

Name of Facility

DEFICIENCIES		COMMENTS
1. DATA TAG NO.	2. CoP/STND NO.	

DEFICIENCIES		COMMENTS
1. DATA TAG NO.	2. CoP/STND NO.	

**INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES
DEFICIENCIES REPORT****FOR INITIAL OR ANNUAL RECERTIFICATION SURVEY**

I certify that I have reviewed the following requirements and conditions for: (a) Full Survey _____, (b) Extended Survey _____, or (c) Fundamental Survey _____, and unless indicated on this form, the facility was found to be in compliance with the Standards and the Conditions of Participation.

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

FOR FOLLOW-UP SURVEY

For the purpose of this onsite visit, I certify that I have reviewed each Condition of Participation and related Standard(s) found not to be in compliance during the survey on _____, and unless indicated on this form, the facility was found to be in compliance with the Standards and/or the Conditions of Participation.

SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES DEFICIENCIES REPORT

Evaluate each of the requirements identified in the ICF/IID Interpretive Guidelines, (Appendix "J" to the SOM). For each identified deficiency:

- A. In the first column, identify the data tag number.
- B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.
- C. In column three, describe deficient facility practice and supporting findings.
- D. Draw horizontal lines to separate identified tag numbers.
- E. If more space is needed, photocopy FIRST page (front and back).
- F. Each surveyor must sign the certifying statement on the last page.
- G. If there are more surveyors to sign the last page, than are lines available on which to sign, photocopy the last page, and add the additional signatures.

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.