



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: S&C-02-18

DATE: February 6, 2002

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)
Form 3070G Revisions - **ACTION**

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

As you know, the Centers for Medicare & Medicaid Services has undertaken several initiatives in response to the unfortunate reports of abuse and neglect on our nation's beneficiaries. In an effort to monitor the number of allegations of abuse and neglect investigated and the number of deaths related to restraints and unusual incidents, we revised Form 3070G, the ICF/MR survey report form, to now include an item "M" - Allegations of Abuse and Neglect, to capture this information. All surveys, including initials, recertifications, complaints, and follow-ups, occurring after January 2, 2002, must be entered into the On Line Survey and Certification System (OSCAR).

To ensure that this information is entered into OSCAR in a clear and consistent fashion, please have your survey and certification staff follow the attached data entry instructions. If you or your staff have questions or concerns regarding this matter, please contact Dennis Glover of my staff on (410) 786-2162.

Effective Date: This survey change is effective immediately.

Training: This policy should be shared with all appropriate survey and certification staff, their managers, and the state/regional office training coordinator.

/s/
Steven A. Pelovitz

Attachments

ICFs/MR Form 3070G
Allegations of Abuse and Neglect and
Number of Deaths
Data Entry Instructions

(Data entered into the respective fields should reflect the time period since the date of the last survey, i.e. initial, recertification, complaint or follow up.)

M. Allegations of abuse and neglect

(W68) Number of allegations of abuse investigated.

(W69) Number of allegations 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 deaths 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 in 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.

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) (W4) (End) (W5) <small>Month / Day / Year</small>		
12. Type of Ownership or Control (enter number in box below) (W6)				
<input type="checkbox"/> 1. Private (non-profit) <input type="checkbox"/> 2. Private (proprietary)		3. State 4. City/Town		5. County 6. City/County
7. Other (specify) _____				
13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? (W7)		14. If "Yes" to block 13, indicate either (W8)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		A. Hospital Provider No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> B. SNF Provider No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> C. NF Provider No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
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 QMRP. Indicate Name(s) and Title(s) on last page of this form.		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) <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If "No", proceed to item C. (W13)</small>		
A. Administrator <input type="text"/> (W9) <input type="text"/> (W10) B. Nurse <input type="text"/> <input type="text"/> C. Dietitian <input type="text"/> <input type="text"/> D. Pharmacist <input type="text"/> <input type="text"/> E. Records Administrator <input type="text"/> <input type="text"/> F. Social Worker <input type="text"/> <input type="text"/> G. LSC Specialist <input type="text"/> <input type="text"/> H. Laboratorian <input type="text"/> <input type="text"/> I. Sanitarian <input type="text"/> <input type="text"/> J. Therapist <input type="text"/> <input type="text"/> K. Physician <input type="text"/> <input type="text"/> L. Psychologist <input type="text"/> <input type="text"/> M. Other (specify) _____ <input type="text"/> <input type="text"/> N. Total number of Surveyors onsite (W11) <input type="text"/> <input type="text"/> <input type="text"/> O. Total number of QMRP Surveyors onsite (W12) <input type="text"/> <input type="text"/> <input type="text"/>		B. If "Yes", indicate name and address of larger organization. Name _____ Address _____ City _____ State _____ ZIP Code _____ Name of CEO _____ Total Number of Beds (W14) <input type="text"/> <input type="text"/> <input type="text"/> Total Number of Clients (W15) <input type="text"/> <input type="text"/> <input type="text"/> <small>(including ICF/MR clients directly served)</small> C. Total Number of ICF/MR Clients (W16) <input type="text"/> <input type="text"/> <input type="text"/> D. Is this ICF/MR community-based? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No (W17) E. Total number of ICF/MR beds under this Provider No. (W18) <input type="text"/> <input type="text"/> <input type="text"/> F. Total number of discrete living units under this Provider No. (W19) <input type="text"/> <input type="text"/> <input type="text"/> G. Age range of clients served (W20) <input type="text"/> <input type="text"/> from <input type="text"/> <input type="text"/> (W21) to <input type="text"/> <input type="text"/> H. Total number of off-campus day program sites used by ICF/MR clients (W22) <input type="text"/> <input type="text"/> <input type="text"/>		
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="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		A. How many clients in the sample attend off-campus day programs? (W27) <input type="text"/> <input type="text"/> <input type="text"/>		
B. Registered Nurse (W24) (483.480(d)(3)) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		B. In how many off-campus day program sites was an observation done by the Surveyor? (W28) <input type="text"/> <input type="text"/> <input type="text"/>		
C. Licensed Voc./Practical Nurse (W25) (483.480(d)(2)) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
D. Total Personnel (W26) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(List the Full Time Equivalent for all employees)</small>				

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)

(W33) Total

(2) SEX

Male (W34)

Female (W35)

(W36) Total

B. DISABILITIES

(1) Mental Retardation

Mild (W37)

Moderate (W38)

Severe (W39)

Profound (W40)

(W41) Total

(2) Autism (W42)

(3) Cerebral Palsy (W43)

(4) Epilepsy

Controlled (W44)

Uncontrolled (W45)

(W46) Total

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile (W47)

Non-Mobile (W48)

(W49) Total

(2) Speech/Language Impairment (W50)

(3) Hearing Impairment

Hard of Hearing (W51)

Deaf (W52)

(W53) Total

(4) Visual Impairment

Impaired (W54)

Blind (W55)

(W56) Total

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 ASSIGNED BY THE COURT (W64)

L. OTHER (specify)

(1) (W65)

(2) (W66)


(3) (W67)

**INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION
SURVEY REPORT**

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a) (W68)

no. of allegations of neglect investigated (b) (W69)


 (W70) Total

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)

 (W74) Total
