

Facility:
 Date:
 Surveyor:

Individual Record Review Worksheet
 Intermediate Care Facility/Individuals with Intellectual Disabilities

Directions: Document the answers as accurately as possible.

Individual's Name:	
Identifier Number:	Provider Number:
Unit/Building:	Living Area:
Room Number:	
Off-Site and/or Day Program Location:	Federal ID Number:
Discipline:	Day Program Times:
Survey Dates:	Birthdate:
Admission (Readmission) Date:	

Diagnosis	Information
Diagnosis and Level	
Diagnosis (Dx)	
Other Dx	

Selected for Required Interview? Yes _____ No _____ Indiv. _____ Family _____ Staff _____

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Observations

Observations	Information
Residential Location:	
Date:	
Time:	From: _____ To: _____
Staff Ratio to Individuals:	
Group Activity:	
Individual Activity:	

Record Review Notes

Record Review	Information
Residential Location:	
Date:	
Time:	From: _____ To: _____
Staff Ratio to Individuals:	
Group Activity:	
Individual Activity:	

Record Review	Information
Residential Location:	
Date:	
Time:	From: _____ To: _____
Staff Ratio to Individuals:	
Group Activity:	
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Record Review	Information
Residential Location:	
Date:	
Time:	From: _____ To: _____
Staff Ratio to Individuals:	
Group Activity:	
Individual Activity:	

Record Review	Information
Residential Location:	
Date:	
Time:	From: _____ To: _____
Staff Ratio to Individuals:	
Group Activity:	
Individual Activity:	

Questions

Directions: Fill out all information as appropriate. If the response (Yes or No) is marked with an asterisk (*), document the specific non-compliance with the requirement on this form or on a Form CMS-807, Surveyors Note Worksheet.

Item	Yes <input checked="" type="checkbox"/>	No <input checked="" type="checkbox"/>
Does the facility practice and promote opportunities for individual choice and self-management?	<input type="checkbox"/>	<input type="checkbox"/>
Sufficient Staff: Are there sufficient direct care staff to manage and supervise individuals in accordance with their Individual Program Plan (IPP)?	<input type="checkbox"/>	<input type="checkbox"/>

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Fundamental Requirements Review

Directions: Fill out all information as appropriate. If the response (Yes or No) is marked with an asterisk (*), document the specific non-compliance with the requirement on this form or on a Form CMS-807, Surveyors Note Worksheet.

Requirements	Information
Services provided under agreement with outside sources:	
<ul style="list-style-type: none"> • Does the facility assure that outside services meet the needs of each individual? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ This tag refers to the assurance programs are coordinated/integrated and consistent with implementation between the programs provided in outside services and the programs provided in the residential area; see guidance to surveyors. [Added as a fundamental survey requirement on Transmittal No. 4, Effective December 15, 1998] 	
Individual Rights and Protections	
<ul style="list-style-type: none"> • Is the individual subject to experimental, invasive, or potentially harmful treatment? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Is there compliance with informed consent for all treatments? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility obtain consent in a timely manner? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Are individuals encouraged to exercise their rights (i.e., vote, right to file complaints, right to due process, right to refuse treatment)? 	Yes: _____ No: _____

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Requirements	Information
<ul style="list-style-type: none"> • Is the individual allowed to manage their financial affairs, or is being taught to do so to the maximum extent possible? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If no, reason why not? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Is the individual subject to any form of abuse? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Is the individual subject to unnecessary drugs and/or chronic use of restraints? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If yes, specify. 	
<ul style="list-style-type: none"> ○ If yes, does the facility provide active treatment to reduce dependency on drugs and physical restraints? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility discontinue drugs or restraints if not effective? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Are drugs used at toxic levels or otherwise result in deterioration of the individual? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the active treatment plan address drug use, physical restraints, and/or “time-out?” 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If so, specify. 	
<ul style="list-style-type: none"> • Does the facility use drugs for which there is no substantiated use or active monitoring to support their use? 	Yes: _____ No: _____
Privacy/Participation	
<ul style="list-style-type: none"> • Does the facility afford the individual opportunities for personal privacy? (i.e., for significant relationships; “private area” behavior)? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility afford the individual privacy during treatment and personal care and/or hygiene times? 	Yes: _____ No: _____

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<ul style="list-style-type: none"> • Does the facility afford the individual the opportunity to communicate, associate, and meet privately with individuals of their choice? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Is freedom of movement restricted? <ul style="list-style-type: none"> ○ If yes, how often does the facility re-evaluate the restriction? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Do individuals have the opportunity to participate in social, religious, and community group activities? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Are individuals involved in various types of activities (i.e., movies, restaurants, church, community events, etc.) in the community based on their interests and choices? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Personal possessions: Ensure individuals have the right to retain and use appropriate personal possessions and clothing. 	Yes: _____ No: _____
<ul style="list-style-type: none"> • If access is limited (i.e., locked closets) is this part of the program plan? 	Yes: _____ No: _____
Active Treatment:	
<ul style="list-style-type: none"> • Does the facility promote participation of parents (if individual is a minor), the individual, or legal guardian in the process of providing active treatment, unless inappropriate? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility staff answer communications for and/or from the individuals' families and friends promptly and appropriately? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If no, why not? 	

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<ul style="list-style-type: none"> • Does the facility promote visits by family, close friends, legal guardians, or advocates? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If, no, did the Interdisciplinary Team (IDT) determine the visit would not be appropriate? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility promote visits by parents or guardians to any direct care area of the facility, consistent with other individuals' right to privacy? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility promote frequent and informal leave from the facility for visits, trips, or vacations? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Did they facility notify the family notified promptly of any significant changes (i.e., medical condition, serious illness, accidents, abuse, unauthorized absences, etc.)? 	Yes: _____ No: _____ N/A: _____
<ul style="list-style-type: none"> • Reporting investigations: Are there any allegations of mistreatment, neglect, abuse, or injuries of unknown source with respect to this individual? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If yes, did the facility implement regulatory requirements? (Allegations investigated and/or prevented further abuse and/or results investigation within five days and/or corrective action taken) 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Generally independent individuals: Does the facility maintain the independence of individuals as part of the Active Treatment Program? 	Yes: _____ No: _____

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Requirements	Information
There are no identified concerns regarding the individual receiving a continuous active treatment program. Is the program consistent with the IPP?	Yes: _____ No: _____
Behavior Modification Programs:	
<ul style="list-style-type: none"> • Are behavior modification programs present, including chemical and physical restraints? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If NO, skip the remainder of this section. If YES, proceed. 	
<ul style="list-style-type: none"> • Is the program in compliance with the requirements of the Specially Constituted Committee? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Date of the committee review: 	
<ul style="list-style-type: none"> ○ Date of the committee approval: 	
<ul style="list-style-type: none"> • Are there interventions to manage inappropriate behavior with sufficient safeguards and supervision to ensure the facility protects the safety, welfare, and civil and human rights of the individuals? 	Yes: _____ No: _____
During Observations:	
<ul style="list-style-type: none"> • Does the facility use techniques to manage inappropriate behavior used for disciplinary purposes? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility use techniques to manage inappropriate behavior for convenience of staff? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility use techniques to manage inappropriate behavior as a substitute for active treatment? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility use a time-out room? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If yes, is the facility in compliance with the regulatory requirements? 	Yes: _____ No: _____

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<ul style="list-style-type: none"> • Does the facility use physical restraints? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If yes, is the facility in compliance with the requirements for 30-minute checks and release as soon as possible? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Consents: Is evidence present to support the facility's compliance with appropriate informed consent? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Date of consent: 	
<ul style="list-style-type: none"> ○ Signed by whom? 	
<ul style="list-style-type: none"> • Are drugs used for control of inappropriate behavior being adequately assessed for: 	
<ul style="list-style-type: none"> ○ Consideration of side effects (i.e., harmful effects or behavior outweigh harmful effects of the drugs)? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Monitored by physician? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Monitored by pharmacist (in conjunction with drug regime review requirements)? 	Yes: _____ No: _____
Health Care Services:	
<ul style="list-style-type: none"> • Does the facility provide nursing services in accordance with the individual's needs? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Based on the quarterly health status reviews, have referrals been recommended and/or addressed? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility provide appropriate dental care services? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the individual self-administer drugs? 	Yes: _____ No: _____

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<ul style="list-style-type: none">Does the individual receive healthcare services in a timely manner?	Yes: _____ No: _____

Physician Orders

Directions: Document physician orders as appropriate.

Date of Current Physician's Order [list orders if needed]
1.
2.
3.
4.
5.
6.
7.

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Assistive and/or Adaptive Devices

Directions: Fill out all information as appropriate.

Devices	Information
<ul style="list-style-type: none"> • Does the individual use 	
<ul style="list-style-type: none"> ○ Eyeglasses 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Ambulation devices (specify) 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Eating utensils (specify) 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ Other (i.e., communication board and/or hearing aids) 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ During observations, are appropriate devices in use? 	Yes: _____ No: _____

IPP Review

Directions: Fill out all information as appropriate.

Item	Data
Date of Comprehensive Functional Assessment (CFA):	
Annual review date:	
Individual participated?	Yes: _____ No: _____
If less than three months, compare with 90-day ID team review	
Dates of quarterly reviews:	
Did the facility identify individual's needs, problem, or strengths?	Yes: _____ No: _____

IPP Review: Goals, Objectives, Progress

Directions: The facility may document specifics (Goals, Objectives, Progress) of IPP by exception. Use the Key Codes to document progress for each problem, goal or objective on the IPP. Key Codes: P/R/S = progress, regression, or stability, P/A = number of sessions “planned versus attended.”

