

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

Diagnosis	Information
Diagnosis/Level:	
Diagnosis:	
Other Diagnosis:	

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

Observations:

Directions: Fill out all information appropriately.

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

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

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

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

Observation	Information
Residential Location:	
Date:	
Time:	From: _____

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Observation	Information
	To: _____
Staff Ratio to Individual:	
Group Activity:	
Individual Activity:	

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

Fundamental Requirements Review

Directions: Fill out all information as appropriate.

Item	Information
Services provided under agreement with outsidess 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 and/or integrated and consistent with implementation, between the programs provided in outside services, and the programs provided in the residential area; see guidance to surveyors. 	
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: _____

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<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: _____
<ul style="list-style-type: none"> • Is the individual allowed to manage their financial affairs, or being taught to do so to the maximum extent possible? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If no, reason why not? 	<ul style="list-style-type: none"> ○ 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 and/or 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: _____

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<ul style="list-style-type: none"> • Does the facility afford the individual privacy during treatment and personal care and/or hygiene times? 	Yes: _____ No: _____
<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? 	Yes: _____ No: _____
<ul style="list-style-type: none"> ○ If yes, how often does the facility re-evaluate the restriction? 	
<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 they 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 practice 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 team determine the visit would not be appropriate? 	○ Yes: _____ No: _____
<ul style="list-style-type: none"> • Does the facility practice 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 practice promote frequent and informal leave from the facility for visits, trips, or vacations? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Did the facility notify the family 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"> ○ If yes, did the facility implement regulatory requirements? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Generally independent individuals: Does the facility maintain generally independent individuals as part of its Active Treatment Program? 	Yes: _____ No: _____
<p>There are no identified concerns regarding the individual receiving a continuous active treatment program. Is the program consistent with the Individual Program Plan (IPP)?</p>	Yes: _____ No: _____

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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"> • Do staff members use techniques to manage inappropriate behavior for disciplinary purposes? 	Yes: _____ No: _____
<ul style="list-style-type: none"> • Do staff members use techniques to manage inappropriate behavior for convenience? 	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: _____
<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: _____

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

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

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Assistive/Adaptive Devices:

Directions: Fill out all information appropriately.

Item	Information
• Does the individual use	
○ Eyeglasses	○
○ Ambulation devices (specify)	○
○ Eating utensils (specify)	○
○ Other (i.e., communication board, hearing aids, etc.)	○
○ During observations, are appropriate devices in use?	○ Yes: _____ No: _____

Individual Program Plan (IPP) Review

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

The facility may document specifics (Goals, Objectives, and Problems) of IPP by exception.

