be organized to reflect a developmental progression appropriate to the individual; and

Guidance §483.440(c)(4)(iv)

Objectives must be relevant to the client's current skill sets and abilities as identified in the CFA.

The ICF/IID must consider the person's current functional abilities and project what steps, methods, and strategies are likely to be effective in achieving the objective.

W233

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(4)(v) Be assigned priorities.

Guidance §483.440(c)(4)(v)

Priorities are established based on the needs and in consideration of the desires of the client and emphasize the development of greater independence, self-choice, and community integration.

The team determines which objectives are the highest priority to be addressed, either because the client has an immediate need or the priority objectives must be accomplished before other priorities are addressed.

§483.440(c)(5) Each written training program designed to implement the objectives in the individual program plan must specify:

Guidance §483.440(c)(5)

The following regulations (5) (i-iv) apply to formal training programs developed for current implementation.

W234

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(i) The methods to be used;

Guidance §483.440(c)(5)(i)

The training program provides clear directions to any staff person working with the client on how to implement the teaching strategies. To comply with this requirement the methodologies must be written in a clear enough manner that a substitute staff person will be able to read the methodologies and implement them without substantial differences from a regularly assigned staff person. Methodologies should be consistent across settings, such as when the client is in the day program.

W235

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(ii) The schedule for use of the method;

Guidance §483.440(c)(5)(ii)

Active treatment (the implementation of training programs pursuant to objectives) should be provided in formal and informal settings throughout the rhythm of the client's day. While there may be structured episodes when the client works intensively and singularly on one or more objectives (schedule), the provision of active treatment is not adequate when confined solely to these types of formal settings but should be incorporated into all activities when appropriate (client's routine). For example, objectives on grasping may be as effectively carried out during the client's use of a toothbrush and a spoon as in an isolated session.

W236

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(iii) The person responsible for the program;

Guidance §483.440(c)(4)(v)

The IPP should include the actual name of the staff person who is responsible for the ongoing monitoring of the client's program to ensure it is being implemented appropriately, as well as the designated position which will implement the program.

The QIDP should be familiar with the assessment and recording requirements for each client for each formal objective, including who is responsible for making these observations and completing the recording, and demonstrate a familiarity with the current data recorded for each client.

W237

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

Guidance §483.440(c)(5)(iv)

The IDT must determine the type of data necessary to judge a client's progress on an objective, and describe the data collection method in the written training program. The facility determines what data to collect, but whatever system is chosen for collection must yield accurate measurement of the criteria stated in the client's IPP objectives. For example, if the criteria in the client's IPP objective specified a behavior to be measured by "accuracy," or "successes out of opportunities," then it would not be acceptable for the prescribed data collection method to record "level of prompt".

Examples of a few data collection systems include, but are not limited to:

- *level of prompt;*
- *successful trials completed out of opportunities given;*
- *frequency counts; and*
- *frequency sampling.*

The IDT must consider and select the type and frequency of data collection for each objective based upon the need to measure appropriately the client's performance toward the targeted IPP skill development. The facility should collect data with enough frequency and content to be able to appropriately measure the client's performance toward the targeted IPP skill development. The frequency of data collection may vary with the objective but must be made at sufficient intervals to allow analysis of the progress of the client.

W238

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(v) The inappropriate client behavior(s), if applicable; and The inappropriate client behavior(s), if applicable; and

Guidance §483.440(c)(5)(v)

Any specific behaviors which would interfere with the client's ability to function in, or benefit from the training program are identified (e.g. a fear of water could interfere with the client's bathing program).

W239

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(5)(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

Guidance §483.440(c)(5)(vi)

The training program provides specific information as to how to elicit or strengthen appropriate behavior and what behaviors to teach reinforce or encourage which would reduce or replace the inappropriate behavior.

If a client is exhibiting an inappropriate behavior, the CFA should discover why the behavior is occurring and the team should develop associated training objectives to help the client develop more appropriate behaviors. The objective for decelerating targeted inappropriate behaviors is not solely the reduction of these behaviors. The objective should also include the positive functional replacement behavior (adaptive behavior).

A replacement behavior allows a client to substitute an unconstructive or disruptive behavior with something more constructive and functionally equivalent. For example, instead of throwing work materials as a way to get a break from vocational task demands, teach the client to say or sign for 'break'.

§483.440(c)(6) The individual program plan must also:

W240

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(i) Describe relevant interventions to support the individual toward independence.

Guidance §483.440(c)(6)(i)

Appropriate materials, adaptations and modifications to equipment and the environment are available in order to promote and support individual training programs. Examples may include, but are not limited, to built-up toilet seats, adaptive eating utensils, extended reach devices, and modification to the facility van to accommodate a wheelchair.

The IPP describes supports and services, in addition to the individual goals and objectives that will be provided by the facility to assist the client to function with greater independence.

W241

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

Guidance §483.440(c)(6)(ii)

This requirement refers to the training program plans, objectives, descriptions of staff interventions and data collection tools which must be readily accessible to any staff in order for the programs to be consistently and effectively carried out and data collected.

W242

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

Guidance §483.440(c)(6)(iii)

All clients who lack the skills listed within this standard have associated training programs developed to meet their needs according to prioritization. These programs are consistently implemented in both formal and informal settings.

"Developmentally incapable" is a decision made by the IDT that means a client does not have the capacity to acquire certain skill sets. The decision must be based on an assessment of the client's strengths, needs, and functional limitations.

The determination of developmental incapability must be accompanied by written evidence supporting this determination.

Such evidence may include training programs which failed after many different strategies were tried, or physical limitations that preclude the acquisition of the skill. Examples are:

1) *Eye contact program was attempted using seven different methods over a two year period;*
2) *An client has two frozen elbow joints which do not allow her to get her hands to her mouth and consequently she will not be trained on any hand to mouth skills; and*
3) *Some clients may have insufficient neuromuscular and sensory control to ever be totally independent in toileting skills.*

Toilet scheduling alone without any plan to progress would not be considered a toilet training program.

The components of functional skills "training" as used in this regulation means aggressive implementation of a systematic program of formal and informal techniques, which are:

- *targeted toward assisting the client achieving the measurable behavioral level of skill competency specified in IPP objectives;*
- *implemented at natural occurrences of activity and training programs; (e.g.: an objective for a client to increase grasping may be implemented as easily in the workshop with a built up tool as in the bathroom with a toothbrush);*
- *conducted by all personnel involved with the client including those outside the home such as in day programs; and*
- *carried out in conversation and interaction with the client appropriate to the situation.*

§483.440(c)(6)(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify

Guidance §483.440(c)(6)(iv)

The use of mechanical supports are based upon an individual assessment and fitting. Mechanical devices are used to support a client's proper body position or alignment and may be essential to prevent contractures or deformities. However, mechanical supports restrict movement and the client should be released from the support periodically for exercise and free movement. Mechanical supports may not be used as a substitute for programs or therapy. For example, the use of a bolster to position a client upright in a sitting position without any indication there has been an assessment for the need for muscle re-training may be an indication of a mechanical device in lieu of programming. Some supports allow movement and provide opportunity for more increased functioning. Some examples of devices used as mechanical supports include splints, wedges, bolsters, lap trays, etc.

Wheelchairs are not generally used to position or align the body and would not alone constitute a mechanical support. However, adaptations to a wheelchair which facilitate correct body alignment by inhibiting reflexive, involuntary motor activity are mechanical supports and should be included in the plan for the client.

W243
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(iv) the reason for each support,

W244
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(iv) the situations in which each is to be applied,

W245
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(iv) and a schedule for the use of each support.

W246
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

Guidance §483.440(c)(6)(v)

Clients with sensory or physical difficulties should be given the same opportunities to move around in their environments as clients who do not have those difficulties. Even clients who use specialized wheelchairs should be given the opportunity to utilize other devices such as walkers, wagons and scooters to move about and/or change their positions.

With the exception of those clients who are acutely ill (such as those who are hospitalized or incapacitated by a "short term" illness), all clients should be out of bed and outside their bedroom area as long as possible each day, and in proper body alignment at all times. This is a necessity in order to prevent regression, contractures, and deformities and to provide sensory stimulation.

Bed rest is a temporary situation associated most usually with a medical condition and must be ordered by the medical staff of the facility. The term implies that the client will remain in his/her bed for most of any 24-hour period. Although active treatment programs may be carried out to some extent while the client is on bed rest, the client's program cannot be completed in its entirety. While there may be situations where continuous bed rest may be necessary, these situations are rare.

For those rare instances where out-of-bed activity is a threat to a client's health and safety (e.g., blood clot in the leg), active treatment adapted to the medical capacity of the client must be continued.

W247

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(6)(vi) Include opportunities for client choice and self-management.

Guidance §483.440(c)(6)(vi)

Choice and self-management are integral components of becoming independent. Clients should be given opportunities for choice and self-management in both formal and informal settings through the IPP process, leisure activities, and other life choices.

The ICF/IID must incorporate opportunities into daily life experiences that promote choice making and decision making by clients. Examples of some activities leading toward responsibility for one's own self-management include, but are not limited to:

1) *choosing housing or roommates;*
2) *choosing clothing to purchase or wear;*
3) *choosing what, where, and how to eat (e.g. the use of family style dining, access to condiments and second helpings).*

Choices can be made by all clients. The type of choices the person makes may vary from simple to complex, dependent upon client abilities.

Clients are provided opportunities for choice and self-management and the facility does not limit choices by making decisions for the people being served without their input. Clients are provided the opportunity to demonstrate skills to the degree they are capable and only assisted by staff as indicated in their IPP. A lack of facility staffing or staff convenience must not result in a limitation of choices of self-management for the clients.

W248

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

Guidance §483.440(c)(7)

The client or legal representative, as well as the facility staff, and staff from outside agencies, with appropriate consent, have, or can access, a copy of the IPP.

(d) Standard: Program implementation

W249

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Guidance §483.440(d)(1)

There should be no delay in the development and implementation of the IPP. To promote a team process and meaningful discussion, IPP development should take place during IDT meetings. Any IPP objective or modification that is critical to the health and safety of any client should be implemented immediately following IDT discussion."

Each individual receives training and services consistent with the current IPP.

The time period between admission and the 30 day IDT meeting is primarily to assist the client to become adjusted and acclimated to his or her new living environment and to enable the facility to complete the CFA. During this time period the facility should also be providing those services and activities determined during the pre-admission assessment as essential to the client's daily functioning.

The active treatment program for the client is consistently implemented in all relevant settings both formally and informally as opportunities present themselves. It should not be limited to specific periods of time during the day or specific environments.

Each client should receive aggressive and continuous training, treatments and supports in accordance with their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day.

- *During observations confirm that the client activities relate directly to the strengths, needs and objectives in the IPP for each client and are not "busy work," generalized or non-developmental time fillers. For example, screwing nuts on bolts and then unscrewing them repeatedly with no goal or transferable skills is "busy work." Screwing nuts on bolts that will be part of a product is functional reinforcement of skill acquisition.*
- *Clients use adaptive equipment, assistive devices, environmental supports, materials, supplies, etc., as specified in each client's IPP to assist the client to accomplish stated objectives.*

There is no specific number or frequency of interventions that meets this requirement. The surveyors should see that the facility capitalizes on all opportunities throughout the course of the day that promote progress toward the achievement of goals and objectives.

Informal opportunities ("teachable moments") should be utilized to reinforce learning or appropriate skill development and needs are addressed as they present.

Although a client may not be able to reach complete independence in a functional skill, it is crucial that retention of their current skills be supported.

Clients may have defined periods of time where they may engage in leisure activities of their choice which are not necessarily directly associated with their IPP goals and objectives.

W250

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

Guidance §483.440(d)(2)

The schedule is individualized, consistent with the client's objectives, and reflects normal daily routines.

The staff working with individual clients are familiar with their daily schedules and can produce the schedule upon request.

The active treatment schedule allows flexibility and is adjusted to the needs and preferences of the client, as necessary. It's a schedule of the client's general daily plans, but can be changed.

The active treatment schedule is a functional schedule which enables client and staff to be in the right location in order to participate in the training as scheduled by the IPP.

W251

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

Guidance §483.440(d)(3)

All disciplines, including direct care staff, interacting with the client work together to provide a uniform, consistent approach to implementation of the IPP.

(e) Standard: Program documentation

W252

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

Guidance §483.440(e)(1)

"Data" are defined to be performance information collected and reported in numerical or quantifiable form for each training objective assigned priority in the IPP.

Data are those performance measurements collected at the time the treatment, procedure, intervention or interaction occurs with the client and recorded as soon as possible. The data should be located in a place accessible to staff who conduct training.

Data should be collected in a form and frequency as required by the plan to enable quantitative (frequency or numbers) analysis of the client's progress.

Data are accurate (e.g., reflective of actual client performance.)

§483.440(e)(2) The facility must document significant events that

W253

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(e)(2) are related to the client's individual program plan and assessments and

Guidance §483.440(e)(2)

Significant events are those events which would cause a reasonable person to be affected and which impact a normal routine. Such events include changes in the client's functional status,

emotional health, physical health, accomplishments, activities or needs which impact the CFA and IPP, as well as instances of abuse, neglect or mistreatment.

The client record should contain documentation that such events are evaluated and monitored.

W254

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(e)(2) that contribute to an overall understanding of the client's ongoing level and quality of functioning.

(f) Standard: Program monitoring and change

§483.440(f)(1) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client- -

Guidance §483.440(f)(1)

Program implementation is a critical piece of each client's active treatment program. The QIDP must review or revise client programs according to 483.440(f)(1)(i-iv) and at such an interval that any of the requirements are promptly identified and addressed.

W255

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(1)(i) Has successfully completed an objective or objectives identified in the individual program plan;

Guidance §483.440(f)(1)(i)

The QIDP ensures the program has been modified or changed in response to the client's specific accomplishments or need for new program.

W256

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(1)(ii) Is regressing or losing skills already gained;

W257

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(1)(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

Guidance §483.440(f)(1)(iii)

There should be evidence that the QIDP has reviewed and revised the IPP in those situations when the client's IPP has been consistently implemented yet the client fails to achieve their objectives.

W258

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(1)(iv) Is being considered for training towards new objectives.

§483.440(f)(2) At least annually,

Guidance §483.440(f)(2)

For the "annual" review to meet this requirement, it must be completed by at least the 365th day following the previous review, unless in an isolated or rare instance a client or the client's family is not available for a projected period of time and the subsequent delay is a minimal number of days.

W259

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(2) the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed;

Guidance §483.440(f)(2)

The CFA is reviewed at least annually.

The review of the CFA occurs sooner than annually if:

- *indicated by the needs of the client;*
- *reflects any changes in the client since their last evaluation; and*
- *incorporates information about the client's progress or regression with objectives.*

The review of the CFA applies to all evaluations conducted for a client. It is not required that each assessment be completely redone each year, except the physical examination. It is required that at least annually the assessment(s) be updated when changes occur so as to accurately reflect the client's current status.

W260

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(2) and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

Guidance §483.440(f)(2)

The IPP reflects the functional changes for the client which occurred since the last IPP. It is unlikely that an active treatment program will have no changes from year to year without

documentation to support not changing the plan. Question an IPP that is a duplication of the prior year's plan without explanation.

W261

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to- -

Guidance §483.440(f)(3)

The facility must have a specially constituted committee whose primary function is to proactively protect client rights by monitoring facility practices and programs. The purpose of the committee is to assure that each client's rights are protected utilizing a group of both internal staff and outside clients (who do not have a vested interest in the facility). There should be evidence that the committee members have been trained annually on the rights of the clients, what constitutes a restriction of a right and the difference between punishment and training.

Depending on size, complexity and available resources, the ICF/IID may establish more than one specially constituted committee. However, each committee must contain the required membership and participate regularly and perform the functions of the committee according to the requirements. Participation on the specially constituted committee(s) must be in real time allowing all membership to speak and discuss in an interactive mode.

The regulation does not specify the professional credentials of the "qualified persons" (who have either experience or training in contemporary practices to change inappropriate client behavior). There is no requirement that any specific discipline, such as nurse, physician or pharmacist be a member of the committee.

The intent of including "persons with no ownership or controlling interest" on the committee is to assure that, in addition to having no financial interest in the facility, at least one member of each constituted committee is an impartial outsider in that he/she would not have an "interest" represented by any other of the required members or the facility itself. Staff and consultants employed by the facility or at another facility under the same governing body, cannot fulfill the role of person with no ownership or controlling interest.

Although occasional absences from committee meetings are understandable, patterns of absence by the required membership of the committee is not acceptable. At least a quorum of committee members (as defined by the facility) must review, approve and monitor the programs which involve risk to client rights and protections and that quorum must include one person from each of the required categories.

W262

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- *restraints;*
- *drugs to manage behavior;*
- *restrictions on community access;*
- *contingent denial of any right; or*
- *restrictions of materials or locations in the home.*

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W263

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(3)(ii) Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and

Guidance §483.440(f)(3)(ii)

The committee must ensure that written informed consent must be obtained prior to implementation of any restrictive or intrusive program. In the event of an emergency, the facility may obtain a verbal consent, which must be authenticated in writing as soon as possible and subsequently submitted to the committee as verification.

The consent is required for the entire behavior management program not just the specific restrictive technique.

Consent is informed when the person giving consent is fully aware of the:

- *specific treatment;*
- *reason for treatment or procedure;;*
- *the attendant risks vs. benefits;*
- *alternatives;*
- *right to refuse; and*
- *the consequences associated with consent or refusal of the program.*

Informed consent must be in writing and must be specific to the program and restrictive practice and reflect a specific time frame. Blanket consents are not allowed. In the case of unplanned events such as assault and property destruction requiring immediate action, verbal consent may be obtained. However, it should be authenticated in writing as soon as reasonably possible (within 30 days).

For clients up to the age of 18, their parent or legally appointed guardian must give consent for him or her. At the age of 18, however, clients become adults and are assumed to be competent unless otherwise determined by a court.

For clients who are adults and have not been adjudicated incompetent and have not been assigned a legal guardian who may not fully understand the consequences of the program, informed consent for use of restrictive programs, practices or procedures should be obtained from a person or an entity in accordance with state law, to act as the representative or advocate of the client's interests.

The specially constituted committee must ensure that the informed and voluntary consent of the client, parent of a minor, legal guardian, or the person or organization designated by the state is obtained prior to each of the following circumstances:

- *The involvement of the client in research activities; or*
- *Implementation of programs or practices that could abridge or involve risks to client protections or rights.*

W264

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.440(f)(3)(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

Guidance §483.440(f)(3)(iii)

The committee has been made aware of and reviewed:

- *facility policies and procedures;*
- *facility services;*
- *programs; and*
- *practices which may restrict or violate the rights of client.*

The committee has established and uses a mechanism for monitoring clients' rights issues and informs the governing body of any issues of concern in a timely manner. This process is at the discretion of the committee. There is no requirement for periodic review of the policies by the committee.

The function of the committee is not limited to the review, approval and monitoring of restrictive behavior management practices. Examples of issues involving client rights that might be reviewed by the committee, in addition to behavior management, include, but are not limited to:

1) *Research proposals involving clients;*
2) *Abuse, neglect and mistreatment of clients;*
3) *Allegations dealing with theft of a client's personal property or funds;*
4) *Damage to a client's goods or denial of other client rights;*
5) *Client grievances;*
6) *Visitation procedures;*
7) *Guardianship/advocacy issues;*
8) *Rights training programs;*
9) *Confidentiality issues;*
10) *Advance directives/DNR orders;*
11) *Practices which restrict clients (e.g. locked doors, fenced in yards); and*
12) *Video monitoring.*

W266

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450 Condition of participation: Client behavior and facility practices

(a) Standard: Facility practices-- Conduct toward clients

W267

(Rev.135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.

Guidance §483.450(a)(1)

The primary survey emphasis is on the implementation of the policies and procedures developed by the facility.

Conduct between staff and clients refers to language, actions, discipline, rules, order and other types of interactions exchanged between staff and clients or imposed upon clients by the staff during a client's daily experiences that affect the quality of a client's life.

§483.450(a)(1) These policies and procedures must –

W268

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(1)(i) Promote the growth, development and independence of the client;

Guidance §483.450(a)(1)(i)

Consistent with facility policies, staff is observed to be engaged in activities which promote the client's growth, development and independence.

1) *IPPs and data support the fact that from the time of admission, clients are learning new adaptive and functional skills while becoming more independent.*

2) *Interactions between clients and staff are consistent and positive.*

3) *Staff teach and encourage clients to interact with each other in a manner that promotes social integration both in the facility and out in the community.*

4) *All opportunities to teach and reinforce skill acquisition are utilized.*

5) *Staff identify and remove impediments in the learning environment (e.g. client is unable to concentrate in a room with a television because when they see the television, they want to watch their favorite show. Staff must identify this learning impediment and train in an environment without a television).*

6) *Staff encourage clients to complete tasks with as much independence as possible.*

7) *Staff encourage clients to take risks while providing reasonable safeguards to prevent injury.*

8) *Encourage clients to make choices during their daily activities.*

W269

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(1)(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;

Guidance §483.450(a)(1)(ii)

Written facility policies describe how the facility will offer choice to the clients during the course of their day.

Written policies describe how self-determination, as defined by free choice of one's own acts and decisions without external coercion or direction, to the extent possible and self-management, as

defined by control of one's own routine and daily responsibilities, to the extent possible, are incorporated into the development of program plans and daily routines.

W270

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(1)(iii) Specify client conduct to be allowed or not allowed; and

Guidance §483.450(a)(1)(iii)

"Client conduct" refers to any behavior, choice, action, or activity in which a client may choose to engage alone or with others.

Written policies and procedures which may be in the form of "house rules", must not impinge on individual client rights and must not be used as a substitute for the development of individualized programs and plans.

W271

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(1)(iv) Be available to all staff, clients, parents of minor children, and legal guardians.

Guidance §483.450(a)(1)(iv)

Policies and procedures for management of conduct between staff and clients (483.450(a)(1)) should be provided to clients, parents of minor children, and legal guardians at admission and upon request. Policies and procedures are available on the residential and program areas if these are in separate buildings.

W272

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(2) To the extent possible, clients must participate in the formulation of these policies and procedures.

Guidance §483.450(a)(2)

"To the extent possible" does not mean that the clients are excluded due to the clients' schedule or intellectual or developmental level. Facilities should be able to provide documentation that substantiates that clients were offered the opportunity and participated in the development of the policies. This could be accomplished through client committees or in house meetings. There should be documentation of these discussions between the client representatives and the facility.

W273

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

Guidance §483.450(a)(3)

Staff will promptly intervene when any clients tries to independently impose discipline upon another client. For example, a client who is serving dessert to the group withholds dessert from another client based upon their own evaluation of that client's behavior.

(b) Standard: Management of inappropriate client behavior

W274

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior

Guidance §483.450(b)(1)

At a minimum, the facility must have written policies and procedures regarding the management of maladaptive behaviors addressing the following:

483.450(b)(1) (W 275 – W284).

- *the use of a functional behavior assessment in the development of behavior management programs;*
- *a hierarchy of least to most intrusive measures; and*
- *incorporation of behavior management programs into the IPP.*

§483.450(b)(1) These policies and procedures must be

W275

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1) consistent with the provisions of paragraph (a) of this section.

§483.450(b)(1) These procedures must

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive

interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- *the types of physical restraint that are allowed in the facility;*
- *the persons who apply such restraints;*
- *the parameters for duration of application;*
- *the methods that assure the health and safety of clients while in restraints; and*
- *the specific training required for staff allowed to apply such restraints.*

W281
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

Applicable policies may include a discussion of:

- *When a drug can be used to manage inappropriate behavior;*
- *Consistency with diagnosis;*
- *Alternatives tried before a drug is used;*
- *Precautions that must be followed prior to and during the use (lab values, monitoring of side effects);*
- *Implementation of a plan to address the behaviors for which the drug was prescribed; and*
- *Plan to reduce the medication as appropriate.*

Drugs to manage inappropriate behavior are defined as any medication prescribed and administered for purposes of modifying the maladaptive behavior of a client.

W282

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(D) The application of painful or noxious stimuli;

Guidance §483.450(b)(1)(iv)(D)

"Application of painful or noxious stimuli" is defined as any procedure by which staff apply, contingent upon the exhibition of maladaptive behavior, startling, unpleasant, or painful stimuli, or stimuli that have a potentially noxious effect.

While the regulation permits the use of painful or noxious stimuli these techniques are the last resort and can only be utilized for behaviors that are causing significant harm and have not responded to competently administered interventions of less intrusive nature.

Facility policies must state that:

- *The use of noxious stimuli is only permitted when the client exhibits behaviors so severe that they present a potential risk for significant or even life-threatening circumstances;*
- *the IDT and facility must weigh the potential risk of the behavior against the risk involved in the use of the painful or noxious techniques to manage behavior;*
- *that safeguards and strict oversight must be in place for consideration to use techniques that may be painful or even unpleasant;*
- *techniques that may be painful or noxious must be time limited;*
- *the proposed use of these techniques requires scrutiny of clinical effectiveness and specially constituted committee review; and*
- *on-going monitoring and safeguards must be in place during implementation of the technique.*

W283

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(E) The staff members who may authorize the use of specified interventions;

Guidance §483.450(b)(1)(iv)(E)

W284

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(F) A mechanism for monitoring and controlling the use of interventions.

Guidance §483.450(b)(1)(iv)(F)

Facility policies must address what supervisory oversight is provided during the application of the intervention in order to ensure that procedures were followed correctly. Procedures should also address what retrospective analysis is done on each intervention to ensure that procedures are being consistently followed.

W285

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

§483.450(b)(3) Techniques to manage inappropriate client behavior must never be used

W286

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(3) for disciplinary purposes,

Guidance §483.450(b)(3)

No intervention, whether as a part of a formal program or in emergency situations (see W289) may be used as punishment, retaliation or retribution. A staff member cannot employ a behavior management technique simply because a client refuses to follow a staff request.

The implementation of all interventions, except in emergency situations, must be administered consistent with the IPP and the specific behaviors identified in the IPP requiring the intervention. Instances where an intervention is done as a punishment because the client did not comply with staff instructions and not associated with the IPP include:

- *Personal property confiscated for behavior at staff discretion;*
- *Rights restricted without approved plans; and*
- *Punitive house rules, such as prohibiting reentry into the kitchen for snacks if a meal is not eaten completely.*

W287

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(3) for the convenience of staff

Guidance §483.450(b)(3)

Inadequate numbers of staff, inefficient deployment of staff, and insufficient training of staff can lead to restrictive practices used for staff convenience.

Examples of techniques used to manage client behavior for staff convenience including, but are not limited to:

- *Clients allowed to discipline other clients;*
- *Clients restricted to one area of the home; and*
- *Unauthorized use of restraints (e.g., lap trays, bean bags, gait belt, and merry walkers for the purpose of restricting movement)*

W288

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(3) or as a substitute for an active treatment program.

Guidance §483.450(b)(3)

Substitutions for active treatment programming occur when the staff utilizes interventions and restrictive techniques on their own, either because there is not a formal behavioral program to address the client's behaviors or because the staff do not follow the plan as written.

W289

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.

Guidance §483.450(b)(4)

The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment.

However, there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, the least restrictive intervention must be employed and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the clients program.

W290

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted.

Guidance §483.450(b)(5)

The staff of the facility may not maintain or use, outside of the IPPs, any list of "as needed" interventions that can be used with any client at any time. With the exception of isolated and rare emergency situations, all restrictive behavior interventions must be incorporated into the formal IPP and individualized for the client.

(c) Standard: Time-out rooms

W291

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(c)(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)

(ii) The client is under the direct constant visual supervision of designated staff.

(iii)The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Guidance §483.450(c)(1)

Seclusion, defined as the placement of a client alone in a locked room, is never allowed.

Time out procedures allows a client to be alone in a room, but do not allow that room to be locked. During a time out procedure, egress can only be prevented by a person standing in the door way, or holding the door closed, but as soon as the staff move from the door way or let go of the door the client can come out.

Use of the timeout room or procedure must be part of an approved behavioral plan and may involve the separation of a client from a group or a particular situation, in a non-locked setting for the purpose of calming or removing the client from the reinforcing stimuli that are sustaining an identified maladaptive behavior.

Designated time out rooms must be set up so that the staff has continuous, direct observation of the client at all times. Because of the danger that staff can get distracted by other events or duties, this cannot be accomplished by a camera in lieu of the staff having direct visual of the client.

Key locks, latch locks, and doors that open inward without an inside doorknob are not permitted by the regulations for use in time out rooms as they do not require constant physical pressure from a staff member to keep the door shut. In each instance where a time out room is used, the client's IPP must include:

- *The functional behavioral assessment which resulted in a recommendation for the use of time out procedures; and*
- *Instructions on how often data is to be collected during the time out period and the criteria for release from time out.*

The use of a time out room must be approved by the Specially constituted committee as part of an approved program.

W292
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(c)(2) Placement of a client in a time-out room must not exceed one hour.

W293
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) *The specific type of client behavior to be managed by this plan;*

2) *The less restrictive behavioral approaches which were previously used, but were unsuccessful;*
3) *The hierarchy of measures that must be utilized prior to the application of physical restraint;*
4) *The type of physical restraint;*
5) *The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and*
6) *The replacement behavior being taught to the client to reduce the need for future restraints.*

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) *the client has not exhibited before;*
2) *were not identified in the functional analysis of behavior; or*
3) *are harming other people or themselves.*

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were

attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g. circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the restraint is still properly applied and the client appears comfortable.

W307
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

W310

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

Guidance §483.450(e)(1)

Clients are alert and available for participation in daily living activities.

Some medications administered for medical reasons or to manage behavior may cause drowsiness as a side effect or due to an accumulation of the drug in the client's system. For clients who are observed to be sleeping in chairs during their work day, their programs or recreational times, there should be evidence that the facility staff notified the medical staff and an assessment was performed of the client including their medication regimen. Medical staff should make adjustments to address the issue if indicated.

§483.450(e)(2) Drugs used for control of inappropriate behavior must

W311

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(2) be approved by the interdisciplinary team and

Guidance §483.450(e)(2)

The physician and other team members discuss the risks and benefits of the medication to address the target behavior/symptoms, and approve the use of the drug as being consistent with the active treatment program. Decisions about the necessity of the use of drugs to manage inappropriate behavior should be made by the IDT. It is the responsibility of the IDT members to provide the physician with sufficient information regarding the need for a client to receive a drug for inappropriate behavior. The physician will make the ultimate decision to order the use of the drug. The IDT should document any disagreement with the physician's order.

In those instances where a client returns from a physician's visit with an order for an unsolicited drug to manage client's inappropriate behaviors, there must be evidence (e.g. IDT meeting notes or clients record) that the team concurred with the necessity for the order without trying less restrictive measures first and discussed any concerns with the physician.

W312

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

Guidance §483.450(e)(2)

All medications to manage behavior must be integrated into the IPP and the IPP must specify how the specific target behavior for which the medication is prescribed will be reduced or eliminated. This includes medications which are typically used for medical conditions that may be used to manage behavior (e.g. 1. propranolol (Inderal), an antihypertensive used for self-injurious behavior, and 2. carbamazepine (Tegretol), an anticonvulsant, used for aggression).

Drugs for behavior management must not be ordered on a PRN basis for a client. The facility staff must contact the physician to obtain a one-time order if the situation necessities the use of medication. The facility policy must address the maximum number of times a medication can be used as an emergency prior to being incorporated in the IPP, side effects of such medications, and the frequency of re-evaluation of ongoing behavior and its treatment.

Clients or their legal guardian have the right to choose sedation for medical and dental procedures. However, the facility cannot do routine administration of medication for sedation for medical and dental procedures without the agreement/consent of the client or their parent/legal guardian and they must follow the specific orders of the healthcare practitioner who will be providing services to the client. Decisions to order medications prior to medical and dental procedures must be made on an individual basis. Clients who demonstrate severe anxiety around these procedures should be considered for desensitization programs.

W313

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

Guidance §483.450(e)(3)

The risk(s) associated with the drug being used is consistent with the type and severity of the behavior/symptoms it is intended to affect.

At the time the drug was started and incorporated into the IPP, the behaviors were discussed and presented to team members. It was the documented decision of the team that the behaviors were of such a severity that pharmacological intervention was required and the physician was provided with the team information to assist him in his decision to prescribe the medication.

§483.450(e)(4) Drugs used for control of inappropriate behavior must be- -

§483.450(e)(4)(i) Monitored closely,

W314

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(4) in conjunction with the physician and the drug regimen review requirement at §483.460(j),

Guidance §483.450(e)(4)

The physician and pharmacist must regularly review use of drugs for control of inappropriate behavior for their effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use, and communicate this information to relevant staff.

W315

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(4) for desired responses and adverse consequences by facility staff; and

Guidance §483.450(e)(4)

Direct support staff members are the people who most closely and most frequently observe and record client behaviors. There should be evidence that the direct support staff receive information via the IPP as to the behaviors to be observed, the side effects associated with the medication, the amount and types of documentation required and the communication with clinical staff which is indicated. See 483.430 (e)(1) for training on observations, documentation and communication related to behavior management.

§483.450(e)(4)(ii) Gradually withdrawn

W316

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(4) at least annually

Guidance §483.450(e)(4)

Clients receiving medications to control behavior must be evaluated at least annually for a possible reduction of the medication progressing the client toward final elimination of the drug or lowest possible therapeutic level of the drug. However, evaluation should be done earlier than annually if observations indicate that the client's behavior has improved to the point that reduction may be considered as determined by the IPP, unless otherwise ordered by the client's physician.

W317

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.450(e)(4) in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

Guidance §483.450(e)(4)

The IDT is aware of and involved in planning the drug reduction program and participates in its implementation and monitoring.

Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal.

In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and IDT should consider the client's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness.

If a client also has a diagnosis of a psychiatric condition that requires a stable level of a psychiatric medication in order to control the symptoms associated with the psychiatric diagnosis, the annual evaluation for reduction of that particular medication for the symptoms of the psychiatric diagnosis would not apply. Documentation in the client's record from their psychiatrist or physician that medication reduction would be contraindicated or that the current level of medications is therapeutic meets the intent of this regulation.

W318

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460 Condition of participation: Health care services

(a) Standard: Physician services

W319

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(1) The facility must ensure the availability of physician services 24 hours a day.

Guidance §483.460(a)(1)

A designated physician must be available via telephone, pager, e-mail or on-site in the facility on a 24 hour per day basis for consultation regarding both emergency and non-emergency medical issues. If the facility employs a fulltime physician, there must be procedures in place for coverage in the absence of the physician from the facility.

If the facility contracts with a community-based physician for 24 hour per day coverage, there must be written arrangements in place to detail the responsibilities of the contract physician regarding direct services to the clients, interactions with the direct support staff and the interactions between the nursing staff of the facility and the contract physician. The contract with the contract physician must delineate the process for coverage when he/she is not available.

Upon interview, the staff should be aware of the procedures they are to follow to contact a physician in the event of an illness or injury. Routinely sending clients to emergent care or the emergency room of a hospital because there are no facility physicians available for consultation is not consistent with the regulations.

Interview and record review verify that the physician is available and responsive 24 hours a day.

W320

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care.

Guidance §483.460(a)(2)

A medical care plan of treatment is developed for those clients who are either acutely ill and require licensed nursing care and monitoring temporarily on a 24 hour basis or clients whose chronic medical conditions require or indicate 24 hour licensed nursing care and monitoring. The physician determines when 24 hour nursing care is required.

The medical care plan is based upon the orders from the physician for treatments and care and nursing standards of practice. There is evidence in the client's record that the physician and the nursing staff at the facility work together to ensure that the medical care plan is current and appropriate (e.g. changes in physician written orders for care pursuant to observations from the nursing staff and/or direct observations and interactions with the client, and nursing documentation of care).

The fact that a client has a medical care plan in place should not preclude him/her from an active treatment program, except in instances of acute illness where the active treatment program is temporarily suspended. For clients with chronic medical conditions, it may be necessary for their active treatment program to be modified due to the tolerance level of the client or adapted to accommodate medical limitations. However, active treatment must be provided on a continuous basis.

W321

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(2) This plan must be integrated in the individual program plan.

Guidance §483.460(a)(2)

Although the medical care plan can be a separate document, it is always an integral part of the IPP process. There should be evidence that the plans are shared and discussed at the time of all interdisciplinary discussions and the information from the medical care plan is utilized in the development of the IPP objectives.

§483.460(a)(3) The facility must provide or obtain

W322

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3) preventive and general care

Guidance §483.460(a)(3)

The facility has procedures in place to ensure that the clients receive general health care services to assure optimal levels of wellness. General health care services include assessment and treatment of acute and chronic complaints or situations; teaching relevant heath care principles to staff and clients; and periodic surveillance of the health status of the clients.

As a result of clinical assessment, referrals are made for specialized assessment and tests. Facility health care staff follow-up to ensure the assessments are done and the findings incorporated into the medical care plan and/or the IPP.

The facility must have arrangements in place to provide routine or episodic laboratory, and radiology services for the clients if not provided in-house or through the clients physician. There must be a written agreement that specifies the responsibilities of the facility and outside provider. (See §483.410(a)).

Preventive health care services include screening procedures designed to identify health concerns and initiate treatment as early as possible. The facility should have a health prevention program in place and follow the plan to address those screenings that the facility will perform periodically that are relevant to all clients, and those screenings associated with a particular gender or age or vulnerability.

Physician refusal to perform a test, such as a pap smear, must be consistent with guidelines for clients, per the local standard in the community.

If the facility has a physician that refuses to provide preventative healthcare based on the client's level of functioning, medical staff at the facility should meet with and consult with this physician in order to ensure that clients receive the same health services as persons living in the local community.

Refer to these websites for current recommended screenings:

Agency for Healthcare Research and Quality (AHRQ)
For men: http://www.ahrq.gov/ppip/healthymen.htrm

Centers for Disease Control (CDC)
For women: http://www.cdc.gov/women/pubs/cancer.htm

§483.460(a)(3) as well as annual physical examinations of each client that at a minimum include the following:

W323

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3)(i) Evaluation of vision and hearing;

Guidance §483.460(a)(3)(i)

Information relevant to the client's ability to see and hear is a critical component in the development of appropriate active treatment strategies.

All clients, including clients who are non-verbal, should have evidence in his/her record that they receive an annual evaluation of their vision and hearing which includes a screening as a minimum, follow-up examination as indicated by the screen and timely referrals as indicated by the examination. Screening is a gross assessment of the client's vision and hearing and usually does not include a measurement of acuity. Examinations are conducted to follow-up on issues noted in the screening and are conducted by qualified professionals.

Clients who appear to have vision or hearing problems or the staff indicate that they have vision or hearing problems and no accommodations have been made. The annual vision and hearing evaluation verifies that clients appearing to have vision/hearing issues or if staff indicate that a client has vision/hearing issues that these issues have been/are being addressed.

If a client's vision or hearing can only be assessed through examinations conducted by specialists (e.g., comprehensive ophthalmological examinations and evoked response audiometry (ERA)), these tests need not be conducted yearly, but rather upon the specialist's expressed recommendations. During discussions at the annual IPP review the team reviews information from the health professional, speech and hearing professional, and direct support staff and makes referrals back to the specialist if indicated.

W324

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3)(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;

Guidance §483.460(a)(3)(ii)

These immunization guides may be obtained from:

American Academy of Pediatrics
www.aap.oxg/healthtopics/immunizations.cfm

Centers for Disease Control (CDC)
www.cdc.gov/vaccines/recs/schedule/default.htm

W325

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3)(iii) Routine screening laboratory examinations as determined necessary by the physician,

Guidance §483.460(a)(3)(iii)

The facility may have a set of routine laboratory tests which are to be done on every client annually which is developed and approved by the facility physician. However, such a list is not required. The physician may write orders individually for the clients based upon their medical history, age, gender or medical vulnerabilities.

W326

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3)(iii) and special studies when needed;

W327

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(3)(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.

Guidance §483.460(a)(3)(iv)

The facility should have in place a system for the identification, reporting, investigation, and control of Tuberculosis (TB) in order to prevent its transmission within the facility. This system should include:

1) *Policies and procedures for screening new employees, new clients, and other people who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility (such as volunteers and contract professional staff);*
2) *Policies and procedures for subsequent screening for clients and for employees, and other people (such as volunteers and contract professional staff) who interact on a consistent basis with clients residing in the facility when those persons are volunteers*

or professional staff hired or utilized directly by the facility per State Health Department requirements;

3) *Policies and procedures for reporting positive TB test results to the appropriate State authorities;*
4) *Policies for the investigative procedures, per the local health department, that would be put in place should a client or staff person test positive for TB;*
5) *Policies and procedures for treatment and precautions to be used with clients who display TB symptoms, as substantiated by positive skin testing or x-ray results; and*
6) *Policies and procedures for the evaluation of the effectiveness of the surveillance system.*

When one or more clients or staff display TB symptoms, as substantiated by positive skin testing or x-ray results, they do not return to work until a physician has cleared them to return to work.

W328

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(a)(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

Guidance §483.460(a)(4)

Refer to the applicable State Nurse Practice Act or applicable Board of Medicine Practice Act to determine the extent that the nurse practitioner or physician assistant may provide physician services.

(b) Standard: Physician participation in the individual program plan

§483.460(b) A physician must participate in-

W329

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(b)(1) The establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs; and

Guidance §483.460(b)(1)

During the admission process, which takes place from the time the client is admitted to the facility to the time the initial IPP is completed, a physician is required to ensure that an assessment of the client's medical status is thoroughly considered and incorporated into the IPP planning process by the team as it develops the IPP. The physician's input may be by means of written reports, evaluations, and recommendations.

The physician (consistent with Medicaid Utilization Control regulations at §456.380) must evaluate the client at the time of admission to identify all diagnoses and complaints, provide

orders for all medications and treatments and provide recommendations for restorative and rehabilitative services.

§456.380 requires that a physician conduct this initial assessment therefore, it may not be done by a physician extender (e.g. Physician assistant or Advanced Practice Registered Nurse).

W330

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(b)(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

Guidance §483.460(b)(2)

The need for physician participation on an individual client's IPP team is determined by the medical needs of the client. How the physician participates (whether through written report, telephone consultation, attendance at the meeting, etc.) is to be left to the discretion of the facility. In instances where a client has no overriding medical issues, the nurse of the facility can represent the medical component on the IDT process or consult with the appropriate physician and share the information with the team. However, in situations where a client's medical condition is unstable/fragile to the extent that it impacts the training/work that may be planned, the physician must participate in providing guidance on the types and extent of programs that would be appropriate considering the client's physical/medical limitations.

If a client is noted to be having difficulty participating in the objectives set forth in his/her IPP due to serious medical concerns, review the input that was provided by the physician into the development of the plan and whether the IPP team requested such input.

(c) Standard: Nursing services

W331

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c) The facility must provide clients with nursing services in accordance with their needs.

Guidance §483.460(c)

The nurse responds in a timely manner to all medical concerns reported, conducts assessments as indicated, effects timely and appropriate interventions, communicates with the client's physicians and other health care professionals as indicated, provides treatments as ordered, monitors client progress following illness or injury and provides training to clients and/or staff as indicated.

§483.460(c) These services must include

W332
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;

Guidance §483.460(c)(1)

For those clients who have had an uneventful year medically and have no medical/health concerns at the time of the IPP meeting the facility nurse may submit a summary report to the IDT unless the IDT determines that his/her attendance is necessary. An eventful year medically would include a year which required unplanned hospital admissions or in which medical issues necessitated treatment for a prolonged or continuing period. However when a client has had an eventful year medically or current medical/health concerns, this could have an impact on their objectives and accordingly the nurse should participate in the IDT discussion directly.

W333
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

Guidance §483.460(c)(2)

A medical care plan addresses those clinical treatments and observations that are to be done for the client by the medical staff and other staff of the facility in order to either improve an acute medical condition or to maintain a medically fragile client as clinically stable as possible. The medical care plan is an adjunct to the IPP and is not considered a substitution for the IPP.

§483.460(c)(3) For those clients certified as not needing a medical care plan, a review of their health status which must-

W334
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(3)(i) Be by a direct physical examination;

Guidance §483.460(c)(3)(i)

A direct physical examination means a visual review of the body as well as examination/assessment of body systems. This includes observations made through non-verbal communication (including visual, tactile, nonverbal gestures, grimaces, etc.) which may be an indication that there is a potential for further assessment and/or monitoring. A paper review of the client's medical record and health statistics does not meet the intent of the regulation for a direct physical examination.

W335
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(3)(ii) Be by a licensed nurse;

Guidance §483.460(c)(3)(ii)

The term "licensed nurse", for purposes of these guidelines, means a registered nurse, a licensed practical nurse or a licensed vocational nurse currently licensed by the State in which the facility is located. The nurse must operate consistent with the requirements of the applicable Nurse Practice Act. If this direct physical examination is done by a physician, it is not necessary for the nurse to repeat the exam.

W336

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(3)(iii) Be on a quarterly or more frequent basis depending on client need;

Guidance §483.460(c)(3)(iii)

"On a quarterly basis" means that the examinations are conducted approximately 90 days apart (e.g. scheduled to be conducted approximately once every 90 days). If during the course of a calendar year, there were three quarterly examinations conducted by a licensed nurse and in the fourth quarter the annual physical examination was performed by a physician, the intent of this requirement is met without the nurse performing an additional examination.

W337

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(3)(iv) Be recorded in the client's record; and

Guidance §483.460(c)(3)(iv)

The actual findings of each examination and the date conducted must be incorporated into the client's record.

W338

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(3)(v) Result in any necessary action (including referral to a physician to address client health problems).

Guidance §483.460(c)(3)(v)

The nursing staff document that referrals are made in a timely manner, if indicated, for any concerns identified. Nurses must ensure all concerns they identify are communicated and addressed appropriately, including:

- *Need is fully identified in assessment;*
- *Appropriate referrals are made;*
- *Revisions are made to IPP/Medical care plan; and*
- *Follow-up occurs to the new plan.*

W339
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(4) Other nursing care as prescribed by the physician or as identified by client needs; and

Guidance §483.460(c)(4)

Nursing interventions are implemented as indicated by the needs of the client and consistent with either standard nursing practice principles or orders from the attending physician. Health and wellness are actively promoted, problems are attended to before they negatively impact the client's health and wellness, and steps are taken to prevent the recurrence of such problems while responding promptly to client's needs.

Client health care complaints that are reported either directly by the client or by the direct care staff are addressed promptly by the nursing staff. Client health care complaints and response by nursing staff are documented in the client's record.

§483.460(c)(5) Implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to- -

W340
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(5)(i) Training clients and staff as needed in appropriate health and hygiene methods;

Guidance §483.460(c)(5)(i)

Nursing staff periodically provides training to clients and staff on how to care for health needs or conditions, personal hygiene, health maintenance, and disease prevention. Nursing staff actively participates in periodic discussions with client and staff to promote health habits in the areas of diet, exercise and non-smoking.

Based upon individual training needs, the nursing staff provides training to individuals in areas such as medications, family planning, prevention of sexually transmitted diseases, control of other infectious diseases, self-monitoring of health status and self-prevention of health problems, etc. The nurses may train clients directly on their objectives or train other staff to do this training as appropriate.

W341
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(5)(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and

Guidance §483.460(c)(5)(ii)

Nursing staff should actively participate in surveillance and reporting of communicable diseases per the Centers for Disease Control (CDC) guidelines and applicable state laws. They should teach and promote infection control techniques such as hand washing by clients and staff and should be making periodic observations to ensure that such good infection control techniques are consistently utilized.

W342

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(c)(5)(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

Guidance §483.460(c)(5)(iii)

Nursing staff must train and ensure direct support staff demonstrate competency in detecting signs and symptoms of illness, injury, or change in the client's health baseline (e.g. responsiveness, fatigue, irritability, constipation, diarrhea, dehydration, confusion, unexplained weight loss, changes in endurance and changes in respiratory function).

Staff is responsive to health care needs or injuries of clients and receives instruction and support during temporary illness of clients.

If not, review staff training records to determine whether training was provided periodically to the involved employee. Interview direct care staff to determine their level of understanding regarding the signs and symptoms of illness that are to be reported to the medical staff. The records of clients with recent hospitalizations verify that staff detected and reported relevant symptoms promptly.

(d) Standard: Nursing staff

W343

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(d)(1) Nurses providing services in the facility must have a current license to practice in the State.

Guidance §483.460(d)(1)

The facility should have a procedure in place to ensure that any contract nursing staff members are currently licensed prior to the provision of services. Include any contract nurses used by the facility in the sample of nurses reviewed for licensure.

W344

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

Guidance §483.460(d)(2)

The facility provides for nursing services based on the health needs and conditions of clients residing there. Examples include:

1) *physician ordered treatments that require the skills of a licensed nurse;*
2) *preventive screenings ;*
3) *assessment and intervention;*
4) *direct physical examination and examination of body systems;*
5) *teaching; and*
6) *advocacy for the medical services needed by the client.*

Client health care needs are met in a timely manner (within 24 hours) by the available nursing staff.

If nurses who do not have experience in the care of persons with intellectual disabilities are employed by the facility, they should be provided with a formal orientation period and on-going educational opportunities to increase their understanding of the client population.

When one or more clients in the facility has an active medical care plan, there must be 24 hour nursing services available to come to the facility as needed to make skilled assessments and interventions.

W345

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(d)(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

Guidance §483.460(d)(3)

Refer to the applicable State Nurse Practice Act.

W346

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(d)(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.

Guidance §483.460(d)(4)

The facility must have written arrangements with a registered nurse (RN) to provide consultation in those instances where LPNs/LVNs provide all the direct nursing care for the clients. Verify that the agreement requires the RN to respond promptly to all calls from the LPN/LVN and to come on-site to the facility if necessary. The facility must also ensure registered nurse back-up when the primary registered nurse consultant is unavailable (vacations, etc.). Review documentation in the client records to confirm that the LPNs/LVNs of the facility are consulting the registered nurse consultant when indicated and that she/he responds promptly to such calls.

W347

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(d)(5) Non- licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.

The work of any direct support staff (caring for clients with a medical care plan) is directed by an onsite licensed nurse). The nurse evaluates the care provided by the staff as needed, but at least each shift. If observations of care indicate that direct care staff are not providing care as directed by the medical care plan, then review the supervision provided by the nursing staff.

(e) Standard: Dental services

W348

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.

Guidance §483.460(e)(1)

It is expected that the clients will obtain dental services (both diagnostic and treatment) from community dentists whenever possible. In some instances, there may be clients residing in the facility who are physically unable to travel to the community for services. The facility must secure dental services (both diagnostic and treatment) for these clients either through an in-house program, which is part of the organizational and administrative structure of the facility, or through a written agreement with an outside dental service to come into the facility to provide such services.

W349

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(e)(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

Guidance §483.460(e)(2)

Reports of dental care may be submitted to the IDT for inclusion in their discussions surrounding either development of the plan or update to the plan. This includes procedures a client may have had or be having during the plan development period, such as root canal or singular extractions. Actual attendance at the IDT meeting by the dentist may be left to the request of the IDT.

W350

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(e)(3) The facility must provide education and training in the maintenance of oral health.

Guidance §483.460(e)(3)

Formal or informal training in the maintenance of oral hygiene is provided to clients who require it, and to those staff who are responsible for carrying out such activities. The IPP should include an assessment of the client's ability to perform oral hygiene independently and an associated program if the client is not independent.

(f) Standard: Comprehensive dental diagnostic services

§483.460(f) Comprehensive dental diagnostic services include

W351

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(f)(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

Guidance §483.460(f)(1)

A "month" is defined as the interval between the date of admission and close of business of the corresponding day in the following month.

A complete intraoral examination includes an oral cancer screen.

§483.460(f)(2) Periodic examination and diagnosis performed

W352

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(f)(2) at least annually,

Guidance §483.460(f)(2)

Dental examinations occur no less frequently than annually. Clients without teeth must receive an annual oral cancer screening examination by a dental professional.

W353

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(f)(2) including radiographs when indicated and detection of manifestations of systemic disease; and

Guidance §483.460(f)(2)

There should be evidence in dental reports that dentists follow current standards of practice for the performance of x-rays in order to assist in the diagnosis and treatment of the client.

W354

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(f)(3) A review of the results of examination and entry of the results in the client's dental record.

Guidance §483.460(f)(3)

The entry referenced at this regulation is the dental entry into the dental record. See W359 for requirement of copying this dental record into the facility record.

(g) Standard: Comprehensive dental treatment

§483.460(g) The facility must ensure comprehensive dental treatment services that include- -

W355

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(g)(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

Guidance §483.460(g)(1)

The facility should be able to produce upon request, a written contract/agreement between the facility and a licensed dentist for 24/7 guidance/provision of emergency services for the clients. The agreement should also indicate what back-up coverage will be provided when the dentist is not available.

W356

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(g)(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) Standard: Documentation of dental services

§483.460(h)(1) If the facility maintains an in-house dental service, the facility must

W358

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(h)(1) with a dental summary maintained in the client's living-unit.

Guidance §483.460(h)(1)

The "dental summary" refers to the summary of each visit entered by the dental professional. The note includes any care instructions to be followed up by facility staff as a result of treatment.

§483.460(h)(2) If the facility does not maintain an in-house dental service, the facility must

W359

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(h)(2) obtain a dental summary of the results of dental visits

Guidance §483.460(h)(2)

The facility should receive a written report of each dentist visit for inclusion in the client's record at the facility and for reference by the medical and direct support staff.

W360

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(h)(2) and maintain the summary in the client's living unit.

See guideline above at W359.

(i) Standard: Pharmacy services

W361

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

Guidance §483.460(i)

The facility either has an onsite pharmacy or has formal arrangements in place for the provision of routine, unanticipated, or emergency drugs. There are no instances where a client does not receive needed medications due to the unavailability of drugs.

(j) Standard: Drug regimen review

W362

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

Guidance §483.460(j)(1)

The primary function of the pharmacist during the quarterly drug review is to identify possible drug interactions, check for evidence of any side effects associated with the drug usage,

determine if laboratory results associated with the drug are within normal limits and verify that the facility is administering the medication appropriately and to comment upon the efficacy of the drug use (e.g. blood sugar controlled, blood pressure within normal limits). In the case of drugs used to manage behavior, the pharmacist may need information from the IDT to determine efficacy. See Appendix PP, Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews, to the State Operations Manual (Pharmaceutical Service Requirements in Long Term Care Facilities).

W363

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

Guidance §483.460(j)(2)

The physician and IDT members must discuss, document and take necessary follow-up action for any irregularities noted.

W365

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(j)(4) An individual medication administration record must be maintained for each client.

W366

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(j)(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

Guidance §483.460(j)(5)

Pharmacist participation on the IDT is at the request of the team. It would not be necessary for the pharmacist to routinely attend all team meetings when the client is on a stable drug regimen that does not appear to be influencing his/her active treatment programs. Pharmacist participation may be appropriate, in situations such as assisting the IDT develop the most effective training programs for when the client is in an evolving situation with their medication.

For example:

- *A client begins a new or more complex drug regimen;*
- *The physician orders off-label use of a medication;*
- *Frequent changes in the drug regimen are affecting IPP implementation.*

(k) Standard: Drug administration

W367
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k) The facility must have an organized system for drug administration that identifies each drug up to the point of administration.

§483.460(k) The system must assure that

W368
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(1) All drugs are administered in compliance with the physician's orders;

Guidance §483.460(k)(1)

Administration errors identified in previous medication administration records qualify as non-compliance with physician's orders.

W369
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;

Guidance §483.460(k)(2)

A medication error is an observed discrepancy during the medication pass between what is ordered and what is administered.

This also applies to self-administered medications.

For small facilities (16 beds or less), the medication administration pass will encompass a total of eight (8) drug doses. The observations should be split between two separate drug passes 4/4 (one in the morning and one in the late afternoon or early evening). The medications observed during the observations may or may not be for clients in the survey sample. Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

For large facilities (17 or more beds) with either single or multiple buildings, the medication administration pass will encompass a total of 12 doses. The observations should be split between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). . Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

W370
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

Guidance §483.460(k)(3)

Unlicensed personnel administer only those forms of medication which state law permits. Licensed nurse(s) in the facility oversee any administration of medications by unlicensed persons and periodically evaluate their performance.

W371

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;

Guidance §483.460(k)(4)

The IDT decision that a self-administration program is appropriate, as is the case for all formal training objectives, must be based upon accurate, current, valid assessment of the client's skills and potential. The determination as to the appropriateness of a self-administration program must never be made singularly on the client's diagnosis or current functional abilities.

For clients assessed to be inappropriate for a self-administration program, but determined by the IDT to possess the capacity to functionally, cognitively, emotionally or developmentally benefit from participation in the drug administration process, it is expected that the facility will provide opportunities for the client to participate in the medication administration process under direct supervision. This participation can include but is not limited to, identifying the medication taken, reaching/grasping a cup of water during the process and placing oral medications in the mouth, etc.

W372

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client;

Guidance §483.460(k)(5)

While the IDT may set an objective of self administration of medication for a client, they are required to notify the client's physician of this proposed objective. If the client's physician objects on medical grounds, the team must not proceed with the objective until such time as a discussion is held with the physician and he/she agrees to proceed after receiving additional information.

W373

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(6) No client self-administers medication until he or she demonstrates the competency to do so;

Guidance §483.460(k)(6)

The written self-administration program for a client must detail the criteria that will be employed by the facility staff to verify that the client successfully completes all phases of the program and continues to comply with all necessary requirements for self administration. Clients who self-administer medications must secure all medications in such a manner as to protect access by other clients or visitors.

W374

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law;

Guidance §483.460(k)(7)

When clients go out of the facility for home visits, or to attend work or school, drugs they are taking must be packaged and labeled in accordance with state law by a person authorized by state law to package and label.

§483.460(k)(8) Drug administration errors and adverse drug reactions are

Guidance §483.460(k)(8)

Documentation of any medication error should be entered into the client's record and should include what error was made, who was notified of the error, the response of the medical person notified, the physical condition of the client at the time of the notification and subsequent observations of the clients physical condition related to the error.

W375

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(8) recorded

Guidance §483.460(k)(8)

Documentation of adverse drug reactions must be entered into the client's record and should include all complaints made by the client or observations made by the staff following the drug administration, the notification of medical personnel, and the response of the medical personnel, any emergency actions that were required and all subsequent observations of the client's condition related to the reaction.

W376

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(k)(8) and reported immediately to a physician.

Guidance §483.460(k)(8)

"Immediately" means at the time the error or reaction is identified.

(l) Standard: Drug storage and recordkeeping

§483.460(l)(1) The facility must store drugs under proper conditions of

Guidance §483.460(l)(1)

Drugs are stored according to manufacturer's recommendations.

W383

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.

Guidance §483.460(l)(2)

"Authorized persons" is restricted to those who administer the drugs (as allowed by state law) and nursing supervisors (if any). No other personnel should have access to these keys.

W384

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(l)(2) Clients who have been trained to self-administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.

Guidance §483.460(l)(2)

Drugs that are self-administered do not have to be double locked. The purpose for the double locking is to limit access to scheduled drugs. Since the client is generally the only one who has access to his/her drug supply (with perhaps the exception of a licensed nurse or whoever has overall responsibility for medication administration at the facility and a facility's Director of Nursing Services, who may have access to all of the facility's drug supplies), there is no need to further limit access.

W385

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

Guidance §483.460(l)(3)

The facility must follow state requirements for the control and disposition of controlled drugs.

W386

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).

Guidance §483.460(l)(4)

The facility should follow state requirements for the reconciliation of controlled drugs.

W392

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.

(n) Standard: Laboratory services

W393

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(n)(1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.

Guidance §483.460(n)(1)

If the facility performs laboratory services, it must have a current, valid Clinical Laboratory Improvement Amendment (CLIA) certificate for the types of tests it is performing.

For the purposes of this regulation, a "laboratory service or test" is defined as any examination or analysis of materials derived from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings.

W394

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.460(n)(1) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

Guidance §483.460(n)(1)

A facility performing any laboratory service or test must have applied to CMS, and received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. An application for a Certificate of Waiver may be made if the facility performs only those tests on the waived list. A complete list of waived tests can be found at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

If the facility performs any test, not appearing on the waived list, a Certificate of Compliance or Certificate of Accreditation is required. An appropriate CLIA certificate is required regardless of the frequency with which the laboratory services or tests are conducted. When no tests are performed, a CLIA certificate is not needed. Facilities only collecting specimens and not performing testing do not need a certificate.

A not-for-profit, a state, or local government organization may have one certificate covering all the facilities it operates (e.g., all the separately certified residences which fall under its governing body), if no more than a total of 15 types of waived or moderately complex laboratory tests are used. This exception applies only to laboratories performing limited public health testing. See State Operations Manual (SOM) 6008. Each location where a laboratory tests are performed must file a separate application to be separately certified unless the laboratory meets one if the exceptions outlined at 42CFR493.35(b), 493.443(b), or 493.55(b).

Any laboratory located in a state that has a CMS-approved laboratory program is exempt from CLIA certification. Currently there are two states with approved programs: Washington and New York. New York has a partial exemption; therefore, if the laboratory is located in New York, contact the New York State Agency to determine if the exemption applies.

W406

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.470 Condition of participation: Physical environment.

(a) Standard: Client living environment.

W407

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

Guidance §§483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation supports the placement:

- *Assessment;*
- *Client program plan;*
- *Staff documentation of client response to training programs; and*
- *QIDP notes.*

W408

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.

(b)Standard: Client bedrooms.

(1) Bedrooms must- -

W414

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

Guidance §483.470(b)(l)(v)

If a facility was initially certified on or after October 3, 1988 and/or is under renovations or conversions, they must have walls that extend floor to ceiling.

W415

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) If a bedroom is below grade level, it must have a window that--
(i) Is usable as a second means of escape by client(s) occupying the room; and
(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.

Guidance §483.470(b)(2)

The intent of the regulation is to prohibit the housing of clients in basements that are entirely below grade. Clients may be housed on the lower level of housing (e.g. a bi-level house), provided the window height requirements are met and the window is of sufficient size to be used as a means of escape.

W416

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disabilities professional--
(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and
(ii) Documents the reason why housing in a room of only four or fewer persons would not be medically feasible.

Guidance §483.470(b)(3)

The medical care plan for each client housed in a room with more than four clients should indicate the need for continuous monitoring. The medical care plan will include:

- *the physician certification that the client is severely medically impaired and requires direct and continuous monitoring during sleeping hours; and*
- *the reason why this housing arrangement for fewer than four people would not be medically feasible.*

(4) The facility must provide each client with—

W417

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(i) A separate bed of proper size and height for the convenience of the client;

Guidance §483.470(b)(4)(i)

The client's preference, chronological age, and physical and medical needs are the determining factors in bed size and height.

W419

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(iii) Bedding appropriate to the weather and climate; and

W420

(Rev.135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(iv) Functional furniture, appropriate to the client's needs,

Guidance §483.470(b)(4)(iv)

Client preferences and program needs should be considered in furniture selection. For clients with physical disabilities, furniture is adapted to accommodate the client's physical challenges and enable the client to use the furniture with minimal support.

W421

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

Guidance §483.470(b)(4)(iv)

Closets should have enough space for a reasonable amount of the current season's clothing.

Clients who use wheelchairs or have other physical challenges can reach the racks and shelves in their closets.

The facility is permitted either to provide the client with an individualized closet or with a designated area in a shared closet. The use of central clothing bins in a facility clothing room, in the absence of required client closet space in the bedroom, is not an acceptable practice.

(c) Standard: Storage space in bedrooms.

The facility must provide—

W422

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) Space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and

Guidance §483.470(c)(1)

Sufficient space that permits the use of wheelchairs, walkers and other adaptive equipment should be provided within the bedroom.

W423

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

Guidance §483.470(c)(2)

Each client should have storage in their bedroom for their personal belongings. Clients should have free access to this storage without the assistance of staff. If it is necessary for clients' personal belongings to be locked due to the behavior of other clients, the client must still be provided free access to his own possessions (See W137 for requirements for locked areas).

(d) Standard: Client bathrooms

The facility must—

W424

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;

Guidance §483.470(d)(1)

In a home setting, the toilet facilities need to be of sufficient number to meet the needs of the client without prolonged delay. There must be enough toilets in the living units to meet the program needs of the clients at any given time, as well as provide for intermediate toileting needs of the clients living in the unit.

In a home setting, it may be unrealistic to say a client would never have to wait for a shower or bath or to brush his/her teeth.

Bathrooms and fixtures must be adapted to accommodate clients with physical disabilities.

W425

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) Provide for individual privacy in toilets, bathtubs, and showers; and

Guidance §483.470(d)(2)

A bathroom containing multiple toilets, showers or bathtubs, must have doors, curtains, or some other means of protecting the client from view when fully or partially unclothed.

Clients should not be able to be seen through the door or window by passersby when they are using the bathrooms.

Client privacy does not preclude the assistance provided by facility staff when necessitated by the client's condition.

W426

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110□Fahrenheit.

(e) Standard: Heating and ventilation.

(1) Each client bedroom in the facility must have--

W427

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(i) At least one window to the outside; and

Guidance §483.470(e)(1)(i)

(See also W415)

W428
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility must—

W429
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and

Guidance §483.470(e)(2)(i)

A "normal comfort range" in most instances is defined as not going below a temperature of 68 degrees Fahrenheit or exceeding a temperature of 80 degrees Fahrenheit in facilities in most geographic areas of the country.

In extremely hot or extremely cold weather, precautions are taken by the facility to protect the clients, particularly those who are medically compromised, from ill effects of the temperature.

W430
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

Guidance §483.470(e)(2)(ii)

Refer to Life Safety Code Chapters 32 and 33
Unvented fuel fired heaters are prohibited. NFPA 101 2000 Edition.
32/33.2.5.23

(f) Standard: Floors.

The facility must have—

W431
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

W435
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services, as required by this subpart and as identified in each client's individual program plan.

Guidance§483.470(g)(1)

Staff and clients must have the space, materials and equipment needed to implement formal and informal active treatment programs.

There must be sufficient space to accommodate group activities, including groups with clients who use wheelchairs.

Recreational supplies, equipment, and materials are available and reflect the interests, physical abilities and chronological age of the clients.

W436

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Guidance §483.470(g)(2)

The term "furnish" means that the facility is responsible for obtaining or purchasing these items once an assessment has identified the need and is responsible for making any necessary arrangements for the client to receive them. Clients' personal funds should not be used for these items since this is a covered service under the ICF/IID benefit.

The term "maintain in good repair" means that the facility is responsible for ensuring that these items are kept in good working order, and is responsible for any resulting expense that may be incurred.

Programs must be in place, when identified by assessment and determined by the ID team, to teach clients about the use and care for their equipment to the extent of their capabilities.

W437

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(3) Provide adequate clean linen and dirty linen storage areas.

Guidance §483.470(g)(3)

Clean linen must be is separated from dirty linen and stored in a manner which prevents contamination.

Linen soiled with bodily fluids must be stored separately and in a manner which protects clients from exposure to possible infectious sources.

A bedroom hamper can be an acceptable dirty linen storage "area" if kept odor free and consistent with the infection control requirements at §483.470(1).

(h) Standard: Emergency plan and procedures.

W438
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

Guidance §483.470(h)(1)

These plans may include identification of transportation and alternative shelter needs in cases when the facility must be evacuated and may incorporate state-specific emergency preparedness requirements as applicable.

W439
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

Guidance §483.470(h)(2)

"Periodic review" is a judgment made by the facility based on the circumstances of the facility. If the facility changes its physical plant or if changes external to the facility necessitates a review of the disaster plan, then the facility is responsible for carrying out the review.
Interview staff about where emergency plans and procedures are located and what the facility policy is regarding how often, and under what circumstances the plans and procedures are reviewed and updated.

(i) Standard: Evacuation drills.

(1) The facility must hold evacuation drills

W440
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

at least quarterly for each shift of personnel

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33 code: Clients have to participate in an evacuation drill each shift at least quarterly.

Chapter 18/19 code: There must be an evacuation drill on each shift at least quarterly. This drill is designed to train staff on evacuation procedures.

Review facility records to verify that evacuations drills are held each shift at least once in each 3-month period.

Refer to (S&C 10-26-LSC)

W441

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

and under varied conditions to—

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33: Expects that all clients living in that unit are capable of self-evacuation during an emergency. This self evacuation should be practiced under varying conditions including various times of the day or night and in various weather conditions.

Chapter 18/19: Requires drills which simulate emergency situations which familiarize facility staff with emergency actions they may be required to perform. The general emphasis of these sections of the code is upon training of the staff and not upon providing practice for the client. Drills should be practiced under varying conditions including various times of the day or night and in various weather conditions.

W442

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;

Guidance §483.470(i)(1)(i)

For facilities under Chapter 18/19 of the LSC

Staff should be able to verbalize the proper procedures to be followed during emergency drills. Staff training records should document that all staff have received training on emergency drills and evacuations.

W443

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

Guidance §483.470(i)(1)(ii)

Staff on all shifts are able to express familiarity with the use of fire extinguisher, alarms, and any other safety features in the facility.

W444

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

Guidance §483.470(i)(1)(iii)

See also W448. The plan(s) must be revised as needed and must be based upon analysis completed under W448.

(2) The facility must--

W445

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(i) Actually evacuate clients during at least one drill each year on each shift;

Guidance §483.470(i)(2)(i)

All clients totally evacuate the building at least once per year per shift, regardless of the occupancy chapter under which the building falls.

All facilities, regardless of their size require actual evacuation. "Actually evacuate", as used in this standard, applies to all clients. The drills are conducted not only to rehearse the clients and staff for a fire emergency (see §483.470(i)(2)(v)), but for other disasters such as hurricanes, tornadoes, floods, etc. Such disasters would require the entire occupancy to be evacuated, and, therefore, the actual evacuation must be practiced, as required.

W446

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(ii) Make special provisions for the evacuation of clients with physical disabilities;

Guidance §483.470(i)(2)(ii)

Clients with physical or medical disabilities may require special procedures for evacuation, taking into account equipment or staff that must be maintained for the client's care at all times. The facility's evacuation plan should:

- *identify such clients;*
- *clearly delineate any special evacuation procedures for those clients.*

Staff should be familiar with the facility's special evacuation procedures when working with clients who are in need of unique provisions.

W447

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(iii) File a report and evaluation on each evacuation drill;

Guidance §483.470(i)(2)(iii)

There is a written report of each evacuation drill held.

W448

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(iv) Investigate all problems with evacuation drills, including accidents,

Guidance §483.470(i)(2)(iv)

The documentation for each evacuation drill includes an analysis of:

- *The timeliness of the evacuation;*
- *Any difficulties observed during the drill;*
- *Investigates the cause of the difficulties; and*
- *Develops a plan to ensure the difficulties will not reoccur.*

W449

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

and take corrective action; and

Guidance §483.470(i)(2)(iv)

When a problem is identified during the evacuation drill and the facility develops a plan to prevent reoccurrence, there is evidence the facility implemented corrective action and follow-up completed to ensure corrective action was successful.

W450

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

Guidance §483.470(i)(2)(v)

The Life Safety Code NFPA 101, 2000 Edition at 3.3.167 defines safe location as "a location remote or separated from the effects of a fire so that such effects no longer pose a threat."

W451
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(3) Facilities must meet the requirements of paragraph (i)(1) and (2) of this section for any live-in and relief staff they utilize.

Guidance §483.470(i)(3)

In the case of live-in staff, drills must occur quarterly. Typically, live-in staff can be found in facilities that fall under Chapter 32/33 of the LSC code. Drills should be held at varying times of the day and night for clients to practice evacuation including morning, afternoon, evening and the middle of the night.

(j) Standard: Fire protection.

Guidance §483.470(j)

These standards are covered by the Life Safety Code (LSC) survey. The facility must meet the appropriate chapter of the Life Safety Code, 2000 edition.

When surveying an ICF/IID for compliance with the LSC, it is first necessary to determine whether the facility will be surveyed under Health Care (HC) or Board and Care (BC) occupancy.

- *If clients receive nursing services, or if the provider elects to use Health Care, the facility should be surveyed as a Health Care Facility under Chapter 18 or 19 of the LSC, as appropriate.*
- *If clients receive personal care and protective oversight but not continuing nursing services, the facility is to be surveyed under Board and Care and the following three steps should be followed:*
  1) *Determine the size (16 or less = small; 17 or more = large);*
  2) *Determine the Evacuation Difficulty (PROMPT, SLOW, or IMPRACTICAL) using Appendix F of the fire safety evaluation system for board and care facilities (FSES/BC); and*
  3) *Survey the building using one of two methods:*
     a. *The prescriptive requirements of Chapters 32 or 33; or*
     b. *The FSES/BC, Appendix G.*

(1) General. Except as otherwise provided in this section—
(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at

NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

Guidance §483.470(j)(1)(ii)

Roller latches are prohibited on corridor doors as a latching device.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

Guidance §483.470(j)(3)

The evacuation capability of residents is determined using Chapter 6 of NFPA 101A, 2001 edition.

4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

Guidance §483.470(j)(5)

Battery powered emergency lighting must last at least 90 minutes.

6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

Guidance §483.470(j)(6)

Roller latches are prohibited on corridor doors as a latching device.

(7) Facilities that meet the LSC definition of a health care occupancy.

(i) After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

Guidance §483.470(j)(7)(i)

Waivers may be granted only to facilities that meet the Life Safety Code definition of a Health Care Occupancy. Waivers are not granted to facilities that met the requirements of a Residential Board and Care Occupancy.

Waivers are recommended by the State Survey Agency and approved by the Regional Office.

(A) The waiver would not adversely affect the health and safety of the clients.

B) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

ii) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a facility may install alcohol-based hand rub dispensers if—

(A) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(B) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(C) The dispensers are installed in a manner that adequately protects against inappropriate access;

D) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and

(E) The dispensers are maintained in accordance with dispenser manufacturer guidelines

(k) Standard: Paint.

The facility must—

W454

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.

Guidance §483.470(l)(1)

The facility is clean and staff have eliminated opportunities for cross-contamination of infections. Food is stored, prepared, distributed, and served in a sanitary manner to prevent food borne illness.

W455

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

Guidance §483.470(l)(1)

Facilities maintain an ongoing surveillance program of communicable disease control and investigation of infections and an active training program that ensures the clients served receive adequate prevention of transmission information and skills, according to needs.

The facility's infection control program should include procedures for:

- *identification of the extent of infestation or infection;*
- *protection of clients;*
- *treatment of clients;*
- *notification of family or legal guardian;*
- *reporting to the health department as indicated; and*
- *continued follow-up to resolution.*

Both the Occupational Safety and Health Administration (OSHA) and the CDC have specific requirements regarding human immuno-deficiency virus (HIV), TB, and hepatitis precautions. These requirements should be incorporated into the facility's practices when relevant to the clients residing in the facility. Concerns about OSHA violations should be referred to OSHA.

W456

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(2) The facility must implement successful corrective action in affected problem areas.

W457

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(3) The facility must maintain a record of incidents and corrective actions related to infections.

W458

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

Guidance §483.470(l)(4)

The facility should have and implement a policy that clearly delineates those signs and symptoms for which they will restrict staff access to clients or to clients' food.

W459

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480 Condition of participation: Dietetic services

(a) Standard: Food and nutrition services

W460

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(1) Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets.

Guidance §483.480(a)(1)

"Well balanced diets" are defined as diets that contain a variety of foods from the food groups currently recommended by the Academy of Nutrition and Dietetics (AND).
"Modified and specially-prescribed" diets are defined as diets that are altered in any way to enable the client to eat (e.g. food that is chopped, pureed) or diets that are intended to correct or prevent a nutritional deficiency or health problem.

Refer to W463 and W474 regarding modified and specially prescribed diets.

The following may be indicators of or may lead to compromised nutritional status:

- *Unplanned significant weight gain or loss;*
- *Fever/infection;*
- *Diarrhea;*
- *Chronic disease;*
- *Chewing and Swallowing problems;*
- *Teeth and gum diseases;*
- *Excessive use of laxatives;*
- *Abnormal laboratory values;*
- *Brittle, dry hair;*
- *Ridged or spoon shaped nails;*
- *Dry flaky skin; and*
- *Unexplained changed in mood such as general fatigue, apathy, irritability, lack of concentration.*

If one or more of these indicators are present, determine the facility's response through observation, interview, and record review.

Surveyors should assure the facility is responsive to client food allergies and the potential for adverse food/drug interactions. If surveyors suspects these may exist, investigate further.

Examples of facility responsiveness to allergies and food/drug interactions include, but are not limited to:

- *Clients on long term anticonvulsant drug regimens (e.g., phenobarbital, phenytoin, primidone) are periodically monitored per facility policy for decreased serum levels of folic acid and vitamin D;*
- *Therapeutic doses of nutrients are provided to decrease the likelihood of anemia and prevent decreased bone density, etc.; and*
- *Fiber and fluids are increased in the diet of clients to decrease the likelihood of constipation.*

Guidance §483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation support the placement:

- *Assessment;*
- *Client program plan;*
- *Staff documentation of client response to training programs; and*
- *QIDP notes.*

W461

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

Guidance §483.480(a)(2)

The facility employs a registered dietitian either on a part-time, full-time or on a consultant basis.

W462

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

Guidance §483.480(a)(3)

Where the facility does not have a full-time qualified dietitian, verify that the director of food services coordinates with a dietitian to assure the nutritional adequacy of meals and snacks.

The food service director coordinates with the part-time or consultant dietitian to develop client meal plans and monitor client nutritional status.

The qualifications of the food service director may be dictated by facility policy or by state law, if applicable.

In small group home settings where the staff and clients plan and prepare meals cooperatively, there may not be a designated food services director. In these cases, the consultant or part-time dietitian would meet with the available home staff to ensure adequacy of menus and diets.

§483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe

W463

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(4) all modified and special diets

W464

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(4) including those used as a part of a program to manage inappropriate client behavior.

Guidance §483.480(a)(4)

Modifying a clients' diet must never be used as punishment.

W465

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

Guidance §483.480(a)(5)

This regulation addresses the use of food in shaping positive adaptive behavior. Where clients have specialized nutritional needs, these needs must be taken into consideration.

When food is used as a primary reinforcement of behavior for a client who has a dietary restriction, these foods should be consistent with the foods allowed by the prescribed diet.

Food used as a reinforcement must be part of a behavior plan approved by the IDT and consistent with nutritional parameters for that client. For example, a client with diabetes does not receive concentrated sweets as a reinforcement.

W466

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(a)(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

Guidance §483.480(a)(6)

For suggested guidelines write to:

U.S. Department of Agriculture
Human Nutrition Information Services
Washington, D.C. 20250

http://fnic.nal.usda.gov

(b) Standard: Meal services

W467
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(1) Each client must receive at least three meals daily,

Guidance §483.480(b)(1)

Meal times may be flexible and accommodate a variety of activities (e.g. holiday and weekend activities). Clients should be offered the opportunity of three meals every day, but may be given the choice of not participating in a meal due to their schedule or preference.
For example, a client wakes up late on a Saturday morning and decides to have brunch.

W468
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(1) at regular times comparable to normal mealtimes in the community

Guidance §483.480(b)(1)

Generally, meal times conform to the norms of the community, however the clients' schedules and preferences may result in slight variations. Slight variations are acceptable, but gross variations such as breakfast at 3 am would not be acceptable.

§483.480(b)(1) with –

W469
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(1)(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day,

Guidance §483.480(b)(1)(i)

A "substantial evening meal" is defined as an offering of three or more items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements.

W470
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(1)(i) except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may lapse between a substantial evening meal and breakfast; and

Guidance §483.480(b)(1)(i)

A "nourishing snack" is an offering of items, single or in combination, from the basic food groups. Snack supplies are available in the facility and are accessible to clients. Interview staff and clients about their access to snacks.

W472
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(2)(i) In appropriate quantity;

Guidance §483.480(b)(2)(i)

Meal observations verify that portions served, either by staff or by the clients, match the designated serving sizes on menus.

W473
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(2)(ii) At appropriate temperature;

Guidance §483.480(b)(2)(ii)

Hot foods are served hot and cold foods are served cold, according to facility policy specific to the type of food or as desired by the client. The facility follows current state requirements for safe food temperatures.

W474
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(2)(iii) In a form consistent with the developmental level of the client; and

Guidance §483.480(b)(2)(iii)

The term "form", as used in this requirement, refers to food consistency (e.g., pureed, chopped, ground, etc.). Food that is ground, chopped or pureed is based on assessed client need, and only to the extent required.

Food consistency modifications due to an acute medical or dental condition are temporary and; client's food consistency is upgraded at the soonest possible time. Clients with chronic medical or dental conditions are periodically reviewed and at least annually for the possibility of an upgrade in food consistency.

Client assessments must document the justification for modified texture of the client's diet.

W475

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(2)(iv) With appropriate utensils.

Guidance §483.480(b)(2)(iv)

"Appropriate utensils" refers to eating utensils and adaptive eating equipment that enable clients to eat as independently as possible in accordance with their highest functional level.

Commonly used utensils (fork, knife, and spoon) appropriate to the food being consumed are provided to all clients except those using adaptive equipment instead. Clients should be afforded the opportunity to use forks, spoons, and knives as indicated by the food served.

Utensils must be in good condition, clean, allow portion sizes appropriate to the client's prescribed diet and meet the client's needs.

W476

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(b)(3) Food served to clients individually and uneaten must be discarded.

Guidance §483.480(b)(3)

This standard does not apply to food served in family-style dishes, unless the length of time the food is on the table or other considerations (such as clients fingering or drooling in the food) compromise the safety and nutritive value for later consumption of the food.

(c) Standard: Menus

W477

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(c)(1)(i) Be prepared in advance;

Guidance §483.480(c)(1)(i)

The facility should be able to produce a copy of client menus prospectively to verify that meal planning is done in advance.

W478

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(c)(1)(ii) Provide a variety of foods at each meal;

Guidance §483.480(c)(1)(ii)

A "variety" of food at each meal includes offerings from each of the food groups.

W479

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(c)(1)(iii) Be different for the same days of each week and adjusted for seasonal changes; and

Guidance §483.480(c)(1)(iii)

Menus should make use of seasonal foods in order to capitalize on the availability of fresher more vitamin enriched foods.

In certain portions of the country, there may be cultural preferences that influence the frequency with which a food appears on the menu. This is acceptable in the facility if it is acceptable in the community.

W480

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(c)(1)(iv) Include the average portion sizes for menu items.

Guidance §483.480(c)(1)(iv)

Verify the menu lists client portion sizes and observe that the portions served correspond to the clients prescribed diet.

W481

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(c)(2) Menus for food actually served must be kept on file for 30 days.

(d) Standard: Dining areas and service

§483.480(d) The facility must –

W482

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

Guidance §483.480(d)(1)

For purposes of this standard, "dining areas" mean discrete eating areas located outside of bedrooms, established, furnished, and equipped for the purpose of eating meals.

When a client is not eating in a designated dining area, there must be either a medical rationale or this must be an isolated instance when the client has a personal reason to eat in another area, such as a television area to watch his or her favorite program.

Interview with the client should confirm that this is not routine, but is for a particular isolated reason.

W483

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

Guidance §483.480(d)(2)

Clients must have the opportunity to participate in the normal dining experience with their companions in the dining room.

Clients in wheelchairs are included in dining groupings of their peers without physical disabilities.

Clients in wheelchairs eat at the table and not with lap trays/hospital trays unless medically contraindicated.

W484

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;

Guidance §483.480(d)(3)

Clients use adaptive equipment or are being trained to use such equipment when the need is identified in the IPP.

Examples of adaptive equipment that may be needed are:

- *Double suction cups or other devices to anchor dishes on a table or tray for clients with major coordination problems;*
- *Rocking one-handed knife-fork or knife-spoon for a client with the use of only one hand;*
- *Built-up or extended handles or silverware for those with problems of grasp or range of motion;*
- *Plate guards or plates with raised rims to provide a surface against which the client with a physical disability can push food onto a fork or a spoon;*
- *Flexible drinking straws;*
- *Spoon bent to a 90 degree angle at the bowl or a swivel spoon to assist a client without normal wrist motions; and*

- *Any other adaptive device deemed by the team as needed by the client to eat more independently.*

W485
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(4) Supervise and staff dining rooms adequately

Guidance §483.480(d)(4)

There should be sufficient staff to implement eating programs for clients who require them and to provide necessary intervention and supervision for normalization including normal meal time behavior.

Client mealtime should not be inadequately delayed due to insufficient staff assistance.

W486
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(4) to direct self-help dining procedures,

Guidance §483.480(d)(4)

Staff is present during meal times to monitor clients who are able to eat independently, promoting, supporting, reinforcing and encouraging them to eat in an appropriate and normalized manner (e.g., manners, social behaviors, etc.)

W487
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client receives enough food and

Guidance §483.480(d)(4)

Clients can request and receive second helpings unless contraindicated by a prescribed diet.

For clients on restrictive diets that prefer not to be on these diets or seek seconds, the facility resolves the personal choice issues vs. health risks.

W488
(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client eats in a manner consistent with his or her developmental level; and

Guidance §483.480(d)(4)

The intent of this regulation is to promote the acquisition of skills that lead to greater independence in eating.

Clients should be actively encouraged to eat independently to the extent possible and in accordance with their assessed abilities.

Clients should receive training to develop independent eating skills consistent with their developmental potential as identified through the CFA.

Clients learn skills in accordance with their functional levels. Skills may include:

- *Use of utensils;*
- *Meal preparation;*
- *Socialization during meals;*
- *Family style dining; and*
- *Ordering food in restaurants.*

Clients' eating programs are implemented in accordance with their training objectives.

To the maximum extent possible, staff model appropriate mealtime behavior and conversation by sitting at the table with clients, and when possible, eating meals with clients.

W489

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

§483.480(d)(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

Guidance §483.480(d)(5)

If a client eats in any position other than an upright position, the physician should document the medical necessity for the position, and/or the IPP should include the program plan to teach the client the physical skill necessary for eating upright.

This applies to all clients, including those fed by nasogastric tube or gastrostomy tube. The IPP should identify the most appropriate position for the client to be positioned during mealtime, in relation to the placement of the food contents

EXHIBIT 355
Probes and Procedures for Appendix J, Part II- Interpretive Guidelines- Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

(Rev. 135, Issued: 02-27-15, Effective: 04-27- 15, Implementation: 04-27-15)

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 hasreviewed 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)

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): www.cdc.gov/tb/topic/testing/default.htm

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)

W412and 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(l)(3)

W458 §483.470(l)(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?