

**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 No.	7. Name of CEO		8. Telephone No	
9. State/Region code	10. State/County code	11. Dates of Survey	(Begin)	(End)
W2	W3	Month / Day / Year	W4	Month / Day / Year
12. Type of Ownership or Control (enter number in box below)				
<input type="checkbox"/> 1. Private (non-profit) 3. State 5. County 7. Other (specify) _____				
<input type="checkbox"/> 2. Private (proprietary) 4. City/Town 6. City/County				
W6				
13. Is this ICF/IID a distinct part of a Hospital, SNF or NF?		14. If "Yes" to block 13, indicate either		
<input type="checkbox"/> Yes <input type="checkbox"/> No		A. Hospital Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
W7		B. SNF Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
		C. NF Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
		W8		
15. Survey Team Composition		16. Facility Data		
Column 1: Indicate the number of disciplines represented on the Survey team.		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?		
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.		(check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If "No", proceed to item C.		
W9 W10		W13		
A. Administrator		Name		
B. Nurse.....		Address		
C. Dietitian		City		
D. Pharmacist.....		State		
E. Records Administrator.....		ZIP Code		
F. Social Worker		Name of CEO		
G. LSC Specialist		Total Number of Beds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
H. Laboratorian.....		Total Number of Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
I. Sanitarian		(including ICF/IID clients directly served)		
J. Therapist.....		C. Total Number of ICF/IID Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
K. Physician.....		D. Is this ICF/IID community-based? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		
L. Psychologist		E. Total number of ICF/IID beds under this Provider No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
M. Other (specify)		F. Total number of discrete living units under this Provider No.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
N. Total number of Surveyors onsite W13		G. Age range of clients served.....from <input type="checkbox"/> <input type="checkbox"/> to <input type="checkbox"/> <input type="checkbox"/>		
O. Total number of QIDP Surveyors onsite W12		H. Total number of off-campus day program sites used by ICF/IID clients <input type="checkbox"/> <input type="checkbox"/>		
17. Staffing: List the full time equivalents who function in this capacity:		18. Off-Campus Day Programs:		
A. Direct Care Personnel W23		A. How many clients in the sample attend off-campus day programs? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
(483.430(d)(3))..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>		B. In how many off-campus day program sites was an observation done by the Surveyor?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
B. Registered Nurse W24				
(483.480(d)(3))..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
C. Licensed Voc./Practical Nurse W25				
(483.480(d)(2))..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
D. Total Personnel W26..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/>				
(List the Full Time Equivalent for all employees)				

20. 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.		C. OTHER DISABILITIES	
(1) Age		(1) Non-ambulatory	
under 22(a)	W29	Mobile	W47
22-45 (b)	W30	Non-Mobile	W48
46-65 (c)	W31		
66+ (d)	W32		
	Total		W49
	W33	(2) Speech/Language Impairment	W50
(2) SEX		(3) Hearing Impairment	
Male	W34	Hard of Hearing	W51
Female	W35	Deaf	W52
	Total		W53
	W36	(4) Visual Impairment	
B. DISABILITIES		Impaired	W54
(1) Intellectual Disability		Blind	W55
Mild	W37		W56
Moderate	W38	D. MEDICAL CARE PLAN	W57
Severe	W39	E. DRUGS TO CONTROL BEHAVIOR	W58
Profound	W40	F. PHYSICAL RESTRAINTS	W59
	Total	G. TIME-OUT ROOMS	W60
	W41	H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	W61
(2) Autism	W42	I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	W62
(3) Cerebral Palsy	W43	J. NUMBER OF COURT ORDERED ADMISSIONS	W63
(4) Epilepsy		K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	W64
Controlled	W44	L. OTHER (specify)	
Uncontrolled	W45	(1)	W65
	Total	(2)	W66
	W46	(3)	W67

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES SURVEY REPORT

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	W68
no. of allegations of neglect investigated (b)	W69
<div></div> 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
<div></div> Total	W74

ALLEGATIONS OF ABUSE AND NEGLECT AND NUMBER OF DEATHS DATA ENTRY INSTRUCTIONS

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0062 (Expires 2/28/2021). This information collection is mandatory for states to complete as authorized by Title XIX of the Social Security Act, Section 1905(d). To determine compliance with the requirements, section 1902(a)(33)(B) of the Social Security Act requires the State to utilize the same agency used by the Secretary under Section 1864 of the Act to determine whether institutions meet the requirements for participating in the program. The information collection records data relative to facility characteristics, including a description of the client population served and essential characteristics of the survey conducted in order to determine compliance with discreet requirements and to report to the Federal government. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. The time required to complete this information collection is estimated to average three hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. *****CMS Disclaimer*****Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the ICF/IID mailbox at QSOG_ICFIID@cms.hhs.gov.