Intermediate Care Facilities for Persons with Mental Retardation Questions & Answers

Please note: In the State of Idaho, Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) have been re-titled as Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/ID). However, Federal regulations have not changed. Therefore, for the purposes of this document, ICF/MR and ICF/ID are used interchangeably.

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General

Q1: Can a provider be cited for something that might happen?

A1: Yes. This is especially true in cases of immediate jeopardy. Appendix Q of the State Operations Manual (SOM) issued by The Centers for Medicare and Medicaid Services (CMS) defines an immediate jeopardy as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death of a resident." *State Operations Manual, Appendix Q, page 2.*

Q2: Does the state have an appeal process for survey?

A2: A formal appeal process is applicable only when a remedy or adverse action is initiated against a facility. The appeal process related to federal Medicaid certification regulation is found at CFR 42 431 Subpart D – Appeals Process for NF's and ICF's/MR. The appeal process applicable to adverse action taken against a facility's license is described in IDAPA 16.05.03.308 – Contested Cases.

ADDENDUM: The Idaho Department of Health and Welfare (DHW), Bureau of Facility Standards (Department), and the Idaho Health Care Association (IHCA), representing Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) established an independent review process for the purpose of resolving disputes with ICFs/MR over federal and state deficiencies cited during a survey. The process was implemented in December 2006. Please refer to BFS Informational Letter 2007-02, dated 1/29/07, for additional information.

Q3: What method do you use to select individuals for the sample?

A3: The survey team follows the process described in Appendix J of the State Operations Manual (SOM).

Q4: How does the survey team determine scope and severity?

A4: The Compliance Principles found in the Interpretive Guidance at each Condition of Participation and the Facility Practices included for many regulations, guide the surveyors in determining compliance. However, these were not intended to replace professional surveyor judgment. The State Operations Manual (SOM), on pages J-17 and J-18, states "The threshold at which the frequency of occurrence amounts to a deficiency varies. One occurrence directly related to a life-threatening or fatal outcome can be cited as a deficiency. On the other hand, a few sporadic occurrences may have so slight an impact on delivery of active treatment or quality of life that they do not warrant a deficiency citation."

Q5: Is the record review portion of the survey designed to review only those records that apply to the observations conducted by the surveyors?

A5: No. The State Operations Manual (SOM) indicates that record review is conducted for:

- Identifying the developmental, behavioral, and health objectives the facility has committed itself to accomplish during the current Individual Program Plan (IPP) period; and

- Identifying what revisions were made to the IPP and determine if the revisions were based on objective measures of the individual's progress, regression, or lack of progress toward his/her objectives; and

- Verifying that needed health and safety supports are in place. This includes reviewing documents to determine if the individual received follow up for health and dental needs identified on the IPP, review of the individual's drug regimen, and if restrictive or intrusive techniques are used, verification that the necessary consents and approvals are in place.

This does not, however, preclude the surveyor from reviewing other portions of the clients' records if necessary to determine compliance. This would be especially true when extended or full surveys are completed.

Q6: Can a facility use cameras to monitor activity in an ICF?

A6: Yes. CMS received an opinion in 1997 to questions they had about security cameras which stated the following:
1. The use of security cameras in the day rooms of ICFs/MR does not violate an individual's privacy;
2. Clients cannot reasonably expect privacy in day rooms;
3. The specially constituted committee must review the facility's use of cameras; and,
4. Whether the cameras are used in place of direct staff supervision must be decided on a case-by-case basis by surveyors.

Q7: Can a facility be reimbursed for respite care?

A7: No. Facilities cannot receive ICF/MR reimbursement for respite care. However, facilities can admit persons whose care is funded through private sources as long as the presence of private pay persons in the facility does not negatively affect services being provided to the ICF/MR residents, interfere with the delivery of active treatment to ICF/MR clients, or jeopardize the health and safety of either the ICF/MR residents or other people admitted for respite care. A facility can set aside a small number of non-certified beds for respite care under the following conditions:

1. The facility would still be engaged primarily in ICF/MR care.
2. Services provided to ICF/MR residents are not hampered.

3. The person is admitted to the ICF/MR if the stay will be over 30 days.
4. The facility must have at least 4 beds for ICF/MR care.

In facilities of 6, no more than 2 beds can be set aside for respite care. In facilities of 7-15, no more than 3 beds may be set aside for respite care. In facilities of over 15, no more than 3 beds or 10 percent of beds may be set aside for respite care, whichever is greater.

Q8: How long must a facility maintain records?

A8: If the licensure rules and/or Medicare requirements are silent and the provider is a Medicaid provider, IDAPA 16.03.09.330.05 requires Medicaid providers to keep records for at least 5 years.

Q9: Can a family member bring home canned fruits or vegetables to the facility for use?

A9: No. IDAPA 16.03.11.350.09(c)(1) states "All processed or canned foods must be obtained from approved commercial sources or from custom canneries or food processing plants."

Q10: If a hospice patient has a DNR completed when they are of sound mind stating s/he does not want to be resuscitated, can a family member with power of attorney decide to have the patient resuscitated anyway? Which has ultimate authority?

A10: Under the Idaho law, the wishes of the patient are to be followed. So, they should trump the family member's wishes. There is a grey area, however. If the patient, since completing the DNR, has expressed a desire to revoke their original statement and go for resuscitation, then that revocation, even if oral, is to be honored. But, a POA's [Power of Attorney] wishes do not trump the stated wish of the person giving the power. The POA has the obligation to make decisions consistent with the wishes of the patient giving the POA.

Please refer to the Informational Letters section of the ICF/MR web site: 2002-02 Section 66-405, Idaho Code, Regarding Treatment and Care of Residents with Developmental Disabilities.

Q11: Are there protective equipment guidelines for staff when they bathe individuals? If so, where are they kept?

A11: The facility would need to consult the Code of Federal Regulations (CFR) for OSHA blood-borne standard (1910.1030) and/or the personal protective equipment standards (starting at 1910.132). The CFR for OSHA can be accessed through the U.S. Department of Labor at www.osha.gov.

There will be nothing specific to bathing. The protective equipment needed depends upon the hazards encountered (i.e. blood, chemicals, biting from a client, etc.). Additionally, if the staff is bathing a client and their work shoes get wet, the employer is expected to provide protective foot gear. OSHA does not want workers walking around in wet shoes or clothing for the rest of the day, especially if they are exposed to biological hazards such as blood, fecal material, urine, etc.

Q12: How does a facility apply for special rates?

A12: The facility may contact the Medicaid office at (208) 287-1156 in order to apply for special rates.

Q13: Can an agency request someone from the Bureau attend meetings and trainings provided by the facility, or provide training directly to the facility?

A13: Yes. Requests for training or presentations must be sent to the Bureau Chief, either via e-mail through the web-site or in letter form.

Q14: Can you give me all of the tags that relate to items that should be in a company's Standard Operating Procedures (SOP) or policy? What is the regulatory view on SOPs?

A14: All of the tags (regulations), which would include Appendix J and Idaho Administrative Code (IDAPA), are pertinent to company policy. There are some regulations which speak specifically to policy such as W149, W267 – W270, W276, etc.). However, W104 covers everything. The Interpretive Guidance at W104 states, in part, that "The governing body provides, monitors, and revises, as necessary, policies and operating directions which ensures the necessary staffing, training, resources, equipment and environment to provide individuals with active treatment and to provide for their health and safety."

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§483.410 Condition of Participation: Governing Body and Management

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§483.420 Condition of Participation: Client Protections

Q1: Does W137 talk about the residents' right to display their possessions, or the right to retain and use them?

A1: One of the Facility Practices statements at W137 states "Individuals have free access to their own possessions and clothing." The Interpretive Guidance also states "Individuals should not be without personal possessions because of the behavior of others with whom they live." Probes in the Interpretive Guidance include:

- Are individuals assisted in clothing selection, room decoration and other forms of self expression?
- Are individuals satisfied with the access to and choice of the kinds and numbers of personal possessions they have?
- Are individuals' personal decorative possessions displayed?
- Are individuals' possessions protected?

We recognize the difficulty in both allowing and encouraging individuals to display personal possessions, and keeping those possessions safe from others. Various issues come into play when assessing compliance at W137.

- A positive living environment which promotes growth and independence is an essential element of the active treatment process. Having to keep one's personal possessions locked up because of the destructive behavior of another brings into question the quality of the living environment.

- Is it appropriate for the person who is destructive to have a roommate? Perhaps the individual's behavior is such that a private room would better serve the needs of all involved.

- What measures has the facility taken which would allow the individual to display personal possessions, yet protect them from destruction (e.g. Plexiglas over posters, firmly secured wall pictures, enclosed cabinets, which would allow possessions to be seen yet protected behind a see through door)?

- Is the individual who engages in the destructive behaviors adequately supervised?

Q2: How many social, religious, and community group activities are required each month to satisfy W136?

Q2: There is not a set number of activities. The type and number of social, religious, and community group activities is based on the assessed needs, interests, and choices of each individual.

Q3: Would it be acceptable for an ICF/MR to use Depo-Provera and/or Lupron in the treatment of sex offenders – providing of course, that the offenders meet ICF/MR level of care requirements and numerous other less restrictive interventions have been tried and found to be unsuccessful?

A3: Yes. The use of these drugs would fall under the W128, W261 – W265, and W311 – W317 requirements for drugs used to control inappropriate behaviors. They can be used if approved by the IDT (Interdisciplinary Team) and specially constituted committee, are used as an integral part of the client's IPP (Individual Program Plan), the behavior outweighs the drug's potential harmful side effects, the client is monitored closely for desired response/adverse reactions, and there is a gradual withdrawal. As for the gradual withdrawal, it may not be appropriate to withdraw the drug. However, the IDT needs to periodically re-evaluate the decision not to attempt a gradual withdrawal based on the individual's progress or other changes in clinical status. It may be that because of the individual's current status or psychiatric illness (if that is what they identify it as) the gradual withdrawal of the drug would be unwise in which case the team must indicate why.

Q4: Must a health facility employee report suspected child abuse, or is the legal obligation restricted to observed acts?

A4: The reporting requirement extends to health care workers "having reason to believe" that a child has been abused, neglected or abandoned, as well as those who observe conditions or circumstances [I.C. 16-1619 (a)]. Even so, there is a fairly extensive gray area surrounding what constitutes "reason to believe." For example, an out of control child being brought to a health facility for biting through a sibling's ear, then being sent back home without having been stabilized, would give reason to believe the sibling will continue to be exposed to an abusive situation. However, another reasonable person might view it otherwise, with the mother alerted to her child's conduct, etc. So, this would be a situation by situation call, taking into account all the facts and circumstances.

Q5: Does the Administrator need to be immediately notified of all client to client altercations (including name calling) or only physical contact, and all SIB [Self Injurious Behavior] regardless of severity (i.e., hand sucking vs. notable injury)?

A5: The following clarification was received from CMS:

W153 – 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…

The term "immediate" in the above regulation truly means immediate. Policies and practices which allow time intervals for reporting to the administrator (e.g., within 2 hours, etc.) are not allowed. This requirement for immediate reporting includes ALL allegations, regardless of severity or frequency. For example, client-to-client aggression and self-injurious behaviors must be reported immediately to the administrator, even in situations where there is no observable injury.

The administrator (not a designee) is notified of the incidents during his/her routine hours of work (e.g., 8:00 a.m. – 5:00 p.m.) Monday – Friday when he/she is on duty. A rotating on-call schedule is acceptable for other hours of the day/week, however, the staff designated to be on-call must have the authority to take whatever actions necessary to ensure clients are protected. None of the above precludes the administrator from going on vacation, etc. and appointing a qualified staff person to act on the administrator's behalf when he/she is absent.

Q6: Does the facility need to report client-to-client assaults/abuse between minors to child protection?

A6: Client-to-client assault/abuse between minors would not need to be reported to Child Protection, as they do not involve abuse perpetrated by the parent, guardian, or legal custodian. However, if the abuse is a result of staff-to-client abuse or neglect, the facility would be responsible to report as it involves the "legal custodian."

Q7: Historically, Child Protection (CP) does not get involved in cases like Adult Protection (AP) does. AP will investigate a case, but CP seems to have more requirements on when they would get involved. What is the best way to approach the cases in which CP will not take a referral?

A7: As of October, 2012, Child Protection Services has created the Idaho Central Intake Unit. This unit takes all child protection referrals. All allegations of abuse, neglect or mistreatment directed towards an individual under the age of 18 must be reported within 24 hours to the Idaho Central Intake Unit. Within the Treasure Valley, the number is 334-KIDS (5437). Outside the Treasure Valley call 1-855-552-KIDS (5437).

Q8: What is the definition of "immediate" relative to W153 and W376?

A8: CMS expects the ICF/MR to report the incident as soon as individuals and staff are safe. In smaller facilities, it may take time to get additional staff into place to assure safety. Once achieved, the report must be made.

Q9: Is the facility required to obtain consent when an individual receives anesthesia?

A9: **W124** – The facility must 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.

The Facility Practices section states "Individuals and their representative, if applicable, are aware of the individual's medical condition and treatment, therapies, services and other treatment or prescribed approaches being received, the reason for their use, as well as any risks involved in those treatments or approaches."

The guidance states "The term 'attendant risks of treatment' refers to all treatment, including medical treatment."

Q10: Is the use (by the client) of a company computer, network and internet access a right or a privilege?

A10: Use of a company computer for entertainment vs. work is governed by the company. The company should have "rules" for its use.

However, if an individual in the ICF wants to learn to use a computer (either for fun or for work purposes), then the team would need to determine if the use is appropriate. If so, the team would then need to figure out how to provide computer access, as well as assistance for its use, to the individual. If the reason for the computer is over and above that of fun or hobby, such as communication, work and perhaps socialization, then the computer is no different than any other type of assistive technical device an individual would need and the ICF should provide it. The ICF can obtain a donated one, talk to the State Tech Group about acquiring one, lease one, or buy one. Having their needs met is the right of the individual.

The company should use caution as access to a company computer may provide an excuse for some staff that may choose to use the computer inappropriately. For example, the individual may then be blamed if pornography is found on the computer, the computer breaks, etc. Additionally, the company's information may be at risk for being lost or accessed inappropriately if the computer has multiple users (i.e. individuals and staff).

Q11: If it is made available to one client should all clients be encouraged to utilize this as a training resource?

A11: If the company has made a computer available to one individual for a specific use, it does not mean the company has approved all use of the computer. Additionally, each individual should be assessed to see if current technology has a role in their lives. This should include, but not be limited to, cell phones, e-mail, answering machines, computers, etc.

Q12: Can it be used as a reinforcer if it is a privilege?

A12: If a computer is available for general use by clients, then use may be based on the clients meeting the "rules" of its use. If the "rules" (e.g., no food or beverages over the keyboard, no use unless cleared to use independently, or other community rules similar to what the library may impose on their computer use) are followed, then its use would be neutral, not necessarily a reinforcer or a privilege.

If the company assesses and chooses to use the computer as reinforcement for an individual, it would need to be part of a written behavior plan. Additionally, if the

computer were used as a communication device for an individual, its use could not be as reinforcement.

Q13: Regulations: §483.420(a)(9) Tag W133 - "Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice." and §483.420(a)(9) Tag 134 - "and to send and receive unopened mail." – Does this pertain to electronic mail and chat room contact?

A13: Yes, electronic mail and chat room contact would be included, unless it is part of a training program with plans to teach use and appropriateness, and then fade the restrictiveness. Additionally, HRC approval and guardian consent would need to be obtained for any restrictive components of the program.

Q14: If internet access is utilized as a recreational resource, communication tool, and is identified in the client's IPP, does the facility have to furnish this resource?

A14: As stated previously, if the computer is used as a communication tool the facility is obligated to provide the device.

Q15: If a client wants to post pictures of himself and pictures of another client on-line is this restricted? If so, how?

A15: If the client is their own guardian and wants to post pictures of him/herself, then they have a right to do so. If the client has a guardian, then the guardian would have to make the decision to allow the individual to post pictures or not. Posting pictures of another client (peer, friend, etc.) would require the same questions to be asked regarding the other individual.

Additionally, as with dating, the facility must ensure that no individual residing at the facility is taken advantage of, that each individual understands their right to say "no," and that each individual understands the possible consequences of saying "yes."

Q16: Are minor injuries of unknown origin (i.e. a small scratch) required to be reported immediately to the Administrator?

A16: Yes. All injuries of unknown origin, regardless of size and/or severity, need to be reported immediately to the Administrator or AOD (Administrator On Duty).

Q17: What is the definition of "injury of unknown source?"

A17: An "injury of unknown source" is any injury, regardless of significance, that's origin is not known, meaning the cause of the injury was not witnessed, and/or the individual or others cannot reliably report where the injury came from.

Q18: Does the reporting of incidents to the AOD meet the requirements of reporting to the Administrator?

A18: Yes.

Q19: Who can serve as the Administrator Designee, and what authority are they required to have?

A19: Anyone can be appointed Administrator Designee per the Administrator's choosing (i.e. QMRP). The AOD would be expected to have the same authority as the Administrator as it relates to ensuring the protection of individuals (i.e. the ability to suspend staff pending an investigation due to allegations/suspicion of abuse, neglect, and mistreatment, to implement policy to begin an investigation of abuse, neglect, mistreatment, etc.). The AOD does not necessarily need to have the ability to hire and fire staff. The authority and qualification requirements of the AOD would need to be defined within the facility's policy.

Q20: Can an individual residing in an ICF/MR request a lock be installed on his bedroom door to keep other individuals out?

A20: Yes. It is acceptable for an individual to have a lock on their bedroom door as long as the individual is able to independently operate the lock and would be free to enter and exit at will. Staff should have access to a key as well in case of emergency situations. The lock can be a standard bedroom door knob lock with a thumb-switch on the inside or a deadbolt that has a thumb-switch on the inside. Padlocks would not be acceptable.

Q21: Does the facility's Policy and Procedures have to address situations where the Administrator is the one accused of abuse, neglect, or mistreatment?

A21: Yes. W149 states the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Although the regulation does not specify abuse by whom, when looking at the regulation set holistically, the guidance under W127 states "Individuals must not be subjected to abuse by anyone…" Additionally, the probes under W156 state "If a report of known or suspected abuse or neglect involves the acts or omissions of the administrator, how has the provider arranged for an unbiased review of the allegation…?" The facility must include the procedures to address "acts or omissions" by the administrator in the policy and procedures for abuse, neglect, and mistreatment to ensure protection of the individual.

Q22: What is the definition of psychological abuse and assault in relation to interaction between clients?

A22: The definition of abuse includes the concept of willful intent. For example, striking out at other individuals may or may not be willful. If there is a question, we expect it to be reported.

Q23: Is it acceptable for the facility to lock the front door at night for safety?

A23: Yes, it is acceptable to lock doors at night for safety purposes as long as staff are inside and can facilitate egress in the case of an emergency. What staff can not do is lock the doors and go outside for a break, leaving no staff inside. Staff also can not use the locked doors as a behavior modification technique. For example if you only have one staff on graveyard shift and people with elopement risks, staff can not lock the doors to keep individuals from eloping. So while it is acceptable to lock the doors at night, the reason must be clear.

Q24: Is the facility required to have a money management training objective included within the IPP?

A24: The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis. Refer to CMS Informational Letter at http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09_47.pdf

Q25: Can an individual be charged for damage to facility property or the property of others which was caused by that individual's destructive behavior?

A25: No. Clients may not be charged. The ICF/MR has a general responsibility to maintain the environment as a cost of doing business. These costs are included in the rate which the ICF/MR is paid. Under 42 CFR 447.15, a certified facility agrees to accept, as payment in full, the amounts paid to it by the Medicaid agency. A surveyor who finds that residents are being charged for covered services should make a referral to the Associate Regional Administrator, Division of Medicaid in their Regional Office for action under 42 CFR 447.15. It may be appropriate for a facility to use financial restitution as a consequence for maladaptive behavior in limited circumstances, when that consequence is meaningful to the individual. In this case, the behavior is required to be addressed through an active treatment program [483.450(b)(3)]. Since the program involves risk to client rights (i.e. use of personal funds), written informed consent and review by the specially constituted committee is required [483.440(f)(3)].

Q26: Is the facility required to pursue guardianship for those individuals who do not have a guardian?

A26: Yes. Clients who need guardianship or advocacy and do not have this need addressed would not be prepared to exercise their rights as citizens of the United States. A facility's failure to pursue guardianship or advocacy should be cited under W125.

Based on survey findings, if these clients' "rights" are unofficially being delegated to others (like parents, family, advocacy groups, etc.) further deficiencies would be cited – under W123, W124, W143, and W163 – as well.

Q27: What constitutes informed consent, and what must be assessed to determine if the consent given is in fact "informed?"

A27: W124 – Informed consent consists of permission by the legally responsible party after having been informed of: the specific issue, treatment or procedure; the client's specific status with regard to the issue; the attendant risks regarding the issue; acceptable alternatives to the issue; the right to refuse; and the consequences of refusal.

The following guidance is provided at W124 to assist in the determination as to whether the individual giving consent had sufficient information to be "informed" for Treatment, Research Activity, and Restrictive Programs:

1. Was the individual aware of the intended proposal, program or treatment, the procedures to be followed, and the identification of the person proposed to perform the treatment activity?

2. Was the individual aware of the indented outcome of the proposal, program or treatment, including the anticipated benefits?

3. Was the individual aware of the possible risks, including side effects and attendant discomfort of the intended proposal, program or treatment, and the steps to be taken to minimize risk?

4. If the consent was for treatment or a restrictive program to manage behavior, was the individual aware of the risks involved if consent was not given, and the alternatives offering less risk or adverse effects?

5. Was the consent time-limited (that is, include the date the consent was signed, and the date by which the specific consent becomes invalid)?

6. Was the consent given voluntarily? Did the individual have the opportunity to have questions about the activity answered? Did the individual realize that the consent could be withdrawn at any time without risk of punitive action?

7. Was the information about the activity presented in language that could be readily understood by the individual giving consent?

8. Was the individual who gave consent the legally appropriate party to do so for the client?

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§483.430 Condition of Participation: Facility Staffing

Q1: Do you have any general QIDP training that you feel is a "hot topic" or important issue to cover?

A1: Recent survey work has shown an increase in the number of citations related to Client Protections and Client Behavior and Facility Practices. In some of these cases, QIDPs (QMRPs) were unaware of what was occurring as responsibility had been delegated down to Assistants (AQs) or Home Managers. The regulation at W159 holds the QMRP ultimately responsible. Per regulation, "Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional." A QMRP simply signing off on an AQ's or Home Manager's work is not acceptable. For facilities that allow this to occur, W104 may also be cited for the governing body's failure to ensure sufficient operating direction.

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§483.440 Condition of Participation: Active Treatment Services

Q1: Can an objective be clear enough that it serves as both the objective and the specific methods to be used?

A1: Objectives and methods are clearly identified as separate requirements in the regulations.

The federal regulations at 483.440(c)(4)(i-v) state that training objectives must:
W229 – Be stated separately, in terms of a single behavioral outcome;
W230 – Be assigned projected completion dates;
W231 – Be expressed in behavioral terms that provide measurable indices of performance;
W232 – Be organized to reflect a developmental progression appropriate to the individual; and
W233 – Be assigned priorities.

The regulations go on to state at 483.440(c)(5)(i-vi) that each written training program designed to implement the objectives in the individual program plan must specify:
W234 – The methods to be used;
W235 – The schedule for the use of the method;
W236 – The person responsible for the program;
W237 – The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
W238 – The inappropriate client behavior(s), if applicable; and
W239 – Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

The Facility Practices statement at W234 states the methods are to provide clear directions to any staff person working with the individual on how to implement the teaching strategies. The objective, on the other hand, states the desired behavioral outcome. Objectives do not include all information necessary for ensuring consistent implementation by providing clear instructions to staff, such as the type and frequency of reinforcement, what to do if the individual does not correctly achieve each step or task, etc. The degree to which a task must be broken down, and the resulting number of steps in a program, is based on the individual's abilities as identified in the comprehensive functional assessment.

Q2: Would it be acceptable for an ICF/MR to use Depo-Provera and/or Lupron in the treatment of sex offenders – providing of course, that the offenders meet ICF/MR level of care requirements and numerous other less restrictive interventions have been tried and found to be unsuccessful?

A2: Yes. The use of these drugs would fall under the W128, W261 – W265, and W311 – W317 requirements for drugs used to control inappropriate behaviors. They can be used if approved by the IDT (Interdisciplinary Treatment Team) and specially constituted committee, are used as an integral part of the client's IPP (Individual Program Plan), the behavior outweighs the drug's potential harmful side effects, the client is monitored closely for desired response/adverse reactions, and there is a gradual withdrawal. As for the gradual withdrawal, it may not be appropriate to withdraw the drug. However, the IDT needs to periodically re-evaluate the decision not to attempt a gradual withdrawal based on the individual's progress or other changes in clinical status. It may be that because of the individual's current status or psychiatric illness (if that is what they identify it as) the gradual withdrawal of the drug would be unwise in which case the team must indicate why.

Q3: Is it necessary to obtain guardian consent for restrictive interventions prior to receiving HRC (Human Rights Committee) approval?

A3: Yes. W263 states the HRC (Human Rights Committee – a.k.a. Specially Constituted Committee) must ensure that restrictive programs are conducted only with the written informed consent of the "client, parents (if the client is a minor) or legal guardian." Particularly for new medications/restrictive interventions, experimental treatments, high risk invasive procedures, when guardian interview indicates a concern, or when otherwise indicated, failure of the HRC to ensure the guardian had given consent could result in a citation.

Q4: At what age does active treatment stop?

A4: W197 – Age is not an issue in determining need for active treatment. Attending a senior center may be a justifiable part of the active treatment program for an elderly individual. Surveyors should refer to the Interpretive Guidance under W196 which addresses the issue of active treatment for older individuals residing in an ICF/MR.

Q5: Under what circumstances are maintenance programs appropriate? Are there any recommendations for ensuring active treatment requirements are met when working with individuals that have extremely limited to no physical capability, profound intellectual disability, and/or are struggling with declining capabilities related to a severe seizure disorder?

A5: The second half of the regulation at W196 speaks to the prevention or deceleration of regression or loss of current optimal functional status.

Individuals with degenerative conditions receive training, treatment and services designed to maintain skills and functioning and to prevent further regression to the extent possible. Those "active" interventions necessary to prevent or decelerate regression are considered to be part of the overall active treatment program.

For example, if the application of a specific stimulation technique to the area of the mouth of an individual with severe physical and medical disabilities, decelerates the individual's rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth, then this intervention is considered to be a component of active treatment for the individual.

Active treatment is the sum total of the major components of the active treatment process or loop which make up the requirements under this Condition of Participation (i.e., assessment, individual program planning, implementation, program documentation, program monitoring and change).

Note: The BFS website has a PowerPoint Presentation related to severe and profound disabilities that may be of interest.

Q6: Which evaluations need to be reviewed by the IDT each year?

A6: W259 – This requirement applies to all evaluations conducted on a client, unless otherwise specified in the regulations (e.g., annual physical examination). For example, an occupational therapy evaluation is not required to be completely redone every year. However, at least annually (more often if indicated by the client's needs), the sensory-motor segment of the comprehensive functional assessment must be reviewed for its relevancy, and updated only if needed.

Q7: What constitutes informed consent, and what must be assessed to determine if the consent given is in fact "informed?"

A7: W124 – Informed consent consists of permission by the legally responsible party after having been informed of: the specific issue, treatment or procedure; the client's specific status with regard to the issue; the attendant risks regarding the issue; acceptable alternatives to the issue; the right to refuse; and the consequences of refusal.

The following guidance is provided at W124 to assist in the determination as to whether the individual giving consent had sufficient information to be "informed" for Treatment, Research Activity, and Restrictive Programs:

1. Was the individual aware of the intended proposal, program or treatment, the procedures to be followed, and the identification of the person proposed to perform the treatment activity?

2. Was the individual aware of the indented outcome of the proposal, program or treatment, including the anticipated benefits?

3. Was the individual aware of the possible risks, including side effects and attendant discomfort of the intended proposal, program or treatment, and the steps to be taken to minimize risk?

4. If the consent was for treatment or a restrictive program to manage behavior, was the individual aware of the risks involved if consent was not given, and the alternatives offering less risk or adverse effects?

5. Was the consent time-limited (that is, include the date the consent was signed, and the date by which the specific consent becomes invalid)?

6. Was the consent given voluntarily? Did the individual have the opportunity to have questions about the activity answered? Did the individual realize that the consent could be withdrawn at any time without risk of punitive action?

7. Was the information about the activity presented in language that could be readily understood by the individual giving consent?

8. Was the individual who gave consent the legally appropriate party to do so for the client?

Q8: Does the specially constituted committee review guardian consent?

A8: Yes. W263 requires the facility's specially constituted committee to assure that restrictive programs or any program involving risk to client protections and rights, are conducted only with informed consent. This includes the use of drugs to manage inappropriate behavior. Therefore, the specially constituted committee does need to review and ensure guardian consent is obtained.

Q9: Is consent given for the program, the technique, or the restriction?

A9: W263 – Informed consent must be given for "programs" incorporating the usage of techniques specified in W262, not merely given for use of the techniques or restriction in isolation. W312 requires that these active treatment programs include amongst other things, the medication's usage and define how that usage will change in relation to

progress (or regression) in the active treatment program objective(s). Therefore, if the program, as described above, has received informed consent by the legally appropriate party, and if the physician changes the dose of the medication in accordance with this drug treatment component of the active treatment plan, then there is no need to have to get informed consent for a change in drug dosage.

Q10: If an individual is restrained by a parent/guardian during a home visit, is the facility required to have consent for that restraint?

A10: No. As long as the restraint is not being used by the facility, then no, the facility would not need consent. The facility cannot be held responsible for what the parent/guardian does outside the facility. However, if the individual was to return with bruises or injuries as a result of the restraint, the facility would be required to investigate as an injury of unknown origin and report to the appropriate agencies.

Q11: If we have a program, such as a hand washing program, that is run both at home and in the community at the day program, and we specify on the data sheet where each particular trial is being run, do we need to have a separate criteria and separate entry on the flow sheet for each setting, or can we have one criteria and one entry on the flow sheet for both?

A11: Refer to appendix J, W120, W237 and W249. It really comes down to a matter of assessment and how the Interdisciplinary Team (IDT) sets the individual objectives in the IPP (Individual Program Plan). Environment impacts behavior. In the hand washing example, it could be there is a difference in the environment that inhibits a person's abilities and independence (e.g. spin knobs verses flip knobs). In those situations, the IDT should track separately because there are going to be data differences. Again, this goes back to assessment and identifying those differences and then developing objectives. When developing objectives some facilities have separate objectives for the home and day program. If this is the case, data would then need to be tracked separately.

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§Condition of Participation: Client Behavior and Facility Practices

Q1: What is the definition of restrictive? Who defines restrictive?

A1: A program to manage inappropriate behavior would be considered restrictive if it infringes on the rights of, or presents a risk to, the individual. Examples of restrictive procedures include, but are not limited to, the following:

- The use of drugs to modify or control behavior.
- Restitution.

- The use of items, procedures, or systems which are potentially stigmatizing to the individual or otherwise would represent a substantial departure from the behavior of comparable peers without disabilities, such as a locked residence without being given a key or ability to use the key, use of a high crib with bedrails for an adult who gets out of bed at night and wanders or upsets others, wearing a jumpsuit backwards to prevent an individual from stripping clothes off, and wearing gloves to prevent an individual from picking at his/her skin.
- Positive Practice and Overcorrection training of extensive duration.
- Satiation.
- Physical Restraint, defined as any manual method or physical or mechanical device that the individual cannot remove easily, and which restricts the free movement of, normal function of, or normal access to a portion or portions of an individual's body (e.g. prone or supine restraint, basket holds, arm splints, posey mittens, helmets, straight jackets).
- Application of painful or noxious stimuli.
- Use of time-out rooms.
- Contingent denial of any right or earning of a right as part of a behavior shaping strategy.
- Behavioral consequences involving issues of client dignity.
- Restrictions on community access.
- Restricting free access to personal belongings.
- Time-out procedures.
- Forced compliance.

Keep in mind that this list is not all inclusive.

Q2: Would it be acceptable for an ICF/MR to use Depo-Provera and/or Lupron in the treatment of sex offenders – providing of course, that the offenders meet ICF/MR level of care requirements and numerous other less restrictive interventions have been tried and found to be unsuccessful?

A2: Yes. The use of these drugs would fall under the W128, W261 – W265, and W311 – W317 requirements for drugs used to control inappropriate behaviors. They can be used if approved by the IDT (Interdisciplinary Team) and specially constituted committee, are used as an integral part of the client's IPP (Individual Program Plan), the behavior outweighs the drug's potential harmful side effects, the client is monitored closely for desired response/adverse reactions, and there is a gradual withdrawal. As for the gradual withdrawal, it may not be appropriate to withdraw the drug. However, the IDT needs to periodically re-evaluate the decision not to attempt a gradual withdrawal based on the individual's progress or other changes in clinical status. It may be that because of the individual's current status or psychiatric illness (if that is what they identify it as) the gradual withdrawal of the drug would be unwise in which case the team must indicate why.

Q3: Can a facility choose to ignore SIB such as repeatedly slapping one's self on the face/head hard enough to cause pain and redness or bumping head on a wall (but no

obvious external injury) if they feel the behavior is attention seeking and attending to the behavior will only increase its frequency?

A3: No. If these types of behaviors occur, they cannot be simply ignored due to the potential for internal damage to eyes, ears, brain, etc. If the facility ignores a behavior in an attempt to extinguish the behavior, and that approach results in tissue damage, or could lead to injury for the individual, the failure of the facility to protect the individual can result in deficient practice. The facility must identify when staff should intervene short of tissue damage, and develop and implement behavioral interventions to address the attention seeking behavior.

Q4: If a facility has programs in place that call for an individual (child or adult) to stand in the corner or sit on the floor for anywhere from 1 – 10 minutes (whatever is specified in the program) as a consequence for a specific behavior, does this procedure constitute a restrictive intervention and, therefore, require an informed consent from the parent/guardian?

A4: Yes. Since the use of this technique will work only if the individual does not like to be removed from an activity or from people, this would be considered a restrictive program. Since this is a restrictive program, it needs to go through the usual review and approval processes. In addition, the plan needs to identify how it will move to lesser restrictive measures.

Q5: Regulation: §483.450(b)(1) Tag W274 – "The facility will develop written policies and procedures that govern the management of inappropriate client behavior" – Will this policy need revision to take into account what is to be acceptable conduct using facility computers, network, and internet access, etc?

A5: Yes. See questions related to computer use by individuals residing in ICFs/MR under the Condition of Participation for Client Protections.

Q6: Does criteria need to be established for medications used to control inappropriate behavior if reduction of the medication is contraindicated?

A6: It would depend on whether the situation was short term or long term. The following two examples illustrate:

If you have a person with chronic mental illness who has had severe psychotic breaks every time you have done an annual medication reduction over the past 5 years, it may be sufficient to say that the medications are not going to be reduced and a reduction plan would not be necessary. However, the contraindication would have to have periodic review by the team to ensure the individual's situation had not changed and that the contraindication was still warranted.

However, if it was time for the annual reduction of an individual's anti-depressant medications and their mother, who they were close to passed away, it would only be

contra-indicated for that time period. The contraindication could state the reduction was being deferred until the individual completed the grieving process and was stable. In those situations the medication reduction criteria would still be present, as the reduction was simply being delayed.

Q7: Is one-to-one staffing due to maladaptive behavioral issues considered restrictive? If so, where should it be incorporated?

Q7: Yes. CMS views continual monitoring of a one-to-one staff for behavioral purposes restrictive. The use of one-to-one staffing must be incorporated into the facility's policies (W276 and W277) and the intervention must be incorporated into the individual's IPP (W238, W239, and W289). Additionally, because one-to-one staffing for behavioral purposes is always restrictive, the plan must be reviewed and approved by the individual's guardian (W124) and the specially constituted committee (W262).

Q8: Can an individual be charged for damage to facility property or the property of others which was caused by that individual's destructive behavior?

A8: No. Clients may not be charged. The ICF/MR has a general responsibility to maintain the environment as a cost of doing business. These costs are included in the rate which the ICF/MR is paid. Under 42 CFR 447.15, a certified facility agrees to accept, as payment in full, the amounts paid to it by the Medicaid agency. A surveyor who finds that residents are being charged for covered services should make a referral to the Associate Regional Administrator, Division of Medicaid in their Regional Office for action under 42 CFR 447.15. It may be appropriate for a facility to use financial restitution as a consequence for maladaptive behavior in limited circumstances, when that consequence is meaningful to the individual. In this case, the behavior is required to be addressed through an active treatment program [483.450(b)(3)]. Since the program involves risk to client rights (i.e. use of personal funds), written informed consent and review by the specially constituted committee is required [483.440(f)(3)].

Q9: Can drugs be used for sedation prior to routine medical and/or dental appointments?

A9: Yes. W297 – It is permissible for drugs to be used in order to sedate clients prior to medical or dental appointments, if this decision is made on an individual basis, and with the input from the interdisciplinary team. The surveyor should question whether or not such decisions are made routinely for all individuals regardless of individual need. (See also W312).

Q10: Can the IDT refuse to follow a physician's prescription for a drug to control inappropriate behavior?

A10: Yes. W311 – Although only a physician can prescribe medication, the regulation requires that the physician's prescription must be based on input from other team members, not just the physician's alone. W329 and W330 address the physician's

participation in the client's individual program plan as part of the interdisciplinary team. The physicians of individuals residing in ICFs/MR can not prescribe these types of medications in a vacuum.

If a medication is recommended and the IDT disagrees, the facility must ensure the reason for disagreement is documented, and that alternative interventions are developed to address the behavioral concerns.

Q11: Are medication reduction plans required for individuals receiving psychotropic medications for a diagnosed psychiatric condition; if so, how often?

A11: Yes. W312 – Individuals who receive psychoactive drugs used for behaviors demonstrated as a result of a psychiatric diagnosis, require an active treatment program designed to reduce or eliminate the psychiatric symptoms. The psychiatric diagnosis must be based on a comprehensive psychiatric evaluation in which the evidence supports the conclusion of a psychiatric diagnosis. The focus of the active treatment, in this instance, would be on the mental health of the individual.

W316-W317 – The decision on drug withdrawal will need to be reevaluated on a regular basis in light of the individual's clinical status. It is not acceptable to preclude drug withdrawal for a person with a psychiatric impairment merely because of the possibility that his or her behavior may be exacerbated.

This requirement applies only to those drugs prescribed to modify behavior. Therefore, if Thorazine is prescribed to decrease aggressive behavior, then the annual drug withdrawal requirement applies. However, if Phenobarbital is prescribed to prevent seizures, or Insulin is prescribed to control diabetes, then W316-W317 does not apply.

Q12: Are medication reduction plans required for all medications used to control inappropriate behavior?

A12: Yes. All drugs used to control inappropriate behavior must meet the criteria listed at W310 – W317.

Q13: Are PRNs allowed for behavioral control?

A13: W312 – Emergency (last resort) PRN usage of a drug to manage inappropriate behavior is only allowed as part of an active treatment program specific to the individual when the criteria for its usage is clearly specified in the active treatment program.

Q14: What is the best practice for doing a "med challenge?" It has been mentioned that an acceptable practice to determine necessity of a medication is to hold or give a reduced dose of a medication on the same day every week over a set amount of time and then monitor for behavior changes. Is this an accurate way to determine the need for a medication?

A14: W312, W316, and W317 speak to the use of behavior modifying drugs. *Medication should be gradually and continuously reduced, dose or frequency or both,* while monitoring for a *defined point where the lines of increased symptoms and decreased medication dosage cross.* While a decreased dose of medication will still be present in the individual's system, this type of challenge will determine the minimal dosage needed for symptom control. The physician and the pharmacist should be involved in determining the appropriate rate of reduction for a specific medication within the context of the active treatment program.

Note: The regulation at W314 speaks to the importance of closely monitoring behavior modifying drugs in conjunction with the physician and the drug regimen review requirement at W362 – W366. Physician and pharmacy involvement are important because of the variability of medications. For example, Abilify has a half-life of 48 – 68 hours. Withholding or reducing Abilify for just 1 day may have little effect as 5 mg of a 10 mg dose would still be in the individual's system 2 – 3 days later. Antidepressants also have long half-lives. For example, Celexa's half-life is approximately 35 hours and Prozac's half-life can be 2 – 4 days.

Q15: When is a medication contraindication plan appropriate? What are the necessary components that need to be included in a contraindication plan?

A15: There is no regulation that identifies specific components (e.g., diagnosis, criteria, order by, etc.). However, W317 states drugs used for control of inappropriate behavior must be annually reduced unless clinical evidence justifies that this is contraindicated.

The Interpretive Guidance states: *In the absence of an annual drug withdrawal program,* ***there must be strong, objective clinical evidence*** *(e.g., results of previous reduction, research-based justification, etc.) which supports that decision.* Changes in the individual, his environment or program, are taken into consideration in determining the validity of this evidence. In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and interdisciplinary team should consider the individual's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness. The individuals' current clinical status or the nature of a psychiatric illness may indicate that gradual withdrawal of the drug is unwise at this time.

It is not acceptable, however, to preclude a gradual drug withdrawal for a person, including a person with a psychiatric impairment, merely because of the possibility that his or her behavior may be exacerbated. Data which shows a direct relationship between past attempts at withdrawal, and an increase in the targeted behavior or symptoms should be available to support the decision not to attempt a gradual withdrawal. This data should reflect the programmatic interventions utilized to respond to the behavior prior to determining that gradual withdrawal is contraindicated.

The team should periodically re-evaluate the decision not to attempt a gradual withdrawal based on the individual's progress or other changes in clinical status.

Caution: Typically, if the individual's behaviors are not well controlled at the current med dose, reduction should probably not be attempted. If the individual has a deteriorating psychiatric status, reduction should probably not be attempted. However, there are those circumstances when the facility will have no choice (e.g. adverse reactions to medications, etc.). It's the responsibility of the facility to ensure monitoring of side effects occurs.

Q16: Explain W313 and give an example?

A16: W313 states *"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."* 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.

The following example demonstrates that a behavior modifying drug was being used without evidence of harmful behavior.

Individual #1 was a 53 year old male diagnosed with a severe intellectual disability and intermittent explosive disorder. His behavior modifying drugs included Zyprexa (an antipsychotic drug) 10 mg in the morning and 10 mg in the evening for spitting.

The 2012 Nursing Drug Handbook listed multiple potential side effects of Zyprexa which included, but were not limited to neuroleptic malignant syndrome, somnolence, insomnia, dizziness, abnormal gait, personality disorder, tremor, articulation impairment, tardive dyskinesia, fever, chest pain, constipation, dry mouth, increased appetite, increased salivation, vomiting, thirst, urinary incontinence, weight gain, and joint and back pain.

The facility failed to ensure the intensity/severity of Individual #1's spitting behavior clearly outweighed the potential harmful effects of Zyprexa prior to its continued use.

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§483.460 Condition of Participation: Health Care Services

Q1: Are Physician's Re-Cap orders required to be revised every 60 days?

A1: No. Neither ICF/MR Federal Regulations or State Rules include language that requires Physician's Re-Cap orders to be revised every 60 days.

Q2: Can the facility purchase over-the-counter [OTC] items ordered by the physician (e.g., Desitin, vitamins, aspirin, fiber tablets, milk of magnesia, etc.), copy the physician's order, and attach the copied order to the OTC drug?

A2: The facility cannot label OTC medications pursuant to a physician's order; that may only be done by the pharmacy. However, the facility may purchase OTC drugs and place an individual's name on the packaging so long as the original packaging is maintained and pertinent information is not covered, including dose information, manufacturer, expiration date, and UPC information.

The facility may also use house supplies for OTC drugs so long as the product is maintained in the original package and the label intact. The facility may not purchase "stock" supply for the purpose of refilling old bottles or re-packaging OTC drugs (i.e. purchasing a bottle of Tylenol, and then dividing the pills in the bottle among multiple individuals by placing in them in separate bottles for each individual). Re-packaging of OTC drugs may only be completed by a pharmacy.

Q3: Must controlled drugs be maintained under a double lock system?

A3: Yes. The purpose for the double locking is to limit access to scheduled drugs. If the individual self-administers medications there is no need for a double lock in the individual's room if the controlled medication is secured, the storage area is appropriate for the medications, and it is properly serviced.

However, if the controlled drugs are kept in a central location (i.e. locked in a cabinet in the bathroom or laundry room) and the individual can not yet self administer, the double lock requirement would apply.

Q4: If an individual owns their own blood glucose monitor and is able to complete testing with little or no assistance, is a CLIA waiver still required?

A4: Yes. Any time a facility completes any laboratory testing indicated in the waiver list located in the interpretive guidance at W394, the facility is required to obtain a CLIA waiver. In cases where the individual owns the equipment and completes testing with little or no assistance, the facility is required to maintain a record of those test results in the individual's medical file. Therefore, the facility must obtain a CLIA waiver as the information is being used for diagnostic and treatment purposes.

Q5: What are the requirements for nursing services in an ICF/MR?

A5: Nursing services in an ICR/MR are outlined in a Bureau of Facility Standards informational letter, dated 3/19/08. The letter can be found at:
2008-01 Nursing Services in ICFs/MR.

Q6: Are Hospice Services allowable in an ICF/MR setting?

A6: Yes. Information related to Hospice Services in ICF/MR settings can be found at:
2010-01 Hospice Care in Medicare- and Medicaid- Certified Facilities

Q7: If an individual residing in the facility requires a daily injection, can his/her parents come to the facility and give the injections periodically (i.e. weekends)?

A7: No. The facility LPN or RN must administer the injections due to content of care and delivery of nursing services.

Q8: What is the requirement for bone mineral density tests (i.e., Dexa Scan) for individuals who have taken anti-epileptic drugs (AEDs) long term or other medications such as Depo Provera?

A8: The Interpretive Guidance at W322 states *the individual receives the services indicated by his/her health status. There is follow-up to recommendations for referrals to specialists, specific examinations or evaluations, and treatments. Medical services are provided as necessary to maintain an optimum level of health for each individual and to prevent disability. Medical services include evaluation, diagnosis, and treatment, as needed, by individuals.*

In March 2009, the American Epilepsy Society stated AED therapy was associated with metabolic bone disease and a high risk for fractures, with a reduction in bone mineral density reported in 20% - 75% of individuals taking AEDs. The article further recommended assessment of bone mineral density 3-5 years after initiation of AED therapy.

A letter to health care professionals from Pfizer, dated 11/18/2004, stated "Use of Depo-Provera Contraceptive Injection reduces serum estrogen levels and is associated with significant loss of BMD as bone metabolism accommodates to a lower estrogen level. This loss of BMD is of particular concern during adolescence and early adulthood, a critical period of bone accretion."

Additionally, there are numerous other medication classes such as anti-depressants and proton pump inhibitors that can impact bone density. When considering Dexa Scans for drug class, the IDT must consider consistent, strong clinical evidence accepted by Nationally Recognized Organizations and Nationally Accepted Standards of Practice and the regulation at W322 would apply. If there is not consistent, strong clinical evidence, then it may be best practice to have a Dexa Scan, but the minimum standard at W322 could not be cited. When considering specific medications, the IDT must consider the side effects, cautions and alerts of the particular medication. The regulation at W124 requires the facility to inform the individual and/or guardian of the associated risks and benefits of treatment. Therefore the facility must be aware of all potential medication side effects and cautions.

Q9: What are the recommendations for Zoster vaccinations and what are the applicable regulations?

A9: W324 states the facility *must provide or obtain immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices.* Currently (as of July 2012) the Centers for Disease Control (CDC)

recommends the Zoster vaccine be given at age 60 unless a physician tells you it would not be safe. If the vaccination is not given for safety reasons, this should be documented in the individual's record. Please note CDC recommendations change over time. Please refer to the CDC website for the most updated recommendations.

Q10: What are the requirements for prostate-specific antigen (PSA) tests?

A10: The United States Preventative Services Task Force (USPSTF) made a final recommendation on May 21, 2012 which aligned consistently with their draft recommendation publicly announced on October 7, 2011.

The recommendation is against prostate-specific antigen (PSA) based screening for healthy men, asserting that there is "moderate or high certainty that the service has no benefit or that the harms outweigh the benefits." The USPSTF discouraged the use of the test by issuing it a Grade D rating. The D rating applies to men of all ages but does not apply to the use of PSA testing for monitoring patients after a prostate cancer diagnosis or treatment.

Therefore, if an individual is asymptomatic, a PSA would not be required. However, if an individual has been diagnosed with prostate cancer or is receiving treatment, then PSA testing may be indicated.

Q11: If a physician determines a recommended procedure is un-necessary, what is the facility's responsibility?

A11: W124 applies to ensuring the individual and/or guardian is aware of the associated risks and benefits of the procedure as well as the consequences of refusing the procedure. If consent is required, it must be specific and must be in writing.

For example, surveyors are often asked if a cervical screen and pelvic examination can be deferred because a physician or a legal guardian does not feel it is needed.

If a physician or legal guardian does not feel a cervical screen and pelvic examination is needed, then according to W124, the facility must ensure the individual and/or guardian is aware of the associated risks and benefits of the procedure as well as the consequences of refusing the procedure.

Note: As of March 2012, the United States Preventative Services Task Force (USPSTF) recommends, for women who have a cervix and regardless of sexual history, screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years. For women ages 30 to 65 years who want to lengthen the screening interval, the USPSTF recommends screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.

Q12: What are the requirements for medical screenings for individuals who are receiving hospice services?

A12: The Condition of Participation for Health Care Services at W318 requires individuals receive preventative services and prompt treatment for acute and chronic health conditions and individuals' health is improved or maintained unless the deterioration is due to a documented clinical condition for which deterioration or lack of improvement is an accepted prognosis.

For individuals receiving hospice services, a coordinated plan of care must be developed with consideration given to the individual's medical needs as they relate to both their terminal and non-terminal diagnoses. Given the need for a coordinated plan, W120 also applies.

Q13: Is a Written Informed Consent (WIC) necessary for all hormone therapy use?

A13: Hormone therapy given solely for physical symptoms does not require a WIC. However, W124 does apply. Hormone therapy given for behavioral symptoms is considered restrictive and requires a WIC. It is subject to the regulatory requirements for HRC approval at W262, guardian approval at W263, and a medication reduction plan at W312. The Interpretive Guidance at W312 states *"The regulation was written to encompass any drug when its use is for purposes of controlling inappropriate behavior."*

Q14: Are there revisions to the nursing oversight requirements in an ICF/ID?

A14: No. There may be changes coming in the revised interpretive guidance of Appendix J, but that is not in place yet. There are also some proposed rule changes to the Board of Nursing Rules that people may be interested in. Board of Nursing Rules can be located at www.ibn.idaho.gov

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§483.470 Condition of Participation: Physical Environment

Q1: Does W427 require a window to the outside or a window that opens to the outside?

A1: 483.470(e) is the Standard of Heating and Ventilation. 483.470(e)(1)(i), or W427, falls under this standard and is, therefore, directly related to heating and ventilation. The Interpretive Guidance provide further information regarding the intent of the regulation, and state that "Since a door serves primarily to provide egress rather than to perform the ventilation and aesthetic functions of an outside window, it may not be used for room ventilation in place of a window."

Additionally, the State Life Safety Code requires operable windows and IDAPA 16.03.11.120.04.c referencing client bedrooms, states that "…one-half (1/2) of the window area must be openable."

ADDENDUM: The Fire Safety Code Chapter 33 states the following regarding bedroom windows that are a secondary means of escape from sleeping rooms:

33.2.2.3(c) * It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 ft2 (0.53 m2). The width shall be not less than 20 in. (51 cm), and the height shall be not less than 24 in. (61 cm). The bottom of the opening shall be not more than 44 in. (112 cm) above the floor.

Q2: Can an individual residing in an ICF/MR request a lock be installed on his bedroom door to keep other individuals out?

A2: Yes. It is acceptable for an individual to have a lock on their bedroom door as long as the individual is able to independently operate the lock and would be free to enter and exit at will. Staff should have access to a key as well in case of emergency situations. The lock can be a standard bedroom door knob lock with a thumb-switch on the inside or a deadbolt that has a thumb-switch on the inside. Padlocks would not be acceptable.

Q3: Must individuals actually leave the facility during an evacuation drill?

A3: Yes. All facilities regardless of size require actual evacuation.

CMS recognizes that the Health Care Occupancies chapter of the LSC states that fire drills in health care facilities are to train staff and not to disturb "patients." However, full evacuation for purposes other than fire (such as hurricanes, tornadoes, floods, etc.) might be the only safe course of action. Therefore, all clients must be evacuated at least once a year.

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§483.480 Condition of Participation: Dietetic Services

Q1: Can a facility serve fish caught by, and vegetables grown by, an individual residing in an ICF/MR? Can an individual have eggs from chickens the individual has raised?

A1: Yes. If an individual catches fish, grows vegetables, or raises chickens for eggs, the individual may eat those items. However, the facility cannot serve those items to other individuals residing at the facility.

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