CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 94 **Date: December 6, 2013**

SUBJECT: State Operations Manual (SOM) Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities, nomenclature revisions.

I. SUMMARY OF CHANGES: Revisions have been made to Appendix J, Part I-Investigative Procedures for Intermediate Care Facilities for Individuals with Intellectual Disabilities and Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities, to reflect the federally mandated ICF/IID nomenclature (the nomenclature is no longer ICF/MR).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: December 6, 2013
IMPLEMENTATION DATE: December 6, 2013

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
R	Appendix J/Table of Contents
R	Appendix J/Part 1-Investigative Procedures for Intermediate Care Facilities for Individuals with Intellectual Disabilities
R	Appendix J/Part 1/I-Introduction
R	Appendix J/Part 1/II-Principal Focus of Surveys
R	Appendix J/Part 1/IV-Components of Active Treatment
R	Appendix J/Part 1/V/A-Purpose of the Sample
R	Appendix J/Part 1/V/C/2-Facilities with over 100 individuals
R	Appendix J/Part 1/V/C/3-Alternate Sampling Procedure
R	Appendix J/Part 1/V/D-Program Audit Approach
R	Appendix J/Part 1/VIII/B-Interview Procedure
R	Appendix J/Part 1/VIII/F-Documentation
R	Appendix J/Part 1/XII-Task 8- Team Assessment of Compliance and Formation of the Report of ICF/IID Deficiencies
R	Appendix J/Part 1/XII/A-General

R	**Appendix J/Part 1/XII/D-Composing the Report of ICF/IID Deficiencies (CMS-3070H/(10/95))**
R	**Appendix J/Part 1/XIII/A-Summary Listing of all ICF/IID Individuals Comprising the Survey Sample (include any additional individuals added to the sample)**
R	**Appendix J/Part 1/XIII/B-Description of the Representative Sample Selection**
R	**Appendix J/Part 1/XIII/D-Summary of Interviews**
R	**Appendix J/Part 1/XIV-Completing the Revised Form CMS-3070-G-I (10/95) ICF/IID Survey Report Form (SRF)**
R	**Appendix J/Part II-Interpretive Guidelines-Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities**
R	**Appendix J/Part II/§440.150(c)/W100**
R	**Appendix J/Part II/§483.410(d)(1)/W117**
	Appendix J/Part II/§483.410(d)(2)(ii)/W119
R	**Appendix J/Part II//§483.410(d)(4)/W121**
R	**Appendix J/Part II/§483.420(a)(5)/W127**
R	**Appendix J/Part II/§483.420(d)(1)(iii)/W152**
R	**Appendix J/Part II/§483.430(a)/Standard: Qualified Intellectual Disabilities Professional**
R	**Appendix J/Part II/§483.430(a)/W159**
R	**Appendix J/Part II/§483.430(a) (1)/W160**
R	**Appendix J/Part II/§483.430(b)(1)/W166**
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R	**Appendix J/Part II/§483.430(b)(5)(x)/W180**
R	**Appendix J/Part II/§483.430(b)(5)(xi)/W181**
R	**Appendix J/Part II/§483.440(a)(1)/W196**
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R	**Appendix J/Part II/§483.440(c)(4)(iv)/W232**
R	**Appendix J/Part II/§483.440(c)(6)(iii)/W242**
R	**Appendix J/Part II/§483.440(c)(6)(v)/W246**
R	**Appendix J/Part II/§483.440(c)(6)(vi)/W247**
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R	**Appendix J/Part II/§483.440(f)(3)/W261**
R	**Appendix J/Part II/§483.440(f)(3)(ii)/W263**
R	**Appendix J/Part II/§483.450(d)(1)(ii)/W296**

R	**Appendix J/Part II/§483.460(a)(2)/W320**
R	**Appendix J/Part II/§483.460(j)(2)/W363**
R	**Appendix J/Part II/§483.460(k)(2)/W369**
R	**Appendix J/Part II/§483.470(b)(3)/W416**
R	**Appendix J/Part II/§483.470(g)(2)/W436**
R	**Appendix J/Part II/§483.470/W451/§483.470(j)(1)/Standard: Fire Protection**

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.**

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for *Individuals with Intellectual Disabilities*

Table of Contents
(Rev.94, Issued: 12- 06- 13)

Part 1 - Investigative Procedures for Intermediate Care Facilities for Individuals with Intellectual Disabilities

(Rev. 94, Issued: 12- 06- 13)

I - Introduction

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

This revised ICF/*IID* survey protocol is to assist surveyors to focus attention on the outcomes of individualized active treatment services. The Centers for Medicare & Medicaid Services (CMS) intends the revised survey process to be less resource intensive for providers who consistently demonstrate compliance with the regulations. The survey process is based on the October 3, 1988, regulation and is applicable to all ICFs/*IID*, regardless of size.

In 1988, when the current ICF/*IID* regulation was implemented, it was viewed as a great step forward in promoting a focus on the actual outcomes experienced by consumers,

rather than on the policies, procedures and paperwork of the facility. Since that time there has been an evolution on thinking in both the field of developmental disabilities (DD) and in the field of quality assurance (QA).

The field of DD is increasingly emphasizing supporting individuals in their own homes and communities, rather than placing people in facilities. In addition services in virtually all States are placing increased emphasis on person-centered planning and person-centered services that focus on the preferences, goals and aspirations of each individual and on supporting them in reaching their personal goals. The field of QA is placing increased emphasis on outcomes related to choice, control, relationships, community inclusion, and satisfaction with life, as well as satisfaction with services and supports. Many QA systems also include organizational self-assessment and continuous quality improvement components. These trends have contributed to the perception by providers and advocates that the ICF/*IID* regulation and oversight process is too prescriptive and cumbersome, and should be altered to reflect newer values of quality enhancement and continuous quality improvement.

This revised survey protocol gives facilities broader latitude to develop the processes by which it implements active treatment services. While the facility practice must comply with the requirements of 42 CFR 483, Subpart I, the survey is to center on the fundamental requirements that produce outcomes for individuals. When those outcomes occur, review of additional supporting requirements of process and structure is not indicated.

A survey that focuses on observations of staff/consumer interaction and on interviews with consumers regarding their participation and choice of services is sufficiently informative to determine the outcomes of active treatment. In the presence of problems, a more in-depth review of how the process unfolded for a particular individual(s) occurs.

A facility may receive reimbursement only for the cost of care of individuals classified as eligible for the ICF/*IID* level of care who are receiving active treatment. Determine facility compliance with Conditions of Participation and with standards in the context of individual experiences within the facility. When performing certification surveys to assess facility compliance, assess whether individuals are receiving needed active treatment services.

II - Principal Focus of Surveys

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

The principal focus of the survey is on the "outcome" of the facility's implementation of ICF/*IID* active treatment services. Direct your principal attention to what actually happens to individuals: whether the facility provides needed services and interventions; whether the facility insures individuals are free from abuse, mistreatment, or neglect; whether individuals, families and guardians participate in identifying and selecting services; whether the facility promotes greater independence, choice, integration and productivity; how competently and effectively the staff interact with individuals; and whether all health needs are being met.

Use observation and interview as the primary methods of information gathering. Conduct record reviews after completion of observations and interviews to confirm specific issues. Verify that the facility develops interventions and supports that address the individuals' needs, and provides required individual protections and health services. Do not conduct in-depth reviews of assessments, progress notes or historical data unless outcomes fail to occur for individuals.

IV - Components of Active Treatment

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

The definition of "active treatment in intermediate care facilities for *individuals with intellectual disabilities*" in 42 CFR 435.1009 refers to treatment that meets the requirements specified in the standard for active treatment 42 CFR 483.440(a). The components of the active treatment process are:

V - Task 1 - Sample Selection

A - Purpose of the Sample

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

The purpose of drawing a sample of individuals from the facility is to reflect a proportionate representation of individuals by the four functional levels (mild, moderate, severe, and profound *intellectual disability*) as defined by the American Association on *Intellectual and Developmental Disabilities,* "*Intellectual Disability: Definition, Classification, and Systems of Supports*," (*eleventh* edition, *2010*).

The sampling process is not designed to produce a "statistically valid" sample. Apply the method with flexibility based upon the prevailing developmental strengths and needs presented by the individuals served by the facility. A "statistically valid" sample would not accommodate this need.

While the individuals in the sample are targeted for observation and interview, conduct each program audit of the individual within the context of each of the environments in which the individual lives, works, and spends major leisure time. Although you focus on the individual, the behavior and interactions of all other individuals and staff within those environments also contribute to the total context and conditions for active treatment. Therefore, other individuals will be included in the overall sample.

As the sample is built, additional information about the facility's services and special individual needs may emerge. If you find that a disproportionate number of disabilities or needs are present within the facility's population add to or replace originally selected individuals of the same functional level in the program audit sample to ensure that the appropriate care and services are reviewed. Staff interview for individual characteristics (see the back of Form CMS-3070G) may help identify areas of individual need that should be reflected in the sample.

For example, if you discover a significant percentage of individuals are nonambulatory, and this characteristic has not been represented in the sample, add additional individuals. Likewise, if while observing Individual A (a member of the sample), you note that Individual B (who was not targeted for the sample) engages in a particular problematic behavior for which staff do not appear to provide appropriate intervention, add Individual B to the sample in order to probe further if needs are addressed. You are free by this methodology to add to the sample on an as needed basis.

C - Sample Selection

Do not allow the facility staff to select the sample.

2 - Facilities With Over 100 individuals

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Request a listing of all individuals by overall functional (cognitive and adaptive) level (i.e., mild, moderate, severe, profound) and building location.

Determine the number of individuals to draw based upon the total individuals from Section III B.

Determine the percentage occurrence of each functional level in the overall population (e.g., 12 percent mild; 24 percent moderate; 63 percent severe).

Determine the number of individuals to draw in each functional category (for example, if the sample size is 50, and 12 percent of the individuals have mild *intellectual disability*, then multiply 50 by .12 = 6, and draw 6 individuals who have mild *intellectual disability* into the sample).

Draw the sample for each functional category. (Assume there are 60 with mild *intellectual disability*, and 6 are to be sampled. Divide 60 by 6 = 10, and draw every tenth individual.) The interval of selection varies with each functional category because there will be a different percentage occurrence at each. Thus, assuming there are 16 individuals with severe *intellectual disability* and 4 are to be sampled, draw every fourth name from the list of individuals with severe *intellectual disability*.

Locate each selected individual's living unit on a map of the facility building(s) to see if too many are concentrated in too few buildings. To provide a comprehensive look at the facility, drop some individuals and add others in other buildings for a better distribution. Each individual replacing an originally selected individual must be of the same functional level.

3 - Alternate Sampling Procedure

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

In the rare situation in which the facility is unable to produce the necessary data on which to draw the sample, draw a random sample, to the maximum extent possible. Supplement it as described in Section VA.
Intellectual Disability, as defined by the American Association on *Intellectual and Developmental Disabilities* (*AAIDD*) in "*Intellectual Disability*: Definition, Classification and Systems of Supports" (*eleventh* edition, *2010*), is no longer classified in four functional levels (mild, moderate, severe, and profound.) Most facilities have not yet adopted the classification system; however, when the facility does use the classification system and information regarding the four functional levels is not available, revise the sampling procedure. Follow the instructions in A and B above but, instead of using the four functional levels referenced in AAMR's Classification System of 1983, use the four levels of intensity of supports (intermittent, limited, extensive, and pervasive) on Dimension I for Self-Care from the new classification system. Although not equivalent to the 1993 classifications, this method should provide a sample of individuals within the facility who represent a variety of functional abilities.

D - Program Audit Approach

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

To maximize the advantage of an interdisciplinary survey team, the team leader assigns each member an equitable number of individuals on whom to focus. For each individual, assess all applicable fundamental requirements of the ICF/*IID* Conditions of Participation based on the individual's need for that particular service. Each member of the team shares salient data about findings relative to his or her assigned individuals. Consult with one another, on a regular basis during the survey, to maximize sharing of knowledge and competencies.

VIII - Task 4 - Required Interviews With Individuals and/or Family/Advocate Direct Care Staff

B - Interview Procedure

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Start with the individual in the sample and the people most closely associated with the individual's daily program implementation. Use the following hierarchy of sources, to the maximum extent possible, in the order shown:

- Individual;
- Families, legal guardian, or advocate;
- Direct care staff;
- Qualified *intellectual disabilities* professional (*QIDP*) and/or professional staff; and
- Managers, administrators, or department heads.

Determine from your observations and from the staff how the individual communicates with others. Also determine from the staff the extent of involvement of family members, guardians or advocates with the individuals in the sample. Based on this information, select the individuals from the sample with whom you will conduct more in-depth interviews. Select those individuals who will be able to communicate at least some basic information or those who have actively involved family members, guardians or advocates. Do not exclude from interviews individuals who use alternate means of communication, such as communication boards, sign language, and gestures. Most individuals are able to communicate in some manner. At a minimum conduct the number of in-depth interviews specified in Section V, Task 1B.

Attempt to obtain the required number of interviews first from individuals and then from family members, guardians or advocates. In the absence of individuals who are able to communicate and active significant others, interview the direct care staff person who works most closely with the individual in order to obtain the required number of in-depth interviews.

The questions and communication method will vary from person to person. For individuals who use a specialized communication method, attempt to begin the interview on a one to one basis. If you find you are unable to communicate with the individual, ask someone familiar with the person to assist you (e.g., a family member or a staff person.) For this individual, pay close attention to how the staff communicates with him or her. If the person uses sign language or a communication board, does staff understand and interact with the individual using the same method? If the person uses gestures, does staff take time to determine his or her needs?

Family members, guardians or advocates may be interviewed at the facility, at a location convenient to both the surveyor and the interviewee, or by telephone. All interviews should be conducted in private locations and scheduled at mutually agreed upon times in order to minimize disruptions to individual, family, or staff activities.

F - Documentation

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Record each interview you conduct with individuals, staff, consultants, off-site day program staff, legal guardians, etc., in your personal notes or on the optional observation worksheet (Form CMS-3070I). Include the following information in your notes for each interview:

- Date and time of interview;
- Job title and assignment at the ICF/*IID*;
- Relationship to the individual or reason for the interview; and
- Summary of the information obtained.

XII - Task 8 - Team Assessment of Compliance and Formation of the Report of ICF/*IID* Deficiencies

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

A - General

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

The Survey Report Form (Form CMS-3070H) is composed during the pre-exit conference and contains the negative findings that contribute to a determination that an ICF/*IID* requirement is "not met." Meet as a team, in a pre-exit conference, to discuss the findings and make conclusions about the deficiencies, subject to additional information provided by facility officials. Review the summaries/conclusions from each task and decide whether further information and/or documentation is necessary. Ask the facility for additional information or clarification about particular findings, if necessary. Consider information provided by the facility. If the facility maintains that a practice in question is acceptable, request reference material or sources that support the facility's position.

D - Composing the Report of ICF/*IID* Deficiencies (CMS-3070H/(10/95))

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

During the pre-exit conference, the survey team records on the Form CMS-3070H those requirements that are determined to be deficient and the findings that support that determination. Write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. Do not delve into the facility's policies and procedures to determine or speculate on its root cause, or sift through various alternatives to prescribe an acceptable remedy. Indicate on the Form CMS-3070H the data prefix tag, followed by a summary of the deficient facility practice(s). Briefly identify the supporting findings for each deficiency (i.e., transfer to the Form CMS-3070H the identifier numbers of all individuals to whom the deficient practice applies.) It is not necessary to write a full description of the findings on the Form CMS-3070H since they will be described in more detail on the completed Statement of Deficiencies (Form CMS-2567). It is necessary to complete the Form CMS-3070H for each survey because the Form CMS-3070H is the only document in which the survey team's recommendations for deficiencies are recorded (which may be changed later on the final Form CMS-2567 as a result of supervisory review) and because not all individual examples may be used on the Form CMS-2567. Instructions for the Form CMS-3070H are found in "Section XIV - Completing the Revised Form CMS-3070-G-I."

Alternatively, when the survey team enters its findings directly into a computerized system such as Automated Survey Processing Environment during the pre-exit conference, the statement of deficiencies (Form CMS-2567) that is generated onsite at the facility may be substituted for the Form CMS-3070H. The Form CMS-2567 generated onsite then must contain the information required for the Form CMS-3070H and must be clearly marked "DRAFT - SUBJECT TO STATE AGENCY REVIEW" on each page.

XIII - Additional Survey Report Documentation (For the File)

Upon the completion of each survey, the team leader completes the following additional documentation. This information remains at the survey agency with the Form CMS-3070-G-H (10/95) in the official file:

A - Summary Listing of all ICF/*IID* Individuals Comprising the Survey Sample (include any additional individuals added to the sample)

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

At a minimum, identify:

- The name or Medicaid number of each individual chosen to be part of the sample;
- Any individual identifier codes used as a reference to protect the individual's confidentiality; and

The reason for including the individual in the sample (e.g., "Random Program Audit," "Discharge," "New Admission," "Death," "Abuse Investigation," "Drugs to Control Behavior"). This listing serves as a future reference to any individual identifiers recorded in surveyors' notes, the Form CMS-3070-G-I, and the Form CMS-2567.

B - Description of the Representative Sample Selection

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

At a minimum, identify at the time of the survey:

- How the sample was selected;
- What was the percentage occurrence of each functional level of *intellectual disability* in the facility's overall population;
- The distribution of the individuals in the sample across the facility's living units;
- The number of people in the sample;
- The number, if any, of individuals substituted in the sample, and the reason; and
- Any other characteristic of individuals served that was specifically introduced into the sampling process and the reason.

D - Summary of Interviews

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Include all surveyor notes containing information obtained during interviews with individuals, families, guardians, direct care staff, Q*ID*Ps, professional staff or consultants, administrators and managers, and others. These notes should identify the person interviewed by name or position, and date and time of interview.

XIV - Completing the Revised Form CMS-3070-G-I (10/95) ICF/*IID* Survey Report Form (SRF)

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Part 1 (3070G):	This is the cover sheet for the ICF/*IID* SRF which summarizes data relative to: facility characteristics; description of the individual population served; special needs represented by that population; and essential characteristics of the survey conducted. Portions of this information are entered into the Onsite Survey and Certification Automated Reporting (OSCAR) System and used to review trends about the ICF/*IID* program nationwide.
General Instructions:	1. Complete all portions of Part 1 onsite, preferably during the first day of the survey. Work with the facility to complete the form according to these instructions and to ensure accurate information is obtained prior to leaving the facility. 2. If a number is requested (e.g., No. of beds, No. of individuals), and the answer is NONE or ZERO, enter a "O" in the space provided. 3. If a box is provided to "check one" of the answers provided, enter a check mark. 4. Abbreviations used: "CEO" means Chief Executive Officer; "*QIDP*" 5. Regulatory references on the form refer to regulations found in the Code of Federal Regulations, and refer to regulations applicable to ICFs/*IID*. 6. Review all portions for accuracy prior to leaving the facility.
Specific instructions:	
Blocks 1-10, 13-14:	Enter identifying data, as requested.
Block 11:	Enter the dates of the first and last days of the survey (even if there is a break in survey days).
Block 12:	Enter the number describing the ownership/control type in the box marked "W6." If "other" best describes the facility, specify the other type on the space provided.
Blocks 15 (A-M):	(Col. 1): Enter the No. of disciplines that best describe your team's composition. If a surveyor has multiple areas of expertise (e.g., a nurse surveyor who is also a dietitian), include **each** discipline of expertise. (Col. 2) Enter the No. of disciplines represented on the team that also qualified as a Q*ID*P (as per 42 CFR 483.430(a)(1)(2)(i)-(iii) and 42 CFR 483.430(b)(5) of the ICF/*IID* Conditions of Participation.

Blocks 15 (N-O):	Enter the number, as requested.
Blocks 16 (A-B):	A "Yes" indicates that the CEO directs not only the activities of the ICF/*IID*, but also those of another residential services program (e.g., another ICF/*IID*; another Medicare/Medicaid Provider that serves persons with *ID* regardless of funding source). A "No" indicates that the CEO of the ICF/*IID* does not direct the activity of another residential services program for persons with *IID*. If "Yes" was indicated for 16A, identify the name, address and CEO of the larger organization or agency in 16B (could be the same information for this ICF/*IID* in Block 7. Enter the total bed capacity of all residential services for which the CEO is directly responsible (including the ICF/*IID* bed capacity) in "W14." Do **not** include beds for which the CEO is indirectly responsible. (For example, in some States the CEO of a State-operated institution is also indirectly responsible for **all** beds in a region, including those operated by private providers within that region. Do not include beds directly operated by another agency or organization for the purposes of W14.) Enter the total No. of individuals residing in the beds (including ICF/*IID* individuals) in "W15."
Block 16C:	Enter the No. as requested.
Block 16 D:	A "Yes" indicates that this ICF/*IID* (i.e., the beds under this provider number) is the only house or apartment at the address stated in Block 2 and is located in close proximity to other houses or apartments occupied by people who are not disabled. A "No" indicates that there is other bed capacity to provide residential services to persons with disabilities at the address stated in Block 2 or that this ICF/*IID* is surrounded by other buildings or residential units serving people with disabilities.
Block 16 E:	Enter the No., as requested.
Block 16 F:	Enter the total No. of discrete units. If the ICF/*IID* encompasses several bldgs, count the total No. of discrete living units within all buildings.
Block 16 G:	List the ages of the youngest individual in W20 and oldest in W21.
Block 16 H:	Each day's program site included in this number should be located off the grounds or campus of the ICF/*IID*. Any individual going to this program should be scheduled to attend regularly (at least 3 hrs.a day, 2-5 days a wk.). If the day program provides 2 or more programs at the same address, for purposes of this item, consider it one site.
Blocks 17 (A-D):	Enter the full time equivalents (FTEs) for each category listed. For 17A, include only staff who provides direct care services to individuals at their living units. Include direct care supervisors only if they are also responsible to provide direct care as part of their

	duties. (See 42 CFR 483.430(d).) For 17D, include all personnel, including the No. of direct care and licensed nursing personnel, as well as professional and support staff employed by the facility. To determine FTEs: add the total No. of hrs. worked the week prior to the survey, by all employees identified in each category of 17 (A-D); Divide this No. by the No. of hrs. in the standard workweek. Express FTE's to the nearest quarter decimal (i.e. ".00," ".25," ".50," and ".75").
Block 18 A:	Enter the No. of individuals in the total sample (i.e., the representative sample and any other individuals added to the sample for other reasons.)
Block 18 B:	Enter the No. of sites visited in which observations of individuals in the sample were completed.
Blocks 20 (A-L):	INDIVIDUAL CHARACTERISTICS: The last date of the survey is the date by which age is determined. The term "Total" No. refers to the No. of ICF/*IID* individuals fitting the characteristic listed who are currently in the facility.
20 A (1):	Enter the total No. of individuals within each age group regardless of sex.
Blocks 20 A (2):	Enter the No. of individuals by sex and the total. The total should equal the No. entered in 20 (A)(1), Total (W33).
Blocks 20 (B-C):	Enter the total No. of individuals by each characteristic requested; and the total. Count individuals with more than one disability in every applicable column. Use the following definitions: **Autism** is a diagnosis whereby the individual exhibits extreme forms of self-injurious, repetitive, aggressive, or withdrawal behaviors; extremely inadequate social relationships; or extreme language disturbances. **Cerebral Palsy** is a diagnosed condition whereby gross and fine movements and speech clarity of the individual may be impaired but performance of activities of daily living is functional; or, the individual is unable to perform adequately activities of daily living such as walking, using hands, or using speech for communication. ***Intellectual disability*** levels (**mild, moderate, severe,** and **profound**) are described in the American Association on *Intellectual and Developmental Disabilities*' Manual on "Classification in *Intellectual Disability*" (*2010* edition). **Nonambulatory** means unable to walk independently. **Mobile nonambulatory** means unable to walk independently, but able to move from place to place with the use of such devices as walkers, crutches, wheelchairs, and wheeled platforms. **Nonmobile** means unable to move from place to place.

	Epilepsy means a neurological disorder characterized by seizures of motor and sensory movements.
	Hard of Hearing means able to hear speech, including with amplification.
	Deaf means unable to hear speech, even with amplification.
	Impaired vision means able to see objects, with correction.
	Blind means unable to see objects.
Blocks 20 (D-K):	Enter the total No. of ICF/*IID* individuals who have the following care needs or characteristics: Medical Care Plan (i.e., requires 24 hour licensed nursing care as defined at (42 CFR 483.450(a)(2)); Drugs to Control Behavior (42 CFR 483.450(b)(1)(iv)(C)); Restraints (42 CFR 483.450(b)(1)(iv)(B));Time-out rooms (42 CFR 483.450(b)(1)(iv)(A)); Application of Painful or Noxious Stimuli (42 CFR 483.450(b)(1)(iv)(D)); Attend Off-Campus Day Programs; Court Ordered Admissions; and the No. Over Age 18 with a Legally Appointed Guardian.
Block 20 L:	If the facility or you believe that a particular individual or program characteristic that describes the population has not been requested on this form, identify it, programs provided, etc., in the space provided. Enter the total Nos. of individuals having this characteristic.
Part 2 (3070-H):	REPORT OF DEFICIENCIES Use this part in conjunction with the regulation text and interpretive guidelines. Include basic information on non-compliance. Complete the report during the pre-exit conference for all surveys. Record all deficiencies found during the survey. Sign it, certifying that all other facility requirements not documented as deficiencies, are in compliance. Evaluate each discrete requirement identified by a tag number in the ICF/*IID* Interpretive Guidelines. For each identified deficiency: In the first column, identify the data tag number; In the second column, write the standard number. If it is a Condition of Participation, enter "CoP" below the standard number. Identify the deficient facility practice, findings and evidence in the "Comments" column. Draw horizontal lines to separate identified tag numbers. Use as many sheets as needed. Each surveyor must sign the appropriate certifying statement on the last page of Part 2.
Part 3	INDIVIDUAL OBSERVATION WORKSHEET

(3070-I): Part 3 of the SRF is an optional worksheet that may be used to record and structure observations so that individual data relative to compliance with the statutory active treatment requirement are available for analysis and retrieval. This is completed for each observation as follows:

Heading: Enter requested names, locations, codes, times and dates. Enter "individual codes" only if individuals in the sample are present.

Column 1 - Time: Enter the time of discrete observations or consecutive time intervals.

Column 2 - Observation: Include the information specified in Section V-B of this Appendix for each observation (e.g., number of individuals; number of staff; activity in progress).

Part II- Interpretive Guidelines-Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§440.150 Intermediate Care Facility Services, Other Than in Institutions for Mental Diseases

W100

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§440.150(c) "Intermediate care facility services" may include services in an institution for the *intellectually disabled* (hereafter referred to as intermediate care facilities for *individuals with intellectual disabilities*) or persons with related conditions if--

(1) The primary purpose of the institution is to provide health or rehabilitative services for *intellectually* disabled individuals or persons with related conditions;

(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and

(3) The *intellectually disabled* recipient for whom payment is requested is receiving active treatment as specified in §483.440.

Facility Practices §440.150(c)

The facility is in compliance with the Condition of Participation at W195, i.e., individuals are in need of and receiving active treatment.

Guidelines §440.150(c)

The statutory and regulatory use of the word "institution" includes settings that serve four or more *individuals with intellectual* disabilities and/or related conditions.

See §435.1009 for definition of "persons with related conditions."

The presence or absence of an individual requiring a medical care plan, as defined at W320, is not salient in the determination of whether a facility is eligible to participate in the ICF/*IID* program.

§483.410(d) Standard: Services Provided Under Agreements With Outside Sources

W117

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Guidelines §483.110(d)(1)

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

§483.410(d)(2) The agreement must

W119

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

(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.

Guidelines §483.410(d)(2)(ii)

Outside providers of day services would not have to meet certain requirements relating to physical environment under §§483.470 (a)-(g), (j), and (k) unless that source also provides living quarters for ICF/*IID* individuals. Outside sources must, of course, meet any applicable State and local requirements.

The facility's responsibility includes assuring that any restrictive techniques proposed for use by outside service providers are used only when warranted and with the required safeguards and approvals.

W121

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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).

Guidelines §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.

§483.420(a) Standard: Protection of Clients' Rights

The facility must ensure the rights of all clients. Therefore, the facility must

Guidelines §483.420(a)

"Ensure" means that the facility actively asserts the individual's rights and does not wait for him or her to claim a right. This obligation exists even when the individual is less than fully competent and requires that the facility is actively engaged in activities which result in the pro-active assertion of the individual's rights, e.g., guardianship, advocacy, training programs, use of specially constituted committee, etc.

W127

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.420(a)(5)

No patterns, isolated incidents, unexplained functional regression, or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals are present, are likely to occur, or have occurred without corrective action.

The following situations constitute evidence of abuse:

1. Individuals are involved in serious incidents (e.g., injuries, elopements) caused by one or more of the following:

    - Insufficient or incompetent supervision, regardless of the location of the incident;

    - Program structure not meeting individual needs;

- Failure to intervene when indicated (i.e., neglect);

- Active treatment strategies that have proven to be ineffective and have not been revised to meet individual needs;
- Placement in an unsafe environment;

- Monitoring systems that are absent or are inadequate to prevent such incidents; or

- Placement with aggressive/assaultive individuals in the absence of adequate supervision.

2. Individuals are found with serious injuries of unknown origin that are suspicious based on the nature or circumstances of the injury, and on the functional or medical status of the individual.

3. Individuals are found with suspicious injuries of unknown origin and have been provided care and supervision by a person who has a confirmed history of abuse.

4. Individuals are subject to punitive techniques in the absence of positive teaching strategies or in the absence of their effectiveness.

5. Individuals suffer death/deterioration due to lack of medical attention and oversight.

6. There is observed abuse and the facility takes no action to correct the situation and protect the individual.

Guidelines §483.420(a)(5)

The facility is responsible to organize itself in such a manner that it proactively assures individuals are free from serious and immediate threat to their physical and psychological health and safety. Citing of this requirement indicates that there is a high probability that abuse to individuals could occur at any time, or already has occurred and may well occur again, if the individuals are not effectively protected from the serious physical or psychological harm or injury, or if the threat is not removed. A citation of this requirement, therefore, must result in a determination of Condition level non-compliance due to immediate and serious threat. Cross reference W122 for additional guidance.

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

"Abuse" refers to the ill-treatment, violation, revilement, malignment, exploitation and/or otherwise disregard of an individual, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator.

"Physical abuse" refers to any physical motion or action, (e.g., hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment. Observe individuals to see if they are bruised, cut, burned (cigarettes, etc.).

"Verbal abuse" refers to any use of oral, written or gestured language by which abuse occurs. This includes pejorative and derogatory terms to describe persons with disabilities.

"Psychological abuse" includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.

Individuals must not be subjected to abuse by anyone (including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, other individuals, or themselves).

Since many individuals residing in ICFs/*IID* are unable to communicate feelings of fear, humiliation, etc., the assumption must be made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, is also viewed as abusive by the individual residing in the ICF/*IID*, regardless of that individual's perceived ability to comprehend the nature of the incident.

The facility must take whatever action is necessary to protect the individuals residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee believed to be abusive, the facility may need to take other measures (such as assigning the employee to an area where there is no contact with beneficiaries, providing increased supervision and additional training for the employee, appealing the arbitration or court decision or pursuing formal criminal charges) in order to ensure beneficiary safety.

Survey Procedures §483.420(a)(5)

Use the following procedures in the order shown:

- Review incident/accident reports or logs for at least a 3-6 month period and for all three shifts.

- Review recent hospitalizations or transfers to the facility infirmary as a result of an individual incident or accident.

- Note any failure of the facility to provide protective supervision, especially after knowing an individual has in the past been injured as a result of omissions in supervision. (For example, usually after 3 incidents of injury, within a short timeframe, one begins to think about the repetitive nature of the incidents. However, if even one very serious incident resulting in medical intervention has

occurred, review it to assure that the facility has taken effective, corrective action.)

- After identifying those individuals repeatedly being injured, go to the living unit or wherever the injuries are reoccurring and observe the level of supervision provided.

- There are going to be unexplained injuries, given the nature of the population served. However, as a surveyor, you are examining what the facility has done to reduce the probability of further injury.

- Observe individuals to determine if there is a pattern of individuals appearing fearful, suspicious, timid, shaking when approached, avoiding eye contact, overly obedient, etc.

- Other factors to evaluate include: the needs of the individuals served, the degree of program structure available in the environment, the effectiveness of active treatment strategies, and whether or not the frequency or intensity of injuries is abnormally high or low, etc. These conditions may indicate the potential for a threat which requires in-depth investigation and evaluation.

Probes §483.420(a)(5)

Are there patterns of staff conduct which may be punitive, abusive, retributive, 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 (i.e., investigative systems, abuse management, analysis of incident and injury patterns, individual/parent/guardian ombudsman systems)?

Cross-reference W150 for more probes.

W152

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.420(d)(1)(iii)

No one hired after October 3, 1988, has had a conviction or a prior employment history of child or client abuse, neglect or mistreatment of which the facility was aware based on pre-employment screening.

No one with a conviction or substantiated allegation of child or client abuse, neglect or mistreatment occurring outside the jurisdiction of the ICF/*IID* after October 3, 1988, regardless of employment date, is employed by the facility.

Guidelines §483.420(d)(1)(iii)

This regulation applies to the hiring of new employees on or after October 3, 1988. 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 be directed toward a child or an individual who is a client (resident, patient) in order for the prohibition of employment to apply.

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). A **substantiated** allegation of abuse, neglect or mistreatment which occurred after October 3, 1988, (regardless of the date of the person's employment in the ICF/*IID*), **and** which resulted in the termination of that person's employment from another health care facility, becomes a part of the person's employment history and the ICF/*IID* is prohibited from continuing to employ the individual. For example, an individual 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 or client (resident, patient) abuse, neglect or mistreatment. Therefore, conviction for abusing one's own child is also a reason employment would be prohibited.

The definition of "mistreatment" under the guideline at W153 includes financial exploitation. Therefore, if an employee was convicted or had a prior employment history of theft of an individual's funds, that would also be a reason employment would be prohibited.

Access other information, as appropriate, including information contained in "closed" records, in order to adequately evaluate compliance.

Probes §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?

§483.430(a) Standard: Qualified *Intellectual Disabilities* Professional

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

W159

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Each client's active treatment program must be integrated, coordinated and monitored by a qualified *intellectual disabilities* professional

Facility Practices §483.430(a)

There is an assigned qualified *intellectual disabilities* professional (*QIDP*).

There are sufficient numbers of *QIDPs* to accomplish the job.

The *QIDP* observes individuals, reviews data and progress, and revises programs based on individual need and performance.

The *QIDP* ensures consistency among external and internal programs and disciplines.

The Q*ID*P ensures service design and delivery which provides each individual with an appropriate active treatment program.

The *QIDP* ensures that any discrepancies or conflicts between programmatic, medical, dietary, and vocational aspects of the individual's assessment and program are resolved.

The *QIDP* ensures a follow-up to recommendations for services, equipment or programs.

The Q*ID*P ensures that adequate environmental supports and assistive devices are present to promote independence.

Guidelines §483.430(a)

View the person serving in the Q*ID*P role as pivotal to the adequacy of the program the individual receives, since it is this role that is intended to ensure that the individual receives those services and interventions necessary by competent persons capable of delivering them. The paramount importance of having persons competent to judge and supervise active treatment issues cannot be overstated.
An individual's IPP may be coordinated and monitored by more than one *QIDP* or by other staff persons who perform the Q*ID*P duties. There must, however, be one Q*ID*P who is assigned primary responsibility and accountability for the individual's IPP and the Q*ID*P function.

The regulations do not specify if the person designated as Q*ID*P must do the duties of a Q*ID*P exclusively, or is allowed to perform other professional staff duties in addition. The facility has the flexibility to allocate staff resources in whatever manner it believes is

necessary as long as it ensures that the Q*ID*P function is performed effectively for each individual.

The test of whether the number of Q*ID*Ps is adequate rests with the ability of the facility to provide the services described in §483.430(a) in an effective manner. The number will vary depending on such factors as the number of individuals the facility serves, the complexity of needs manifested by these individuals, the number, qualifications and competencies of additional professional staff members, and whether or not other duties are assigned to the Q*ID*P function.

Probes §483.430(a)

Are the Q*ID*P 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 Q*ID*P function?

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

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

Does the Q*ID*P make recommendations and requests on behalf of individuals? How does the facility respond?

W160

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

Who--

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

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

§483.430(b) Standard: Professional Program Services

W166

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

and with paraprofessional, nonprofessional and other professional program staff who work with clients.

Facility Practices §483.430(b)(1)

When required by individual need, program design, implementation, or monitoring, professional staff work directly with paraprofessional, nonprofessional and other

professional program staff to assure that these individuals have the skills necessary to carry out the needed interventions.

Guidelines §483.430(b)(1)

There are some individuals in ICFs/*IID* who can often have their needs effectively met without having direct contact with professional staff on a daily basis. The intent of the requirement is not to require that professionals work directly with individuals on a daily basis, but only as often as an individual's needs indicate that professional contact is necessary. The amount and degree of direct care that professionals must provide will depend on the needs of the individual and the ability of other staff to train and direct individuals on a day-to-day basis.

W171

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Guidelines §483.430(b)(5)(i)-(ix)

The introductory phrase "to be designated as…" means that a provider is allowed to represent him or herself as a professional provider in that discipline, only if the provider meets State licensing requirements, or if the particular discipline does not fall under State licensure requirements, the provider meets the qualifications specified in §§483.430(b)(5)(i)-(ix). A person who is not qualified, for example, as a social worker, may not be referred to as a social worker per se. Nevertheless, such a person may be able to provide social services in an ICF/*IID* if there is no conflict with State law, and as long as the individuals' needs are met.

W180

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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).

Guidelines §483.430(b)(5)(x)

The intent for including a "human services professional" category is to expand the number and types of persons who could qualify as Q*ID*Ps, while still maintaining acceptable professional standards.

"Human services field" includes all the professional disciplines stipulated in §§483.430(a)(3)(i)(ii) and §§483.430(b)(5)(i)-(ix), as well as any related academic disciplines associated with the study of: human behavior (e.g., psychology, sociology,

speech communication, gerontology etc.), human skill development (e.g., education, counseling, human development), humans and their cultural behavior (e.g., anthropology), or any other study of services related to basic human care needs (e.g., rehabilitation counseling), or the human condition (e.g., literature, the arts).

An individual with a "bachelors degree in a human services field" means an individual who has received: at least a bachelor's degree from a college or university (master and doctorate degrees are also acceptable) and has received academic credit for a major or minor coursework concentration in a human services field, as defined above. Although a variety of degrees may satisfy the requirements, majors such as geology and chemical engineering are not acceptable.

Taking into consideration a facility's needs, the types of training and coursework that a person has completed, and the intent of the regulation, the facility and you can exercise wide latitude of judgment to determine what constitutes an acceptable "human services" professional. Again, the key concern is the demonstrated competency to do the job.

W181

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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--

(b)(5)(xi)(A) Except for qualified *intellectual disabilities* professionals;

(b)(5)(xi)(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and
(b)(5)(xi)(C) Unless otherwise specified by State licensure and certification requirements.

§483.440(a) Standard: Active Treatment

W196

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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--

(a)(1)(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(a)(1)(ii) The prevention or deceleration of regression or loss of current optimal functional status

Facility Practices §483.440(a)(1)

When viewed as a whole, the active treatment program is pervasive, systematic and sufficient in scope to assure that individuals are appropriately served.

The major elements of the active treatment process are present and functioning in a consistent, cohesive manner including:

- Each individual's needs and strengths have been accurately assessed and relevant input has been obtained from team members;
- Each individual's IPP is based on assessed needs and strengths and addresses major life areas essential to increasing independence and ensuring rights;
- Identified priority needs are addressed formally and through activities which are relevant and responsive to individual need, interest and choice;
- Active treatment is consistently implemented in all relevant settings both formally and informally as the need arises or opportunities present themselves;
- Each individual receives aggressive and consistent training, treatment, and services by trained staff in accordance with their needs and the IPP;
- New skills and appropriate behaviors are encouraged and reinforced;
- Each individual has the adaptive equipment and assistive technology necessary for him/her to function with increased independence;
- Individual's routines and environments are organized to facilitate acquisition of skills, appropriate behavior, greater independence and choice;
- Each individual's performance is accurately measured and programs are modified based on data and major life changes; and
- Individuals with degenerative conditions receive training, treatment and services designed to maintain skills and functioning and to prevent further regression to the extent possible.

Guidelines §483.440(a)(1)

"Continuous" is defined to mean the competent interaction of staff with individuals served at all times, whenever the need arises or opportunities present, in both formal and informal settings.

Verify that active treatment is identifiable during formal and informal interactions between staff and individuals served. The performance of the individual should reflect the success, if any, of interventions being applied or the need to alter the intervention procedures.

The ICF/*IID* ensures that each individual receives active treatment daily regardless of whether or not an outside resource(s) is used for programming (e.g., public school, day habilitation center, senior day services program, sheltered workshop, supported employment).

Those "active" interventions necessary to prevent or decelerate regression are considered to be part of the overall active treatment program. For example, if the application of a specific stimulation technique to the area of the mouth of an individual with severe physical and medical disabilities, decelerates the individual's rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth, then this intervention is considered to be a component of active treatment for the individual.

Active treatment for elderly individuals may increasingly need to focus on interventions and activities which promote physical wellness and fitness, socialization and tasks that stress maintaining coordination skills and reducing the rate of loss of skills that accompanies the physical aspects of the aging process. Attending a senior center may be a justifiable part of an active treatment program for an elderly person.

Active treatment is the sum total of the major components of the active treatment process or loop which make up the requirements under this Condition of Participation (i.e., assessment, individual program planning, implementation, program documentation, program monitoring and change). It defines the primary nature of the services which must be provided by a facility (and received by its clients) in order to make it eligible under the law to be "certified" as an ICF/*IID*. Active treatment results in the positive outcomes identified by the Condition-level compliance principles. Surveyors must examine and evaluate all negative findings related to active treatment, and if determined to be significant, those findings should be cited at the salient tag numbers related to each of the components of the active treatment process. When review of those deficiencies leads to the conclusion that active treatment is not being received, then this standard and the explicit statutory requirement for active treatment at §1905(d)(2) of the Social Security Act are not met. A determination of noncompliance with this requirement, therefore, must also result in a determination of noncompliance at the Condition of Participation level for Active Treatment Services and at §440.150(c), tag number W100.

Although the active treatment process must be identifiable in documentation, it must be observable in daily practice. Determine how the ICF/*IID* accomplishes (or fails to accomplish) an environment of competence that enables active treatment to occur.

Survey Procedure §483.440(a)(1)

Record each observation done of individuals served by the facility. The optional Client Observation Worksheet (CMS-3070-I) is the mechanism by which answers to identified

data probes may be recorded. The worksheet is applicable to any observation, regardless of whether or not the individual is part of the representative random sample. See Section VII - Task 3 - Individual Observations, for instructions for completing observations.

Probes §483.440(a)(1)

How does the facility address the active treatment needs of individuals 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 individuals 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 individuals 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? Do staff demonstrate the skills necessary to train or reinforce training on the IPP objectives?
- Are individuals observed to engage in aggression, self-injurious behavior or self-stimulatory behavior (e.g., finger flicking)? If so, do staff intervene as per the IPP?

W197

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(a)(2)

As a practice, the facility does not serve individuals who, to a large extent, are able to care for their own basic needs, require minimal supervision and do not require the structure, support and resources of a comprehensive service program on an ongoing basis.

Guidelines §483.440(a)(2)

The regulations define the target population eligible for the ICF/*IID* benefit, by defining the services that are required for a facility to provide in order for it to qualify as an ICF/*IID* and receive Federal Financial Participation (FFP). At the front end, one of the "required services" is training in basic fundamental skills. The type of skills described in W242, by their very nature, target a population who have significant deficits in growth and development.

The presence of any group of individuals (court-ordered or not), could call into question the overall nature of the services provided by the ICF/*IID*. Individuals displaying some or all of the characteristics described in the Interpretive Guideline at §483.440(b)(1), do not "need active treatment services" or ICF/*IID* level of care, and are not appropriately placed. Agencies which provide residential services to *individuals* with *intellectual disabilities* do not qualify automatically for participation in Medicaid as ICFs/*IID*. Although the facility may be providing services to meet the needs of these types of individuals, the services provided by the facility do not meet the regulatory definition of "active treatment."

Furthermore, if the primary purpose of the facility is no longer to provide services to *individuals* with *intellectual disabilities* or related conditions who are in need of active treatment, then the facility does not meet the statutory requirement at §1905(d) of the Social Security Act and the regulatory definition of an ICF/*IID*, and therefore cannot be certified. A determination of noncompliance with this requirement, therefore, must result in a determination of noncompliance at the Condition of Participation level and at §440.150(c).

Conversely, if the overall facility meets the definition of an ICF/*IID*, the law does tolerate the presence of a few individuals for whom payment cannot be claimed. If an entity must serve both people who are generally independent and people who are in need of active treatment, then the entity may need to consider establishing a distinct part ICF/*IID* to serve those individuals who are in need of active treatment.

Negative findings about active treatment with regard to generally independent clients may be in conflict with level of care determinations made by State inspection of care (IOC) teams. Bring these negative active treatment findings to the attention of the IOC agency within the State for appropriate disposition of Medicaid ICF/*IID* certification. (See also W198, if the negative findings involve newly admitted individuals.)

There are some individuals who need the help of an ICF/*IID* to continue to function independently because they have learned to depend upon the programmatic structure it provides. The fact that they are not yet independent, even though they can be, makes it

appropriate for them to receive active treatment services directed at achieving needed and possible independence.

§483.440(b) Standard: Admissions, Transfers, and Discharge

W198

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.440(b)(1)

The facility has determined that each individual admitted into the ICF/*IID* benefit program since October 3, 1988, is in need of a program of active treatment.

Each individual needing active treatment receives it from the time of their admission to the facility.

Guidelines §483.440(b)(1)

Individuals with the following characteristics do not necessarily require a continuous active treatment program in order to function or to achieve optimal independence. Review closely to what extent the ICF/*IID* serves individuals, who in the aggregate:

- Are independent without aggressive and consistent training;
- Are usually able to apply skills learned in training situations to other settings and environments;
- Are generally able to take care of most of their personal care needs, make known to others their basic needs and wants, and understand simple commands;
- Are capable of working at a competitive wage level without support, and to some extent, are able to engage appropriately in social interactions;
- Are engaged in productive work within the facility which is done at an acceptable level of independence (i.e., not done as part of a training program to teach the individual new skills);
- Are able usually, to conduct themselves appropriately when allowed to have time away from the facility's premises; and
- Do not require the range of professional services or interventions in order to make progress.

Based on the order of a court, the ICF/*IID* may be required to admit individuals who do not need active treatment. Although CMS has no jurisdiction to prevent the courts from ordering the placements of such individuals into institutions certified as ICFs/*IID*, the individuals, by definition, would be ineligible to be classified by Medicaid for the ICF/*IID* benefit. To the extent that the placement of these court-ordered individuals does not interfere with the ability of the ICF/*IID* to provide active treatment for its individuals, the facility's overall certification is not affected.

W199

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(b)(2)

A preliminary evaluation to determine the need for active treatment is conducted, obtained or updated.
The information from the preliminary evaluation is used by the facility to make an admission decision.

Guidelines §483.440(b)(2)

No admission should be regarded as permanent. Readmission of an individual to the ICF/*IID* falls under the same requirements as initial admission.

In the absence of State regulations designating the person(s) authorized to approve admission (e.g., State or Regional Admissions Committees), the decision to admit an individual to the ICF/*IID* is based on the findings of an interdisciplinary team, including a *QIDP*.

Occasionally, emergency admissions of individuals may occur without benefit of a preliminary evaluation having been conducted prior to admission. For purposes of §483.440(b)(2) and consistent with §456.370(a), this requirement will be considered as "met" at such time that an evaluation is conducted which supports the need for an individual's placement in the ICF/*IID*. Refer to W210.

W201

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

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

Facility Practices §483.440(b)(4)(i)

Transfer or discharge occurs only when the facility cannot meet the individual's needs, the individual 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, either internal or external, would be more beneficial, or for any other "good cause," as defined below.

Guidelines §483.440(b)(4)(i)

"Transfer" means the temporary movement of an individual between facilities, the temporary movement from the ICF/*IID* to a psychiatric or medical hospital for medical reasons, the permanent movement of an individual between living units of the same facility, or the permanent movement of an entire facility (including individuals served, staff and records) to a new location. "Discharge" means the permanent movement of an individual to another facility or setting which operates independently from the ICF/*IID*. Moving an individual for "good cause" means for any reason that is in the best interest of the individual.

Probes §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 individual in the transfer/discharge decision-making process?

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

W209

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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.

Guidelines §483.440(c)(2)

Meetings should be scheduled and conducted to facilitate the participation of all members of the team, but especially the individual, unless he or she is clearly unable or unwilling, the individual's parents (except in the case of a competent adult who does not desire them to do so) or the individual's guardian or legal representative. The ICF/*IID* is expected to pursue aggressively the attendance of all relevant participants at the team meeting, (e.g., a conference call with a consultant during deliberations meets this requirement). Question routine "unscheduled" absences by individuals, guardians and particular

disciplines or consultants, and determine the impact on effectiveness and responsiveness of the IPP to meet the individual's needs.

Probes §483.440(c)(2)

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 individuals/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 individuals served do not attend IPP meetings, what reasons do staff give to explain their absence?

How does staff prepare individuals to participate in interdisciplinary team meetings?

Does the facility respect individual wishes for additional representatives on the interdisciplinary team, such as friends or advocates?

W228

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

and the planned sequence for dealing with those objectives.

Facility Practices §483.440(c)(4)

The objectives identified in W227 are arranged in a sequence identifying the logical order in which they will be addressed.

Objectives are organized in a sequence relevant to the individual's long term development.

Guidelines §483.440(c)(4)

To organize objectives into a planned sequence the ICF/*IID* must consider the outcomes it projects for the individual in the long term. For example, if the long term objective is for the individual to travel independently in the community, the planned sequence may involve training the individual to recognize traffic signs, cross a street safely, and to obtain help when needed if lost or an emergency arises. Interview staff to discover the

purpose to be achieved upon completion of the objective. For example, does staff know why an individual is taught to stack rings?

§483.440(c)(4) These objectives must--

W232

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.440(c)(4)(iv)

Objectives and criteria for success are based on the individual's current or baseline functional abilities.

Objectives are designed to allow the individual to experience success in achieving those objectives.

Objectives are individualized to take into consideration the individual's abilities and disabilities.

Objectives are organized to begin with the next logical step, given the individual's current functioning, and move toward more complex behavior.

Guidelines §483.440(c)(4)(iv)

To organize an objective in an appropriate progression, 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. Baseline data are one means of establishing an appropriate starting point for an objective. Objectives must be adapted based upon the person's functional abilities. For example, if the objective is to learn to put on shoes independently and the person does not have the manual dexterity to tie shoe laces, then the objective could include the use of slip-on shoes or shoes with velcro closures in order to facilitate the person learning this skill.

Probes §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?

W242

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(c)(6)(iii)

All individuals who lack the skills listed have training programs designed to meet their needs.

These programs are consistently implemented in both formal and informal settings. There is documentation of consistent, appropriate attempts to teach individuals these skills, or specific evidence as to a medical condition which would preclude acquisition, prior to determination of developmental incapability.

Appropriate materials, adaptations and modifications to equipment and the environment are available in order to promote and support individual training programs.

Guidelines §483.440(c)(6)(iii)

The receipt of training targeted toward amelioration of these most basic skill deficit areas is a critical component of the active treatment program needed by individuals who are eligible for the ICF/*IID* benefit, and therefore, is a required ICF/*IID* service. Some ADL skills overlap with each other (e.g., personal hygiene, oral hygiene, grooming and bathing). It is acceptable for the interdisciplinary team to set priorities within these overlapping skills. It must be clear, however, that the facility has organized its services to emphasize training in these areas. This will be seen not only in the IPP, but also in the competent interaction of staff with individuals, in both formal and informal settings. This basic skill training defines the nature of ICF/*IID* services. To the extent that individuals demonstrate that they increasingly do not need the types of services described in this requirement, and increasingly correspond to the characteristics of clients described at W197 such that the "overall" nature of the facility services would not be required to provide the type of emphasis described at W242, question the appropriateness of the individual's placement in an ICF/*IID* and/or the certification of the facility as an ICF/*IID* (see W197 and W198).

"Training" as used in this regulation means:

- Aggressive implementation of a systematic program of formal and informal techniques (competent interactions);
- Continuously targeted toward the individual achieving the measurable behavioral level of skill competency specified in IPP objectives;
- Conducted in all applicable settings; and
- Conducted by all personnel involved with the client.

"Developmental incapability" is a decision to be made by the interdisciplinary team based on its assessment of the individual's developmental strengths and needs. For example, there is ample evidence that even individuals with the most severe physical and mental disabilities can be toilet trained. Recognition is given to the fact that some individuals, however, have insufficient sensory and neuromuscular control ever to be totally independent in toileting skills. For most of this group, there are intermediate steps which can be achieved, including toilet scheduling, in which the individual is able to be trained to a schedule of elimination with needed assistance from staff. The intent of the toileting part of this regulation is met if there is evidence that the individual has been provided an aggressive, well organized, and well executed toilet training program in the past **and** that the team determines the individual's "developmental incapability."

Probes §483.440(c)(6)(iii)

Is evidence of "developmental incapability" based on individual 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 individuals to function more independently or does it merely train the individual to adapt to his/her particular facility (e.g., large institutional living)?
Do staff direct their activities toward the acquisition of individuals to learn increasingly complex skills or do staff accept that individuals will not or cannot grow and change?

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

W246

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(c)(6)(v)

Individuals with sensory or physical difficulties have the same opportunities to move around in their environments as individuals who do not have those difficulties.

Guidelines 483.440(c)(6)(v)

With the exception of those individuals who are acutely ill (such as those who are hospitalized or incapacitated by a short term illness), all individuals 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.

Question patterns of bed rest "orders" or "scheduled" bed rest as a routine part of an individual's program. A nap period of an hour, for example, is not "bed rest." However,

if the ICF/*IID*, as a general pattern of scheduling, expects an individual to be one - two hours in bed in the morning, one - two hours in bed in the afternoon, and an 8:00 p.m. bedtime in the evening, for example, then the practice becomes "bed rest," and the intent of the regulation will more than likely not be met. Question seriously large amounts of time during which a resident is confined to bed.

§483.440(c)(6)(v) Probes

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

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

Is equipment available to provide access to community activities?

Are mobility devices available and used as needed by individuals

W247

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.440(c)(6)(vi)

Individuals are provided opportunities for choice, encouraged and taught to make choices, and to exercise control over themselves and their environment.

Guidelines §483.440(c)(6)(vi)

Due to the basic underlying importance "choice" plays in the quality of one's life, the ICF/*IID* should maximize daily activities for its individuals in such a way that varying degrees of decision-making can be practiced as skills are acquired. Examples of some activities leading toward responsibility for one's own self-management include, but are not limited to, choosing housing or roommates, choosing clothing to purchase or wear, choosing what to eat, making and keeping appointments, and choosing from an array of appropriate activities. Interview staff to determine how attitudes and activities of the team and consultants facilitate or impede individual choice.

Choices can be made by all individuals. The type of choices the person makes may vary from very simple to more complex, depending upon individual abilities. Look at choices in the context of the individuals served by the facility.

§483.440(d) Standard: Program Implementation

W249

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(d)(1)

Each individual is receiving training and services consistent with the current IPP.

Staff use the adaptive equipment, assistive devices, environmental supports, materials, supplies, etc., specified in each individual's IPP to accomplish stated objectives.
A consistent approach is being implemented in all environments.

The pattern of interactions observed supports the active treatment program (e.g., informal opportunities to reinforce learning or appropriate skill development are taken, needs are addressed as they present themselves).

The active treatment program is not delayed or suspended while waiting for the written IPP document.

Activities support the accomplishment of the IPP objectives.

An individual's persistent refusal to participate in active treatment is being addressed by the IDT.

Guidelines §483.440(d)(1)

For an individual newly admitted to the ICF/*IID*, the time period between admission and the 30 day interdisciplinary team meeting should be primarily for purposes of assisting the individual to become adjusted and acclimated to his or her new living environment and completing the functional assessment. During this time period the facility should also be providing those services and activities determined during the pre-admission assessment as essential to the individual's daily functioning. In order to be able to produce the comprehensive assessment, the facility must evaluate the individual's status in as many naturally occurring, functional environments as possible.

It must be clear that the active treatment program received by the individual is internally consistent and not simply a series of disconnected formal intervention applications within certain scheduled intervals.

The criteria of what constitutes a "sufficient number and frequency of interventions" are based on the individual's assessment and the progress the individual makes toward achieving IPP objectives.

Whether "structure" must be imposed by staff or whether the individual can direct his or her own activities for a period of time (without direct staff observation) is based on the individual's ability to engage in constructive, age-appropriate, adaptive behavior (without engaging in maladaptive behavior to self or others). Be certain that an individual's time in the home or living unit is maximized toward the further development and refinement (including self-initiation) of appropriate skills, including, but not limited to, leisure and recreation.

For the active treatment process to be effective, the overall pattern of interaction between staff and individuals must be accountable to the comprehensive functional assessment and the IPP process. During the overall observation of individuals, you should be able to track that: the individual's comprehensive assessment identified the specific developmental need or strength justifying the activity, technique or interaction; in the case of a "need," the team projected a measurable objective or target to address it; and the technique, interaction, or activity which is observed, produced the desired target, produced a close approximation of the target, or was modified based on the individual's response.

Probes §483.440(d)(1)

Does the activity schedule and the content of the activities relate directly to the strengths, needs and objectives in the IPP for each individual 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 individuals observed performing scheduled active treatment activities?

Are 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 individual'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 individual 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?

W251

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Facility Practices §483.440(d)(3)

All staff working with the individual implement all aspects of the active treatment program unless such implementation is restricted to licensed personnel.

Each discipline works together to provide a uniform, consistent approach to implementation of the IPP across disciplines.

Guidelines §483.440(d)(3)

The facility is responsible for ensuring that during staff time spent with individuals, the staff member is able to provide needed interventions or reinforce acquired skills in accordance with the IPP. This is one of the ways the ICF/*IID* implements active treatment. "All" staff includes direct care staff.

The activities of the ICF/*IID* are coordinated with other habilitative and training activities in which the individual may participate outside of the ICF/IID, and vice versa.

Probes §483.440(d)(3)

Do staff assigned to work with the individual 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 individual integrates, as appropriate, other disciplines' objectives and techniques? (For example, does direct care staff implement manual communications systems? Does the O.T. implement behavior management programs, if needed by the individual, during O.T. training sessions?)

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

W254

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

that contribute to an overall understanding of the client's ongoing level and quality of functioning.

§483.440(f) Standard: Program Monitoring and Change

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

W258

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.440(f)(1)(i)-(iv)

The Q*ID*P ensures the program has been modified or changed in response to the individual's specific accomplishments, need for new programs, or difficulties in acquiring or maintaining skills.

Guidelines §483.440(f)(1)(i) - (iv)

The interval within which IPP reviews are conducted is determined by the facility. However, the facility's review system must be sufficiently responsive to ensure that the IPP is reviewed whenever the conditions specified in §§483.440(f)(1)(i-iv) occur. Information relevant to IPP changes should be recorded as changes occur.

Probes §483.440(f)(1)(i)--(iv)

Is the Q*ID*P actually monitoring individual programs, or does the Q*ID*P 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 Q*ID*P?

Does the Q*ID*P routinely visit program areas and discuss performance and problems of individuals?

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

Can the Q*ID*P describe the programs implemented with individuals for whom they are responsible or do they need to go to the record for this information?

§483.440(f)(2) At least annually,

Guidelines §483.440(f)(2)

For the "annual" review to meet the requirement, it must be completed by at least the 365th day after the last review. The ICF/*IID* may be required to conduct reviews at more frequent intervals by other, more stringent regulations (e.g., 90 day reviews required by §456.380(6)(c), State regulation, etc.). The facility's failure to comply with these other, more stringent regulations would NOT be cited under this requirement. Refer cases of suspected non-compliance to the authority having jurisdiction for the regulations in question.

W260

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

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

Facility Practices §483.440(f)(2)

The IPP reflects and responds to functional changes which have occurred since the last IPP.

Guidelines §483.440(f)(2)

Look for IPPs that are unchanged from one year to the next, for priority skills and behaviors that are deferred or ignored for one reason or the other, and for informal, vague, and programmatically worthless statements in the review (such as "John did better this year - he wasn't as upset most of the time like he used to be"). If the ICF/*IID* has not been providing the individual with a systematic, behaviorally-oriented active treatment program during the year, the review will be incapable of making systematic, behaviorally-oriented statements about progress and change. If you find problem behaviors which do not decrease significantly, relatively frequent usage of restraint or other intrusive restrictive procedures, a "plateauing" (e.g., reaches partial desired performance, but does not improve over time and staff does not reassess) of skills development, or any other signs of "sameness" year after year, questions should be raised about the extent to which the ICF/*IID* is providing active treatment, the adequacy of IPPs, staff training, etc., particularly, if many individuals' annual reviews reveal these characteristics.

Probes §483.440(f)(2)

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

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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

Facility Practices §483.440(f)(3)

The facility has a specially constituted committee.

The committee is used to accomplish the requirements of W262, W263 and W264.

The committee has the required membership and those members participate regularly in the functioning of the committee.

Guidelines §483.440(f)(3)

Depending on its size, complexity and available resources, the ICF/*IID* may establish one multi-purpose committee to serve it for all advisory functions, or it may establish separate single-purpose committees. The facility's human rights committee may be shared among other agencies or the ICF/*IID* may utilize a human rights committee established by another governing body, e.g., a county or a statewide group, as long as all pertinent regulatory requirements are met.

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 disciplines, such as nurse, physician or pharmacist be members 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 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 this role.

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 must review, approve and monitor the programs which involve risk to client rights and protections. Depending upon the size of the facility and the number of individuals who need intrusive or restrictive techniques as a part of active treatment programs, more than one specially constituted committee may be needed to effectively meet the intent of the regulation. The facility is responsible to organize itself in a manner which permits the timely review of proposed programs.

W263

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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

Facility Practices §483.440(f)(3)(ii)

Written consent is present prior to implementation of any restrictive program.

Consent is given by the legally appropriate party.

The consent is for the program which incorporates the use of a restrictive technique, rather than the restrictive technique alone.

The consent is informed, i.e., the person giving consent is aware of the risks, benefits, alternatives, right to refuse and consequences.

Guidelines §483.440(f)(3)(ii)

Informed consent consists of permission by the legally responsible party after having been informed of the specific issue, treatment or procedure; the individual's specific status with regard to the issue, treatment or procedure; the attendant risks and benefits; alternative forms of treatment; the right to refuse treatment and the consequences of that refusal. Informed consent implies that the person who is to give consent is competent to evaluate the decision requiring consent.

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

For individuals who are minors or who are clearly incompetent, but have no appointed legal guardian, informed consent for use of restrictive programs, practices or procedures must be obtained from the legal guardian, parent or someone or some agency designated by the State, in accordance with State law, to act as the representative of the individual's interests. Become familiar with the statutes of the State in which the ICF/*IID* is located to determine who or what mechanism is designated to give informed consent in such

circumstances. Verify whether or not consent was obtained in accordance with law. Additionally, under these circumstances, the facility is required to identify those individuals, and expected to advocate for them by demonstrating continuing efforts to obtain timely adjudication of the individual's legal status.

The committee must ensure that the informed and voluntary consent of the individual, 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 individual in research activities, or implementation of programs or practices that could abridge or involve risks to individual protections or rights.

Informed consent should be specific, separate ("blanket" consents are not allowed), and in writing. In case of unplanned events requiring immediate action, verbal consent may be obtained, however, it should be authenticated in writing as soon as reasonably possible.

§483.450(d) Standard: Physical Restraints

W296

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Facility Practices §483.450(d)(1)(ii)

Emergency physical restraint for an unanticipated type or severity of behavior is used only to prevent injury to the individual or others.

Guidelines §483.450(d)(1)(ii)

"Emergency measure" is defined as use of the least restrictive procedures and for the briefest time necessary to control severely aggressive or destructive behaviors that place the individual or others in imminent danger when those behaviors reasonably could not have been anticipated, and only as they are necessary within the context of positive behavioral programming. Examine closely how frequently "emergency measures" are employed. Repeated applications of such measures within short intervals of time, without subsequent incorporation into a written active treatment program, as required by §483.440(c), raises serious questions about the individual's receipt of active treatment and the individual's right to be free from unnecessary restraint.

Probes §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 Q*ID*P or designee with appropriate follow-up?

§483.460(a) Standard: Physician Services

W320

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§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.

Guidelines §483.460(a)(2)

The use of a medical care plan is intended only for those who are so ill or so at medical risk that 24-hour licensed nursing care is essential. A medical care plan need not be developed unless the individual requires licensed nursing care around the clock. Thus, individuals with chronic, but stable health problems such as controlled epilepsy, diabetes, etc. do not require a medical care plan.

It is not required that an individual have a health deficit and/or a medical care plan in order to receive ICF/*IID* services. The regulation is sufficiently flexible that the entire range of individuals, from those in good physical health to those who are very medically fragile, may be served.

A medical care plan may be temporary, in that it may be established to address acute health problems and then discontinued when those problems are resolved.

W363

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

Facility Practices §483.460(j)(2)

The pharmacist identifies apparent irregularities and determines their significance.
The pharmacist reports apparent irregularities which are significant to the physician and the IDT.

The physician and IDT are aware of all irregularities in the individual's drug regimen.

Guidelines §483.460(j)(2)

The physician and interdisciplinary team must consider the report of the pharmacist and determine whether to accept or reject the recommendations in the report. The pharmacist

is not required to repeatedly report the same minor irregularities which have already been considered by the physician and the interdisciplinary team, but were rejected based upon the individual's specific condition.

Survey Procedure §483.460(j)(2)

Review the drug regimen reviews of sampled individuals in order to determine if the pharmacist has appropriately reviewed the drug regimen on a quarterly basis. Refer to the "Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews" as stated in Part One of Appendix N (Pharmaceutical Service Requirements in Long Term Care Facilities). Appendix N lists many apparent drug irregularities that can occur. The following exceptions apply to the "List of Apparent Irregularities" in Section II.E.2 of Appendix N:

1. "Use of a listed antipsychotic drug unless one of the following specific conditions exists..." At the present time we have not developed a list of conditions which limit the use of antipsychotic drugs for individuals in ICFs/*IID*.

2. "Use of antipsychotic drugs in the absence of gradual dose withdrawal attempted every six months..." In ICFs/*IID*, the requirement is that gradual reduction be attempted at least annually unless clinically contraindicated. See W316 and W317.

3. "The use of a p.r.n. [as needed] antipsychotic drug more than five times..." Standing or as needed programs to control inappropriate behavior are not permitted under the ICF/*IID* regulations. A drug may be used in an emergency situation, but emergency drug usage cannot continue until that usage has been approved by the interdisciplinary team and included in the active treatment program. See W290, W311 and W312.

§483.460(k) Standard: Drug Administration

W369

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;

Guidelines §483.460(k)(2)

A medication "error" is a discrepancy between what the physician has ordered, and what you observe during the drug pass observation. The regulation does not allow for any medication errors.

"Self administered" means administration of medications by the individual, independent of a staff person obtaining, selecting, and preparing the medications for the individual. This includes all usage forms (oral, injections and suppositories).
The individual should be trained until he/she can perform this function without error.

Survey Procedure §483.460(k)(2)

Use the observation technique to determine medication errors. The observation technique involves observing the administration of drugs, recording what is observed, and reconciling the record of observation with the physician's orders to determine whether or not medication errors have occurred.

Do **not** rely on paper review to determine medication errors. Detection of blank spaces on the medication administration record does **not** constitute the detection of actual medication errors. Paper review only identifies possible errors.

Observation Technique

Follow these steps to detect medication errors:

1. Identify the drug product. Determine what drugs, in what strength and dosage forms, etc., are being administered. There are two principle ways of doing this. In most cases, they are used in combination.

    - Identify the product by its size, shape and color. Many products have a distinctive size, shape or color. However, this technique can be problematic because not all products are distinctive.

    - Identify the product by observing the label. When the punch card or unit dose system is used, you can usually observe the label and adequately identify the drug product. When the vial system is used, observing the label is sometimes difficult. Ask the person administering medications to identify the drug product.

2. Observe the administration of drugs. Record your observations in your notes. Follow the person administering medications and observe the individuals receiving drugs (e.g., actually swallowing oral dosage forms). Be as neutral and as unobtrusive as possible during this process.

Watch 16 drug doses being administered to the individuals residing in the facility, or observe a 100 percent sample of the residents in the facility whichever is smaller. For example, in a four bed facility with each individual taking two morning doses, you would watch a 100 percent sample of the individuals since only eight doses would have been administered. In an eight bed facility with each individual taking four morning doses you would observe a sample of 16 doses being administered.

In a large facility, a larger sample (40 to 50 doses) taken from different units in the facility should be observed to ensure that an adequate sample of the drug distribution system has been evaluated.

It is usually preferable to watch the morning pass because more doses per individual are administered at that time; however, you may observe the pass at any time. Observe more than one staff member administering drugs, if possible. You may observe the drugs being administered in the individual's living quarters or in the day program if the day program is operated by the ICF/*IID* on its grounds (i.e., the day program is not a separately certified entity).

If there are individuals at the facility who self-administer medications, attempt to observe the self-administration (see W373). Respect the individual's right to privacy by verbally asking the individual for permission to observe.

Note every detail about drug administration in your notes. For example, "eye drops administered to both eyes" or "nurse took pulse" or "all drugs crushed and administered in applesauce."

3. Record, in your notes, the most current physician's orders for those individuals who were observed receiving medications. The latest recapitulation of drug orders is sufficient for determining whether a valid order exists, provided that the physician has signed the "recap." The signed "recap" and subsequent orders constitute a legal authorization to administer the drug. You should now have a complete record of what you observed, and what should have occurred according to the physician orders.

4. Reconcile your record of observation with the physician's orders. Compare your record of observation to the most current signed orders for drugs.

    - For each drug on your list: Was it administered according to the physician's orders? For example, in the correct strength, by the correct route? Was there a valid order for the drug?

    - For drugs not on your list: Are there orders for drugs that should have been administered, but were not? Such circumstances represent omitted doses, which is one of the most frequent types of errors.

5. Determine the number of errors by adding the errors for each individual. Before concluding that an error has occurred, discuss the apparent error with the person who administered the drug. There may be a logical explanation, such as a more recent physician order which you have not seen.

6. Timing errors: If a drug is ordered before meals (AC) and administered after meals (PC) or vice versa, always count this as an error. If the drug is administered more than 60 minutes later or earlier than its scheduled

administration time, count this as an error ONLY IF THAT WRONG TIME ERROR CAN CAUSE THE INDIVIDUAL DISCOMFORT OR JEOPARDIZE THE RESIDENT'S HEALTH AND SAFETY. Counting a drug with a long half-life (beyond 24 hours) as a wrong time error when it is 15 minutes late is improper because there is no significant impact on the individual. To determine the scheduled administration time, examine the facility's policy relative to dosing schedules.

§483.470(b)Standard: Client Bedrooms

W416

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§483.470(b)(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--

(b)(3)(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

(b)(3)(ii) Documents the reason why housing in a room of only four or fewer persons would not be medically feasible.

Guidelines §483.470(b)(3)

The only acceptable reason for individuals to be housed in bedrooms serving more than four people is because the individual is in very fragile health and needs extensive life support services, such as posturing for clearing the airways, or monitoring for uncontrolled seizures. If more than four people are housed together in the same room, the number should remain small, and each individual placed in the grouping must have a high level of medical monitoring need.

Most extensive life support services, by their very nature are able to be provided by licensed personnel alone, or only under the direct visual supervision of licensed personnel. The presence of a medical care plan is not required because all such life threatening possibilities are difficult to predict. However, the greatest majority of individuals who might qualify for this variance will be on a medical care plan.

See §2140 for the documentation required for a medical variance.

Survey Procedure §483.470(b)(3)

The absence of a medical care plan for individuals for whom a variance is requested constitutes a "flag," and will necessitate an investigation into the individual circumstances to ensure that the facility has not routinely "certified" individuals as

requiring more supervision as a means of justifying the continued use of open wards or nominally partitioned wards.

If the medical risk of an individual is so potentially life threatening that the individual requires continuous unobstructed surveillance during sleeping hours to ensure the health and safety of the individual, then the individual's needs indicate that licensed personnel should be present and 24-hour on-duty staffing patterns will be validated by the surveyor. (See also W344, W333, and W183.)

§483.470(b)(4) The facility must provide each client with—

§483.470(g) Standard: Space and Equipment

The facility must--

W436

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

§483.470(g)(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.

Facility Practices §483.470(g)(2)

Individuals in need of adaptive/assistive/supportive/prosthetic equipment specified by the IDT are observed to have them and are taught to use and care for this equipment to the extent of their capabilities.

Individuals are observed using braces, mobility aids, positioning devices, and other adaptive equipment which meet their needs and increase functionality.

Equipment is observed to be in good repair.

Guidelines §483.470(g)(2)

The term "furnish" means that the facility is responsible for obtaining or purchasing these items and is responsible for making any necessary arrangements to enable the individual actually to receive them. However, if an item is available free of charge the facility would satisfy the requirement simply by making the necessary arrangements for the individual to receive them. Individuals' 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.

Probes §483.470(g)(2)

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 individuals who are resistive of their use?

W451

§483.470(i)(3) Facilities must meet the requirements of paragraph (i)(1) and (2) of this section for any live-in and relief staff they utilize.

Guidelines §483.470(i)(3)

Since live-in staff and their relief personnel are generally the same staff who work with the individuals on a round-the-clock basis, they must conduct a minimum of 4 drills a year, each of which must occur at different times within the day (24-hour period) (i.e., morning, afternoon, and night (sleep time)), and generally when individuals are at different locations within the house. If the facility has large numbers of relief personnel, more drills may be needed to meet the intent of this requirement.

§483.470 (j) Standard: Fire Protection

(Rev. 94, Issued: 12- 06- 13, Effective: 12- 06-13, Implementation: 12- 06-13)

(j)(1) General.

(j)(1)(i) Except as specified in paragraph (j)(2) of this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

(j)(1)(ii) 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.

(j)(1)(iii) A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds, must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

Guidelines §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, 1985 edition.

Survey Procedures §483.470(j)

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 individuals receive nursing services, or if the provider elects to use Health Care, the facility should be surveyed as a Health Care Facility under Chapter 12 or 13 of the LSC, as appropriate.
- If individuals receive personal care and protective oversight but not chronic 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 Chapter 21; or

        b. The FSES/BC, Appendix G.

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