

CHAPTER 64
INTERMEDIATE CARE FACILITIES FOR THE
INTELLECTUALLY DISABLED¹

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—64.1 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.2(135C) Waivers. Waivers from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for a waiver has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the waiver will apply only to an individual intermediate care facility for the intellectually disabled. Waivers will be reviewed at the discretion of the director of the department of inspections and appeals.

64.2(1) To request a waiver, the licensee must:

- a. Apply for a waiver in writing on a form provided by the department;
- b. Cite the rule or rules from which a waiver is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the waiver;
- e. Demonstrate that the requested waiver will not endanger the health, safety, or welfare of any resident.

64.2(2) Upon receipt of a request for a waiver, the director of the department of inspections and appeals will:

- a. Examine the rule from which a waiver is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested waiver on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

64.2(3) Based upon these studies, approval of the waiver will be either granted or denied within 120 days of receipt.

[ARC 0764C, IAB 5/29/13, effective 7/3/13; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—64.3(135C) Application for license.

64.3(1) Initial application. In order to obtain an initial intermediate care facility for the intellectually disabled license for an intermediate care facility for the intellectually disabled which is currently licensed, the applicant must:

- a. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- b. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- c. Submit a floor plan of each floor of the intermediate care facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;
- d. Submit a photograph of the front and side elevation of the intermediate care facility for the intellectually disabled;
- e. Submit the statutory fee for an intermediate care facility for the intellectually disabled license;
- f. Meet all of the rules, regulations and standards contained in 481—Chapter 64.
- g. Comply with federal, state, and local laws, codes, and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medications and controlled substances; building, construction, maintenance and equipment standards; sanitation; communicable and reportable diseases; and postmortem procedures;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

64.3(2) In order to obtain an initial intermediate care facility for the intellectually disabled license for a facility not currently licensed as an intermediate care facility for the intellectually disabled, the applicant must:

**a.* Meet all of the rules, regulations, and standards contained in 481—Chapters 61 and 64; exceptions noted in 481—subrule 61.1(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the intermediate care facility for the intellectually disabled, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the rooms will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the intermediate care facility for the intellectually disabled;

f. Submit the statutory fee for an intermediate care facility for the intellectually disabled;

g. Comply with federal, state, and local laws, codes, and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medications and controlled substances; building, construction, maintenance and equipment standards; sanitation; communicable and reportable diseases; and postmortem procedures;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

64.3(3) Renewal application. In order to obtain a renewal of the intermediate care facility for the intellectually disabled license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of intermediate care facility for the intellectually disabled license;

b. Submit the statutory license fee for an intermediate care facility for the intellectually disabled with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

64.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

* Nullified by 1989 Iowa Acts, SJR 10

481—64.4(135C) General requirements.

64.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

64.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

64.4(3) The posted license shall accurately reflect the current status of the intermediate care facility for the intellectually disabled. (III)

64.4(4) Licenses expire one year after the date of issuance or as indicated on the license.

64.4(5) Each citation or a copy of each citation issued by the department for a Class I or Class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

64.4(6) The facility shall have in effect a transfer agreement with one or more hospitals sufficiently close to the facility to make feasible the transfer between them of residents and their records. (III) Any facility which does not have such an agreement in effect but has attempted in good faith to enter into such an agreement with a hospital shall be considered to have such an agreement so long as it is in the public interest and essential to ensuring intermediate care facility for the intellectually disabled services for eligible persons in the community.

64.4(7) A resident's personal funds and property shall not be used without the written consent of the resident or the resident's guardian. (II)

64.4(8) A resident's personal funds and property shall be returned to the resident when the funds or property have been used without the written consent of the resident or the resident's guardian. The department may report findings that funds or property have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

64.4(9) A properly trained person shall be charged with the responsibility of administering non-parenteral medications.

a. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

b. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

c. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

d. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

481—64.5(135C) Notifications required by the department. The department shall be notified:

64.5(1) Within 48 hours, by letter, any reduction or loss of direct care professional or dietary staff lasting more than seven days which places the staffing ratio of the intermediate care facility for the intellectually disabled below that required by 42 CFR 483.430(d)(3). No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

64.5(2) Of any proposed change in the intermediate care facility for the intellectually disabled's functional operation or addition or deletion of required services; (III)

64.5(3) Thirty days before addition, alteration, or new construction is begun in the intermediate care facility for the intellectually disabled, or on the premises; (III)

64.5(4) Thirty days in advance of closure of the intermediate care facility for the intellectually disabled; (III)

64.5(5) Within two weeks of any change in administrator; (III)

64.5(6) When any change in the category of license is sought; (III)

64.5(7) Prior to the purchase, transfer, assignment, or lease of an intermediate care facility for the intellectually disabled, the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; and (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed. (III)

[ARC 0764C, IAB 5/29/13, effective 7/3/13; ARC 6972C, IAB 4/5/23, effective 5/10/23]

481—64.6(135C) Veteran eligibility.

64.6(1) Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

64.6(2) If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

64.6(3) The provisions of this rule shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care. (II, III)

481—64.7(135C) Licenses for distinct parts.

64.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

64.7(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. The distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—64.8 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.9 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.10 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.11 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.12 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.13 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.14 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.15 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.16 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.17(135C) Contracts. Each party shall receive a copy of the signed contract. (III) Each contract for residents shall:

64.17(1) State the rate or scale per day or per month for services included in the rate or scale and method of payment; (III)

64.17(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in this subrule; (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

64.17(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on a preadmission evaluation assessment which is determined in consultation with the administrator; (III)

64.17(4) Include the total fee per day to be charged to the resident; (III)

64.17(5) State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges, at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in charges, based on a change in the resident's condition. Notification must occur prior to the date such revised charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

64.17(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

64.17(7) State the terms of agreement concerning the holding and charging for a bed in the event of temporary absence of the resident; such terms shall include, at a minimum, the following provisions:

a. If a resident has a temporary absence from a facility for medical treatment, the facility shall ask the resident or responsible party if they wish the bed held open. This shall be documented in the resident's record including the response. Upon request of the resident/responsible party, the facility shall hold the bed open for at least ten days during the resident's absence and the facility shall receive payment for the absent period in accordance with provisions of the contract. (II)

b. If a resident has a temporary absence from a facility for therapeutic reasons as approved by a physician or qualified intellectual disabilities professional, the facility shall ask if the resident or responsible party wishes that the bed be held open. This request shall be documented in the resident's record, including the response. The bed shall be held open at least 30 days per year, and the facility shall receive payment for the absent periods in accordance with the provisions of the contract. The required holding during temporary absences for therapeutic reasons is limited to 30 days per year. (II)

c. For Title XIX residents, the department of health and human services shall continue funding for the temporary absence as provided under paragraphs "a" and "b" and in accordance with department of health and human services guidelines.

d. Private pay residents shall have a negotiated rate stated in the signed contract relating to these provisions. (II)

64.17(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

64.17(9) State the conditions of voluntary discharge or transfer; (III)

64.17(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

[ARC 0764C, IAB 5/29/13, effective 7/3/13; ARC 6972C, IAB 4/5/23, effective 5/10/23]

481—64.18(135C) Records.

64.18(1) *Resident record.* The licensee shall keep a permanent record about each resident, with all entries current, dated, and signed. (II) The record shall include:

a. Name and previous address of resident; (III)

- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation of resident; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of resident's next of kin or legal representative; (III)
- g. Name, address, and telephone number of the person to be notified in case of emergency; (III)
- h. Funeral director's telephone number and address; (III)
- i. Pharmacy's name, telephone number and address; (III)
- j. Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)
- k. Physician's orders for medication and treatments in writing, which shall be signed by the physician quarterly, and diet orders, which shall be renewed yearly; (III)
- l. A notation of the resident's yearly or other visits to physician or other professionals and all consultation reports and progress notes; (III)
- m. Documentation describing any change in the resident's condition; (II, III)
- n. A notation describing the resident's condition on admission, transfer, and discharge; (III)
- o. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- p. A copy of instructions given to the resident, the resident's legal representative, or receiving facility in the event of the resident's discharge or transfer; (III) and
- q. Disposition of personal property. (III)

64.18(2) Confidentiality of resident records. The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automated data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the release of the information, how the information is to be used, and the period of time for which the release is in effect. A third party not requesting the release shall witness the signing of the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This paragraph is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request. (II)

64.18(3) Incident records. Each facility shall maintain an incident record report and shall have available incident report forms. (II, III)

a. The report of every incident shall be in detail on a printed incident report form. (II, III)

b. The person in charge at the time of the incident shall oversee the preparation of the report and sign the report. (III)

c. The facility shall maintain a copy of the incident report as part of the facility's administrative records and shall make the record available for review. (III)

64.18(4) Retention of records. A resident's records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership of the facility. (III)

When the facility ceases to operate, the resident's records shall be released to the receiving facility. If no transfer occurs, the records shall be released to the resident's physician. (III)

481—64.19 to 64.32 Reserved.

481—64.33(135C) Allegations of dependent adult abuse.

64.33(1) *Allegations of dependent adult abuse.* Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)

64.33(2) *Separation of accused abuser and victim.* Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the department's abuse investigation is completed and an abuse determination is made. (I, II)

[ARC 1204C, IAB 12/11/13, effective 1/15/14]

481—64.34(135C) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0903C, IAB 8/7/13, effective 9/11/13; ARC 6972C, IAB 4/5/23, effective 5/10/23]

481—64.35(135C) Care review committee. Rescinded ARC 1205C, IAB 12/11/13, effective 1/15/14.

481—64.36(135C) Involuntary discharge or transfer.

64.36(1) *Involuntary discharge or transfer permitted.* A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

- a. Medical reasons;
- b. The resident's welfare or that of other residents;
- c. Nonpayment for the resident's stay, as described in the contract for the resident's stay;
- d. Due to action pursuant to Iowa Code chapter 229;
- e. By reason of negative action by the Iowa department of human services; or
- f. By reason of negative action by the quality improvement organization (QIO). (I, II, III)

64.36(2) *Medical reasons.* Medical reasons for transfer or discharge shall be based on the resident's needs and shall be determined and documented in the resident's record by the primary care provider. Transfer or discharge may be required in order to provide a different level of care to the resident. (II)

64.36(3) *Welfare of a resident.* Welfare of a resident or that of other residents refers to a resident's social, emotional, or physical well-being. A resident may be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Written documentation that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall include specific information to support this determination. (II)

64.36(4) *Involuntary discharge or transfer prohibited—payment source.* A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A or because the resident's source of payment is changing from private support to payment under Iowa Code chapter 249A. (I, II)

64.36(5) *Notice.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident and the responsible party. (II, III)

- a. The notice shall contain all of the following information:
 - (1) The stated reason for the proposed transfer or discharge. (II)
 - (2) The effective date of the proposed transfer or discharge. (II)
 - (3) A statement, in not less than 12-point type, that reads as follows: (II)

You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as

“department”) within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department’s receipt of your request and you will not be transferred before a final decision is rendered. Extension of the 14-day requirement may be permitted in emergency circumstances upon request to the department’s designee. If you lose the hearing, you will not be transferred before the expiration of either (1) 30 days following your receipt of the original notice of the discharge or transfer, or (2) no sooner than 5 days following final decision of such hearing, including the exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.

b. The notice shall be personally delivered to the resident, and a copy shall be placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, the resident’s primary care provider, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation “cc:” and listing the names of all parties to whom copies were sent.

c. The notice required by paragraph 64.36(5) “a” shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs:

(1) An emergency transfer or discharge is mandated by the resident’s health care needs and is in accordance with the written orders and medical justification of the primary care provider. Emergency transfers or discharges may also be mandated in order to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) The transfer or discharge is subsequently agreed to by the resident or the resident’s responsible party, and notification is given to the responsible party, the resident’s primary care provider, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility.

(3) The discharge or transfer is the result of a final, nonappealable decision by the department of human services or the QIO.

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 64.36(7).

64.36(6) *Emergency transfer or discharge.* In the case of an emergency transfer or discharge, the resident must be given a written notice prior to or within 48 hours following the transfer or discharge. (II, III)

a. A copy of this notice shall be placed in the resident’s file. The notice shall contain all of the following information:

(1) The stated reason for the transfer or discharge. (II)

(2) The effective date of the transfer or discharge. (II)

(3) A statement, in not less than 12-point type, that reads as follows: (II)

You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as “department”) within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department’s receipt of your request. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.

b. The notice shall be personally delivered to the resident, and a copy shall be placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 64.36(7).

64.36(7) Hearing.

a. Request for hearing.

(1) The resident must request a hearing within 7 days of receipt of written notice.

(2) The request must be made to the department, either in writing or verbally.

b. The hearing shall be held no later than 14 days after the department's receipt of the request unless either party requests an extension due to emergency circumstances.

c. Except in the case of an emergency discharge or transfer, a request for a hearing shall stay a transfer or discharge pending a final decision, including the exhaustion of all appeals. (II)

d. The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to Iowa Code chapter 17A and 481—Chapter 9. The hearing shall be public unless the resident or representative requests in writing that the hearing be closed. In a determination as to whether a transfer or discharge is authorized, the burden of proof by a preponderance of the evidence rests on the party requesting the transfer or discharge.

e. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the facility, the resident, and the responsible party not later than five full business days after the department's receipt of the request. The notice shall also inform the facility and the resident or the responsible party that they have a right to appear at the hearing in person or be represented by an attorney or other individual. The appeal shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present.

f. The administrative law judge's written decision shall be sent by certified mail to the facility, resident, and responsible party within 10 working days after the hearing has been concluded.

g. If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the QIO, an appeal shall be filed with those entities as appropriate. Continued payment shall be consistent with rules of those entities.

64.36(8) Nonpayment. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

64.36(9) Discussion of involuntary transfer or discharge. Within 48 hours after notice of involuntary transfer or discharge has been received by the resident, the facility shall discuss the involuntary transfer or discharge with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

a. The facility administrator or other appropriate facility representative serving as the administrator's designee shall provide an explanation and discussion of the reasons for the resident's involuntary transfer or discharge. (II)

b. The content of the explanation and discussion shall be summarized in writing, shall include the names of the individuals involved in the discussion, and shall be made part of the resident's record. (II)

c. The provisions of this subrule do not apply if the involuntary transfer or discharge has already occurred pursuant to subrule 64.36(6) and emergency notice is provided within 48 hours.

64.36(10) Transfer or discharge planning.

a. The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

b. To minimize the possible adverse effects of the involuntary transfer, the resident shall receive counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling shall be documented in the resident's record. (II)

c. The counseling requirement in paragraph 64.36(10) "b" does not apply if the discharge has already occurred pursuant to subrule 64.36(6) and emergency notice is provided within 48 hours.

d. Counseling, if required, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). (II)

e. The health care facility that receives a resident who has been involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

64.36(11) *Transfer upon revocation of license or voluntary closure.* Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of the voluntary closure of a facility, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

64.36(12) *Intrafacility transfer.*

a. Residents shall not be arbitrarily relocated from room to room within a licensed health care facility. (I, II) Involuntary relocation may occur only in the following situations, which shall be documented in the resident's record: (II)

- (1) A resident's incompatibility with or disturbance to other roommates.
- (2) For the welfare of the resident or other residents of the facility.
- (3) For medical, nursing or psychosocial reasons, as judged by the primary care provider, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.
- (4) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.
- (5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX (Medicaid) assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:

- (1) Change from private pay status to Title XIX, except as outlined in subparagraph 64.36(12) "a"(5). (II)
- (2) As punishment or behavior modification, except as specified in subparagraph 64.36(12) "a"(1). (II)
- (3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 64.36(12) "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required in order to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition that necessitates emergency relocation, and such notification shall be documented. (II)

e. A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility and not as an intrafacility transfer. (II, III)

[ARC 1205C, IAB 12/11/13, effective 1/15/14; ARC 1752C, IAB 12/10/14, effective 1/14/15; ARC 3523C, IAB 12/20/17, effective 1/24/18; ARC 6972C, IAB 4/5/23, effective 5/10/23]

481—64.37 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.38 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.39 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.40 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.41 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.42 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.43 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.44 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.45 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.46 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.47 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.48 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.49 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.50 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.51 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.52 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.53 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.54 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.55 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.56 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.57 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.58 Rescinded IAB 7/26/89, effective 7/7/89.

481—64.59(135C) County care facilities. Rescinded **ARC 0764C**, IAB 5/29/13, effective 7/3/13.

481—64.60(135C) Federal regulations adopted—conditions of participation. Regulations in 42 CFR Part 483, Subpart I, Sections 410 to 480, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

The classifications for violations are I, II, and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility.

NOTE: The federal interpretive guidelines are printed immediately following 481—Chapter 64.

This rule is intended to implement Iowa Code section 135C.2(3).

[**ARC 6972C**, IAB 4/5/23, effective 5/10/23]

481—64.61(135C) Federal regulations adopted—rights. Rescinded **ARC 6972C**, IAB 4/5/23, effective 5/10/23.

481—64.62(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

64.62(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

64.62(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

64.62(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules. (I, II, III)

481—64.63(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

64.63(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

64.63(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

64.63(3) The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

64.63(4) Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.702, 135C.2(3), 135C.14, and 235E.2.

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Interpretive Guidelines****§440.150 Intermediate Care Facility Services, Other Than in Institutions for Mental Diseases****W101**

W101 is reassigned to §483.410(e). Section 442.251, the standard which requires that facilities meet the requirement for a State license, is redesignated to §483.410(e) and W101 is reassigned as well to afford a sense of continuity.

W102

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

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

W103

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

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

Guidance §483.410(a)

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

W104

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

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

Guidance §483.410(a)(1)

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

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

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

W105

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

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

Guidance §483.410(a)(2)

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

W106

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

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

Guidance §483.410(a)(3)

This appointment must be in writing.

**Editor's Note: Verbatim from federal regulations. Neither the Department nor the Iowa Administrative Code editors have changed the content of the guidelines.

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

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

Guidance §483.410(b)

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

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

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

W107

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

§483.410(b) health,

Guidance §483.410(b)

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

W108

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

§483.410(b) safety, and

Guidance §483.410(b)

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

W109

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

§483.410(b) sanitation.

Guidance §483.410(b)

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

(c) Standard: Client Records

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

W110

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

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

W111

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

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

Guidance §483.410(c)(1)

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

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

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

W112

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

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

Guidance §483.410(c)(2)

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

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

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

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

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

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

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

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

W113

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

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

Guidance §483.410(c)(3)

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

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

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

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

W114

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

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

Guidance §483.410(c)(4)

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

Electronic signatures are acceptable in the electronic record system.

W115

§483.410(c)(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

W116

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

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

Guidance §483.410(c)(6)

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

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

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

W117

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

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

Guidance §483.410(d)(1)

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

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

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

W118

(d)(2)(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

W119

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

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

W120

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

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

Guidance §483.410(d)(3)

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

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

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

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

W121

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

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

Guidance §483.410(d)(4)

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

(e) Standard: Licensure

§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.

§483.410(e) Standard: Licensure

W101

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

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

Guidance §483.410(e)

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

W122

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

§483.420 Condition of participation: Client protections

(a) Standard: Protection of clients’ rights

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

Guidance §483.420(a)

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

W123

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

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

Guidance §483.420(a)(1)

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

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

- Signed evidence that the client, his or her family and/or his or her legal guardian have been informed of the client’s rights, and

- Evidence that the communication of these rights were provided at the client’s level of comprehension, and in the language understandable to the client.

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

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

W124**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(a)(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;****Guidance §483.420(a)(2)**

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

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

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

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

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

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

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

When a client is considered for participation in experimental research the client, his/her family and/or legal guardian must be fully informed of the nature of the experiment (e.g., what medications or physical interventions will be utilized, the length of the research, any possible side effects and how the information from the research will be utilized). Information regarding the possible consequences of participating or not participating must be provided to the client, family member or legal guardian. The written consent of the client, his/her family or legal guardian must be received prior to participation. For a client who is a minor or who has been adjudicated as incompetent, the written informed consent of the parents of the minor or the legal guardian is required. The signed, informed consent documentation must be in compliance with HHS Guidelines for Research Involving Human Subjects. The signed consent must also include a clear

discussion of what treatments will be included in the research, the time limits for the research and should clearly inform the client, family member or legal guardian that the client may end participation at any time without fear of recrimination. If the research protocol indicates that clients receive compensation, then clients are compensated per the protocol.

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

W125

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

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

Guidance §483.420(a)(3)

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

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

Clients are not restricted without due cause or due process.

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

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

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

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

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

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

W126

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

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

Guidance §483.420(a)(4)

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

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

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

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

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

W127

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

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

Guidance §483.420(a)(5)

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

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

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

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

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

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

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

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

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

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

W128

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

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

Guidance §483.420(a)(6)

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

For purposes of this Guideline drugs to manage behavior are “unnecessary” if there is evidence the drugs are being used:

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

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

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

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

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

Guidance §483.420(a)(7)

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

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

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

Motion sensors should not be considered cameras.

W130

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

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

Guidance §483.420(a)(7)

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

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

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

W131

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

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

Guidance §483.420(a)(8)

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

W132

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

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

Guidance §483.420(a)(8)

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

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

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

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

Prevailing wage refers to the wage paid to non-disabled workers in nearby industry or the surrounding community for essentially the same type, quality and quantity of work or work requiring comparable skills. A client who works in the facility must be paid at least the prevailing minimum wage, unless an appropriate certificate has been obtained by the facility in accordance with current regulations and guidelines issued under the Fair Labor Standards Act, as amended.

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

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

W133

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

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

Guidance §483.420(a)(9)

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

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

Space must be provided for clients to receive visitors in reasonable comfort and privacy.

W134

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

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

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

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

W135

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

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

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

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

W136

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

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

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

It is not acceptable for all client activities to be provided in the facility.

When a client is identified to be on restriction from community integration opportunities, interview clients, families, legal guardians and staff to determine if due process was afforded for this restriction and whether the restriction is included in the IPP.

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

There should be evidence that the facility assists and encourages all clients, regardless of functioning levels, to have input into the decisions on community integration activities.

It is not acceptable to require clients to attend unwanted activities due to staffing considerations.

W137

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

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

Guidance §483.420(a)(12)

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

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

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

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

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

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

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

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

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

Clients are provided the opportunity, encouraged, and trained to use age-appropriate materials. The term “age-appropriate” refers to anything that reinforces recognition of the client as a person of a certain chronological age. Clients who choose to keep items traditionally used by children such as dolls or model cars are not an automatic citation. There must be evidence the facility is encouraging the client to use these possessions in a socially appropriate, non-stigmatizing manner. The facility’s environment must be furnished with materials and activities that will enhance opportunities for growth.

W138

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

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

Guidance §483.420(a)(12)

Clothing such as pajamas, underwear, socks, hats, mittens/gloves, and coats should be the personal property of the client and not considered “stock” items. There should be no communal clothes. If clients are unable

to do their own personal laundry the facility must ensure that clothing is properly laundered and returned to the appropriate client.

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

W139

§483.420(a)(13) Permit a husband and wife who both reside in the facility to share a room.

§483.420(b) Standard: Client Finances

(b)(1) The facility must establish and maintain a system that

W140

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

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

Guidance §483.420(b)(1)(i)

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

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

W141

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

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

Guidance §483.420(b)(1)(ii)

If the facility elects to pool clients' funds in an interest-bearing account, including common trust accounts, it is expected to know the interest separately accrued by each client, as part of its required accounting of funds. Interest accumulated to a client's account belongs to the client, not the facility.

W142

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

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

Guidance §483.420(b)(2)

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

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

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

§483.420(c)

The Facility must –

W143

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

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

Guidance §483.420(c)(1)

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

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

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

W144

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

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

Guidance §483.420(c)(2)

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

W145

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

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

Guidance §483.420(c)(3)

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

W146

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

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

W147

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

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

Guidance §483.420(c)(5)

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

The facility should not sponsor or allow clients to take a particular type of trip that would jeopardize their safety or health without consultation with parents/legal guardians and/or the IDT.

W148

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

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

Guidance §483.420(c)(6)

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

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

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

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

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

(d) Standard: Staff treatment of clients.**W149**

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

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

Guidance §483.420(d)(1)

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

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

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

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

Refer to W127 for definitions of abuse.

W150

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

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

W151

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

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

W152

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

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

Guidance §483.420(d)(1)(iii)

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

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

Where the facility has terminated an employee based upon confirmation that abuse, neglect or mistreatment occurred during the employee's performance, and the termination decision was overturned by either arbitration finding or a court finding, the employee must be returned to a position which does not involve direct contact between that employee and clients of the facility.

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

W153

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

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

Guidance §483.420(d)(2)

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

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

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

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

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

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

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

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

W154

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

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

Guidance §483.420(d)(3)

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

A thorough investigation includes at a minimum:

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

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

W155

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

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

Guidance §483.420(d)(3)

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

W156

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

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

Guidance §483.420(d)(4)

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

W157

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

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

Guidance §483.420(d)(4)

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

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

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

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

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

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

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

W158

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

§483.430 Condition of participation: Facility staffing.

(a) Standard: Qualified intellectual disability professional

W159

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

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

Guidance §483.430(a)

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

- Orchestrate all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs;

- Effectively coordinate internal and external program services and supports to facilitate the acquisition of client skills and adaptive behaviors; and
- Promote competent interactions of residential staff with clients in program implementation and behavior management.

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

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

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

The number of QIDPs will vary depending on such factors as the number of clients the facility serves, the complexity of needs manifested by these clients, the number, qualifications and competencies of additional professional staff members, and whether or not other duties are assigned to the QIDP function.

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

W160

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

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

Guidance §483.430(a)(1)

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

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

W161

(a)(2)(i) A doctor of medicine osteopathy.

W162

(a)(2)(ii) A registered nurse.

W163

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

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

Guidance §483.430(a)(2)(iii)

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

(b) Standard: Professional program services

W164

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

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

Guidance §483.430 (b)(1)

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

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

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

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

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

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

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

W165

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

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

Examples of professional staff working directly with clients include: performing professional assessments of clients, provision of direct support and services and periodic monitoring by the professional of the client working on the program. The amount and degree of direct care that professionals must provide will depend on the needs of the client and the ability of other staff to effectively work with clients on a day-to-day basis. For those services that must be provided by a professional due to either law, licensure or registration, the client receives the services directly from the professional. Professionals may deliver services through the supervision and direction of subordinates where provided by law.

W166

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

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

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

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

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

W167

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

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

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

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

W168

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

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

When a professional does an assessment and determines there are client needs which become incorporated into the IPP, with a current prioritized objective, the professional should actively participate on the IDT.

This participation may be through written reports or verbally while attending the IPP meeting or participating via telephone or other electronic means, to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs, and to reach decisions as a team, rather than individually, on how best to address those needs.

W169

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

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

Guidance §483.430(b)(4)

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

Formal training: a specific training done at the time a program is implemented or updated by the professional, with all staff who works with the client.

Informal training: when the professional observes the staff not correctly implementing a program, the professional provides informal guidance on correct implementation.

Training on programs that apply to multiple clients: when a particular program applies to several clients in a facility, a professional may provide training to several staff on a particular topic that applies to multiple clients (such as safe transfer techniques).

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

W170

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

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

W171

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

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

Guidance §483.430(b)(5)(i)

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

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

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

W172

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

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

Guidance §483.430(b)(5)(ii)

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

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

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

W173

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

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

Guidance §483.430(b)(5)(iii)

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

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

W174

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

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

Guidance §483.430(b)(5)(iv)

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

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

W175

§483.430(b)(5)(v) To be designated as a psychologist, an individual must have at least a master’s degree in psychology from an accredited school.

§483.430(b)(5)(vi) To be designated as a social worker, an individual must--

W176

§483.430(b)(5)(vi)(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

§483.430(b)(5)(vi)(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

§483.430(b)(5)(vii) To be designated as a speech-language pathologist or audiologist, an individual must--

W177

§483.430(b)(5)(vii)(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or

§483.430(b)(5)(vii)(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

W178

§483.430(b)(5)(viii) To be designated as a professional recreation staff member an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

W179

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

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

Guidance §483.430(b)(5)(ix)

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

W180

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

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

Guidance §483.430(b)(5)(x)

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

W181

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

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

(A) Except for qualified intellectual disability professionals;

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

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

Guidance §483.430(b)(5)(xi)

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

(c) Standard: Facility staffing

W182

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

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

Guidance §483.430(c)(1)

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

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

W183

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

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

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

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

(iii) More than 16 clients; or

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

Guidance §483.430(c)(2)

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

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

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

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

W184

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

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

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

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

(iii) Sixteen or fewer clients.

Guidance §483.430(c)(3)

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

W185

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

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

Guidance §483.430(c)(4)

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

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

(d) Standard: Direct care residential living unit staff

W186

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

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

Guidance §483.430(d)(1)

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

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

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

Guidance §483.430(d)(2)

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

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

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

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

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

W187

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

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

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

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

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

Guidance §483.430(d)(3)

*The minimum ratios in this standard indicate the **minimum** number of direct-care staff that must be present and on duty, 24 hours a day, 365 days a year, for each discrete living unit. For example, to calculate the minimum number of living unit staff that must be present and on duty in a discrete living unit serving 16 individuals with multiple disabilities: divide the number of individuals “16,” by the number corresponding to the regulation “3.2,” the result equals “5.” Therefore, the facility must determine how many staff it must hire to ensure that at least 5 staff will be able to be present and on duty during the 24 hour period in which those individuals are present.*

Using the living unit described above, “calculated over all shifts in a 24-hour period” means that there are present and on duty every day of the year: one direct care staff for each eight individuals on the first shift (1:8), one direct care staff for each eight individuals on the second shift (1:8), and one direct care staff for each 16 individuals on the third shift (1:16). Therefore, there are five (5) direct care staff present and on duty for each twenty-four hour day, for 16 individuals. The same calculations are made for the other ratios, whichever applies. Determine if absences of staff for breaks and meals results in a pattern of prolonged periods in which present and on-duty staff do not meet the ratios.

W188

§483.420(d)(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.

§483.430(e) Standard: Staff Training Program**W189**

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

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

Guidance §483.430(e)(1)

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

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

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

W190

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

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

W191

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

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

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

W192

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

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

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

W193

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

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

Guidance §483.430(e)(3)

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

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

W194

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

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

Guidance §483.430(e)(4)

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

W195

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

§483.440 Condition of participation: Active treatment services

(a) Standard: Active treatment

W196

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

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

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

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

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

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

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

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

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

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

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

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

i. Clients with degenerative conditions receive training, treatment and services designed to retain skills and functioning and to prevent further regression to the extent possible.

ii. Clients may need adjustments to their active treatment programs as functional or endurance limitations are identified associated with the aging process. In such cases, there may be more of an emphasis on the retention of skills already attained and reducing the rate of loss of skills, than on the acquisition of new skills.

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

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

W197

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

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

Guidance §483.440(a)(2)

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

Active treatment moves clients to a more independent setting.

- When a client is in the facility simply for protective oversight and is not in need of training for developmental deficits, this does not constitute active treatment (e.g. a court placement to protect the community or the client from the client's behavior).

- Programs that are simply being provided to maintain a client's independence would not be considered active treatment since the client is not actively being trained to live in a more independent setting. If a client already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support and resources that services that only an ICF/IID can provide, they can be considered generally independent.

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

(b) Standard: Admissions, transfers, and discharge**W198**

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

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

Guidance §483.440(b)(1)

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

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

W199

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

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

Guidance §483.440(b)(2)

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

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

W200

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

§483.440(b)(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

Guidance §483.440(b)(3)

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

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

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

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

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

W201

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

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

Guidance §483.440(b)(4)(i)

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

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

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

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

W202

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

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

Guidance §483.440(b)(4)(ii)

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

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

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

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

**§483.440(b)(5) At the time of the discharge, the facility must-
W203**

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

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

Guidance §483.440(b)(5)(i)

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

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

W204

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

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

Guidance §483.440(b)(5)(i)

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

W205

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

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

Guidance §483.440(b)(5)(ii)

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

The facility utilizes the information from the discharge summary to prepare the discharge plan of care. The post-discharge plan of care identifies the essential supports and services necessary for the client to successfully adjust to the new living environment and describe necessary coordination of services. It should

incorporate the client's preferences. It should identify specific client needs after discharge such as personal care, physical therapy, client/caregiver education needs, and the ability of the client or caregiver to meet those needs after discharge.

(c) Standard: Individual program plan

W206

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

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

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

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

Guidance §483.440(c)(1)

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

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

W207

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

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

Guidance §483.440(c)(2)

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

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

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

W208

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

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

Guidance §483.440(c)(2)

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

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

W209

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

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

Guidance §483.440(c)(2)

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

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

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

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

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

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

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

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

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

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

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

W210

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

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

Guidance §483.440(c)(3)

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

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

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

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

W211

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

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

Guidance §483.440(c)(3)

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

W212

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

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

Guidance §483.440(c)(3)(i)

The CFA includes:

- all diagnoses and developmental deficits for the client;
- the supporting information for each; and
- each evaluation should include conclusions and recommendations which go into the development of

an active treatment program for the client.

W213

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

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

Guidance §483.440(c)(3)(ii)

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

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

W214

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

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

Guidance §483.440(c)(3)(iii)

The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require

adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture.

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

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

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

W215

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

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

Guidance §483.440(c)(3)(iv)

Identification of needed services is based on the CFA.

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

§483.440(c)(3)(v) Include

Guidance §483.440(c)(3)(v)

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

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

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

W216

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

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

Guidance §483.440(c)(3)(v)

Physical development and health: This portion of the CFA includes the client's developmental history, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history); a review and summary of all laboratory reports since the last comprehensive evaluation, a summary of all required medical interventions since the last CFA; skills of the client normally associated with the monitoring and supervision of one's own health status, and administration and/or scheduling of one's own medical treatments. Reports of all specialist consultations should be included in the assessment as indicated by physical examination results.

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

W217

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

§483.440(c)(3)(v) nutritional status,

Guidance §483.440(c)(3)(v)

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

W218

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

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

Guidance §483.440(c)(3)(v)

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

W219

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

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

Guidance §483.440(c)(3)(v)

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

W220

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

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

Guidance §483.440(c)(3)(v)

Speech and language (communication) development: One of the most contributable causes of behaviors, frustration by the clients, etc. is lack of effective communication. It is imperative that the CFA identifies

how the client communicates, what barriers are present, what services are available and what programs and services will be provided to assist the client to go out into and participate fully in the world. Observed client communication skills match the evaluation results and that training programs are in place to address needs.

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

W221

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

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

Guidance §483.440(c)(3)(v)

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

W222

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

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

Guidance §483.440(c)(3)(v)

Cognitive development: Cognitive development refers to the development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the client has and those best used by the trainers. It is critical that the CFA address the individual learning style of the client in order to best direct the way the trainers will teach formal and informal programs.

W223

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

§483.440(c)(3)(v) social development,

Guidance §483.440(c)(3)(v)

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

W224

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

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

Guidance §483.440(c)(3)(v)

Adaptive behaviors or independent living skills: Adaptive behavior refers to the effectiveness or degree with which clients meet the standards of personal independence and social responsibility and community orientation and integration expected of their age and cultural group. Adaptive behaviors are those behaviors that are developed to cope with deficits in order to be able to perform every day skills as independently as possible. Independent living skills include, but are not limited to, such things as food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. Assessment may be

performed by anyone trained to do so. Standardized tests are not required. Standardized adaptive behavior scales which identify all or predominantly all “developmental needs” are not sufficient to meet this requirement, but can serve as a basis for screening.

W225

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

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

Guidance §483.440(c)(3)(v)

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

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

Assessments should be individualized and based on:

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

W226

§483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan

W227

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

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

Guidance §483.440(c)(4)

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

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

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

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

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

W228

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

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

Guidance §483.440(c)(4)

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

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

These objectives must –

W229

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

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

Guidance §483.440(c)(4)(i)

Each objective clearly states one expected learning result.

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

W230

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

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

Guidance §483.440(c)(4)(ii)

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

Completion dates are assigned to each objective on which the client is currently working. Completion dates are individualized (e.g. not all the same for all clients and all objectives).

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

W231

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

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

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

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

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

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

W232

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

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

Guidance §483.440(c)(4)(iv)

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

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

W233

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

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

Guidance §483.440(c)(4)(v)

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

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

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

Guidance §483.440(c)(5)

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

W234

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

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

Guidance §483.440(c)(5)(i)

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

W235

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

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

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

W236

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

§483.440(c)(5)(iii) The person responsible for the program;**Guidance §483.440(c)(4)(v)**

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

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

W237

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

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

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

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

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

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

W238

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

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

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

W239

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

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

Guidance §483.440(c)(5)(vi)

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

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

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

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

W240

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

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

Guidance §483.440(c)(6)(i)

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

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

W241

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

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

Guidance §483.440(c)(6)(ii)

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

W242

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

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

Guidance §483.440(c)(6)(iii)

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

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

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

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

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

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

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

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

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

Guidance §483.440(c)(6)(iv)

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

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

W243

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

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

W244

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

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

W245

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

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

W246

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

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

Guidance §483.440(c)(6)(v)

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

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

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

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

W247

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

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

Guidance §483.440(c)(6)(vi)

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

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

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

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

Clients are provided opportunities for choice and self-management and the facility does not limit choices by making decisions for the people being served without their input. Clients are provided the opportunity to

demonstrate skills to the degree they are capable and only assisted by staff as indicated in their IPP. A lack of facility staffing or staff convenience must not result in a limitation of choices of self-management for the clients.

W248

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

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

Guidance §483.440(c)(7)

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

(d) Standard: Program implementation**W249**

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

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

Guidance §483.440(d)(1)

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

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

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

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

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

- During observations confirm that the client activities relate directly to the strengths, needs and objectives in the IPP for each client and are not “busy work,” generalized or non-developmental time fillers. For example, screwing nuts on bolts and then unscrewing them repeatedly with no goal or transferable skills is “busy work.” Screwing nuts on bolts that will be part of a product is functional reinforcement of skill acquisition.

- Clients use adaptive equipment, assistive devices, environmental supports, materials, supplies, etc., as specified in each client's IPP to assist the client to accomplish stated objectives.

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

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

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

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

W250

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

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

Guidance §483.440(d)(2)

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

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

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

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

W251

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

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

Guidance §483.440(d)(3)

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

(e) Standard: Program documentation

W252

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

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

Guidance §483.440(e)(1)

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

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

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

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

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

W253

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

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

Guidance §483.440(e)(2)

Significant events are those events which would cause a reasonable person to be affected and which impact a normal routine. Such events include changes in the client's functional status, emotional health, physical health, accomplishments, activities or needs which impact the CFA and IPP, as well as instances of abuse, neglect or mistreatment.

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

W254

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

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

(f) Standard: Program monitoring and change

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

Guidance §483.440(f)(1)

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

W255

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

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

Guidance §483.440(f)(1)(i)

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

W256

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

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

W257

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

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

Guidance §483.440(f)(1)(iii)

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

W258

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

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

§483.440(f)(2) At least annually,

Guidance §483.440(f)(2)

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

W259

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

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

Guidance §483.440(f)(2)

The CFA is reviewed at least annually.

The review of the CFA occurs sooner than annually if:

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

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

W260

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

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

Guidance §483.440(f)(2)

The IPP reflects the functional changes for the client which occurred since the last IPP. It is unlikely that an active treatment program will have no changes from year to year without documentation to support not changing the plan. Question an IPP that is a duplication of the prior year's plan without explanation.

W261

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

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

Guidance §483.440(f)(3)

The facility must have a specially constituted committee whose primary function is to proactively protect client rights by monitoring facility practices and programs. The purpose of the committee is to assure that each client's rights are protected utilizing a group of both internal staff and *external participants who have no vested interest in the facility as well as clients as appropriate*. There should be evidence that the committee members have been trained annually on the rights of the clients, what constitutes a restriction of a right and the difference between punishment and training.

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

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

The intent of including "persons with no ownership or controlling interest" on the committee is to assure that, in addition to having no financial interest in the facility, at least one member of each constituted committee is an impartial outsider in that he/she would not have an "interest" represented by any other of

the required members or the facility itself. Staff and consultants employed by the facility or at another facility under the same governing body, cannot fulfill the role of person with no ownership or controlling interest.

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

W262

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

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

Guidance §483.440(f)(3)(i)

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

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

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

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

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

W263

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

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

Guidance §483.440(f)(3)(ii)

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

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

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

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

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

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

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

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

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

W264

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

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

Guidance §483.440(f)(3)(iii)

The committee has been made aware of and reviewed:

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

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

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

- 1) Research proposals involving clients;
- 2) Abuse, neglect and mistreatment of clients;
- 3) Allegations dealing with theft of a client's personal property or funds;

- 4) Damage to a client's goods or denial of other client rights;
- 5) Client grievances;
- 6) Visitation procedures;
- 7) Guardianship/advocacy issues;
- 8) Rights training programs;
- 9) Confidentiality issues;
- 10) Advance directives/DNR orders;
- 11) Practices which restrict clients (e.g., locked doors, fenced in yards); and
- 12) Video monitoring.

W265

§483.440(f)(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

W266

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

§483.450 Condition of participation: Client behavior and facility practices

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

W267

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

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

Guidance §483.450(a)(1)

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

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

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

W268

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

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

Guidance §483.450(a)(1)(i)

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

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

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

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

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

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

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

- 7) Staff encourage clients to take risks while providing reasonable safeguards to prevent injury.
- 8) Encourage clients to make choices during their daily activities.

W269

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

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

Guidance §483.450(a)(1)(ii)

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

Written policies describe how self-determination, as defined by free choice of one's own acts and decisions without external coercion or direction, to the extent possible and self-management, as defined by control of one's own routine and daily responsibilities, to the extent possible, are incorporated into the development of program plans and daily routines.

W270

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

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

Guidance §483.450(a)(1)(iii)

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

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

W271

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

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

Guidance §483.450(a)(1)(iv)

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

W272

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

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

Guidance §483.450(a)(2)

"To the extent possible" does not mean that the clients are excluded due to the clients' schedule or intellectual or developmental level. Facilities should be able to provide documentation that substantiates that clients were offered the opportunity and participated in the development of the policies. This could be accomplished through client committees or in house meetings. There should be documentation of these discussions between the client representatives and the facility.

W273

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

§483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

Guidance §483.450(a)(3)

Staff will promptly intervene when any clients tries to independently impose discipline upon another client. For example, a client who is serving dessert to the group withholds dessert from another client based upon their own evaluation of that client's behavior.

(b) Standard: Management of inappropriate client behavior

W274

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

§483.450(b)(1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior

Guidance §483.450(b)(1)

At a minimum, the facility must have written policies and procedures regarding the management of maladaptive behaviors addressing the following:

483.450(b)(1) (W 275 – W284).

- the use of a functional behavior assessment in the development of behavior management programs;
- a hierarchy of least to most intrusive measures; and
- incorporation of behavior management programs into the IPP.

§483.450(b)(1) These policies and procedures must be

W275

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

§483.450(b)(1) consistent with the provisions of paragraph (a) of this section.

§483.450(b)(1) These procedures must

W276

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

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

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

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and****Guidance §483.450(b)(1)(iii)**

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:**W279****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.450(b)(1)(iv)(A) The use of time-out rooms;****Guidance §483.450(b)(1)(iv)(A)**

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.450(b)(1)(iv)(B) The use of physical restraints;****Guidance §483.450(b)(1)(iv)(B)**

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;****Guidance §483.450(b)(1)(iv)(C)**

Applicable policies may include a discussion of:

- When a drug can be used to manage inappropriate behavior;
- Consistency with diagnosis;
- Alternatives tried before a drug is used;
- Precautions that must be followed prior to and during the use (lab values, monitoring of side effects);
- Implementation of a plan to address the behaviors for which the drug was prescribed; and

Plan to reduce the medication as appropriate.

Drugs to manage inappropriate behavior are defined as any medication prescribed and administered for purposes of modifying the maladaptive behavior of a client.

W282

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

§483.450(b)(1)(iv)(D) The application of painful or noxious stimuli;

Guidance §483.450(b)(1)(iv)(D)

“Application of painful or noxious stimuli” is defined as any procedure by which staff apply, contingent upon the exhibition of maladaptive behavior, startling, unpleasant, or painful stimuli, or stimuli that have a potentially noxious effect.

While the regulation permits the use of painful or noxious stimuli these techniques are the last resort and can only be utilized for behaviors that are causing significant harm and have not responded to competently administered interventions of less intrusive nature.

Facility policies must state that:

- The use of noxious stimuli is only permitted when the client exhibits behaviors so severe that they present a potential risk for significant or even life-threatening circumstances;
- the IDT and facility must weigh the potential risk of the behavior against the risk involved in the use of the painful or noxious techniques to manage behavior;
- that safeguards and strict oversight must be in place for consideration to use techniques that may be painful or even unpleasant;
- techniques that may be painful or noxious must be time limited;
- the proposed use of these techniques requires scrutiny of clinical effectiveness and specially constituted committee review; and
- on-going monitoring and safeguards must be in place during implementation of the technique.

W283

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

§483.450(b)(1)(iv)(E) The staff members who may authorize the use of specified interventions;

Guidance §483.450(b)(1)(iv)(E)

W284

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

§483.450(b)(1)(iv)(F) A mechanism for monitoring and controlling the use of interventions.

Guidance §483.450(b)(1)(iv)(F)

Facility policies must address what supervisory oversight is provided during the application of the intervention in order to ensure that procedures were followed correctly. Procedures should also address what retrospective analysis is done on each intervention to ensure that procedures are being consistently followed.

W285

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

§483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

§483.450(b)(3) Techniques to manage inappropriate client behavior must never be used

W286

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

§483.450(b)(3) for disciplinary purposes,

Guidance §483.450(b)(3)

No intervention, whether as a part of a formal program or in emergency situations (see W289) may be used as punishment, retaliation or retribution. A staff member cannot employ a behavior management technique simply because a client refuses to follow a staff request.

The implementation of all interventions, except in emergency situations, must be administered consistent with the IPP and the specific behaviors identified in the IPP requiring the intervention. Instances where an intervention is done as a punishment because the client did not comply with staff instructions and not associated with the IPP include:

- Personal property confiscated for behavior at staff discretion;
- Rights restricted without approved plans; and
- Punitive house rules, such as prohibiting reentry into the kitchen for snacks if a meal is not eaten completely.

W287

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

§483.450(b)(3) for the convenience of staff**Guidance §483.450(b)(3)**

Inadequate numbers of staff, inefficient deployment of staff, and insufficient training of staff can lead to restrictive practices used for staff convenience.

Examples of techniques used to manage client behavior for staff convenience including, but are not limited to:

- Clients allowed to discipline other clients;
- Clients restricted to one area of the home; and
- Unauthorized use of restraints (e.g., lap trays, bean bags, gait belt, and merry walkers for the purpose of restricting movement)

W288

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

§483.450(b)(3) or as a substitute for an active treatment program.**Guidance §483.450(b)(3)**

Substitutions for active treatment programming occur when the staff utilizes interventions and restrictive techniques on their own, either because there is not a formal behavioral program to address the client's behaviors or because the staff do not follow the plan as written.

W289

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

§483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.

Guidance §483.450(b)(4)

The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment.

However, there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, the least restrictive intervention must be employed and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the clients program.

W290

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

§483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted.**Guidance §483.450(b)(5)**

The staff of the facility may not maintain or use, outside of the IPPs, any list of “as needed” interventions that can be used with any client at any time. With the exception of isolated and rare emergency situations, all restrictive behavior interventions must be incorporated into the formal IPP and individualized for the client.

(c) Standard: Time-out rooms**W291**

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

§483.450(c)(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)

(ii) The client is under the direct constant visual supervision of designated staff.

(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Guidance §483.450(c)(1)

Seclusion, defined as the placement of a client alone in a locked room, is never allowed.

Time out procedures allows a client to be alone in a room, but do not allow that room to be locked. During a time out procedure, egress can only be prevented by a person standing in the door way, or holding the door closed, but as soon as the staff move from the door way or let go of the door the client can come out.

Use of the timeout room or procedure must be part of an approved behavioral plan and may involve the separation of a client from a group or a particular situation, in a non- locked setting for the purpose of calming or removing the client from the reinforcing stimuli that are sustaining an identified maladaptive behavior.

Designated time out rooms must be set up so that the staff has continuous, direct observation of the client at all times. Because of the danger that staff can get distracted by other events or duties, this cannot be accomplished by a camera in lieu of the staff having direct visual of the client.

Key locks, latch locks, and doors that open inward without an inside doorknob are not permitted by the regulations for use in time out rooms as they do not require constant physical pressure from a staff member to keep the door shut. In each instance where a time out room is used, the client’s IPP must include:

- The functional behavioral assessment which resulted in a recommendation for the use of time out procedures; and

- Instructions on how often data is to be collected during the time out period and the criteria for release from time out.

The use of a time out room must be approved by the Specially constituted committee as part of an approved program.

W292

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

§483.450(c)(2) Placement of a client in a time-out room must not exceed one hour.

W293

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

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

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

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

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

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

- 1) The specific type of client behavior to be managed by this plan;
- 2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
- 3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
- 4) The type of physical restraint;
- 5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
- 6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

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

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

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

- 1) the client has not exhibited before;
- 2) were not identified in the functional analysis of behavior; or
- 3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

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

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

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

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

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

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

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

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

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

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

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

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

“As quickly as possible” means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

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

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

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

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer’s directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

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

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint).

See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the restraint is still properly applied and the client appears comfortable.

W307

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

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

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

§483.450(d)(7) must not be more than three feet in height and

W309

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

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

§483.450(e) Standard: Drug Usage

W310

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

§483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

Guidance §483.450(e)(1)

Clients are alert and available for participation in daily living activities.

Some medications administered for medical reasons or to manage behavior may cause drowsiness as a side effect or due to an accumulation of the drug in the client's system. For clients who are observed to be sleeping in chairs during their work day, their programs or recreational times, there should be evidence that the facility staff notified the medical staff and an assessment was performed of the client including their medication regimen. Medical staff should make adjustments to address the issue if indicated.

§483.450(e)(2) Drugs used for control of inappropriate behavior must

W311

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

§483.450(e)(2) be approved by the interdisciplinary team and**Guidance §483.450(e)(2)**

The physician and other team members discuss the risks and benefits of the medication to address the target behavior/symptoms, and approve the use of the drug as being consistent with the active treatment program. Decisions about the necessity of the use of drugs to manage inappropriate behavior should be made by the IDT. It is the responsibility of the IDT members to provide the physician with sufficient information regarding the need for a client to receive a drug for inappropriate behavior. The physician will make the ultimate decision to order the use of the drug. The IDT should document any disagreement with the physician's order.

In those instances where a client returns from a physician's visit with an order for an unsolicited drug to manage client's inappropriate behaviors, there must be evidence (e.g. IDT meeting notes or clients record) that the team concurred with the necessity for the order without trying less restrictive measures first and discussed any concerns with the physician.

W312

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

§483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

Guidance §483.450(e)(2)

All medications to manage behavior must be integrated into the IPP and the IPP must specify how the specific target behavior for which the medication is prescribed will be reduced or eliminated. This includes medications which are typically used for medical conditions that may be used to manage behavior (e.g. 1. propranolol (Inderal), an antihypertensive used for self-injurious behavior, and 2. carbamazepine (Tegretol), an anticonvulsant, used for aggression).

Drugs for behavior management must not be ordered on a PRN basis for a client. The facility staff must contact the physician to obtain a one-time order if the situation necessitates the use of medication. The facility policy must address the maximum number of times a medication can be used as an emergency prior to being incorporated in the IPP, side effects of such medications, and the frequency of re-evaluation of ongoing behavior and its treatment.

Clients or their legal guardian have the right to choose sedation for medical and dental procedures. However, the facility cannot do routine administration of medication for sedation for medical and dental procedures without the agreement/consent of the client or their parent/legal guardian and they must follow the specific orders of the healthcare practitioner who will be providing services to the client. Decisions to order medications prior to medical and dental procedures must be made on an individual basis. Clients who demonstrate severe anxiety around these procedures should be considered for desensitization programs.

W313

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

§483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

Guidance §483.450(e)(3)

The risk(s) associated with the drug being used is consistent with the type and severity of the behavior/symptoms it is intended to affect.

At the time the drug was started and incorporated into the IPP, the behaviors were discussed and presented to team members. It was the documented decision of the team that the behaviors were of such a severity

that pharmacological intervention was required and the physician was provided with the team information to assist him in his decision to prescribe the medication.

§483.450(e)(4) Drugs used for control of inappropriate behavior must be -

§483.450(e)(4)(i) Monitored closely,

W314

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

§483.450(e)(4) in conjunction with the physician and the drug regimen review requirement at §483.460(j),

Guidance §483.450(e)(4)

The physician and pharmacist must regularly review use of drugs for control of inappropriate behavior for their effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use, and communicate this information to relevant staff.

W315

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

§483.450(e)(4) for desired responses and adverse consequences by facility staff; and

Guidance §483.450(e)(4)

Direct support staff members are the people who most closely and most frequently observe and record client behaviors. There should be evidence that the direct support staff receive information via the IPP as to the behaviors to be observed, the side effects associated with the medication, the amount and types of documentation required and the communication with clinical staff which is indicated. See 483.430 (e)(1) for training on observations, documentation and communication related to behavior management.

§483.450(e)(4)(ii) Gradually withdrawn

W316

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

§483.450(e)(4) at least annually

Guidance §483.450(e)(4)

Clients receiving medications to control behavior must be evaluated at least annually for a possible reduction of the medication progressing the client toward final elimination of the drug or lowest possible therapeutic level of the drug. However, evaluation should be done earlier than annually if observations indicate that the client's behavior has improved to the point that reduction may be considered as determined by the IPP, unless otherwise ordered by the client's physician.

W317

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

§483.450(e)(4) in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

Guidance §483.450(e)(4)

The IDT is aware of and involved in planning the drug reduction program and participates in its implementation and monitoring.

Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal.

In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and IDT should consider the client's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness.

If a client also has a diagnosis of a psychiatric condition that requires a stable level of a psychiatric medication in order to control the symptoms associated with the psychiatric diagnosis, the annual

evaluation for reduction of that particular medication for the symptoms of the psychiatric diagnosis would not apply. Documentation in the client's record from their psychiatrist or physician that medication reduction would be contraindicated or that the current level of medications is therapeutic meets the intent of this regulation.

W318

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

§483.460 Condition of participation: Health care services**(a) Standard: Physician services****W319**

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

§483.460(a)(1) The facility must ensure the availability of physician services 24 hours a day.**Guidance §483.460(a)(1)**

A designated physician must be available via telephone, pager, e-mail or on-site in the facility on a 24 hour per day basis for consultation regarding both emergency and non-emergency medical issues. If the facility employs a fulltime physician, there must be procedures in place for coverage in the absence of the physician from the facility.

If the facility contracts with a community-based physician for 24 hour per day coverage, there must be written arrangements in place to detail the responsibilities of the contract physician regarding direct services to the clients, interactions with the direct support staff and the interactions between the nursing staff of the facility and the contract physician. The contract with the contract physician must delineate the process for coverage when he/she is not available.

Upon interview, the staff should be aware of the procedures they are to follow to contact a physician in the event of an illness or injury. Routinely sending clients to emergent care or the emergency room of a hospital because there are no facility physicians available for consultation is not consistent with the regulations.

Interview and record review verify that the physician is available and responsive 24 hours a day.

W320

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

§483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care.**Guidance §483.460(a)(2)**

A medical care plan of treatment is developed for those clients who are either acutely ill and require licensed nursing care and monitoring temporarily on a 24 hour basis or clients whose chronic medical conditions require or indicate 24 hour licensed nursing care and monitoring. The physician determines when 24 hour nursing care is required.

The medical care plan is based upon the orders from the physician for treatments and care and nursing standards of practice. There is evidence in the client's record that the physician and the nursing staff at the facility work together to ensure that the medical care plan is current and appropriate (e.g. changes in physician written orders for care pursuant to observations from the nursing staff and/or direct observations and interactions with the client, and nursing documentation of care).

The fact that a client has a medical care plan in place should not preclude him/her from an active treatment program, except in instances of acute illness where the active treatment program is temporarily suspended. For clients with chronic medical conditions, it may be necessary for their active treatment program to be

modified due to the tolerance level of the client or adapted to accommodate medical limitations. However, active treatment must be provided on a continuous basis.

W321

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

§483.460(a)(2) This plan must be integrated in the individual program plan.

Guidance §483.460(a)(2)

Although the medical care plan can be a separate document, it is always an integral part of the IPP process. There should be evidence that the plans are shared and discussed at the time of all interdisciplinary discussions and the information from the medical care plan is utilized in the development of the IPP objectives.

§483.460(a)(3) The facility must provide or obtain

W322

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

§483.460(a)(3) preventive and general care

Guidance §483.460(a)(3)

The facility has procedures in place to ensure that the clients receive general health care services to assure optimal levels of wellness. General health care services include assessment and treatment of acute and chronic complaints or situations; teaching relevant health care principles to staff and clients; and periodic surveillance of the health status of the clients.

As a result of clinical assessment, referrals are made for specialized assessment and tests. Facility health care staff follow-up to ensure the assessments are done and the findings incorporated into the medical care plan and/or the IPP.

The facility must have arrangements in place to provide routine or episodic laboratory, and radiology services for the clients if not provided in-house or through the clients physician. There must be a written agreement that specifies the responsibilities of the facility and outside provider. (See §483.410(a)).

Preventive health care services include screening procedures designed to identify health concerns and initiate treatment as early as possible. The facility should have a health prevention program in place and follow the plan to address those screenings that the facility will perform periodically that are relevant to all clients, and those screenings associated with a particular gender or age or vulnerability.

Physician refusal to perform a test, such as a pap smear, must be consistent with guidelines for clients, per the local standard in the community.

If the facility has a physician that refuses to provide preventative healthcare based on the client's level of functioning, medical staff at the facility should meet with and consult with this physician in order to ensure that clients receive the same health services as persons living in the local community.

Refer to these websites for current recommended screenings: Agency for Healthcare Research and Quality (AHRQ)

For men: <http://www.ahrq.gov/ppip/healthymen.htm>

Centers for Disease Control (CDC)

For women: <http://www.cdc.gov/women/pubs/cancer.htm>

§483.460(a)(3) as well as annual physical examinations of each client that at a minimum include the following:

W323

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

§483.460(a)(3)(i) Evaluation of vision and hearing;

Guidance §483.460(a)(3)(i)

Information relevant to the client's ability to see and hear is a critical component in the development of appropriate active treatment strategies.

All clients, including clients who are non-verbal, should have evidence in his/her record that they receive an annual evaluation of their vision and hearing which includes a screening as a minimum, follow-up examination as indicated by the screen and timely referrals as indicated by the examination. Screening is a gross assessment of the client's vision and hearing and usually does not include a measurement of acuity. Examinations are conducted to follow-up on issues noted in the screening and are conducted by qualified professionals.

Clients who appear to have vision or hearing problems or the staff indicate that they have vision or hearing problems and no accommodations have been made. The annual vision and hearing evaluation verifies that clients appearing to have vision/hearing issues or if staff indicate that a client has vision/hearing issues that these issues have been/are being addressed.

If a client's vision or hearing can only be assessed through examinations conducted by specialists (e.g., comprehensive ophthalmological examinations and evoked response audiometry (ERA)), these tests need not be conducted yearly, but rather upon the specialist's expressed recommendations. During discussions at the annual IPP review the team reviews information from the health professional, speech and hearing professional, and direct support staff and makes referrals back to the specialist if indicated.

W324

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

§483.460(a)(3)(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;

Guidance §483.460(a)(3)(ii)

These immunization guides may be obtained from: American Academy of Pediatrics

www.aap.org/healthtopics/immunizations.cfm

Centers for Disease Control (CDC)

www.cdc.gov/vaccines/recs/schedule/default.htm

W325

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

§483.460(a)(3)(iii) Routine screening laboratory examinations as determined necessary by the physician,

Guidance §483.460(a)(3)(iii)

The facility may have a set of routine laboratory tests which are to be done on every client annually which is developed and approved by the facility physician. However, such a list is not required. The physician may write orders individually for the clients based upon their medical history, age, gender or medical vulnerabilities.

W326

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

§483.460(a)(3)(iii) and special studies when needed;

W327

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

§483.460(a)(3)(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.

Guidance §483.460(a)(3)(iv)

The facility should have in place a system for the identification, reporting, investigation, and control of Tuberculosis (TB) in order to prevent its transmission within the facility. This system should include:

- 1) Policies and procedures for screening new employees, new clients, and other people who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility (such as volunteers and contract professional staff);
- 2) Policies and procedures for subsequent screening for clients and for employees, and other people (such as volunteers and contract professional staff) who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility per State Health Department requirements;
- 3) Policies and procedures for reporting positive TB test results to the appropriate State authorities;
- 4) Policies for the investigative procedures, per the local health department, that would be put in place should a client or staff person test positive for TB;
- 5) Policies and procedures for treatment and precautions to be used with clients who display TB symptoms, as substantiated by positive skin testing or x-ray results; and
- 6) Policies and procedures for the evaluation of the effectiveness of the surveillance system.

When one or more clients or staff display TB symptoms, as substantiated by positive skin testing or x-ray results, they do not return to work until a physician has cleared them to return to work.

W328

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

§483.460(a)(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

Guidance §483.460(a)(4)

Refer to the applicable State Nurse Practice Act or applicable Board of Medicine Practice Act to determine the extent that the nurse practitioner or physician assistant may provide physician services.

(b) Standard: Physician participation in the individual program plan

§483.460(b) A physician must participate in-

W329

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

§483.460(b)(1) The establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs; and

Guidance §483.460(b)(1)

During the admission process, which takes place from the time the client is admitted to the facility to the time the initial IPP is completed, a physician is required to ensure that an assessment of the client's medical status is thoroughly considered and incorporated into the IPP planning process by the team as it develops the IPP. The physician's input may be by means of written reports, evaluations, and recommendations.

The physician (consistent with Medicaid Utilization Control regulations at §456.380) must evaluate the client at the time of admission to identify all diagnoses and complaints, provide orders for all medications and treatments and provide recommendations for restorative and rehabilitative services.

§456.380 requires that a physician conduct this initial assessment therefore, it may not be done by a physician extender (e.g., Physician assistant or Advanced Practice Registered Nurse).

W330

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

§483.460(b)(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

Guidance §483.460(b)(2)

The need for physician participation on an individual client's IPP team is determined by the medical needs of the client. How the physician participates (whether through written report, telephone consultation, attendance at the meeting, etc.) is to be left to the discretion of the facility. In instances where a client has no overriding medical issues, the nurse of the facility can represent the medical component on the IDT process or consult with the appropriate physician and share the information with the team. However, in situations where a client's medical condition is unstable/fragile to the extent that it impacts the training/work that may be planned, the physician must participate in providing guidance on the types and extent of programs that would be appropriate considering the client's physical/medical limitations.

If a client is noted to be having difficulty participating in the objectives set forth in his/her IPP due to serious medical concerns, review the input that was provided by the physician into the development of the plan and whether the IPP team requested such input.

(c) Standard: Nursing services**W331**

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

§483.460(c) The facility must provide clients with nursing services in accordance with their needs.

Guidance §483.460(c)

The nurse responds in a timely manner to all medical concerns reported, conducts assessments as indicated, effects timely and appropriate interventions, communicates with the client's physicians and other health care professionals as indicated, provides treatments as ordered, monitors client progress following illness or injury and provides training to clients and/or staff as indicated.

§483.460(c) These services must include

W332

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

§483.460(c)(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;

Guidance §483.460(c)(1)

For those clients who have had an uneventful year medically and have no medical/health concerns at the time of the IPP meeting the facility nurse may submit a summary report to the IDT unless the IDT determines that his/her attendance is necessary. An eventful year medically would include a year which required unplanned hospital admissions or in which medical issues necessitated treatment for a prolonged or continuing period. However when a client has had an eventful year medically or current medical/health concerns, this could have an impact on their objectives and accordingly the nurse should participate in the IDT discussion directly.

W333

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

§483.460(c)(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

Guidance §483.460(c)(2)

A medical care plan addresses those clinical treatments and observations that are to be done for the client by the medical staff and other staff of the facility in order to either improve an acute medical condition or to maintain a medically fragile client as clinically stable as possible. The medical care plan is an adjunct to the IPP and is not considered a substitution for the IPP.

§483.460(c)(3) For those clients certified as not needing a medical care plan, a review of their health status which must-

W334**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(c)(3)(i) Be by a direct physical examination;****Guidance §483.460(c)(3)(i)**

A direct physical examination means a visual review of the body as well as examination/assessment of body systems. This includes observations made through non-verbal communication (including visual, tactile, nonverbal gestures, grimaces, etc.) which may be an indication that there is a potential for further assessment and/or monitoring. A paper review of the client's medical record and health statistics does not meet the intent of the regulation for a direct physical examination.

W335**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(c)(3)(ii) Be by a licensed nurse;****Guidance §483.460(c)(3)(ii)**

The term "licensed nurse", for purposes of these guidelines, means a registered nurse, a licensed practical nurse or a licensed vocational nurse currently licensed by the State in which the facility is located. The nurse must operate consistent with the requirements of the applicable Nurse Practice Act. If this direct physical examination is done by a physician, it is not necessary for the nurse to repeat the exam.

W336**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(c)(3)(iii) Be on a quarterly or more frequent basis depending on client need;****Guidance §483.460(c)(3)(iii)**

"On a quarterly basis" means that the examinations are conducted approximately 90 days apart (e.g. scheduled to be conducted approximately once every 90 days). If during the course of a calendar year, there were three quarterly examinations conducted by a licensed nurse and in the fourth quarter the annual physical examination was performed by a physician, the intent of this requirement is met without the nurse performing an additional examination.

W337**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(c)(3)(iv) Be recorded in the client's record; and****Guidance §483.460(c)(3)(iv)**

The actual findings of each examination and the date conducted must be incorporated into the client's record.

W338**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(c)(3)(v) Result in any necessary action (including referral to a physician to address client health problems).****Guidance §483.460(c)(3)(v)**

The nursing staff document that referrals are made in a timely manner, if indicated, for any concerns identified. Nurses must ensure all concerns they identify are communicated and addressed appropriately, including:

- Need is fully identified in assessment;
- Appropriate referrals are made;
- Revisions are made to IPP/Medical care plan; and
- Follow-up occurs to the new plan.

W339

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

**§483.460(c)(4) Other nursing care as prescribed by the physician or as identified by client needs; and
Guidance §483.460(c)(4)**

Nursing interventions are implemented as indicated by the needs of the client and consistent with either standard nursing practice principles or orders from the attending physician. Health and wellness are actively promoted, problems are attended to before they negatively impact the client's health and wellness, and steps are taken to prevent the recurrence of such problems while responding promptly to client's needs. Client health care complaints that are reported either directly by the client or by the direct care staff are addressed promptly by the nursing staff. Client health care complaints and response by nursing staff are documented in the client's record.

**§483.460(c)(5) Implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to –
W340**

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

**§483.460(c)(5)(i) Training clients and staff as needed in appropriate health and hygiene methods;
Guidance §483.460(c)(5)(i)**

Nursing staff periodically provides training to clients and staff on how to care for health needs or conditions, personal hygiene, health maintenance, and disease prevention. Nursing staff actively participates in periodic discussions with client and staff to promote health habits in the areas of diet, exercise and non-smoking.

Based upon individual training needs, the nursing staff provides training to individuals in areas such as medications, family planning, prevention of sexually transmitted diseases, control of other infectious diseases, self-monitoring of health status and self-prevention of health problems, etc. The nurses may train clients directly on their objectives or train other staff to do this training as appropriate.

W341

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

**§483.460(c)(5)(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and
Guidance §483.460(c)(5)(ii)**

Nursing staff should actively participate in surveillance and reporting of communicable diseases per the Centers for Disease Control (CDC) guidelines and applicable state laws. They should teach and promote infection control techniques such as hand washing by clients and staff and should be making periodic observations to ensure that such good infection control techniques are consistently utilized.

W342

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

**§483.460(c)(5)(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.
Guidance §483.460(c)(5)(iii)**

Nursing staff must train and ensure direct support staff demonstrate competency in detecting signs and symptoms of illness, injury, or change in the client's health baseline (e.g. responsiveness, fatigue, irritability, constipation, diarrhea, dehydration, confusion, unexplained weight loss, changes in endurance and changes in respiratory function).

Staff is responsive to health care needs or injuries of clients and receives instruction and support during temporary illness of clients.

If not, review staff training records to determine whether training was provided periodically to the involved employee. Interview direct care staff to determine their level of understanding regarding the signs and symptoms of illness that are to be reported to the medical staff. The records of clients with recent hospitalizations verify that staff detected and reported relevant symptoms promptly.

(d) Standard: Nursing staff

W343

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

§483.460(d)(1) Nurses providing services in the facility must have a current license to practice in the State.

Guidance §483.460(d)(1)

The facility should have a procedure in place to ensure that any contract nursing staff members are currently licensed prior to the provision of services. Include any contract nurses used by the facility in the sample of nurses reviewed for licensure.

W344

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

§483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

Guidance §483.460(d)(2)

The facility provides for nursing services based on the health needs and conditions of clients residing there. Examples include:

- 1) physician ordered treatments that require the skills of a licensed nurse;
- 2) preventive screenings;
- 3) assessment and intervention;
- 4) direct physical examination and examination of body systems;
- 5) teaching; and
- 6) advocacy for the medical services needed by the client.

Client health care needs are met in a timely manner (within 24 hours) by the available nursing staff.

If nurses who do not have experience in the care of persons with intellectual disabilities are employed by the facility, they should be provided with a formal orientation period and on-going educational opportunities to increase their understanding of the client population.

When one or more clients in the facility has an active medical care plan, there must be 24 hour nursing services available to come to the facility as needed to make skilled assessments and interventions.

W345

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

§483.460(d)(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

Guidance §483.460(d)(3)

Refer to the applicable State Nurse Practice Act.

W346

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

§483.460(d)(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.

Guidance §483.460(d)(4)

The facility must have written arrangements with a registered nurse (RN) to provide consultation in those instances where LPNs/LVNs provide all the direct nursing care for the clients. Verify that the agreement requires the RN to respond promptly to all calls from the LPN/LVN and to come on-site to the facility if necessary. The facility must also ensure registered nurse back-up when the primary registered nurse consultant is unavailable (vacations, etc.). Review documentation in the client records to confirm that the LPNs/LVNs of the facility are consulting the registered nurse consultant when indicated and that she/he responds promptly to such calls.

W347

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

§483.460(d)(5) Non- licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.

The work of any direct support staff (caring for clients with a medical care plan) is directed by an onsite licensed nurse). The nurse evaluates the care provided by the staff as needed, but at least each shift. If observations of care indicate that direct care staff are not providing care as directed by the medical care plan, then review the supervision provided by the nursing staff.

(e) Standard: Dental services

W348

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

§483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.

Guidance §483.460(e)(1)

It is expected that the clients will obtain dental services (both diagnostic and treatment) from community dentists whenever possible. In some instances, there may be clients residing in the facility who are physically unable to travel to the community for services. The facility must secure dental services (both diagnostic and treatment) for these clients either through an in-house program, which is part of the organizational and administrative structure of the facility, or through a written agreement with an outside dental service to come into the facility to provide such services.

W349

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

§483.460(e)(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

Guidance §483.460(e)(2)

Reports of dental care may be submitted to the IDT for inclusion in their discussions surrounding either development of the plan or update to the plan. This includes procedures a client may have had or be having during the plan development period, such as root canal or singular extractions. Actual attendance at the IDT meeting by the dentist may be left to the request of the IDT.

W350

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

§483.460(e)(3) The facility must provide education and training in the maintenance of oral health.

Guidance §483.460(e)(3)

Formal or informal training in the maintenance of oral hygiene is provided to clients who require it, and to those staff who are responsible for carrying out such activities. The IPP should include an assessment of the

client's ability to perform oral hygiene independently and an associated program if the client is not independent.

(f) Standard: Comprehensive dental diagnostic services

§483.460(f) Comprehensive dental diagnostic services include

W351

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

§483.460(f)(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

Guidance §483.460(f)(1)

A "month" is defined as the interval between the date of admission and close of business of the corresponding day in the following month.

A complete intraoral examination includes an oral cancer screen.

§483.460(f)(2) Periodic examination and diagnosis performed

W352

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

§483.460(f)(2) at least annually,

Guidance §483.460(f)(2)

Dental examinations occur no less frequently than annually. Clients without teeth must receive an annual oral cancer screening examination by a dental professional.

W353

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

§483.460(f)(2) including radiographs when indicated and detection of manifestations of systemic disease; and

Guidance §483.460(f)(2)

There should be evidence in dental reports that dentists follow current standards of practice for the performance of x-rays in order to assist in the diagnosis and treatment of the client.

W354

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

§483.460(f)(3) A review of the results of examination and entry of the results in the client's dental record.

Guidance §483.460(f)(3)

The entry referenced at this regulation is the dental entry into the dental record. See W359 for requirement of copying this dental record into the facility record.

(g) Standard: Comprehensive dental treatment

§483.460(g) The facility must ensure comprehensive dental treatment services that include- -

W355

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

§483.460(g)(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

Guidance §483.460(g)(1)

The facility should be able to produce upon request, a written contract/agreement between the facility and a licensed dentist for 24/7 guidance/provision of emergency services for the clients. The agreement should also indicate what back-up coverage will be provided when the dentist is not available.

W356

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

§483.460(g)(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) Standard: Documentation of dental services

§483.460(h)(1) If the facility maintains an in-house dental service, the facility must

W357

keep a permanent dental record for each client,

W358

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

§483.460(h)(1) with a dental summary maintained in the client's living-unit.

Guidance §483.460(h)(1)

The "dental summary" refers to the summary of each visit entered by the dental professional. The note includes any care instructions to be followed up by facility staff as a result of treatment.

§483.460(h)(2) If the facility does not maintain an in-house dental service, the facility must

W359

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

§483.460(h)(2) obtain a dental summary of the results of dental visits

Guidance §483.460(h)(2)

The facility should receive a written report of each dentist visit for inclusion in the client's record at the facility and for reference by the medical and direct support staff.

W360

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

§483.460(h)(2) and maintain the summary in the client's living unit.

See guideline above at W359.

(i) Standard: Pharmacy services

W361

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

Guidance §483.460(i)

The facility either has an onsite pharmacy or has formal arrangements in place for the provision of routine, unanticipated, or emergency drugs. There are no instances where a client does not receive needed medications due to the unavailability of drugs.

(j) Standard: Drug regimen review

W362

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

Guidance §483.460(j)(1)

The primary function of the pharmacist during the quarterly drug review is to identify possible drug interactions, check for evidence of any side effects associated with the drug usage, determine if laboratory results associated with the drug are within normal limits and verify that the facility is administering the medication appropriately and to comment upon the efficacy of the drug use (e.g. blood sugar controlled, blood pressure within normal limits). In the case of drugs used to manage behavior, the pharmacist may

need information from the IDT to determine efficacy. See Appendix PP, Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews, to the State Operations Manual (Pharmaceutical Service Requirements in Long Term Care Facilities).

W363

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

Guidance §483.460(j)(2)

The physician and IDT members must discuss, document and take necessary follow-up action for any irregularities noted.

W364

§483.460(j)(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.

W365

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(4) An individual medication administration record must be maintained for each client.

W366

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

Guidance §483.460(j)(5)

Pharmacist participation on the IDT is at the request of the team. It would not be necessary for the pharmacist to routinely attend all team meetings when the client is on a stable drug regimen that does not appear to be influencing his/her active treatment programs. Pharmacist participation may be appropriate, in situations such as assisting the IDT develop the most effective training programs for when the client is in an evolving situation with their medication.

For example:

- A client begins a new or more complex drug regimen;
- The physician orders off-label use of a medication;
- Frequent changes in the drug regimen are affecting IPP implementation.

(k) Standard: Drug administration**W367**

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k) The facility must have an organized system for drug administration that identifies each drug up to the point of administration.

§483.460(k) The system must assure that

W368

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(1) All drugs are administered in compliance with the physician's orders;

Guidance §483.460(k)(1)

Administration errors identified in previous medication administration records qualify as non-compliance with physician's orders.

W369

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;**Guidance §483.460(k)(2)**

A medication error is an observed discrepancy during the medication pass between what is ordered and what is administered.

This also applies to self-administered medications.

For small facilities (16 beds or less), the medication administration pass will encompass a total of eight (8) drug doses. The observations should be split between two separate drug passes 4/4 (one in the morning and one in the late afternoon or early evening). The medications observed during the observations may or may not be for clients in the survey sample. Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

For large facilities (17 or more beds) with either single or multiple buildings, the medication administration pass will encompass a total of 12 doses. The observations should be split between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

W370

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(3) Unlicensed personnel are allowed to administer drugs only if State law permits;**Guidance §483.460(k)(3)**

Unlicensed personnel administer only those forms of medication which state law permits. Licensed nurse(s) in the facility oversee any administration of medications by unlicensed persons and periodically evaluate their performance.

W371

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;**Guidance §483.460(k)(4)**

The IDT decision that a self-administration program is appropriate, as is the case for all formal training objectives, must be based upon accurate, current, valid assessment of the client's skills and potential. The determination as to the appropriateness of a self-administration program must never be made singularly on the client's diagnosis or current functional abilities.

For clients assessed to be inappropriate for a self-administration program, but determined by the IDT to possess the capacity to functionally, cognitively, emotionally or developmentally benefit from participation in the drug administration process, it is expected that the facility will provide opportunities for the client to participate in the medication administration process under direct supervision. This participation can include but is not limited to, identifying the medication taken, reaching/grasping a cup of water during the process and placing oral medications in the mouth, etc.

W372

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client;**Guidance §483.460(k)(5)**

While the IDT may set an objective of self administration of medication for a client, they are required to notify the client's physician of this proposed objective. If the client's physician objects on medical grounds, the team must not proceed with the objective until such time as a discussion is held with the physician and he/she agrees to proceed after receiving additional information.

W373

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(6) No client self-administers medication until he or she demonstrates the competency to do so;

Guidance §483.460(k)(6)

The written self-administration program for a client must detail the criteria that will be employed by the facility staff to verify that the client successfully completes all phases of the program and continues to comply with all necessary requirements for self administration. Clients who self-administer medications must secure all medications in such a manner as to protect access by other clients or visitors.

W374

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law;

Guidance §483.460(k)(7)

When clients go out of the facility for home visits, or to attend work or school, drugs they are taking must be packaged and labeled in accordance with state law by a person authorized by state law to package and label.

§483.460(k)(8) Drug administration errors and adverse drug reactions are

Guidance §483.460(k)(8)

Documentation of any medication error should be entered into the client's record and should include what error was made, who was notified of the error, the response of the medical person notified, the physical condition of the client at the time of the notification and subsequent observations of the clients physical condition related to the error.

W375

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(8) recorded

Guidance §483.460(k)(8)

Documentation of adverse drug reactions must be entered into the client's record and should include all complaints made by the client or observations made by the staff following the drug administration, the notification of medical personnel, and the response of the medical personnel, any emergency actions that were required and all subsequent observations of the client's condition related to the reaction.

W376

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(8) and reported immediately to a physician.

Guidance §483.460(k)(8)

“Immediately” means at the time the error or reaction is identified.

(l) Standard: Drug storage and recordkeeping

§483.460(l)(1) The facility must store drugs under proper conditions of

Guidance §483.460(l)(1)

Drugs are stored according to manufacturer's recommendations.

W377

sanitation,

W378

temperature,

W379

light,

W380

humidity,

W381

and security.

W382

§483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.

W383

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.

Guidance §483.460(l)(2)

“Authorized persons” is restricted to those who administer the drugs (as allowed by state law) and nursing supervisors (if any). No other personnel should have access to these keys.

W384

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(2) Clients who have been trained to self-administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.

Guidance §483.460(l)(2)

Drugs that are self-administered do not have to be double locked. The purpose for the double locking is to limit access to scheduled drugs. Since the client is generally the only one who has access to his/her drug supply (with perhaps the exception of a licensed nurse or whoever has overall responsibility for medication administration at the facility and a facility’s Director of Nursing Services, who may have access to all of the facility’s drug supplies), there is no need to further limit access.

W385

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

Guidance §483.460(l)(3)

The facility must follow state requirements for the control and disposition of controlled drugs.

W386

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 *et seq.*, as implemented by 21 CFR Part 308).

Guidance §483.460(l)(4)

The facility should follow state requirements for the reconciliation of controlled drugs.

W387

§483.460(l)(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs

§483.460(m) Standard: Drug Labeling

§483.460(m)(1) Labeling of drugs and biologicals must

W388

§483.460(m)(1)(i) Be based on currently accepted professional principles and practices; and

W389

§483.460(m)(1)(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

§483.460(m)(2) The facility must remove from use--

W390

§483.460(m)(2)(i) Outdated drugs; and

W391

§483.460(m)(2)(ii) Drug containers with worn, illegible, or missing labels.

W392

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.

(n) Standard: Laboratory services

W393

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(n)(1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.

Guidance §483.460(n)(1)

If the facility performs laboratory services, it must have a current, valid Clinical Laboratory Improvement Amendment (CLIA) certificate for the types of tests it is performing.

For the purposes of this regulation, a "laboratory service or test" is defined as any examination or analysis of materials derived from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings.

W394

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(n)(1) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

Guidance §483.460(n)(1)

A facility performing any laboratory service or test must have applied to CMS, and received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. An application for a Certificate of Waiver may be made if the facility performs only those tests on the waived list. A complete list of waived tests can be found at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>.

If the facility performs any test, not appearing on the waived list, a Certificate of Compliance or Certificate of Accreditation is required. An appropriate CLIA certificate is required regardless of the frequency with which the laboratory services or tests are conducted. When no tests are performed, a CLIA certificate is not needed. Facilities only collecting specimens and not performing testing do not need a certificate.

A not-for-profit, a state, or local government organization may have one certificate covering all the facilities it operates (e.g., all the separately certified residences which fall under its governing body), if no more than a total of 15 types of waived or moderately complex laboratory tests are used. This exception applies only to laboratories performing limited public health testing. See State Operations Manual (SOM)

6008. Each location where a laboratory tests are performed must file a separate application to be separately certified unless the laboratory meets one if the exceptions outlined at 42CFR493.35(b), 493.443(b), or 493.55(b).

Any laboratory located in a state that has a CMS-approved laboratory program is exempt from CLIA certification. Currently there are two states with approved programs: Washington and New York. New York has a partial exemption; therefore, if the laboratory is located in New York, contact the New York State Agency to determine if the exemption applies.

W406

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.470 Condition of participation: Physical environment. (a) Standard: Client living environment.

W407

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

Guidance §§483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation supports the placement:

- Assessment;
- Client program plan;
- Staff documentation of client response to training programs; and
- QIDP notes.

W408

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.

(b) Standard: Client bedrooms.

(1) Bedrooms must- -

W409

§483.470(b)(1)(i) Be rooms that have at least one outside wall

W410

§483.470(b)(1)(ii) Be equipped with or located near toilet and bathing facilities;

W411

§483.470(b)(1)(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;

§483.470(b)(1)(iv) measure

W412

At least 60 square feet per client in multiple client bedrooms

W413

And at least 80 square feet in single client bedrooms; and

W414

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

Guidance §483.470(b)(l)(v)

If a facility was initially certified on or after October 3, 1988 and/or is under renovations or conversions, they must have walls that extend floor to ceiling.

W415

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) If a bedroom is below grade level, it must have a window that--

(i) Is usable as a second means of escape by client(s) occupying the room; and

(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.

Guidance §483.470(b)(2)

The intent of the regulation is to prohibit the housing of clients in basements that are entirely below grade. Clients may be housed on the lower level of housing (e.g. a bi-level house), provided the window height requirements are met and the window is of sufficient size to be used as a means of escape.

W416

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disabilities professional--

(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) Documents the reason why housing in a room of only four or fewer persons would not be medically feasible.

Guidance §483.470(b)(3)

The medical care plan for each client housed in a room with more than four clients should indicate the need for continuous monitoring. The medical care plan will include:

- the physician certification that the client is severely medically impaired and requires direct and continuous monitoring during sleeping hours; and
- the reason why this housing arrangement for fewer than four people would not be medically feasible.

(4) The facility must provide each client with—

W417

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) A separate bed of proper size and height for the convenience of the client;

Guidance §483.470(b)(4)(i)

The client's preference, chronological age, and physical and medical needs are the determining factors in bed size and height.

W418

§483.470(b)(4)(ii) A clean, comfortable, mattress;

W419

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) Bedding appropriate to the weather and climate; and

W420

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iv) Functional furniture, appropriate to the client's needs,

Guidance §483.470(b)(4)(iv)

Client preferences and program needs should be considered in furniture selection. For clients with physical disabilities, furniture is adapted to accommodate the client's physical challenges and enable the client to use the furniture with minimal support.

W421

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

Guidance §483.470(b)(4)(iv)

Closets should have enough space for a reasonable amount of the current season's clothing.

Clients who use wheelchairs or have other physical challenges can reach the racks and shelves in their closets.

The facility is permitted either to provide the client with an individualized closet or with a designated area in a shared closet. The use of central clothing bins in a facility clothing room, in the absence of required client closet space in the bedroom, is not an acceptable practice.

(c) Standard: Storage space in bedrooms.

The facility must provide—

W422

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and

Guidance §483.470(c)(1)

Sufficient space that permits the use of wheelchairs, walkers and other adaptive equipment should be provided within the bedroom.

W423

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

Guidance §483.470(c)(2)

Each client should have storage in their bedroom for their personal belongings. Clients should have free access to this storage without the assistance of staff. If it is necessary for clients' personal belongings to be locked due to the behavior of other clients, the client must still be provided free access to his own possessions (See W137 for requirements for locked areas).

(d) Standard: Client bathrooms

The facility must—

W424

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;

Guidance §483.470(d)(1)

In a home setting, the toilet facilities need to be of sufficient number to meet the needs of the client without prolonged delay. There must be enough toilets in the living units to meet the program needs of the clients at any given time, as well as provide for intermediate toileting needs of the clients living in the unit.

In a home setting, it may be unrealistic to say a client would never have to wait for a shower or bath or to brush his/her teeth.

Bathrooms and fixtures must be adapted to accommodate clients with physical disabilities.

W425

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

**(2) Provide for individual privacy in toilets, bathtubs, and showers; and
Guidance §483.470(d)(2)**

A bathroom containing multiple toilets, showers or bathtubs, must have doors, curtains, or some other means of protecting the client from view when fully or partially unclothed.

Clients should not be able to be seen through the door or window by passersby when they are using the bathrooms.

Client privacy does not preclude the assistance provided by facility staff when necessitated by the client's condition.

W426

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110° Fahrenheit.

(e) Standard: Heating and ventilation.

(1) Each client bedroom in the facility must have--

W427

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) At least one window to the outside; and

Guidance §483.470(e)(1)(i)

(See also W415)

W428

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility must—

W429

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and

Guidance §483.470(e)(2)(i)

A “normal comfort range” in most instances is defined as not going below a temperature of 68 degrees Fahrenheit or exceeding a temperature of 80 degrees Fahrenheit in facilities in most geographic areas of the country.

In extremely hot or extremely cold weather, precautions are taken by the facility to protect the clients, particularly those who are medically compromised, from ill effects of the temperature.

W430

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

Guidance §483.470(e)(2)(ii)

Refer to Life Safety Code Chapters 32 and 33

Unvented fuel fired heaters are prohibited. NFPA 101 2000 Edition.

32/33.2.5.23

(f) Standard: Floors.

The facility must have—

W431

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

W432

§483.470(f) (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and

§483.470(f) (3) Exposed floor surfaces and floor coverings that

W433

promote mobility in areas used by clients,

W434

and promote maintenance of sanitary conditions.

§483.470(g) Standard: Space and Equipment

The facility must--

W435

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services, as required by this subpart and as identified in each client's individual program plan.

Guidance §483.470(g)(1)

Staff and clients must have the space, materials and equipment needed to implement formal and informal active treatment programs.

There must be sufficient space to accommodate group activities, including groups with clients who use wheelchairs.

Recreational supplies, equipment, and materials are available and reflect the interests, physical abilities and chronological age of the clients.

W436

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Guidance §483.470(g)(2)

The term “furnish” means that the facility is responsible for obtaining or purchasing these items once an assessment has identified the need and is responsible for making any necessary arrangements for the client to receive them. Clients’ personal funds should not be used for these items since this is a covered service under the ICF/IID benefit.

The term “maintain in good repair” means that the facility is responsible for ensuring that these items are kept in good working order, and is responsible for any resulting expense that may be incurred.

Programs must be in place, when identified by assessment and determined by the ID team, to teach clients about the use and care for their equipment to the extent of their capabilities.

W437

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) Provide adequate clean linen and dirty linen storage areas.

Guidance §483.470(g)(3)

Clean linen must be is separated from dirty linen and stored in a manner which prevents contamination. Linen soiled with bodily fluids must be stored separately and in a manner which protects clients from exposure to possible infectious sources.

A bedroom hamper can be an acceptable dirty linen storage “area” if kept odor free and consistent with the infection control requirements at §483.470(1).

(h) Standard: Emergency plan and procedures.**W438**

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

Guidance §483.470(h)(1)

These plans may include identification of transportation and alternative shelter needs in cases when the facility must be evacuated and may incorporate state-specific emergency preparedness requirements as applicable.

W439

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

Guidance §483.470(h)(2)

“Periodic review” is a judgment made by the facility based on the circumstances of the facility. If the facility changes its physical plant or if changes external to the facility necessitates a review of the disaster plan, then the facility is responsible for carrying out the review.

Interview staff about where emergency plans and procedures are located and what the facility policy is regarding how often, and under what circumstances the plans and procedures are reviewed and updated.

(i) Standard: Evacuation drills.

(1) The facility must hold evacuation drills

W440

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

at least quarterly for each shift of personnel

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33 code: Clients have to participate in an evacuation drill each shift at least quarterly.

Chapter 18/19 code: There must be an evacuation drill on each shift at least quarterly. This drill is designed to train staff on evacuation procedures.

Review facility records to verify that evacuations drills are held each shift at least once in each 3-month period.

Refer to (S&C 10-26-LSC)

W441

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and under varied conditions to—

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33: Expects that all clients living in that unit are capable of self-evacuation during an emergency. This self evacuation should be practiced under varying conditions including various times of the day or night and in various weather conditions.

Chapter 18/19: Requires drills which simulate emergency situations which familiarize facility staff with emergency actions they may be required to perform. The general emphasis of these sections of the code is upon training of the staff and not upon providing practice for the client. Drills should be practiced under varying conditions including various times of the day or night and in various weather conditions.

W442

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;

Guidance §483.470(i)(1)(i)

For facilities under Chapter 18/19 of the LSC

Staff should be able to verbalize the proper procedures to be followed during emergency drills. Staff training records should document that all staff have received training on emergency drills and evacuations.

W443

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

Guidance §483.470(i)(1)(ii)

Staff on all shifts are able to express familiarity with the use of fire extinguisher, alarms, and any other safety features in the facility.

W444

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

Guidance §483.470(i)(1)(iii)

See also W448. The plan(s) must be revised as needed and must be based upon analysis completed under W448.

The facility must--

W445

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Actually evacuate clients during at least one drill each year on each shift;

Guidance §483.470(i)(2)(i)

All clients totally evacuate the building at least once per year per shift, regardless of the occupancy chapter under which the building falls.

All facilities, regardless of their size require actual evacuation. "Actually evacuate", as used in this standard, applies to all clients. The drills are conducted not only to rehearse the clients and staff for a fire emergency (see §483.470(i)(2)(v)), but for other disasters such as hurricanes, tornadoes, floods, etc. Such disasters would require the entire occupancy to be evacuated, and, therefore, the actual evacuation must be practiced, as required.

W446

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Make special provisions for the evacuation of clients with physical disabilities;

Guidance §483.470(i)(2)(ii)

Clients with physical or medical disabilities may require special procedures for evacuation, taking into account equipment or staff that must be maintained for the client's care at all times. The facility's evacuation plan should:

- identify such clients;
- clearly delineate any special evacuation procedures for those clients.

Staff should be familiar with the facility's special evacuation procedures when working with clients who are in need of unique provisions.

W447

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) File a report and evaluation on each evacuation drill;

Guidance §483.470(i)(2)(iii)

There is a written report of each evacuation drill held.

W448

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iv) Investigate all problems with evacuation drills, including accidents,

Guidance §483.470(i)(2)(iv)

The documentation for each evacuation drill includes an analysis of:

- The timeliness of the evacuation;
- Any difficulties observed during the drill;
- Investigates the cause of the difficulties; and
- Develops a plan to ensure the difficulties will not reoccur.

W449

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and take corrective action; and

Guidance §483.470(i)(2)(iv)

When a problem is identified during the evacuation drill and the facility develops a plan to prevent reoccurrence, there is evidence the facility implemented corrective action and follow-up completed to ensure corrective action was successful.

W450

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

Guidance §483.470(i)(2)(v)

The Life Safety Code NFPA 101, 2000 Edition at 3.3.167 defines safe location as "a location remote or separated from the effects of a fire so that such effects no longer pose a threat."

W451

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) Facilities must meet the requirements of paragraph (i)(1) and (2) of this section for any live-in and relief staff they utilize.

Guidance §483.470(i)(3)

In the case of live-in staff, drills must occur quarterly. Typically, live-in staff can be found in facilities that fall under Chapter 32/33 of the LSC code. Drills should be held at varying times of the day and night for clients to practice evacuation including morning, afternoon, evening and the middle of the night.

(j) Standard: Fire protection.

Guidance §483.470(j)

These standards are covered by the Life Safety Code (LSC) survey. The facility must meet the appropriate chapter of the Life Safety Code, 2000 edition.

When surveying an ICF/IID for compliance with the LSC, it is first necessary to determine whether the facility will be surveyed under Health Care (HC) or Board and Care (BC) occupancy.

- If clients receive nursing services, or if the provider elects to use Health Care, the facility should be surveyed as a Health Care Facility under Chapter 18 or 19 of the LSC, as appropriate.

- If clients receive personal care and protective oversight but not continuing nursing services, the facility is to be surveyed under Board and Care and the following three steps should be followed:

- 1) Determine the size (16 or less = small; 17 or more = large);

- 2) Determine the Evacuation Difficulty (PROMPT, SLOW, or IMPRACTICAL) using Appendix F of the fire safety evaluation system for board and care facilities (FSES/BC); and

- 3) Survey the building using one of two methods:

- a. The prescriptive requirements of Chapters 32 or 33; or

- b. The FSES/BC, Appendix G.

(1) General. Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:

http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

Guidance §483.470(j)(1)(ii)

Roller latches are prohibited on corridor doors as a latching device.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

Guidance §483.470(j)(3)

The evacuation capability of residents is determined using Chapter 6 of NFPA 101A, 2001 edition.

4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

Guidance §483.470(j)(5)

Battery powered emergency lighting must last at least 90 minutes.

6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

Guidance §483.470(j)(6)

Roller latches are prohibited on corridor doors as a latching device.

(7) Facilities that meet the LSC definition of a health care occupancy.

(i) After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

Guidance §483.470(j)(7)(i)

Waivers may be granted only to facilities that meet the Life Safety Code definition of a Health Care Occupancy. Waivers are not granted to facilities that met the requirements of a Residential Board and Care Occupancy.

Waivers are recommended by the State Survey Agency and approved by the Regional Office.

(A) The waiver would not adversely affect the health and safety of the clients.

B) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

ii) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a facility may install alcohol-based hand rub dispensers if—

(A) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(B) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(C) The dispensers are installed in a manner that adequately protects against inappropriate access;

D) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and

(E) The dispensers are maintained in accordance with dispenser manufacturer guidelines

(k) Standard: Paint.

The facility must—

W452

§483.470(k)(1) Use lead-free paint inside the facility; and

W453

§483.470(k)(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

§483.470(l) Standard: Infection Control

W454

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.

Guidance §483.470(l)(1)

The facility is clean and staff have eliminated opportunities for cross-contamination of infections. Food is stored, prepared, distributed, and served in a sanitary manner to prevent food borne illness.

W455

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

Guidance §483.470(I)(1)

Facilities maintain an ongoing surveillance program of communicable disease control and investigation of infections and an active training program that ensures the clients served receive adequate prevention of transmission information and skills, according to needs.

The facility's infection control program should include procedures for:

- identification of the extent of infestation or infection;
- protection of clients;
- treatment of clients;
- notification of family or legal guardian;
- reporting to the health department as indicated; and
- continued follow-up to resolution.

Both the Occupational Safety and Health Administration (OSHA) and the CDC have specific requirements regarding human immuno-deficiency virus (HIV), TB, and hepatitis precautions. These requirements should be incorporated into the facility's practices when relevant to the clients residing in the facility. Concerns about OSHA violations should be referred to OSHA.

W456

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) The facility must implement successful corrective action in affected problem areas.

W457

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) The facility must maintain a record of incidents and corrective actions related to infections.

W458

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

Guidance §483.470(I)(4)

The facility should have and implement a policy that clearly delineates those signs and symptoms for which they will restrict staff access to clients or to clients' food.

W459

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480 Condition of participation: Dietetic services

(a) Standard: Food and nutrition services

W460

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(1) Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets.

Guidance §483.480(a)(1)

“Well balanced diets” are defined as diets that contain a variety of foods from the food groups currently recommended by the Academy of Nutrition and Dietetics (AND).

“Modified and specially-prescribed” diets are defined as diets that are altered in any way to enable the client to eat (e.g. food that is chopped, pureed) or diets that are intended to correct or prevent a nutritional deficiency or health problem.

Refer to W463 and W474 regarding modified and specially prescribed diets.

The following may be indicators of or may lead to compromised nutritional status:

- Unplanned significant weight gain or loss;
- Fever/infection;
- Diarrhea;
- Chronic disease;
- Chewing and Swallowing problems;
- Teeth and gum diseases;
- Excessive use of laxatives;
- Abnormal laboratory values;
- Brittle, dry hair;
- Ridged or spoon shaped nails;
- Dry flaky skin; and
- Unexplained change in mood such as general fatigue, apathy, irritability, lack of concentration.

If one or more of these indicators are present, determine the facility's response through observation, interview, and record review.

Surveyors should assure the facility is responsive to client food allergies and the potential for adverse food/drug interactions. If surveyors suspects these may exist, investigate further.

Examples of facility responsiveness to allergies and food/drug interactions include, but are not limited to:

- Clients on long term anticonvulsant drug regimens (e.g., phenobarbital, phenytoin, primidone) are periodically monitored per facility policy for decreased serum levels of folic acid and vitamin D;
- Therapeutic doses of nutrients are provided to decrease the likelihood of anemia and prevent decreased bone density, etc.; and
- Fiber and fluids are increased in the diet of clients to decrease the likelihood of constipation.

Guidance §483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation support the placement:

- Assessment;
- Client program plan;
- Staff documentation of client response to training programs; and
- QIDP notes.

W461

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

Guidance §483.480(a)(2)

The facility employs a registered dietitian either on a part-time, full-time or on a consultant basis.

W462

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

Guidance §483.480(a)(3)

Where the facility does not have a full-time qualified dietitian, verify that the director of food services coordinates with a dietitian to assure the nutritional adequacy of meals and snacks.

The food service director coordinates with the part-time or consultant dietitian to develop client meal plans and monitor client nutritional status.

The qualifications of the food service director may be dictated by facility policy or by state law, if applicable.

In small group home settings where the staff and clients plan and prepare meals cooperatively, there may not be a designated food services director. In these cases, the consultant or part-time dietitian would meet with the available home staff to ensure adequacy of menus and diets.

§483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe

W463

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(4) all modified and special diets

W464

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(4) including those used as a part of a program to manage inappropriate client behavior.

Guidance §483.480(a)(4)

Modifying a clients' diet must never be used as punishment.

W465

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

Guidance §483.480(a)(5)

This regulation addresses the use of food in shaping positive adaptive behavior. Where clients have specialized nutritional needs, these needs must be taken into consideration.

When food is used as a primary reinforcement of behavior for a client who has a dietary restriction, these foods should be consistent with the foods allowed by the prescribed diet.

Food used as a reinforcement must be part of a behavior plan approved by the IDT and consistent with nutritional parameters for that client. For example, a client with diabetes does not receive concentrated sweets as a reinforcement.

W466

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

Guidance §483.480(a)(6)

For suggested guidelines write to:

U.S. Department of Agriculture

Human Nutrition Information Services

Washington, D.C. 20250

<http://fnic.nal.usda.gov>

(b) Standard: Meal services

W467

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1) Each client must receive at least three meals daily,

Guidance §483.480(b)(1)

Meal times may be flexible and accommodate a variety of activities (e.g. holiday and weekend activities). Clients should be offered the opportunity of three meals every day, but may be given the choice of not participating in a meal due to their schedule or preference.

For example, a client wakes up late on a Saturday morning and decides to have brunch.

W468

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1) at regular times comparable to normal mealtimes in the community

Guidance §483.480(b)(1)

Generally, meal times conform to the norms of the community, however the clients' schedules and preferences may result in slight variations. Slight variations are acceptable, but gross variations such as breakfast at 3 am would not be acceptable.

§483.480(b)(1) with –

W469

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1)(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day,

Guidance §483.480(b)(1)(i)

A “substantial evening meal” is defined as an offering of three or more items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements.

W470

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1)(i) except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may lapse between a substantial evening meal and breakfast; and

Guidance §483.480(b)(1)(i)

A “nourishing snack” is an offering of items, single or in combination, from the basic food groups. Snack supplies are available in the facility and are accessible to clients. Interview staff and clients about their access to snacks.

W471

§483.480(b)(1)(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i).

§483.480(b)(2) Food must be served--

Facility Practices §483.480(b)(2)(i)

Portions served, either by staff or by the individuals themselves, closely match designated serving sizes on menus. Slight variations are not significant enough or frequent enough to affect individual's health.

W472

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(i) In appropriate quantity;

Guidance §483.480(b)(2)(i)

Meal observations verify that portions served, either by staff or by the clients, match the designated serving sizes on menus.

W473

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(ii) At appropriate temperature;

Guidance §483.480(b)(2)(ii)

Hot foods are served hot and cold foods are served cold, according to facility policy specific to the type of food or as desired by the client. The facility follows current state requirements for safe food temperatures.

W474

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(iii) In a form consistent with the developmental level of the client; and

Guidance §483.480(b)(2)(iii)

The term “form”, as used in this requirement, refers to food consistency (e.g., pureed, chopped, ground, etc.). Food that is ground, chopped or pureed is based on assessed client need, and only to the extent required.

Food consistency modifications due to an acute medical or dental condition are temporary and; client’s food consistency is upgraded at the soonest possible time. Clients with chronic medical or dental conditions are periodically reviewed and at least annually for the possibility of an upgrade in food consistency.

Client assessments must document the justification for modified texture of the client’s diet.

W475

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(iv) With appropriate utensils.

Guidance §483.480(b)(2)(iv)

“Appropriate utensils” refers to eating utensils and adaptive eating equipment that enable clients to eat as independently as possible in accordance with their highest functional level.

Commonly used utensils (fork, knife, and spoon) appropriate to the food being consumed are provided to all clients except those using adaptive equipment instead. Clients should be afforded the opportunity to use forks, spoons, and knives as indicated by the food served.

Utensils must be in good condition, clean, allow portion sizes appropriate to the client’s prescribed diet and meet the client’s needs.

W476

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(3) Food served to clients individually and uneaten must be discarded.

Guidance §483.480(b)(3)

This standard does not apply to food served in family-style dishes, unless the length of time the food is on the table or other considerations (such as clients fingering or drooling in the food) compromise the safety and nutritive value for later consumption of the food.

(c) Standard: Menus

W477

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(i) Be prepared in advance;

Guidance §483.480(c)(1)(i)

The facility should be able to produce a copy of client menus prospectively to verify that meal planning is done in advance.

W478

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(ii) Provide a variety of foods at each meal;

Guidance §483.480(c)(1)(ii)

A “variety” of food at each meal includes offerings from each of the food groups.

W479

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(iii) Be different for the same days of each week and adjusted for seasonal changes; and

Guidance §483.480(c)(1)(iii)

Menus should make use of seasonal foods in order to capitalize on the availability of fresher more vitamin enriched foods.

In certain portions of the country, there may be cultural preferences that influence the frequency with which a food appears on the menu. This is acceptable in the facility if it is acceptable in the community.

W480

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(iv) Include the average portion sizes for menu items.

Guidance §483.480(c)(1)(iv)

Verify the menu lists client portion sizes and observe that the portions served correspond to the clients prescribed diet.

W481

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(2) Menus for food actually served must be kept on file for 30 days.

(d) Standard: Dining areas and service

§483.480(d) The facility must –

W482

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

Guidance §483.480(d)(1)

For purposes of this standard, “dining areas” mean discrete eating areas located outside of bedrooms, established, furnished, and equipped for the purpose of eating meals.

When a client is not eating in a designated dining area, there must be either a medical rationale or this must be an isolated instance when the client has a personal reason to eat in another area, such as a television area to watch his or her favorite program.

Interview with the client should confirm that this is not routine, but is for a particular isolated reason.

W483

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

Guidance §483.480(d)(2)

Clients must have the opportunity to participate in the normal dining experience with their companions in the dining room.

Clients in wheelchairs are included in dining groupings of their peers without physical disabilities.

Clients in wheelchairs eat at the table and not with lap trays/hospital trays unless medically contraindicated.

W484

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;

Guidance §483.480(d)(3)

Clients use adaptive equipment or are being trained to use such equipment when the need is identified in the IPP.

Examples of adaptive equipment that may be needed are:

- Double suction cups or other devices to anchor dishes on a table or tray for clients with major coordination problems;
- Rocking one-handed knife-fork or knife-spoon for a client with the use of only one hand;
- Built-up or extended handles or silverware for those with problems of grasp or range of motion;
- Plate guards or plates with raised rims to provide a surface against which the client with a physical disability can push food onto a fork or a spoon;
- Flexible drinking straws;
- Spoon bent to a 90 degree angle at the bowl or a swivel spoon to assist a client without normal wrist motions; and
- Any other adaptive device deemed by the team as needed by the client to eat more independently.

W485

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) Supervise and staff dining rooms adequately

Guidance §483.480(d)(4)

There should be sufficient staff to implement eating programs for clients who require them and to provide necessary intervention and supervision for normalization including normal meal time behavior.

Client mealtime should not be inadequately delayed due to insufficient staff assistance.

W486

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to direct self-help dining procedures,

Guidance §483.480(d)(4)

Staff is present during meal times to monitor clients who are able to eat independently, promoting, supporting, reinforcing and encouraging them to eat in an appropriate and normalized manner (e.g., manners, social behaviors, etc.)

W487

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client receives enough food and

Guidance §483.480(d)(4)

Clients can request and receive second helpings unless contraindicated by a prescribed diet.

For clients on restrictive diets that prefer not to be on these diets or seek seconds, the facility resolves the personal choice issues vs. health risks.

W488

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client eats in a manner consistent with his or her developmental level; and

Guidance §483.480(d)(4)

The intent of this regulation is to promote the acquisition of skills that lead to greater independence in eating.

Clients should be actively encouraged to eat independently to the extent possible and in accordance with their assessed abilities.

Clients should receive training to develop independent eating skills consistent with their developmental potential as identified through the CFA.

Clients learn skills in accordance with their functional levels. Skills may include:

- Use of utensils;

- Meal preparation;
- Socialization during meals;
- Family style dining; and
- Ordering food in restaurants.

Clients' eating programs are implemented in accordance with their training objectives.

To the maximum extent possible, staff model appropriate mealtime behavior and conversation by sitting at the table with clients, and when possible, eating meals with clients.

W489

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

Guidance §483.480(d)(5)

If a client eats in any position other than an upright position, the physician should document the medical necessity for the position, and/or the IPP should include the program plan to teach the client the physical skill necessary for eating upright.

This applies to all clients, including those fed by nasogastric tube or gastrostomy tube. The IPP should identify the most appropriate position for the client to be positioned during mealtime, in relation to the placement of the food contents.

[ARC 3109C, IAB 6/7/17, effective 7/12/17]

◇ Two or more ARCs

1 See Interpretive Guidelines at end hereof

2 See IAB, Inspections and Appeals Department.