

Intermediate Care Facilities for Individuals with Intellectual Disabilities 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 Individuals with Intellectual Disabilities (ICFs/IID). However, Federal regulations have not changed. Therefore, for the purposes of this document, ICF/MR and ICF/IID are used interchangeably.

Abbreviations

General

Governing Body and Management

Client Protections

Facility Staffing

Active Treatment Services

Client Behavior and Facility Practices

Health Care Services

Physical Environment

Dietetic Services

Ctrl + left mouse click on one of the links to the left to be redirected to that section within this document.

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Abbreviations

ADA – Americans with Disabilities Act
AOD – Administrator On Duty
AQIDP – Assistant Qualified Intellectual Disabilities Professional
BFS – Bureau of Facility Standards
CDC – Centers for Disease Control and Prevention
CFA – Comprehensive Functional Assessment
CFR – [Code of Federal Regulations](#)
CMS –Centers for Medicare and Medicaid Services
CoP – Condition of Participation
DNR – Do Not Resuscitate
DHW –Idaho Department of Health and Welfare
HIPAA – Health Insurance Portability and Accountability Act
HRC – Human Rights Committee
ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities (also known as Intermediate Care Facility for Persons with Mental Retardation – ICF/MR)
IDAPA – [Idaho Administrative Code](#)
IDT – Interdisciplinary Team
IHCA – Idaho Health Care Association
IPP – Individual Program Plan
LSC – Life Safety Code
NF – Nursing Facility
OCR – Office of Civil Rights
OSHA – Occupational Safety and Health Administration
POST – Physician's Orders for Scope of Treatment
PRN – As needed
QIDP – Qualified Intellectual Disabilities Professional
SIB – Self Injurious Behavior
SOM – State Operations Manual

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 issued by 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."

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 NFs and ICFs/IID.

11/19/2019

The appeal process applicable to adverse action taken against a facility's license is described in IDAPA 16.05.03 – Contested Cases.

Additionally, the Idaho Department of Health and Welfare, Bureau of Facility Standards, and the Idaho Healthcare Association established an independent review process for the purpose of resolving disputes over federal and state deficiencies cited during an ICF/IID 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 SOM.

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

A4: The Compliance Principles found in [Exhibit 355 page 138](#), Probes and Procedures for Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care facility for Individuals with Intellectual Disabilities, guide the surveyors in determining compliance. However, these were not intended to replace professional surveyor judgment. The State Operations Manual, Appendix J, section XII, part C- Analysis, states "The threshold at which the frequency of occurrences 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 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 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: How does a facility apply for special rates?

A6: The facility may contact the Medicaid office at (208) 287-1156 in order to apply for special rates.

Q7: Can a facility be reimbursed for respite care?

A7: No. Facilities cannot receive ICF/IID 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/IID residents, interfere with the delivery of active treatment to ICF/IID clients, or jeopardize the health and safety of either the ICF/IID 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/IID care.
2. Services provided to ICF/IID residents are not hampered.
3. The person is admitted to the ICF/IID if the stay will be over 30 days.
4. The facility has at least 4 beds for ICF/IID 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 16.03.09330.05 requires Medicaid providers to keep records for at least 5 years.

Q9: Are there protective equipment guidelines for staff when they bathe individuals? If so, where are they kept?

A9: The facility would need to consult the 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.

11/19/2019

Q10: Can an agency request someone from the Bureau attend meetings and trainings provided by the facility, or provide training directly to the facility?

A10: Yes. Requests for training or presentations must be sent to the Bureau Chief via e-mail to FSB@dhw.idaho.gov.

Q11: Can the facility have therapy dogs/animals brought into the facility?

A11: While there is no regulation preventing therapy dogs or animals from being brought into the facility, it would be necessary to ensure individuals' residing in the facility would benefit from the presence of the animal, did not have allergies or medical conditions that could be exacerbated by the presence of the animal, did not have a fear of the animal, and would not present a risk to the animal.

Additionally, the facility would need to ensure the animal's handler provided information related to the health and care of the animal (i.e. veterinary and shot records) and was screened and trained under the same requirements related to HIPAA that other volunteers/employees undergo.

Q12: Is the facility required to provide or accommodate a service animal for an individual residing in an ICF?

A12: The Americans with Disabilities Act protects the rights of individuals to have service animals. Please refer to <http://www.ada.gov/> for additional information. It is recommended the facility consult with their legal representative prior to making decisions related to individuals residing in ICFs/IID with service animals.

[Top of Page ↑](#)

§483.410 Condition of Participation: Governing Body and Management

Q1: Are there admission restrictions for individuals related to the owner of an ICF/IID?

A1: Chapter 2 section 2138C of the SOM states, "An ICF/MR is defined as a facility that furnishes food, shelter, treatment, or services to 4 or more individuals unrelated to the proprietor."

An individual who is the biological, adoptive, foster child, parent, sibling, etc., of the proprietor/owner would be considered to be related to the proprietor and, therefore, prohibited from being admitted to the ICF/IID.

Q2: Can a facility use cameras to monitor activity in an ICF?

A2: Yes. However, Guidance at W129 provides the following cautions:

- 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.

Q3: How will surveyors address HIPAA issues they see during survey? Will the facility be informed by surveyors or do surveyors report potential HIPAA violations directly to the Office of Civil Rights?

A3: The regulation at W112 addresses the confidentiality of records. Facility systems that allow for potential and/or actual violations are cited. Reports to the Office of Civil Rights (OCR) must meet the specific HIPAA reporting requirements. For example, documents posted in the facility which include the first and last name of individuals have the potential to be seen by visitors, maintenance personnel, etc. This can be cited at W112 but would not necessarily meet HIPAA reporting requirements. However, video monitoring, which is streamed to management staffs' home computers in a non-secure/encrypted manner would meet HIPAA reporting requirements. Survey staff will not typically disclose whether or not an identified problem is reported to HIPAA, but the facility will be aware of the breach in confidentiality as it will be discussed at the time of the survey and cited on the 2567.

Q4: Can you give me all of the regulations that relate to items that should be in a company's Standard Operating Procedures (SOP) or policy? What is the regulatory view on SOPs?

A4: All of the regulations, which would include Appendix J and IDAPA, are pertinent to company policy. There are some regulations which speak specifically to policy (such as W149, W267 – W270, W276, etc.). However, W104 applies to all policies. The Interpretive Guidance at W104 states, in part, that "The governing body develops, monitors, and revises, as necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety."

Q5: Can electronic signatures be used? If so, what are the requirements?

A5: Yes, if the facility develops and implements policies and procedures to ensure authenticity of the signature and security of confidential information. Information related to requirements of electronic records may be found on the Department's Medicaid Provider page at:

<http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ElectronicFilingAndSignature.pdf>

[Top of Page ↑](#)

§483.420 Condition of Participation: Client Protections

Q1: Does W137 include the individuals' rights to display their possessions, or the right to retain and use them?

A1: The Interpretive Guidance at W137 states "Clients should have free access to their own possessions and clothing." The Interpretive Guidance also states, "Clients should not be without personal possessions because of the behavior of others with whom they live." Additionally, the Interpretive Guidance asks:

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

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

A2: 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: Are two individuals, over the age of 18 and high functioning but with legal guardians, able to engage in a sexual relationship within the facility if the guardians consent to such a relationship? If the individuals were their own guardians and chose to engage in a sexual relationship, would the facility need to report to A/P?

A3: Title 18 Crimes and Punishment, Chapter 15 Children and Vulnerable Adults, Section 18-1505 defines vulnerable adult as "A person 18 years of age or older who is unable to protect himself from abuse, neglect or exploitation due to physical or mental impairment which affects the person's judgment or behavior to the extent that he lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his person, funds, property or resources."

Please note the definition does not include information related to the individual being their own guardian. The law is not based on whether the individual is capable of making their own decisions. What assessment information does the facility have regarding the individual's ability to make their own decisions regarding sex? Has education been provided to the individuals? Have they been taught and are they capable to protect themselves from sexual abuse and exploitation?

Additionally, Title 18 Crimes and Punishment, Chapter 66, Sex Crimes, 18-6603 addresses fornication. The law still states "sexual intercourse with an unmarried person... shall be deemed guilty of fornication, and upon conviction thereof, shall be punished by a fine of not more than \$300.00 or by imprisonment for not more than six months or both..."

Therefore, regardless of guardian consent, or the individuals being their own guardians, a sexual relationship would not be permitted and the occurrence of one would require reporting to A/P. Given the present laws and depending on the circumstances, it is possible that the police and/or AP will not act on the reporting. However, the facility does not have the liberty of choosing which crimes to report and which crimes not to report.

Q4: Can an individual be charged for damage to facility property or the property of others which was caused by that individual's destructive behavior?

A4: No. Clients may not be charged. The ICF/IID has a general responsibility to maintain the environment as a cost of doing business. These costs are included in the rate which the ICF/IID 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)].

Q5: Is the facility required to have a money management training objective included within the IPP?

A5: The Guidance at W126 states, in part, that for individuals who already possess "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."

The Guidance cautions "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 Guidance also states, "The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis."

Q6: Is the use (by the client) of a company computer, network and internet access a right or a privilege? Could it be used as a reinforcer?

A6: Use of a company computer for entertainment versus work is governed by the company. 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.

The company should have "rules" for its use, and the individual and/or their guardian should be informed of those rules in accordance with W123.

If the company assesses and chooses to use the computer as reinforcement for an individual, it would need to be part of a written plan in accordance to W289 and incorporated into the behavioral policy in accordance with W274 (see question #5 under the CoP for Client Protections). Additionally, if the computer were used as a communication device for an individual, its use is not reinforcement.

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 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, as indicated at W436, which states the facility must "Furnish, maintain in good repair, and teach clients to use and to make informed choices about...other devices identified by the interdisciplinary team as needed by the client."

The ICF can obtain a donated computer, talk to the State Tech Group about acquiring one, lease one, or buy one. Having needs met is the right of the individuals.

Q7: If it is made available to one client should all clients be encouraged to utilize a computer as a training resource?

A7: If the company has made a computer available to one individual for a specific use, it does not mean the company has approved all individuals for computer use. 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.

Q8: Do the regulations at W133 "Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice" and W134 "...send and receive unopened mail" apply to electronic mail and chat room contact?

A8: Yes, electronic mail and chat room contact would be included, unless it is part of a training program to teach use and appropriateness. Additionally, HRC approval and guardian consent would need to be obtained for any restrictive components of the program.

Q9: If internet access is utilized as a recreational resource and communication tool, and is identified in the client's IPP, does the facility have to furnish this resource?

A9: Yes. If the access is used as a communication tool the facility is obligated to provide it in accordance with W436, as indicated in Question #6 above. Additionally, W249 states "each client must receive a continuous active treatment program consisting of needed interventions and services...to support the achievement of the objectives identified in the individual program plan."

Q10: If a client wants to post pictures of himself and pictures of another client on-line, is this restricted? If so, how?

A10: 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 need to make the decision to allow the individual to post pictures or not. Posting pictures of another individual (e.g., peer, friend, etc.) would require the same questions to be asked regarding the other individual.

W125 requires that the facility "Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States..." 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."

Q11: What is the definition of "injury of unknown source?"

A11: Per the Interpretive Guidance at W153, an "injury of unknown source" is any injury where the source of the injury was not witnessed by any person and the source of the injury could not be explained by the individual; and the injury raises suspicions of possible abuse or neglect because of the extent of the injury, the location of the injury, the number of injuries observed at one particular point in time, or the incidence of injuries over time.

Q12: What is the definition of "immediate" relative to W153? Does the Administrator need to be immediately notified of all client to client altercations (including name calling) or only physical contact, and all SIB regardless of severity

(i.e., hand sucking versus notable injury)? Are minor injuries of unknown origin (e.g., a small scratch) required to be reported immediately to the Administrator? Does the reporting of incidents to the AOD meet the requirements of reporting to the Administrator?

A12: The Interpretive Guidance at W153 states "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.)."

"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."

Q13: Who can serve as the Administrator Designee, and what authority are they required to have?

A13: Anyone can be appointed AOD per the Administrator's choosing (e.g., QIDP). Idaho Administrative Code, (IDAPA) 16.03.11102.02(e), states when not on duty, the Administrator can "delegate the necessary authority to an administrator designee who is competent to handle the administrator's duties. Delegation of authority must occur according to the ICF/ID policies and procedures set by the facilities governing body."

The Interpretive Guidance found at W149 states the facility's 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."

Q14: Does the facility's Policy and Procedures have to address situations where the Administrator is the one accused of abuse, neglect, or mistreatment?

A14: Yes. The regulation at 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 the facility must implement, through policies, oversight and training, safeguards to ensure that clients are not "subjected to abuse by anyone..." Additionally, the Interpretive Guidance under W156 asks "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 procedures to address "acts or omissions" by the Administrator in the policy to ensure protection of the individual.

Q15: Must a health facility employee report suspected child abuse, or is the legal obligation restricted to observed acts?

A15: 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 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.

Q16: Does the facility need to report client-to-client assaults/abuse between minors to child protection?

A16: Idaho Code, Title 16, addresses the reporting and investigation of child abuse allegations. Client-to-client assaults/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."

Q17: 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?

A17: 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).

Q18: Is it within regulations to implement a restrictive procedure into an individual's plan if the guardian/resident representative does not give consent (they either do not wish to have the item implemented or repeated efforts to contact them have failed)?

A18: The interpretive guidance at W124 states consent is required. The regulations do not allow for implementation of a restrictive intervention without consent unless it is a physical or chemical intervention employed as an emergency measure. Please refer to regulations W296 (physical restraint) and W312 (chemical restraint) for specific information on emergency measures, as well as W278 for least restrictive intervention requirements in emergency situations. However, once it can be reasonably anticipated that the restrictive intervention will be routinely required, the restrictive intervention must be incorporated into a plan and guardian consent is required in accordance with W124 prior to implementation. If the guardian refuses to give consent, the intervention cannot be implemented. The Interpretive Guidance at W124 also states the facility must present

the guardian with acceptable alternatives for treatment. However, if the guardian also refuses the alternatives, or if no alternatives exist “the facility must consider the effects this refusal may have on other clients, the client himself or herself, and if it can continue to treat the individual client consistent with these regulations.”

W125 requires the facility to allow and encourage individual clients to exercise their rights. The Interpretive Guidance at this regulation and at W123 includes advocates, legally sanctioned surrogates, family members, and representatives. If the facility is unable to contact the legal guardian after reasonable attempts have been made and documented, the facility can seek approval from the individuals’ other advocates in accordance with State Law.

IDAPA 16.03.11, sections 201 – 203, address individual representatives. In part, the Rules state when a resident’s parent or legal guardian is unable or unwilling to participate or is unavailable after reasonable efforts to contact them have been made, the facility’s Administrator must appoint a representative. Priority for selection of representatives is parent(s), an interested family member, or another interested party if there are not interested parents or other interested family. However, continued efforts to contact the individual’s legal guardian and/or efforts to establish a new legal guardian should also be taken and documented.

Q19: What constitutes informed consent, and what must be assessed to determine if the consent given is in fact "informed?"

A19: The regulation at W124 requires informed consent consists of: the attendant risks of any recommended treatments or interventions and of their right to refuse treatment, training or services.

The Interpretive Guidance at W124 states "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."

For behavior management programs the interpretive guidance at W263 states, the consents must be "...specific to the program and restrictive practice and reflect a specific time frame. Blanket consents are not allowed," and "Consent is informed when the person giving consent is fully aware of the:

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

Q20: Is the facility required to obtain consent when an individual receives anesthesia?

A20: Yes. The regulation at W124 requires the facility to 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. While this consent may be executed by an outside service provider, it is the responsibility of the ICF/ID to ensure the individual and their representatives were fully informed and that appropriate services are provided per W120.

Q21: How should the facility document individuals' refusals to medical treatment?

A21: The interpretive guidance at W124 includes the components necessary to ensure the decision making is informed (e.g., risks and benefits, available alternative(s), etc.). This would include informing of risks of refusing prescribed medical treatments. However, the regulations do not specify the form of the documentation. Some providers have chosen to incorporate such medical consents/refusals into the same systems they use for restrictive programs (typically a completed template form). Other providers have chosen to document such information in physician notes, nursing notes, etc. The intent of the regulation is to ensure informed decisions are being made, not to prescribe the form of the documentation. However, if documentation in the individuals' record is vague, guardians may be contacted to ensure sufficient information was provided on which to base consent decisions. Deficient practices may be cited at W111 (records) and/or W124 depending on the individual's record and guardian interview.

Q22: How often should an individual's refusal for medical treatment be re-evaluated?

A22: The Interpretive Guidance at W124 states, in part, that "A client, his or her family member, or legal guardian who refuses a particular treatment...must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available." The Interpretive Guidance states "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 service to the client consistent with these regulations."

The regulations are silent regarding how often refusals for medical treatment should be re-evaluated. Timeframes for re-evaluation is dependent on what is being refused, why it is being refused, individual status and individual need. For example, the CDC currently recommends females between the ages of 21 to 65 have a pap smear every 3 years, if no additional risk factors exist (i.e., previous abnormal results, smoking, etc.). It may be appropriate to review pap smear refusals every 3 years if the person has not been identified as higher risk, but sooner if their physician recommended more frequent testing related increased risks.

11/19/2019

Q23: Can an individual with developmental disabilities have a DNR order?

A23: Yes. However, it must be properly executed in accordance with Idaho State Law. Information related to DNR orders and the Idaho POST can be found at the following links:

[Idaho Code](#)

[Idaho POST](#)

Additionally, information about the individual's condition and need for the DNR would need to be incorporated into the comprehensive functional assessment in accordance with W216, and the facility's specially constituted committee must review, monitor and make suggestions to the facility about its practices in relation to the DNR as it pertains to the individual's client rights, per the Interpretive Guidance under W264.

Q24: Are direct care staff required to initiate CPR for individuals on Hospice services with properly executed POST forms?

A24: No.

Q25: What recourse does the facility have if they feel a guardian or conservator for an individual is not appropriately managing an individual's care or financial decisions?

A25: The facility has a right to file a complaint with the Idaho Supreme Court. Information may be found at: <http://courtselphelp.idaho.gov/home>

Specific information related to the complaint process may be found at: <https://isc.idaho.gov/guardianship/complaintprocess>

The form for filing a complaint may be found at: <http://www.isc.idaho.gov/guardianship/guardianship-conservatorship>

Q26: What particular concerns would you look for in a facility policy pertaining to a garden the individuals maintain?

A26: Who is responsible for the garden? Is it a choice to participate or mandatory? If mandatory, are individuals paid for the work they do? What kind of assessment is to be completed prior to implementing gardening (e.g. pulling weeds, watering, picking items, using chemicals for weed and pest control, etc.). If the garden is producing edible items, does the facility ensure they are only served to those individuals growing the garden (e.g. they cannot be served to the entire facility). Does the facility ensure any menu substitutions that result from garden use are documented?

Q27: A resident has Parkinson's and has been on long term drugs to treat that condition. This resident is now experiencing multiple overt side effects from these Parkinson's drugs requiring other drugs to be prescribed as well as behavioral intervention. Because all of this is due to his medical treatments, are consents still required for the drugs and behavior programs that are now needed to address his side effects?

A27: Yes, consents are required. W124 requires that facilities must inform each client, parent or legal guardian of "the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment." In this situation, the medical side effects are causing behavioral symptoms. The guardian must be informed of the behavioral symptoms caused by the medication. The guardian must also be informed of the interventions used by the facility to address the behavioral symptoms. Without such information, the guardian would not be able to make an informed decision as to continue with the Parkinson's medication and approve the behavior intervention or discontinue the Parkinson's medication and discontinue the behavior intervention. The option has significant pros, cons, risks, benefits, and alternatives. The guardian must be made aware in order to be able to advocate for the individual appropriately.

[Top of Page ↑](#)

§483.430 Condition of Participation: Facility Staffing

Q1: Is it acceptable to have Assistant QIDPs?

A1: No. Per regulation at W159, "Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional." The Interpretive Guidance states "The QIDP function may not be delegated to other employees even though the QIDP co-signs their work."

Q2: How do you determine the ratio for staff to residents?

A2: The regulation at W187 addresses minimum ratios based on the individuals' level of developmental disability (mild, moderate, severe, or profound). However, W186 requires the facility to provide sufficient numbers of staff to meet individuals' needs per their IPPs. Compliance with W186 is evaluated when survey observations do not demonstrate adequate interaction and program implementation and/or the facility's documentation (as-worked schedules, program implementation rates, etc.) does not demonstrate adequate numbers of staff are being provided to meet individuals' needs.

[Top of Page ↑](#)

§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 state 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.

Written training programs 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 Interpretive Guidance at W234 states "The training program provides clear directions to any staff person working with the client 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 CFA.

Q2: How is the facility to determine projected completion dates for training programs?

A2: The Interpretive Guidance at W230 states "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 (i.e., not all the same for all clients and all objectives)."

Q3: If we have a program, such as a hand washing program, that is run both at home and 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?

A3: It is dependent on assessment and how the IDT develops the objectives in the IPP. 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 versus 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 need to be tracked separately. Refer to the regulations at W120, W237 and W249 for additional information.

Q4: 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 physical capability, profound intellectual disability, and/or are struggling with declining capabilities related to a severe seizure disorder?

A4: The second half of the regulation at W196 includes the prevention or deceleration of regression or loss of current optimal functional status.

Individuals with degenerative conditions must 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 CoP (i.e., assessment, individual program planning, implementation, program documentation, program monitoring, and change).

Q5: Some individuals are aging. In what ways can we scale active treatment back and still fulfill the regulatory requirement? At what age does active treatment stop?

A5: Active Treatment does not stop regardless of an individual's age. The regulation at W196 (ii) states prevention of regression or loss of optimal function is a part of an individually tailored active treatment program. "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." Therefore, the regulations do not allow for "scaling" back active treatment, but it will look different based on the individual's assessment. For additional information, please refer to the "Retirement for People With Intellectual Disabilities" PowerPoint training posted on the ICF/IID web site.

Q6: Is it acceptable to scale back or discontinue active treatment once an individual begins receiving hospice services?

A6: W196 does not allow for active treatment to be discontinued or scaled back. However, the focus of active treatment will be different. To receive hospice services, death is expected within 6 months. The focus of active treatment continues to be the deceleration of loss (rather than acquisition of skill) and wellness, socialization, etc. Additionally, for individuals receiving hospice services, assessments may need to be updated frequently (W259) and active treatment adjusted (W260) depending on how the terminal diagnosis progresses. For example, an individual may still be able to eat independently when hospice services are initiated. However, over time, the individual may become weaker or experience swallowing difficulties which preclude them from participating in eating. The CFA would be updated to address the regression in skill and the active treatment program would be adjusted based on the change. For additional information, please refer to the "Hospice Services in an ICF/ID" PowerPoint training posted on the ICF/IID web site.

Q7: Can Active Treatment be provided to individuals who are "high functioning" (e.g. they can self-initiate and complete basic self-care tasks such as dressing, bathing, money management, etc.) but require assistance with mental health and safety issues?

A7: Yes. The regulations at W197 and W198 address individuals who are able to function with little supervision or in the absence of a continuous active treatment program. In some situations, individuals have the skills essential for privacy, medication administration, money management, and basic independence (e.g. dressing, dining, bathing, etc.) but due to the combination of their intellectual disability and mental illness they cannot or will not implement those skills without the support of continuous active treatment provided at the ICF/IID level of care. In those situations, active treatment programs focus on scheduling, use, and implementation of the essential skills (based on

assessment of their individual disabilities and mental health needs) rather than the acquisition of those skills.

Q8: Which evaluations need to be reviewed by the IDT each year?

A8: The regulation at W259 states "the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed." The Interpretive Guidance states "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."

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 if needed.

Q9: Please explain what a HRC should look like, consist of, and frequency of meetings.

A9: The regulation at W261 states the committee consists of members of the facility staff, parents, legal guardians, individuals (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. The regulations do not specify the frequency of meetings.

When discussing the HRC, primarily individuals' programs which involve risk to client protection and rights (W262 and W263) are involved. However, please be aware it is the facility's responsibility to ensure the HRC has been made aware of and reviewed all practices which may affect the rights of the individuals (W264). For example, providers must balance individuals' rights to appropriate medical care with individuals' rights to refuse treatment. Individuals, parents, and guardians may decline medical screening exams (such as pap smears) and immunizations (such as the Human Papillomavirus (HPV) and Zoster) as recommended by the CDC and/or medical treatment as recommended by practitioners (such as dental work, cataracts surgery, surgery to repair other physical problems, etc.). Such refusals for treatment are well within the individuals' rights. However, it is the facility's responsibility to ensure the HRC has been made aware of the facility's practices in presenting information to guardians on which to base these decisions. Similarly, it is the facility's responsibility to ensure the HRC is involved in or made aware of other facility practices involving potential rights violations, which may include issues such as advanced directives/DNR orders, individual allegations of abuse, and guardianship/advocacy concerns. Please refer to the interpretive guidance at W264 for additional examples.

Q10: Is HRC consent given for the program, the technique, or the restriction?

A10: The regulation at W263 requires that informed consent be given for "programs" incorporating the usage of techniques specified in W262, not merely given for use of the techniques or restriction in isolation.

Q11: Is it necessary to obtain guardian consent for restrictive interventions prior to receiving HRC approval? Does the HRC review guardian consent?

A11: Yes. The regulation at W263 states the Specially Constituted Committee (a.k.a. HRC) 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."

Q12: If an individual is restrained by a parent/guardian during a home visit, is the facility required to have consent for that restraint?

A12: No. 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 potential abuse/neglect in accordance with W154, including reporting to the appropriate agencies in accordance with W153.

[Top of Page ↑](#)

§Condition of Participation: Client Behavior and Facility Practices

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

A1: W262 states the specially constituted committee is to review, approve, and monitor programs designed to "management inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights," and W263 states the committee must ensure the programs are only conducted with the written informed consent of the individual/guardian. Any program would be considered intrusive or 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 would otherwise 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, 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, mittens, helmets, strait 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.
- Restrictions of materials or locations in the home.

Keep in mind that this list is not all inclusive.

Q2: Would it be acceptable for an ICF/IID to use Depo-Provera and/or Lupron in the treatment of sex offenders – providing of course, that the offenders meet ICF/IID 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 and specially constituted committee, are used as an integral part of the client's IPP, 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 document 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. While immediate injury or symptoms may not be evident from SIB, conditions such as CTE (chronic traumatic encephalopathy), a progressive degenerative disease found in people who have had a severe blow or repeated blows to the head, may develop.

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. If the individual does not like to be removed from an activity or from people, this would be considered a restrictive program.

Q5: Does the regulation at W274 “The facility will develop written policies and procedures that govern the management of inappropriate client behavior” apply to what is acceptable conduct when using facility computers, network, internet access, etc.?

A5: Yes. See questions related to computer use by individuals residing in ICFs/IID under the CoP for Client Protections.

Q6: Is one-to-one staffing due to maladaptive behavioral issues considered restrictive? If so, where should it be incorporated? When is it necessary to have consent? Would this include going on an outing, going on a medical appointment, etc.?

Q6: CMS views continual monitoring from 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).

Both the Regional Office and Central Office for CMS were consulted in July 2009 and again in June 2012. When one-to-one staffing for maladaptive behavior is provided, which exceeds what would be expected for staff to simply provide training, it becomes a restrictive behavioral intervention and requires the same considerations as other restrictive behavioral interventions.

Q7: Can the IDT refuse to follow a physician's prescription for a drug to control inappropriate behavior?

A7: Although only a physician can prescribe medication, the regulation at W311 requires that the physician's prescription must be based on input from other team members. The Interpretive Guidance states "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...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."

Additionally, W329 and W330 address the physician's participation in the client's IPP as part of the IDT.

Q8: Can drugs be used for sedation prior to routine medical and/or dental appointments?

A8: Yes. The Guidance at W312 states "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."

Q9: Are PRNs allowed for behavioral control?

A9: No. The Guidance at W312 states "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 [sic] 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..."

If individuals are experiencing physical symptoms which are related to a psychiatric diagnosis (e.g. rapid heartbeat, hyperventilation, increased blood pressure, etc. associated with anxiety, panic attacks, etc.) medical PRNs, such as lorazepam may be given to treat the medical symptoms. You will still need to have criteria for use established as you would for any other medical PRN and the medication would need to be reviewed and adjusted as you would for any other medical PRN.

Q10: Are medication reduction plans required for all medications used to control inappropriate behavior?

A10: Yes. All drugs used to control inappropriate behavior must meet the criteria specified in regulations W310 – W317.

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

A11: Yes. The regulation at W312 includes individuals who receive psychoactive drugs used for behaviors demonstrated as a result of a psychiatric diagnosis. The regulation also requires 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 requires drugs be gradually withdrawn at least annually. See question #13 below as it relates to gradual withdrawal and contraindication.

Q12: Sometimes we get people admitted that are on a huge number of medications. What are the timeframes for reducing these medications responsibly?

A12: The regulations do not include specific timeframes. Medication reductions are based on comprehensive assessment information. Please refer to regulation W210 for assessment being completed within 30 days of admission and regulations W310 – W317 related to judicious medication use and reduction.

Additionally, the regulation at W313 states medications cannot be used until the severity of the maladaptive behaviors is determined to outweigh the potentially harmful effects of the drug. There are situations which involve an individual being admitted or re-evaluated and it is determined that the severity of the maladaptive behaviors do not outweigh the potentially harmful effects of the drug. However, depending on the medications being used, it may not be safe to reduce all medications at once. Under those sets of circumstances, the facility must document the contraindication (reducing all medications at once) and implement criteria for reduction (W312) based on the safety of the individual in consultation with the licensed practitioner (e.g., could involve labs, time frames, etc.).

Q13: What are the expectations for annual medication reductions? What type of criteria is expected when the team believes a reduction is inappropriate? Would a medication contraindication plan be appropriate? What are the components that need to be included in a contraindication plan?

A13: The regulations do not identify 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.

W316 requires drugs be gradually withdrawn at least annually. The Interpretive Guidance states "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."

W317 requires that those reductions are part of a carefully monitored program conducted in conjunction with the IDT "unless clinical evidence justifies that this is contraindicated." The Interpretive Guidance at W317 states "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."

The Interpretive Guidance goes on to say that "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."

Q14: Does criteria need to be established for medications used to control inappropriate behavior if reduction of the medication is contraindicated?

A14: W317 states drugs used to control inappropriate behavior must be gradually withdrawn unless clinical evidence justifies that this is contraindicated.

The Interpretive Guidance states "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." The guidance also states, "Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal."

While it may be contraindicated to remove a drug at a particular time, it does not mean the drug would always be contraindicated. Therefore, the IDT and physician would need to develop a plan indicating what would need to occur in order for the drug to be considered for reduction.

Q15: 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?

A15: W312, W316, and W317 include the use of behavior modifying drugs. The regulation at W317 states "Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team..." Medication should be gradually reduced 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 includes the importance of closely monitoring behavior modifying drugs in conjunction with the physician and the drug regimen review requirements 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.

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 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 use.

Q17: Many of us have folks that sometimes experience seasonal depression, but they don't have an official diagnosis of depression. It often isn't something known ahead of time to be addressed in the IPP. What types of interventions do surveyors expect to see?

A17: Seasonal Affect Disorder (SAD) is considered a subtype of depression or bipolar disorder. It is different from depression and mania in that it occurs at the same time every year and can happen during either the winter or summer months (additional information on SAD can be found on numerous web sites including <http://www.mayoclinic.org/diseases-conditions/seasonal-affective->

disorder/basics/definition/con-20021047). W212 states the individual's CFA must identify the presenting problems and disabilities and where possible, their causes. The Interpretive Guidance states the CFA includes "all diagnoses and developmental deficits for the client" and "the supporting information for each [diagnosis and deficit]." The guidance states "each evaluation should include conclusions and recommendations which go into the development of an active treatment program for the client."

When SAD is suspected, comprehensive data is collected (e.g., what symptoms the individual is demonstrating, when the onset of symptoms occurred, what other factors were present at the time of onset, what interventions have been implemented, etc.) and discussed with the IDT, including a diagnostician. Please be aware a diagnosis of SAD takes time as the seasonal pattern has to be established (a minimum of symptoms for 2 consecutive years). However, interventions based on the facility's assessment information should not be delayed in lieu of a formal diagnosis.

As with all programs, all interventions must be individualized and comply with the regulations of the active treatment loop, which is inclusive of behavioral interventions (refer to W195 and related standards and W266 and related standards). Interventions for SAD are not different from other intervention requirements. They must be based on the assessment data collected, specific to the symptoms the individual is displaying and the individual's responses to less restrictive interventions (W278).

[Top of Page ↑](#)

§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/IID Federal Regulations or IDAPA include language that requires Physician's Re-Cap orders 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. Labeling 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 drug name, drug strength, manufacturer, expiration date, and lot number.

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 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.

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 at <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>, the facility is required to obtain a Clinical Laboratory Improvement Amendments (CLIA) waiver. Please refer to regulations W393 and W394 for additional information.

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

A5: Nursing services in an ICF/IID are outlined in a BFS informational letter, dated 3/19/08. The letter can be found at: [2008-01 Nursing Services in ICFs/ID.](#)

For additional information, please refer to the "[Nursing Assessment](#)" PowerPoint training posted on the ICF/IID web site.

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

A6: Yes. Information related to Hospice Services in ICF/IID settings can be found at: [2010-01 Hospice Care in Medicare- and Medicaid- Certified Facilities.](#)

Q7: What are the requirements for medical screenings for individuals who are receiving hospice services?

A7: The CoP 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 the terminal and non-terminal diagnoses. Given the need for a coordinated plan, W120 also applies.

Q8: How are determinations made related to what vaccinations (such as Zoster) are required?

11/19/2019

A8: The regulation at 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. The current CDC guidelines can be found in the "Pink Book" located at: [CDC Immunization Guidelines](#).

Q9: What are the requirements for prostate-specific antigen (PSA) tests?

A9: The United States Preventative Services Task Force (USPSTF) made a final recommendation on May 21, 2012.

The recommendation is against 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.

Q10: What is the requirement for bone mineral density tests (e.g., DEXA Scan) for individuals who have taken anti-epileptic drugs (AEDs) long term or other medications such as Depo-Provera?

A10: The Interpretive Guidance at W322 states "The facility has procedures in place to ensure that the clients receive general health care services to assure optimal levels of wellness...Preventative 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 screening that the facility will perform periodically that are relevant to all clients, and those screening associated with a particular gender or age or vulnerability."

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 certain 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 bone mineral density (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 bone density

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 bone density 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.

Q11: What is expected from the facility when the doctor does not feel a procedure or screening is necessary and/or appropriate (e.g., pap smears and bone density scans)?

A11: The regulations at W322, W325 and W326 apply. The individual's record must document the physician's justification for determining the tests were unnecessary and the IDT must document if they are in agreement with the physician's deferral of the tests based on the individual's needs. Additionally, W124 requires the individual and/or guardian to be aware of the associated risks and benefits of procedures as well as the consequences of refusing the procedure. Please refer to medical refusal questions under the Client Protections section of this document for additional information.

Q12: Is a Written Informed Consent (WIC) necessary for all hormone therapy use?

A12: W124 states 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." Therefore, if hormone therapy given solely for physical symptoms, the facility is required to inform the individual and their guardian of reason and potential risks but would not necessarily need to complete a WIC. If the hormone therapy is given for behavioral symptoms, it would be 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 "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..." Therefore, a WIC would be required.

Q13: Is the facility allowed to maintain "leftover" prescription medications for potential future use?

A13: No. Federal regulations state the facility must remove drugs that are outdated (W390), have worn, illegible, or missing labels (W391), or that have been discontinued by the physician (W392). Additionally, all drugs must be disposed of in a safe and secure manner. Methods of appropriate drug disposal may be found through the Food and Drug Administration at:

11/19/2019

<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm>

Or at the U.S Department of Justice, Drug Enforcement Administration at:
http://www.deadiversion.usdoj.gov/drug_disposal/index.html

Q14: What is the definition of "immediate" relative to W376?

A14: The Interpretive Guidance at W376 states "'Immediately' means at the time the error or reaction is identified."

Q15: Is there a standard of expectations for lab work for individuals that needs to be completed that your team is looking for? Or does lab work requested vary depending on physician overseeing care?

A15: Standard labs are typically ordered with the History and Physical (CBC – complete blood count, CMP – Comprehensive Metabolic Panel, etc.) to monitor general and preventative health. However, dependent on the individual's needs, additional testing (Valproic acid, lithium levels, etc.) are also ordered. All labs are reviewed per physician's recommendations. However, if a lab is indicated, but not ordered, then questions would be asked if the physician had been consulted regarding the lab. For example, if the person is on Depakote and no labs regarding valproic acid are available, it would be questioned. Additionally, if the pharmacy reviews recommend additional monitoring due to drug combinations, surveyors would ask about IDT and physician follow up.

[Top of Page ↑](#)

§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: Yes. The State Life Safety Code requires operable windows and IDAPA 16.03.11.712.02 (existing construction) and 16.03.11.723.03 (new construction) referencing client bedrooms, states that each individual's room window "...must be able to open."

Q2: Can individuals' bedroom windows be covered with an opaque film or obscure glass rather than having drapes or blinds?

A2: IDAPA 16.03.11.712.02(b) (existing construction) and 16.03.11.732.03(b) (new construction) states "Windows must be located to permit an individual to have a view through the windows from a sitting position, allow for natural light, and room

ventilation.” Therefore, the facility would need to apply for a waiver through the State Agency prior to using opaque film or obscure glass.

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

A3: Yes. W445 states the facility must "Actually evacuate clients during at least one drill each year on each shift." The Interpretive Guidance states "All facilities, regardless of their 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.

Q4: Can an individual residing in an ICF/IID request a lock be installed on his bedroom door to keep other individuals out?

A4: 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.

Q5: Is it acceptable for the facility to lock the front door at night for safety?

A5: 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. Staff cannot lock the doors and go outside for a break, leaving individuals unattended. Staff also cannot use the locked doors as a behavior modification technique. For example, if only one staff is present on graveyard shift and individuals with elopement risks are present at the facility, staff cannot lock the doors to keep individuals from eloping. Therefore, while it is acceptable to lock the doors at night, the reason must be clear.

[Top of Page ↑](#)

§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/IID? Can an individual have eggs from chickens the individual has raised?

11/19/2019

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.

Q2: Can a family member bring home canned fruits or vegetables to the facility for use?

A2: No. IDAPA 16.03.11801.01 states "Each ICF/ID must obtain all food and drink from an approved source identified in IDAPA 16.03.19, 'The Idaho Food Code.'"

[Top of Page ↑](#)
