






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 W2 | 10. State/County code W3 | 11. Dates of Survey (Begin) _____ (End) _____ Month / Day / Year W4 Month / Day / Year W5 | | |
| 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 | |
| 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. | | | 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. | | | Name _____ Address _____ City _____ State _____ ZIP Code _____ Name of CEO _____ | |
| A. Administrator <input type="checkbox"/> <input type="checkbox"/> W9 W10 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. Medical Laboratory Technologist <input type="checkbox"/> <input type="checkbox"/> I. Public Health Specialist <input type="checkbox"/> <input type="checkbox"/> J. Physical 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"/> W11 O. Total number of QIDP Surveyors onsite <input type="checkbox"/> <input type="checkbox"/> W12 | | | Total Number of Beds <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W14 Total Number of Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W15 <i>(including ICF/IID clients directly served)</i> C. Total Number of ICF/IID Clients <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W16 D. Is this ICF/IID community-based? (check one) Yes <input type="checkbox"/> No <input type="checkbox"/> W17 E. Total number of ICF/IID beds under this Provider No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W18 F. Total number of discrete living units under this Provider No. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> W19 G. Age range of clients served from <input type="checkbox"/> <input type="checkbox"/> W20 to <input type="checkbox"/> <input type="checkbox"/> W21 H. Total number of off-campus day program sites used by ICF/IID clients <input type="checkbox"/> <input type="checkbox"/> W22 | |
| 17. Staffing: List the full time equivalents who function in this capacity: | | | 18. Off-Campus Day Programs: | |
| A. Direct Care Personnel W23 (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 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"/> <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"/> W27 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"/> 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. | |
| (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 Spectrum Disorder | W42 |
| (3) Cerebral Palsy | W43 |
| (4) Seizure Disorder | |
| Controlled | W44 |
| Uncontrolled | W45 |
|  Total | W46 |

| | |
|--|-----|
| C. OTHER DISABILITIES | |
| (1) Ambulatory Status | |
| Ambulatory | W47 |
| Non-Ambulatory | W48 |
|  Total | W49 |
| (2) Speech/Language Impairment | |
| (3) Hearing Impairment | |
| Partial Hearing Loss | W51 |
| Deaf | W52 |
|  Total | W53 |
| (4) Visual Impairment | |
| Visually Impaired | W54 |
| Blind | W55 |
|  Total | W56 |
| D. Medical care plan | |
| E. Use of drugs to control behavior | |
| F. Use of physical restraints | |
| G. Use of 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 18 with a Court ordered Legal Guardian | |
| L. OTHER (specify) | |
| (1) | W65 |
| (2) | W66 |
| (3) | W67 |

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M. ALLEGATIONS OF ABUSE AND NEGLECT

a. Number of allegations of abuse investigated W68

b. Number of allegations of neglect investigated W69

[REDACTED] Total W70

N. NUMBER OF DEATHS

a. Number of deaths related to unusual incident W71

b. Number of deaths related to restraints W72

c. Number of deaths for any reason 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.

PRA Disclosure Statement

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*****CMS Disclosure*****

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