








## 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 <span style="float: right;">W2</span>	10. State/County code <span style="float: right;">W3</span>	11. Dates of Survey (Begin) _____ (End) _____ <span style="float: right;">Month / Day / Year    W4    Month / Day / Year    W5</span>		
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				
13. Is this ICF/IID a distinct part of a Hospital, SNF or NF?				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
14. If "Yes" to block 13, indicate either				
A. Hospital Provider No. .... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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"/>				
15. Survey Team Composition			16. Facility Data	
<b>Column 1:</b> Indicate the number of disciplines represented on the Survey team.  <b>Column 2:</b> 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.			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) <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", proceed to item C.	
B. If "Yes," indicate name and address of larger organization.			W13	
A. Administrator ..... <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W9 W10</span> B. Nurse ..... <input type="checkbox"/> <input type="checkbox"/> C. Dietitian ..... <input type="checkbox"/> <input type="checkbox"/> D. Pharmacist ..... <input type="checkbox"/> <input type="checkbox"/> E. Records Administrator ..... <input type="checkbox"/> <input type="checkbox"/> F. Social Worker ..... <input type="checkbox"/> <input type="checkbox"/> G. LSC Specialist ..... <input type="checkbox"/> <input type="checkbox"/> H. Laboratorian ..... <input type="checkbox"/> <input type="checkbox"/> I. Sanitarian ..... <input type="checkbox"/> <input type="checkbox"/> J. Therapist ..... <input type="checkbox"/> <input type="checkbox"/> K. Physician ..... <input type="checkbox"/> <input type="checkbox"/> L. Psychologist ..... <input type="checkbox"/> <input type="checkbox"/> M. Other (specify) ..... <input type="checkbox"/> <input type="checkbox"/> N. Total number of Surveyors onsite ..... <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W13</span> O. Total number of QIDP Surveyors onsite ..... <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W12</span>			Name _____ Address _____ City _____ State _____ ZIP Code _____ Name of CEO _____ Total Number of Beds ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W14</span> Total Number of Clients ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W15</span> <i>(including ICF/IID clients directly served)</i> C. Total Number of ICF/IID Clients ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W16</span> D. Is this ICF/IID community-based? (check one) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;">W17</span> E. Total number of ICF/IID beds under this Provider No ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W18</span> F. Total number of discrete living units under this Provider No.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W19</span> G. Age range of clients served ..... from <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W20</span> to <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W21</span> H. Total number of off-campus day program sites used by ICF/IID clients ..... <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W22</span>	
17. Staffing: List the full time equivalents who function in this capacity:			18. Off-Campus Day Programs:	
A. Direct Care Personnel <span style="float: right;">W23</span> (483.430(d)(3)) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> B. Registered Nurse <span style="float: right;">W24</span> (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 <span style="float: right;">W25</span> (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 <span style="float: right;">W26</span> ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> <i>(List the Full Time Equivalent for all employees)</i>			A. How many clients in the sample attend off-campus day programs? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <span style="float: right;">W27</span> 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"/> <span style="float: right;">W28</span>	

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.	
(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	
(3) Hearing Impairment	
Hard of Hearing	W51
Deaf	W52
 Total	W53
(4) Visual Impairment	
Impaired	W54
Blind	W55
 Total	W56
D. MEDICAL CARE PLAN	
E. DRUGS TO CONTROL BEHAVIOR	
F. PHYSICAL RESTRAINTS	
G. TIME-OUT ROOMS	
H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	
J. NUMBER OF COURT ORDERED ADMISSIONS	
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	
L. OTHER (specify)	
(1)	W65
(2)	W66
(3)	W67

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## M. ALLEGATIONS OF ABUSE AND NEGLECT

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no. of allegations of abuse investigated (a) W68

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no. of allegations of neglect investigated (b) W69

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 Total W70

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## N. NUMBER OF DEATHS

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no. of deaths related to unusual incidents (a) W71

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no. of deaths related to restraints (b) W72

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no. of deaths for any reason (c) W73

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 Total W74

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**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.