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 No. | 7. Name of CEO | 8. Telephone No W1 |
|---|---|---|
| | | |

| 9. State/Region code W2 | 10. State/County code W3 | 11. Dates of Survey (Begin) Month / Day / Year W4 | (End) Month / Day / Year W5 |
|---|---|---|---|
| | | | |

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

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

13. Is this ICF/IID a distinct part of a Hospital, SNF or NF? W7

☐ Yes ☐ No

14. If "Yes" to block 13, indicate either W8

A. Hospital Provider No. ☐☐☐☐☐☐
B. SNF Provider No. ☐☐☐☐☐☐
C. NF Provider No. ☐☐☐☐☐☐

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 | W13 ☐☐ | |
| O. Total number of QIDP Surveyors onsite | W12 ☐☐ | |

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

A. Direct Care Personnel W23
(483.430(d)(3)) ☐☐☐☐.☐☐

B. Registered Nurse W24
(483.480(d)(3)) ☐☐☐☐.☐☐

C. Licensed Voc./Practical Nurse W25
(483.480(d)(2)) ☐☐☐☐.☐☐

D. Total Personnel W26 ☐☐☐☐.☐☐
*(List the Full Time Equivalent for all employees)*

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 W13
If "No", proceed to item C.

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)* W17 ☐ Yes ☐ No

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 ☐☐

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 ☐☐☐

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 |
| [redacted] Total | | W33 |
| (2) SEX | | |
| Male | | W34 |
| Female | | W35 |
| [redacted] Total | | W36 |
| B. DISABILITIES | | |
| (1) Intellectual Disability | | |
| Mild | | W37 |
| Moderate | | W38 |
| Severe | | W39 |
| Profound | | W40 |
| [redacted] Total | | W41 |
| (2) Autism | | W42 |
| (3) Cerebral Palsy | | W43 |
| (4) Epilepsy | | |
| Controlled | | W44 |
| Uncontrolled | | W45 |
| [redacted] Total | | W46 |

| | | |
|---|---|---|
| C. OTHER DISABILITIES | | |
| (1) Non-ambulatory | | |
| Mobile | | W47 |
| Non-Mobile | | W48 |
| [redacted] Total | | W49 |
| (2) Speech/Language Impairment | | W50 |
| (3) Hearing Impairment | | |
| Hard of Hearing | | W51 |
| Deaf | | W52 |
| [redacted] Total | | W53 |
| (4) Visual Impairment | | |
| Impaired | | W54 |
| Blind | | W55 |
| [redacted] 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 STIMU | | W61 |
| I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAM | | 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 |
| [redacted] 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 |
| [redacted] 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.