Form Approved
OMB No. 0938-0062

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES SURVEY REPORT

1. Name of Facility

2. Street Address	3. City and/or County	4. State	5. ZIP Code

6. Medicaid Provider Number	7. Name of CEO	8. Telephone No.

9. State/Region Code	10. State/County Code	11. Dates of Survey (mm/dd/yyyy)
W2	W3	Begin: _____ W4 End: _____ W5

12. Type of Ownership or Control (enter number in box below) ☐ W6

1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other (specify): _____

13. Is this ICF/IID a distinct part of a Hospital, SNF or NF? *(check one)*

☐ Yes ☐ No W7

14. If "Yes" to block 13, indicate either:

A. Hospital Provider Number: ☐☐☐☐☐☐

B. SNF Provider Number: ☐☐☐☐☐☐

C. NF Provider Number: ☐☐☐☐☐☐ W8

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in Column 1 represented on the Survey team, indicate the number who also qualify as a QIDP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse		
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify): _____		
N. Total number of Surveyors onsite W11		
O. Total number of QIDP Surveyors onsite W12		

16. Facility Data

A. Is this ICF/IID a residential unit within a larger organization or agency in the State that provides residential services to individuals with intellectual disabilities? (check one)

☐ Yes ☐ No If "No", proceed to item C. W13

B. If "Yes," indicate name and address of larger organization.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of CEO: _____

Total Number of Beds: ☐☐☐ W14 Total Number of Clients: ☐☐☐ W15
(including ICF/IID clients directly served)

C. Total Number of ICF/IID Clients: ☐☐☐ W16

D. Is this ICF/IID community-based? *(check one)* ☐ Yes ☐ No W17

E. Total number of ICF/IID beds under this Provider No: ☐☐☐ W18

F. Total number of discrete living units under this Provider No: ☐☐☐ W19

G. Age range of clients served: from ☐☐ W20 to ☐☐☐ W21

H. Total number of off-campus day program sites used by ICF/IID clients: ☐☐ W22

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel (483.430(d)(3))	☐☐☐☐.☐☐ W23
B. Registered Nurse (483.480(d)(3))	☐☐☐☐.☐☐ W24
C. Licensed Voc./Practical Nurse (483.480(d)(2))	☐☐☐☐.☐☐ W25
D. Total Personnel *(List the Full Time Equivalent for all employees)*	☐☐☐☐.☐☐ W26

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs?	☐☐☐ W27
B. In how many off-campus day program sites was an observation done by the Surveyor?	☐☐☐ W28

19. Individual Characteristics
(**NOTE:** The total number in Items B–L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)

A. AGE AND SEX	
(1) Age	
under 22(a)	W29
22-45 (b)	W30
46-65 (c)	W31
66+ (d)	W32
Total:	W33
(2) Sex	
Male	W34
Female	W35
Total:	W36

B. DISABILITIES	
(1) Intellectual Disability	
Mild	W37
Moderate	W38
Severe	W39
Profound	W40
Total:	W41
(2) Autism	W42
(3) Cerebral Palsy	W43
(4) Epilepsy	
Controlled	W44
Uncontrolled	W45
Total:	W46

C. OTHER DISABILITIES	
(1) Non-ambulatory	
Mobile	W47
Non-Mobile	W48
Total:	W49
(2) Speech/Language Impairment	W50
(3) Hearing Impairment	
Hard of Hearing	W51
Deaf	W52
Total:	W53
(4) Visual Impairment	
Impaired	W54
Blind	W55
Total:	W56
D. MEDICAL CARE PLAN	W57
E. DRUGS TO CONTROL BEHAVIOR	W58
F. PHYSICAL RESTRAINTS	W59
G. TIME-OUT ROOMS	W60
H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	W61
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	W62
J. NUMBER OF COURT ORDERED ADMISSIONS	W63
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	W64
L. OTHER (specify)	
(1) _____	W65
(2) _____	W66
(3) _____	W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

No. of allegations of abuse investigated (a)	W68
No. of allegations of neglect investigated (b)	W69
Total:	W70

N. NUMBER OF DEATHS

No. of deaths related to unusual incidents (a)	W71
No. of deaths related to restraints (b)	W72
No. of deaths for any reason (c)	W73
Total:	W74

M. ALLEGATION OF ABUSE AND NEGLECT

(W68) Number of allegations of abuse investigated.
(W69) Number of allegation of neglect investigated.

According to 42CFR §488.301:
Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Consistent with the referenced definitions, enter the number of allegations of abuse and or neglect investigated, including investigations resulting from complaints, follow ups, initials or recertifications.
If there is no information to report, leave the field blank.

(W70) Total
This field represents a combined total of W68 (allegations of abuse investigated) and W69 (allegations of neglect investigated). The total for this field is program generated therefore, no data input is necessary.

N. NUMBER OF DEATHS

(W71) Number of deaths related to unusual incidents.
Insert the number of deaths that occurred as a result of unusual incidents. This includes all unexpected or unanticipated deaths not included in W72 or W73.

(W72) Number of death related to restraints.
Insert the number of deaths that occurred as a result of the use of restraints.

(W73) Number of deaths for any reason.
Insert the number of deaths occurring for any reason. Do not include information contained is W71 and W72 above.

(W74) Total
This field represents a combined total of W71 (number of deaths related to unusual incidents), W72 (number of deaths related to restraints), and W73 (number of deaths for any reason).

The total for this field is program generated; therefore, no data input is necessary.