(c) Standard: Individual program plan

W206

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

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

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

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

Guidance §483.440(c)(1)

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

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

W207

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

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

Guidance §483.440(c)(2)

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

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

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

W208

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

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

Guidance §483.440(c)(2)

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

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

W209

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

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

Guidance §483.440(c)(2)

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

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

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

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

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

"Inappropriate", for the purposes of this guideline, means that the parent or legal guardian's behavior is so disruptive or uncooperative that others cannot effectively participate; the client does not wish his or her parent to participate, and the client is competent to make this decision; or there is strong and documented evidence that the

parent or legal guardian is not acting on the client's behalf or in the client's best interest. In the case of the latter, determine what the facility has done to bring effective resolution to the problem.

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

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

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

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

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

W210

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

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

Guidance §483.440(c)(3)

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

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

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

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

W211

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

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

Guidance §483.440(c)(3)

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

W212

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

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

Guidance §483.440(c)(3)(i)

The CFA includes:

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

W213

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

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

Guidance §483.440(c)(3)(ii)

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

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

W214

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

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

Guidance §483.440(c)(3)(iii)

The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture. "Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or selfinjurious behavior).

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

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

W215

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

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

Guidance §483.440(c)(3)(iv)

Identification of needed services is based on the CFA.

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

§483.440(c)(3)(v) Include

Guidance §483.440(c)(3)(v)

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

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

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

W216

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

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

Guidance §483.440(c)(3)(v)

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

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

W217

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

§483.440(c)(3)(v) nutritional status,

Guidance §483.440(c)(3)(v)

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

W218

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

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

Guidance §483.440(c)(3)(v)

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

W219

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

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

Guidance §483.440(c)(3)(v)

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

W220

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

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

Guidance §483.440(c)(3)(v)

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

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

W221

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

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

Guidance §483.440(c)(3)(v)

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

W222

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

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

Guidance §483.440(c)(3)(v)

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

W223

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

§483.440(c)(3)(v) social development,

Guidance §483.440(c)(3)(v)

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

W224

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

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

Guidance §483.440(c)(3)(v)

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

W225

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

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

Guidance §483.440(c)(3)(v)

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

sampling, job development, on-site job training and long term follow-up, as appropriate to the client and determined by the IDT.

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

Assessments should be individualized and based on:

- Actual performance of the client against objective criteria;
- Reports by staff/parents/legal guardians; and

Observed performance in a variety of settings.

W226

§483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan

W227

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

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

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

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

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

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

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

W228

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

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

Guidance §483.440(c)(4)

The objectives identified in W227 are organized in a logical sequence, determined by the team that will assist the client toward the attainment of skills resulting in greater self-choice, independence, and community integration. The logical sequencing of objectives means there is a completion of one objective that serves as the building

block for the next with relevance to the client's functional status. Where objectives are logically ordered but do not have relevance to the client's functional status, refer to 483.440(c)(4).

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

These objectives must –

W229

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

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

Guidance §483.440(c)(4)(i)

Each objective clearly states one expected learning result.

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

W230

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

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

Guidance §483.440(c)(4)(ii)

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

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

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

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

W231

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

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

Guidance §483.440(c)(4)(iii)

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

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

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

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

W232

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

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

Guidance §483.440(c)(4)(iv)

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

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

W233

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

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

Guidance §483.440(c)(4)(v)

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

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

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

Guidance §483.440(c)(5)

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

W234

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

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

Guidance §483.440(c)(5)(i)

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

W235

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

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

Guidance §483.440(c)(5)(ii)

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

W236

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

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

Guidance §483.440(c)(4)(v)

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

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

W237

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

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

Guidance §483.440(c)(5)(iv)

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

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

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

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

W238

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

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

Guidance §483.440(c)(5)(v)

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

W239

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

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

Guidance §483.440(c)(5)(vi)

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

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

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

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

W240

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

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

Guidance §483.440(c)(6)(i)

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

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

W241

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

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

Guidance §483.440(c)(6)(ii)

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

W242

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

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

Guidance §483.440(c)(6)(iii)

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

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

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

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

1) Eye contact program was attempted using seven different methods over a two year period;

2) An client has two frozen elbow joints which do not allow her to get her hands to her mouth and consequently she will not be trained on any hand to mouth skills; and

3) Some clients may have insufficient neuromuscular and sensory control to ever be totally independent in toileting skills.

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

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

- targeted toward assisting the client achieving the measurable behavioral level of skill competency specified in IPP objectives;

- implemented at natural occurrences of activity and training programs; (e.g.: an objective for a client to increase grasping may be implemented as easily in the workshop with a built up tool as in the bathroom with a toothbrush);

- conducted by all personnel involved with the client including those outside the home such as in day programs; and

- carried out in conversation and interaction with the client appropriate to the situation.

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

Guidance §483.440(c)(6)(iv)

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

increased functioning. Some examples of devices used as mechanical supports include splints, wedges, bolsters, lap trays, etc.

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

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

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

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

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

Guidance §483.440(c)(6)(v)

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

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

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

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

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

Guidance §483.440(c)(6)(vi)

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

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

1) choosing housing or roommates;

2) choosing clothing to purchase or wear;

3) choosing what, where, and how to eat (e.g., the use of family style dining, access to condiments and second helpings).

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

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

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

Guidance §483.440(c)(7)

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