DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: S&C-02-26

DATE: **April 29, 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

In a memorandum dated February 6, 2002 (attached), you were notified of revisions to Form-3070G, the ICFs/MR Survey Report Form. These revisions included capturing:

1) Number of abuse and neglect allegations investigated; and
2) Number of deaths related to restraints and unusual incidents.

The memo instructed surveyors to input all survey data, from the date of the last survey, for initials, recertifications, complaints and follow ups, occurring after January 2, 2002, into the Online Survey and Certification and Reporting System (OSCAR). However, after consulting with our data division, we understand that limitations of the OSCAR system, at this time, preclude the necessary reprogramming to accommodate this additional information. **Therefore, Form-3070G should only be used on initial and recertification surveys.**

Critical information that is needed on complaints will be obtained from an existing complaint form (CMS-562-Medicare/Medicaid/CLIA Complaint Form), rather than the Form-3070G. In addition, while meeting with the data staff, we were also able to correct the OSCAR screen where it inadvertently requested the number of clients who had allegations of abuse and neglect rather than the number of allegations of abuse and neglect.

If you or your staff have questions or concerns regarding this matter, please contact Dennis Glover, of my staff, at (410) 786-2162.

Effective Date: This 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

cc: Developmental Disabilities Specialists, ROs I – X
Amanda Cade, Council

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
cc: Developmental Disabilities Specials, ROs I - X
Amanda Cade, Council

ICFs/MR Form-3070G
Allegations of Abuse and Neglect and
Number of Deaths
Data Entry Instructions (revised 4/12/02)

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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)* (W4) *Month / Day / Year*	*(End)* (W5) *Month / Day / Year*

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

☐ 1. Private (non-profit) 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)

☐ 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)* (W17) ☐ Yes ☐ No

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 ..... (W20) *from* (W21) *to*

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] (W33) Total

(2) SEX

Male (W34)

Female (W35)

[redacted] (W36) Total

B. DISABILITIES

(1) Mental Retardation

Mild (W37)

Moderate (W38)

Severe (W39)

Profound (W40)

[redacted] (W41) Total

(2) Autism (W42)

(3) Cerebral Palsy (W43)

(4) Epilepsy

Controlled (W44)

Uncontrolled (W45)

[redacted] (W46) Total

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile (W47)

Non-Mobile (W48)

[redacted] (W49) Total

(2) Speech/Language Impairment (W50)

(3) Hearing Impairment

Hard of Hearing (W51)

Deaf (W52)

[redacted] (W53) Total

(4) Visual Impairment

Impaired (W54)

Blind (W55)

[redacted] (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)

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a) (W68)	
no. of allegations of neglect investigated (b) (W69)	
[redacted]	(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)	
[redacted]	(W74) Total