FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION 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/MR 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 QMRP. 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 W11	☐	☐
O. Total number of QMRP Surveyors onsite W12	☐	☐

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(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/MR clients directly served)

C. Total Number of ICF/MR Clients ☐☐☐ W16

D. Is this ICF/MR community-based? *(check one)* ☐ Yes ☐ No W17

E. Total number of ICF/MR 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/MR clients ☐☐☐ W22

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)

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) Mental Retardation	
Mild	W37
Moderate	W38
Severe	W39
Profound	W40
[redacted]	Total W41
(2) Autism	W42
(3) Cerebral Palsy	W43
(4) Epilepsy	
Controlled	W44
Undercontrolled	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 STIMULI	W61
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	W62
J. NUMBER OF COURT ORDERED ADMISSIONS	W63
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN BY THE COURT	W64
L. OTHER *(specify)*	
(1)	W65
(2)	W66
(3)	W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

Number of allegations of abuse investigated (a)	W68
Number of allegations of neglect investigated (b)	W69
	Total W70

N. NUMBER OF DEATHS

Number of deaths related to unusual incidents (a)	W71
Number of deaths related to restraints (b)	W72
Number of deaths for any reason (c)	W73
	Total W74