



State of Illinois
Illinois Department of Public Health

Long-term Care Report to the Illinois General Assembly

July 2014



Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

July 2014

Dear Members of the General Assembly,

Thank you for the opportunity to present the 2014 Illinois Department of Public Health's Annual Report pursuant to Section 3-804 of the Nursing Home Care Act (210 ILCS 45) and Section 6 of the Abused and Neglected Long-Term Care Facility Residents Report Act (210 ILCS 30).

Our mission, to protect the health and wellness of the people in Illinois through the prevention, health promotion, regulation and the control of disease or injury, remains the guiding principal in our success as a national leader in the health care field.

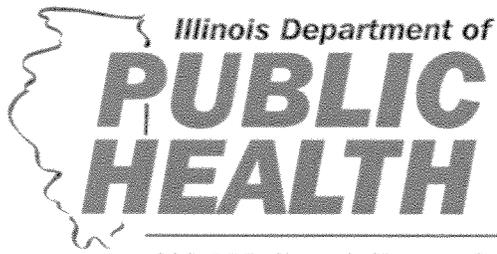
The scope of services provided by the Department of Public Health is critical to the well-being of the state's 12.8 million residents. Through education, collaboration and innovation, the Department of Public Health continues to spearhead the promotion of safe and healthy communities in every corner of the state.

Once again, thank you for your interest. I trust this report will prove to be a valuable resource in your important deliberations on health care for the people of Illinois.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Hasbrouck", is written over a large, faint circular watermark or seal.

LaMar Hasbrouck, MD, MPH
Director



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July 2014

Dear Members of the General Assembly,

The Illinois Department of Public Health is pleased to submit its 2014 Annual Report to the Illinois General Assembly and appreciate your thoughtful review and attention.

Setting standards to ensure health care providers and facilities throughout Illinois are providing the highest quality of services is the primary focus of the Office of Health Care Regulation.

Assisted living, hospice, home health facilities, nursing homes and hospitals are among the myriad of health care providers subject to review and regulation. The Department's dedicated and talented network of highly educated professionals is diligent in identifying issues that may jeopardize the safety of patients. Equally important, the Office of Health Care Regulation promptly investigates and ensures timely and appropriate corrective actions are taken when violations and noncompliance are determined.

On behalf of the more than 400 employees in the Office of Health Care Regulation, thank you for your ongoing support of the Department's mission.

Yours truly,

A handwritten signature in cursive script that reads "Debra D. Bryars".

Debra D. Bryars
Acting Deputy Director
Office of Health Care Regulation

Improving public health, one community at a time

printed on recycled paper

REPORT TO THE ILLINOIS GENERAL ASSEMBLY
by the
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Nursing Home Care Act

The Department shall report to the General Assembly by July 1 of each year upon the performance of its inspection, survey and evaluation duties under this act, including the number and needs of the Department personnel engaged in such activities. The report also shall describe the Department's actions in enforcement of this act, including the number and needs of personnel so engaged. The report also shall include the number of valid and invalid complaints filed with the Department within the last calendar year. [210 ILCS 45]

Abused and Neglected Long-Term Care Facility
Residents Reporting Act

The Department shall report annually to the General Assembly by July 1 on the incidence of abuse and neglect of long-term care facility residents, with special attention to residents who are mentally disabled. The report shall include, but not be limited to, data on the number and source of reports of suspected abuse or neglect filed under this act, the nature of any injuries to residents, the final determination of investigations, the type and number of cases where abuse or neglect is determined to exist, and the final disposition of cases. [210 ILCS 30]

Community Care Act

The Department shall report to the General Assembly by July 1 of each year upon the performance of its inspection, survey and evaluation duties under this act, including the number and needs of the Department personnel engaged in such activities. The report shall also describe the Departments actions in enforcement of this act, including the number and needs of personnel so engaged. The report shall also include the number of valid and invalid complaints filed with the Department within the last calendar year.

TABLE OF CONTENTS

List of Data Tables and Appendices	iv
PART 1 OVERVIEW	1
Nursing Home or Long-term Care Facility	1
Intellectual Disabilities or Long-term care facility for residents under age 22	2
Specialized Mental Health Rehabilitation Facility	2
Size and Variety of Facilities	3
Office of Health Care Regulation Structure	4
Budget & Fiscal Section	4
Education & Training Section	4
Long-Term Care Surveyor Training	5
Nurse Aide Training and Competency	6
Division of Administrative Rules & Procedures	7
Legislative Actions	7
Administrative Rules	8
Health Care Worker Registry	9
Administrative Findings of Abuse, Neglect and Theft	10
Background Checks and Disqualifying Convictions	10
Division of Life Safety and Construction	11
Construction/Renovation/Addition Plans – Design & Construction Section	11
Health Facility Plan Review Fund	11
Summary of Fire Situations	12

Health Care Facilities & Programs	15
Division of Quality Assurance	15
Two-Year Licenses	15
Changes in Licensure	16
Violations	17
Licensure Action	17
Federal Certification Deficiencies in Nursing Homes	18
Federal Certification Actions	19
Federal Certification Civil Money Penalties.....	19
Division of Assisted Living	19
Division of Long-Term Care Field Operations.....	19
Special Investigations Unit.....	20
Abuse.....	20
Monitors	21
Unlicensed Long-Term Care Facilities	21
Identified Offender Project	22
Abuse, Neglect, Theft in Nursing Homes	22
Allegations of Aide Abuse, Neglect or Misappropriation of Resident Property	24
Illinois Department of Human Services – Office of Inspector General	25
Central Complaint Registry	26
Intermediate Care Facility/IID SMHRF Section.....	28

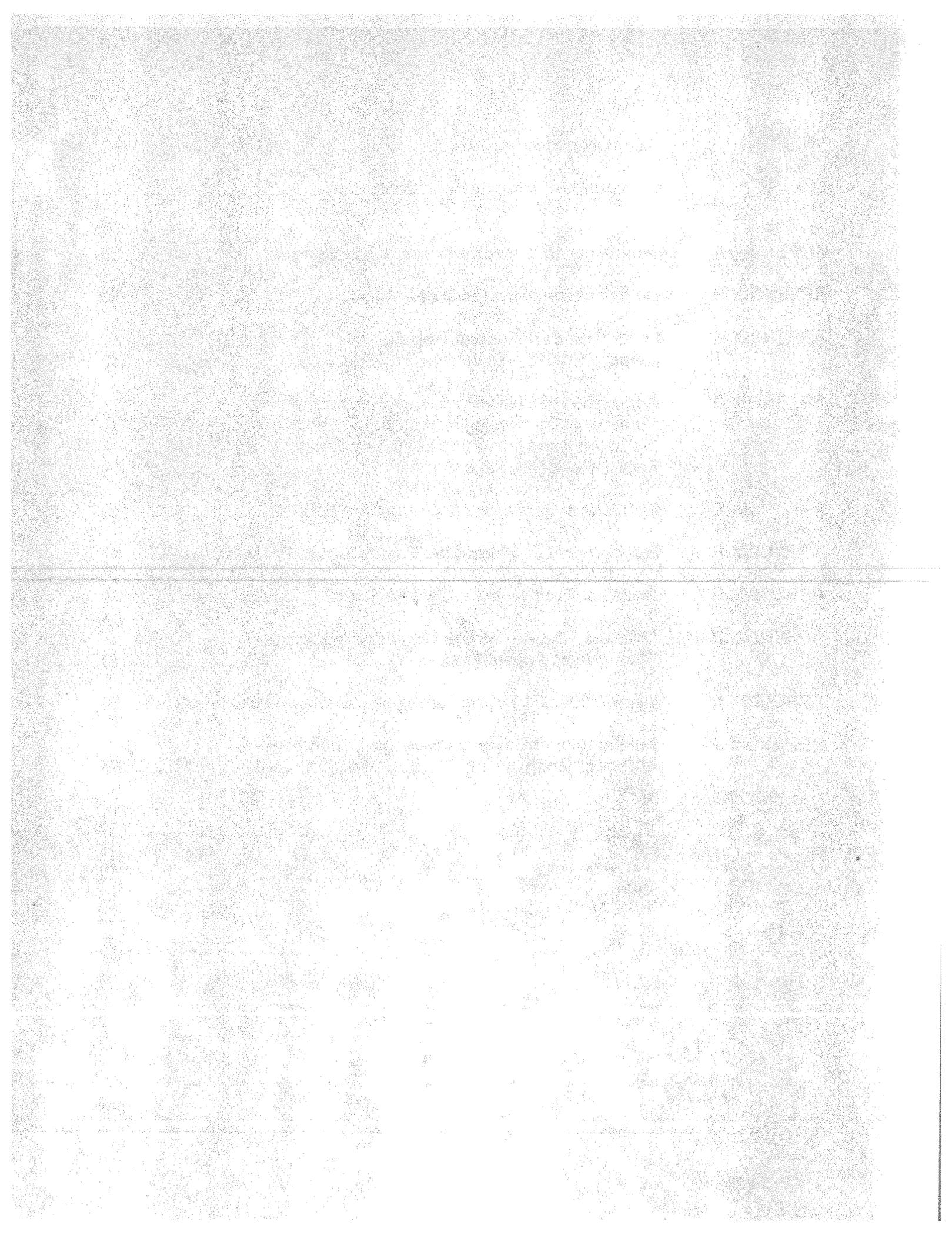
PART II	PERFORMANCE OF INSPECTIONS, SURVEYS AND EVALUATION DUTIES UNDER THE ACT	30
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Inspections and Surveys.....	30
State Survey Performance Standards.....	30
Implementation of Federal Certification Enforcement Regulations	35
Federal Survey Initiatives.....	35

LIST OF DATA TABLES AND APPENDICES

TABLE 1	Number and Type of Licensed and/or Certified Long-term Care Facilities	3
TABLE 2	Number and Type of Licensed and/or Certified Long-Term Care Facility Beds	4
TABLE 3	Health Care Worker Registry Statistics, 2013.....	9
TABLE 4	Administrative Findings Statistics, 2013.....	10
TABLE 5	Background Checks and Waiver Statistics, 2013	11
TABLE 6	2013 License Renewal Information.....	16
TABLE 7	Total Licensure Violations Initially Issued.....	17
TABLE 8	LTC Facility Adverse Licensure Action 2011, 2012 and 2013.....	17
TABLE 9	Aide Abuse, Neglect and Misappropriation of Resident Property Findings 2011, 2012, and 2013.....	25
TABLE 10	Surveys/Investigations/Inspection of Care.....	25
TABLE 11	Allegations made to the CCR 2011, 2012 and 2013.....	27
TABLE 12	Validity of Allegations 2011, 2012 and 2013.....	28
TABLE 13	Violation Levels for Allegations 2011, 2012 and 2013.....	28
FIGURE 1	Reported Causes of Fire, 2013.....	12
FIGURE 2	Methods of Detection of Fires, 2013.....	13
FIGURE 3	Method of Fire Extinguishment, 2013	13

FIGURE 4	Distribution of Fires, 2013.....	13
FIGURE 5	Occurrence of Fires by Hour, 2013.....	14
APPENDIX A	Determination to Issue a Notice of Violation	38
APPENDIX B	Determination of the Level of a Violation	40
APPENDIX C	Long- term Care Federal Training January 1, 2013 – December 31, 2013.....	43
APPENDIX D	Administrative Rules Promulgated Under the Authority of the Nursing Home Care Act and the Abused and Neglected Long-term Care Facility Residents Reporting Act.....	44
APPENDIX E	Definition of Facility or Long-term Care Facility	45
APPENDIX F	Summary of Long-term Care Facility Survey Process	47
APPENDIX G	Report of Fires in Health Care Facilities	49
APPENDIX H	Offenses That Are Always Disqualifying Except Through The Appeal Process.....	50
APPENDIX I	Section 300.661 Health Care Worker Background Check.....	54
APPENDIX J	Further Information from the Illinois Department of Public Health.....	66



PART I OVERVIEW

Nursing Home or Long-term Care Facility

The Nursing Home Care Act defines a facility or a long-term care facility as:

A private home, institution, building, residence, or any other place, whether operated for profit or not, or a county home for the infirm and chronically ill operated pursuant to Division 5-21 or 5-22 of the Counties Code, or any similar institution operated by a political subdivision of the State of Illinois, which provides, through its ownership or management, personal care, sheltered care or nursing for 3 or more persons, not related to the applicant or owner by blood or marriage. It includes skilled nursing facilities and intermediate care facilities as those terms are defined in Title XVIII and Title XIX of the Federal Social Security Act. It also includes homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs. (Section 1-113)

Although "nursing home" is a common and correct phrase to describe these facilities, however, it is a limited term. Some residents do not need nursing, or nursing needs are secondary, while others need extensive nursing care. The following are some examples of persons who live in nursing homes:

A 27-year-old man is semi-comatose following an auto accident. He has a tracheostomy and needs a ventilator to breath. He requires complete personal care and highly complex nursing care. He also receives intensive occupational and physical therapy, as well as emotional support and social services to assist him in attaining the highest level of functioning ability.

A 68-year-old woman is disoriented to time and place. She does not need to take medications, but needs prompting to eat or dress. She requires supervision for safety issues, such as reminders to dress warmly during cold weather or not to get lost when leaving the facility.

A 42-year-old man is developmentally disabled and attends a sheltered workshop during the week. He is learning daily life activities to enable him to live in a group home that offers minimum supervision and allows him to function at the highest level he is able to maintain.

A 97-year-old woman has retained all of her mental faculties, but requires extensive nursing care because of circulatory problems that have resulted from long-standing, uncontrolled diabetes.

Intellectual Disabilities or long-term care facility for residents who are under age 22

The Intermediate Care Facility/Intellectually Disabled Community Care Act defines a facility as:

An intermediate care facility for the developmentally disabled or a long-term care for under age 22 facility, whether operated for profit or not, which provides, through its ownership or management, personal care or nursing for 3 or more persons not related to the applicant or owner by blood or marriage. It includes intermediate care facilities for the intellectually disabled as the term is defined in Title XVIII and Title XIX of the federal Social Security Act. (Section 1-113)

The following is an example of persons who live in an under age 22 facility:

An 18-year-old woman has severe physical and intellectual disabilities. Although she is basically healthy, she needs complete personal care because of physical limitations and delays in cognitive development.

Specialized Mental Health Rehabilitation facility

The Specialized Mental Health Rehabilitation Act of 2013 defines a facility as:

A specialized mental health rehabilitation facility that provides at least one of the following services: (1) triage center; (2) crisis stabilization; (3) recovery and rehabilitation supports; or (4) transitional living units for 3 or more persons. The facility shall provide a 24-hour program that provides intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. It includes facilities that meet the following criteria:

- (1) 100% of the consumer population of the facility has a diagnosis of serious mental illness;
- (2) no more than 15% of the consumer population of the facility is 65 years of age or older;
- (3) none of the consumers are non-ambulatory;
- (4) none of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability; and
- (5) the facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding the effective date of this Act and qualifies as a institute for mental disease under the federal definition of the term.

The Nursing Home Care Act authorizes the Department to establish different levels of care:

- Skilled Nursing Care Facility (SNF)
- Intermediate Care Facility (ICF)
- Intermediate Care Facility for the Developmentally Disabled (ICF/ID)
- Small ICF/ID Facility (16 or fewer beds)
- Long-term Care Facility for those Under Age 22 (22 and under)
- Sheltered Care Facility (SC)
- Veterans' Home

For the purpose of this report, the phrase long-term care (LTC) facility is used generally to indicate all levels of care. Specific levels will be identified when an issue is not applicable to all levels. The words *inspection* and *survey* are used synonymously as are *re-inspection* and *follow-up*. The word *investigation* suggests a more focused approach that evaluates only specific aspects. For instance, a complaint investigation evaluates only the specific allegation(s).

Size and Variety of Facilities

LTC facilities range in size from four beds to 551 beds. Some offer only one level of care, while others may provide two or more levels of care. Tables 1 and 2 describe the number of licensed facilities and beds by the level of care provided. Facilities certified, but not licensed, still require inspections and investigations. There are 96 certified-only and hospital-based facilities with more than 3,997 additional beds in Illinois.

TABLE 1			
Number and Type of Licensed and/or Certified LTC Facilities			
	<u>2011</u>	<u>2012</u>	<u>2013</u>
SNF Only	464	471	485
SNF/ICF	169	161	151
SNF/ICF/SC	23	23	23
SNF/ICF/ICF-DD	2	2	2
SNF/SC	37	38	35
SNF & SNF/22 and Under	1	1	1
22 and Under Only	9	9	9
ICF Only	55	51	48
ICF/IID Only	32	24	22
16 or Fewer Bed Only	262	253	245
ICF/SC	10	8	8
SC Only	48	47	46
CLF only	28	28	28
Hospital-based LTC units	41	38	34
Swing Beds	57	56	55
Supportive Residences	1	1	1
State Mental Health LTC units	8	8	7
TOTAL FACILITIES	1,247	1,219	1,200

TABLE 2			
Number and Type of Licensed and/or Certified LTC Facility Beds			
<u>Type of Facility</u>	<u>Number of Licensed and/or Certified LTC Beds</u>		
	<u>2011</u>	<u>2012</u>	<u>2013</u>
SNF	81,308	81,381	81,988
ICF	19,487	18,534	17,488
ICFDD	9,189	9,045	8,284
22 and Under	932	932	1,019
CLF	396	396	396
SC	<u>6,489</u>	<u>6,359</u>	<u>6,241</u>
TOTAL BEDS	117,801	116,650	115,416

Office of Health Care Regulation Structure

The Office of Health Care Regulation (OHCR) regulates the Budget and Fiscal Section, the Education and Training Section, the Division of Administrative Rules and Procedures (ARP), the Division of Life Safety and Construction (LSC), the Division of Health Care Facilities and Programs (HCFP), and the Bureau of Long Term Care (BLTC). The BLTC is comprised of three divisions: the Division of Quality Assurance (QA), the Division of Assisted Living (AL) and the Division of Long Term Care Field Operations (LTC FO). The LTC FO is comprised of three sections: the Special Investigations Unit (SIU) - within SIU is the Central Complaint Registry (CCR), the Intermediate Care Facility/Individual Intellectually Disabled/Specialized Mental Health Rehabilitation Section (ICF/IID/SMHRF), and the seven Regional offices located in Rockford, West Chicago, Peoria, Champaign, Edwardsville, Marion, and Bellwood/Chicago.

Budget and Fiscal Section

The Budget and Fiscal Section is responsible for all fiscal transactions for the Office of Health Care Regulation. This includes advising the Deputy Director on budget and personnel matters, accounting transactions, (travel vouchers, payroll, vendor payments, contracts, ordering of all supplies and equipment) Information Technology Requests (ESRs), audit compliance, organizing all Federal training requests, monitoring all inventory which includes furniture and equipment and general managing of the daily activities of the Office.

Education and Training Section

The Section coordinates and assists with training the OHCR staff, other agency staff involved in LTC issues, LTC industry representatives and the general public. OHCR

staff is provided education and training for various regulatory programs and survey processes and in preparation for federal testing, if required. Training for OHCR and other agency staff also may be held to meet the requirements of CMS, to introduce new procedures or technical material, or to review commonly used procedures. Training for the industry representatives and the general public may inform and/or clarify the Department's response to certain situations, or introduce new regulations and/or procedures or technical material; it also provides a forum for exchanging information.

Long-term Care Surveyor Training

The Education and Training Section coordinates the three-week State Basic Surveyor Orientation Training Program (BSO). Fifty new surveyors were provided an overview of the federal and state requirements for nursing facilities to assist them in surveying for compliance and in successfully passing the SMQT. Topics covered were: State Operations Manual-Appendices P, PP, Q, Chapters 5 and Survey Tasks 1-7; Pressure Ulcers; Adequate Supervision; Restraints; Immediate Jeopardy, Abuse and Neglect; Basic and Advanced Principles of Documentation; Hands On Practical Application of Principles of Documentation; Principles of Investigation; Deficiency Determination Based on Evidence; FOSS and FMS Surveys; SMQT; Infection Control; Pharmacy Tags and Medication Pass; Environmental and Nutritional Requirements; Enforcement; MDS/RAI; Food Service Sanitation; Administrative Hearing Process; Culture Change; The Role of the Surveyor; ASPEN and ACTS Use; Background Checks; Findings of Abuse, Neglect and Misappropriation of Funds; Legal Issues and Ombudsman program. The new surveyors successfully completed the BSO, Federal Basic Orientation and passed the SMQT, to deem them as qualified to survey LTC facilities.

Seventeen new surveyors attended the State BSO early April 2014. Additional BSOs will be scheduled to train new surveyors, pending hire. The Department continues to implement a plan to hire an additional 141 Health Facility Surveyors to comply with SB 326. All surveyors should be hired and trained by the end of calendar year 2015. This increase in staffing will allow the Department to comply with state and federal laws to ensure surveys are conducted within the required timeframes.

Mandatory training for all surveyor staff included the updates to Appendix P and PP; as well as review of 3 Dementia Videos required by CMS. Training was provided regionally as well as at the quarterly supervisor's meeting. Information included: new protocol revisions for determining IJ's, updates on FOSS Surveys, updates on Comparative Surveys and Performance Measure analysis related to the state's Quality of their survey process. The Division of LTC Field Operations also provided continuing education opportunities for all staff through various outside training programs. Central and regional office staff attended the following: Illinois Pioneer Coalition Annual Summit; Illinois Environmental Health Association seminars; Illinois Food Safety Symposium; as well as computer based learning from discipline specific topics from the Care2Learn System. Federal CMS provides satellite broadcasts and web-based training for all surveyor disciplines in the Office of Health Care Regulation. Information regarding federal surveyor training and education continues to be maintained in the centralized database called the Total Learning Management System.

This Section continues to hold town hall meetings inviting the providers to hear regulatory updates and information regarding the region's most frequently cited deficiencies. The goal of these informational meetings is to assist providers to provide necessary care and services which improves resident outcomes. IDPH also continues in their collaborative effort with the trade associations, to provide educational opportunities for the providers related to regulatory updates and processes to provide necessary care and services as required.

This Section also administers the Nurse Aide Training program, which is authorized by and operated in accordance with the Nursing Home Care Act and federal certification requirements. This section is responsible for review and approval of the resident attendant/paid feeding assistant training programs submitted by skilled and intermediate care facilities and non-facility based entities.

Nurse Aide Training and Competency

Nursing assistants/aides working in licensed skilled nursing facilities, intermediate care facilities and home health agencies must complete required training in order to be employed as a certified nursing assistant (CNA). Training is achieved primarily by successfully completing an IDPH approved basic nursing assistant training program.

All basic nursing assistant training programs are approved by staff of the Education and Training Unit. Rules governing Basic Nursing Assistant Training Programs in Illinois are found in the 77 IL Administrative Code, Part 395. These training programs are sponsored by various entities including community colleges, long-term care facilities, home health agencies, hospitals, private business, vocational schools and high schools. Nurse aide training programs consist of theory instruction, demonstration of manual skills used in providing patient care and successful completion of a written competency examination.

Twenty new Basic Nursing Assistant Training programs were approved in 2013, bringing the total number of active programs to 319.

Breakdown of sponsors for current programs			
Community colleges	107	Hospitals	2
Vocational schools	98	Private businesses	7
High schools	77	Home health agencies	9
Nursing homes	19		

Instructors and evaluators teaching in training programs must be approved by the Department prior to instructing students. In 2013, 846 instructors and 155 evaluators were approved by the Department. Nurse aide training programs are monitored and evaluated by Department staff to ensure compliance with stated program plans. A total of 49 programs were monitored in 2013. Revisions to the 77 Illinois Administrative Code, Part 395, Nurse Aide Training Programs and the model program curriculum were approved by the legislature and became effective.

In response to Illinois Statute ILCS 2310/2310-225 and 227 and based on results of the Illinois Certified Nurse Assistant Incentive Program Survey, draft rules and curriculum for the Advanced Nurse Aide Training program, CNA II, are written.

Division of Administrative Rules and Procedures (ARP)

The ARP maintains three sets of administrative rules written under the authority of the NHCA; two sets of administrative rules written under the authority of the ICF/IID Community Care Act; and promulgates an emergency administrative rule under the authority of the Specialized Mental Health Rehabilitation Act of 2013 (see Appendix D.) This division also administers the Health Care Worker Background Check Act and the Health Care Worker Registry.

Legislative Actions

In 2013, the General Assembly repealed the Specialized Mental Health Rehabilitation Act and replaced it with the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]. Immediately upon passage of the new Act, the Department, working with stakeholders and sister agencies, began drafting new administrative rules to create a regulatory framework for Specialized Mental Health Rehabilitation Facilities (SMHRFs). These facilities have been licensed under the Skilled Nursing and Intermediate Care Facilities Code and certified under Subpart T of that Part. Upon the filing of emergency rules, the SMHRFs will be licensed and certified under the new Act. Office of Health Care Regulation staff, working with stakeholders representing both the industry and residents, has drafted preliminary language to implement language on distressed facilities, from Public Act 96-1372. The language is nearly complete and will be reviewed by both the LTC Advisory Board and the DD Facility Advisory Board.

Public Act 96-1372 also mandated an overhaul of the requirements in Subpart S of the Skilled Nursing and Intermediate Care Facilities Code (the requirements for facilities that provide services to residents with serious mental illness). The Department, through the LTC Advisory Board, worked closely with stakeholders and other state agencies to make extensive changes to Subpart S.

The Department has been working closely with a DD facility work group to draft amendments to the Intermediate Care for Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350) to make the Code consistent with the new ICF/IID Community Care Act. That process is nearly complete and those rules will be proposed for 1st Notice once they're reviewed and voted on by the DD Advisory Board. Similar amendments will be drafted for LTC for Under Age 22 Facilities Code (77 Ill. Adm. Code 390).

The Department adopted comprehensive amendments to the LTC Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395). The comprehensive changes include a complete revamping of the CNA curriculum, a new curriculum for Train the Trainer, updated definitions and job titles, and enhanced background check requirements. The amendments were adopted in July, 2013.

Administrative Rules

The revised Long Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395) was approved and became effective June 2013. The comprehensive changes include a complete revamping of the CNA curriculum, a new curriculum for Train the Trainer, updated definitions and job titles, and enhanced background check requirements. The revised Code also affects facilities licensed under the ICF/IID CCA.

The Department adopted statutorily mandated revisions to the staffing requirements in the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300), including requirements for both licensed and non-licensed direct care staff. Public Act 96-1372, passed by the General Assembly in 2010, overhauled many elements of care in the NHCA. Among the changes was an updated methodology for computing staff-to-resident ratios, especially direct care staff. The amendments to Section 300.1230 (Staffing), including changing its name to "Direct Care Staffing," implement this portion of PA 96-1372. Due to the passage of PA 97-689, while these amendments were in Second Notice, the IDPH added statutory requirements that 25% of the direct care staff be licensed nurses and 10% of the direct care staff be registered nurses.

Public Act 96-1372 also mandated an overhaul of the requirements in Subpart S of the Skilled Nursing and Intermediate Care Facilities Code, i.e., the requirements for facilities that provide services to residents with serious mental illness. The Department, through the Long Term Care Advisory Board, has worked closely with stakeholders and other state agencies to make extensive changes to Subpart S. The advisory board is to meet for one more review of the rules, and then will meet again to vote on them. The Department hopes to propose the amendments before the end of the year.

Additionally, the Department, in conjunction with stakeholders and sister agencies, is working on both rules and legislation to create a regulatory framework for Specialized Mental Health Rehabilitation facilities. These facilities are currently certified under Subpart T of the Skilled Nursing and Intermediate Care Facilities Code, but will be licensed and certified under the Specialized Mental Health Rehabilitation Act, which was enacted in 2011, once rules are adopted under that act.

The Department, working with stakeholders representing both the industry and residents, has drafted preliminary language to implement on distressed facilities, from Public Act 96-1372. The language is nearly complete and will be reviewed by the Long Term Care Advisory Board and the DD Facility Advisory Board.

The IDPH has been working closely with a DD facility work group to draft amendments to the Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350) to make the Code consistent with the new ID/DD Community Care Act. The process is nearly complete and those rules will be proposed for First Notice once they're reviewed and voted by the DD Facility Advisory Board. Similar amendments will be drafted for the Long-Term Care for Under Age 22 Facilities Code (77 Ill. Adm. Code 390). Amendments were proposed last summer to Part 300, the Sheltered Care Facilities Code, and the Illinois Veterans' Homes Code that implement statutory

requirements for the safe handling of disabled residents and beef up the requirements for reporting a death to IDPH when that death results from an incident or an accident. Both sets of amendments were adopted in early 2013.

Health Care Worker Registry (HCWR)

The HCWR's principal responsibility is to provide information to health care employers in Illinois about unlicensed health care workers. It includes CNA training and competency test results; CNA administrative findings of abuse, neglect or theft; background checks, disqualifying convictions; waivers that make an exception to the prohibition of employment when there is a disqualifying conviction; and DD aide training. The HCWR provides necessary applications, forms, and instructions needed to assist health care workers who are seeking to be certified as an Illinois nurse aide or who are seeking to be granted a waiver. The HCWR supports a public and a private website, has a registry call center and answers e-mail inquiries. A health care worker will not appear on the registry unless he or she has a criminal history record check pursuant to the Health Care Worker Background Check Act (225 ILCS 46/).

All health care employers who are licensed or certified long-term care facilities must check the registry before employing a non-licensed individual who will have or may have contact with residents or have access to the resident's living quarters, financial, medical or personal records of residents. For the facility to hire the individual, the background check on the registry must not be more than a year old if the facility has not been implemented into the new fingerprint background check process. If the facility has been implemented, the individual is required to have a fingerprint-based fee (Fee_App) applicant inquiry requested by the IDPH. In either case, the individual may not work with disqualifying convictions unless and until the individual has been granted a waiver of those convictions. If the individual is to be hired as a CNA, the facility must verify that the individual has met proper training and competency test requirements. The individual cannot have any administrative findings of abuse, neglect or theft. The facility can check the registry by visiting the website at www.idph.state.il.us/nar or by calling 217-785-5133. For those who have been granted access to the IDPH's web portal and the registry's web application, they may visit the registry at www.idphnet.illinois.gov

**TABLE 3
Health Care Worker Registry Statistics, 2013**

Active basic nursing assistant training programs	319
CNA competency testing	
Passed	15,819
Failed	2,901
No show	1,042
Total registered to test	19,762
Direct Service Personnel added	5,808
Total number of CNAs on the registry as of 12/31/2013	224,891
Total number of Direct Service Personnel as of 12/31/2013	123,389

Administrative Findings of Abuse, Neglect and Theft

The Nursing Home Care Act and the Abused and Neglected Long-term Care Facility Residents Reporting Act require that allegations of suspected abuse, neglect or misappropriation of a resident's property by CNAs, DD Aides and HAB Aides be reported to the Department. After these allegations have been investigated and processed through an administrative hearing, those that have a final order of abuse, neglect or theft are published on the registry.

Table 4
Administrative Findings Statistics, 2013

Administrative Findings

Abuse	75
Neglect	13
Misappropriation of property	<u>18</u>
Total administrative findings	106

Background Checks and Disqualifying Convictions

The Health Care Worker Background Check Act (Act) required all direct care employees hired prior to January 1, 2006 to have a name-based criminal history records check. Beginning on January 1, 2006, each long-term care facility operating in the state must initiate a criminal history records check for all unlicensed employees hired on or after January 1, 2006, with duties that involve or may involve contact with residents or access to the resident's living quarters or the financial, medical or personal records of residents. If a criminal history records check indicates a conviction of one or more of the offenses enumerated in Section 25 of the act, the individual shall not be employed from the time the employer receives the results of the background check until the time that the individual receives a waiver, if one is granted by the Department.

The Department licenses the following health care employers:

- community living facilities; life care facilities
- long-term care facilities
- home health agencies, home services agencies or home nursing agencies
- hospice care programs or volunteer hospice programs
- sub-acute care facilities; post-surgical recovery care facilities
- children's respite homes
- freestanding emergency centers
- hospitals
- assisted living and shared housing establishments

The Department's goal in evaluating waivers is to continue the prohibition of employment, imposed by the act, of those individuals who might pose a threat to the clients of health care employers.

An amendment to the Health Care Worker Background Check Act was signed into law that requires all background checks to be fingerprint-based with the Department as the requestor. The Department is working on implementing this new amendment. The act gives the discretion to the director on implementing the new amendment as soon as it is determined practical to do so. The administrative rules for this amendment were not adopted until March 26, 2009. The Department began implementing the new fingerprint process in 2009. The newly adopted rules instruct health care employers to follow basically the same guidelines as in the old rules until implemented into the new fingerprint process. The criminal offenses stayed the same but a new dimension in granting waivers was added. If specific criteria are met, the individual may be granted a rehabilitation waiver without submitting a waiver application.

Table 5	
Background Checks and Waiver Statistics, 2013	
Background checks added to the registry	132,131
Waivers	
Granted	1,124
Denied	416
Total waivers processed	1,540
Waivers revoked*	5

* A waiver is revoked if an individual is convicted of a new disqualifying offense

Division of Life Safety and Construction (LSC)

The LSC has the overall responsibility of conducting all plan reviews and inspections of licensed and certified types of facilities. It has the overarching responsibility of coordinating facility surveys with HCFP and the BLTC. It has the responsibility of developing physical plant rules and updates to physical plant rule. The Division also conducts onsite investigations regarding complaints or incidents at licensed facilities. Facility types the Division oversees include, but are not limited to, hospitals (acute care and critical access), ambulatory surgery centers, long term care facilities, assisted living, hospice, and end stage renal dialysis facilities. This Division is comprised of the two sections: Design and Construction Section (for architectural and engineering) and Field Services Section (certification surveys).

Construction/Renovation/Addition Plans – Design and Construction Section

LSC reviewed 118 projects that were submitted in 2013. Plan review fees collected in 2013 were \$392,482.06 for total project costs of \$153,083,819.81.

Health Facility Plan Review Fund [Public Act 90-0327 (Nursing Home Care Act 210 ILCS 45/3-202.5 - Sec. 3-202.5.)]

Establishing the Facility Plan Review Fund allowed the Department to charge a fee for facility plan reviews. The Nursing Home Care Act requires a fee for major construction projects with an estimated cost greater than \$100,000. The difference between fees paid for plan review and the estimated amount required to support the process comes from the general revenue fund.

The Nursing Home Care Act requires review of acceptable plan review submissions to be completed within 30 days for design development submissions and 60 days for construction/working submissions. Item to item responses are required to be reviewed within 45 days after receipt. Most projects require an onsite survey prior to use or occupancy and those are required to be completed within 30 days after acceptance of the facility's certifications. Some projects require the inspection by all disciplines architectural, mechanical, electrical and clinical.

In 2013 the Design and Construction Section completed desk reviews for upgrades of beds from sheltered and intermediate to skilled. LSC approved 29 requests for upgrades in 2013, which resulted in 1,092 beds being upgraded from sheltered or intermediate to skilled. The Field Services Section conducts the annual life safety code nursing home surveys and life safety/physical environment complaint surveys. The Section conducted 1,070 surveys during 2013.

Summary of Fire Situations

The Department received 35 life safety fire incident reports from long-term care facilities in 2013. During this reporting period, no resident deaths occurred. The severity of fires in nursing homes in the state remain at a minimal level due to the Department's enforcement of life safety code standards which focus on early detection, extinguishment system, staff education (fire drills), and effective maintenance programs.

The categories used for graphic purposes are:

- Reported causes of fire
- Methods of detection
- Methods of fire extinguishment
- Distribution of fire by shift
- Occurrence of fire by hour
- Reported causes of fire

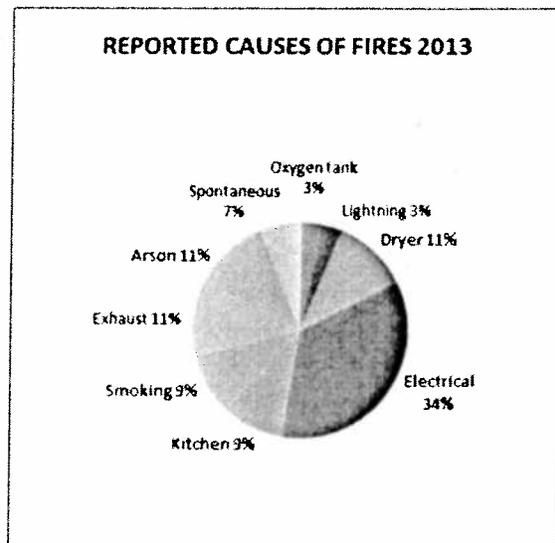


Figure 1

The major cause of the fires were electrical (12 of 35), arson (5 of 35), dryer fires (4 of 35), and exhaust fires (4 of 35), Figure 1. The number of arson fires increased from the previous year from two to five. In four of the five cases, residents were identified as the perpetrators. This supports the importance of resident assessment and subsequent planning of care, resident supervision, maintenance of smoke and fire detection system and fire extinguishment systems, fire drills as part of staff education to ensure familiarity with procedures to be followed in emergency situations, and facility smoking policies.

Electrical-related fires involved primarily electrical outlets and faulty plug-ins on electrical devices. Kitchen-related fires occurred during food preparation. The causes of these fires support the need for staff education and preventative maintenance programs for cooking, laundry, cooling, heating, ventilation and electrical systems.

The most successful means of detection was facility staff percentage of detection (26 of 35), Figure 2. This illustrates the importance of staff education to include properly conducted fire drills. The second most successful means of detection was the fire alarm system (8 of 35). This demonstrates the importance of properly maintaining and testing all components of the fire alarm system.

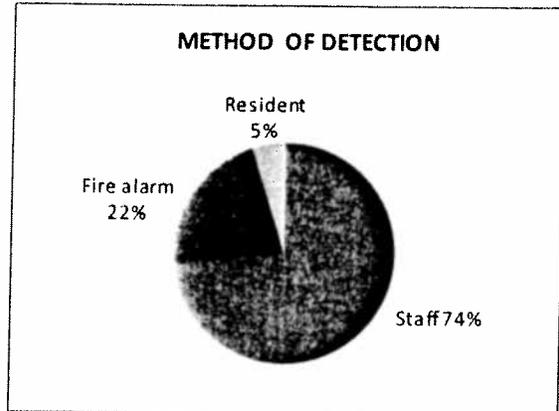


Figure 2

Staff continues to be an important part of fire extinguishment. Staff members were credited with extinguishing sixteen fires. The fire department was credited with extinguishing sixteen fires, while three were extinguished by the sprinkler system.

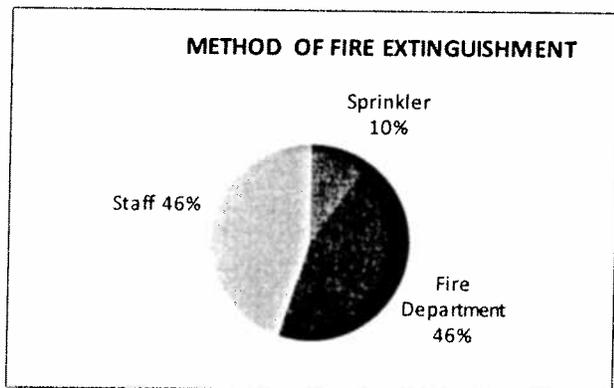


Figure 3

The information obtained allows other statistics relating to fires to be evaluated. An often-asked question is related to distribution of fires by shift times, Figure 4. For report purposes, shifts are presumed to be first shift - 7 a.m. to 3 p.m., second shift, 3 p.m. to 11 p.m., third shift, 11 p.m. to 7 a.m. The greatest number of fires (14 of 35) occurred during first shift. The second highest number of fires (12 of 35) occurred during second shift. The specific hourly periods of occurrence are shown in Figure 5.

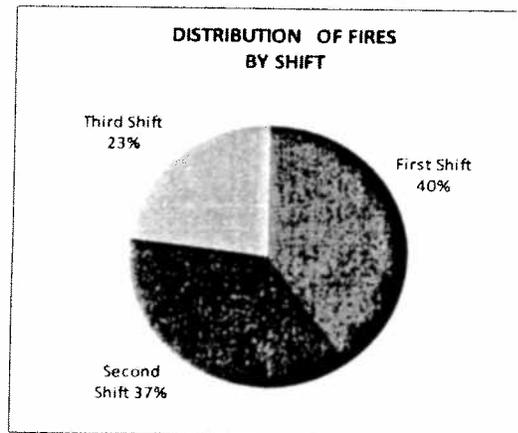


Figure 4

Occurrence of fires by hour
35 Fires Reported 2013

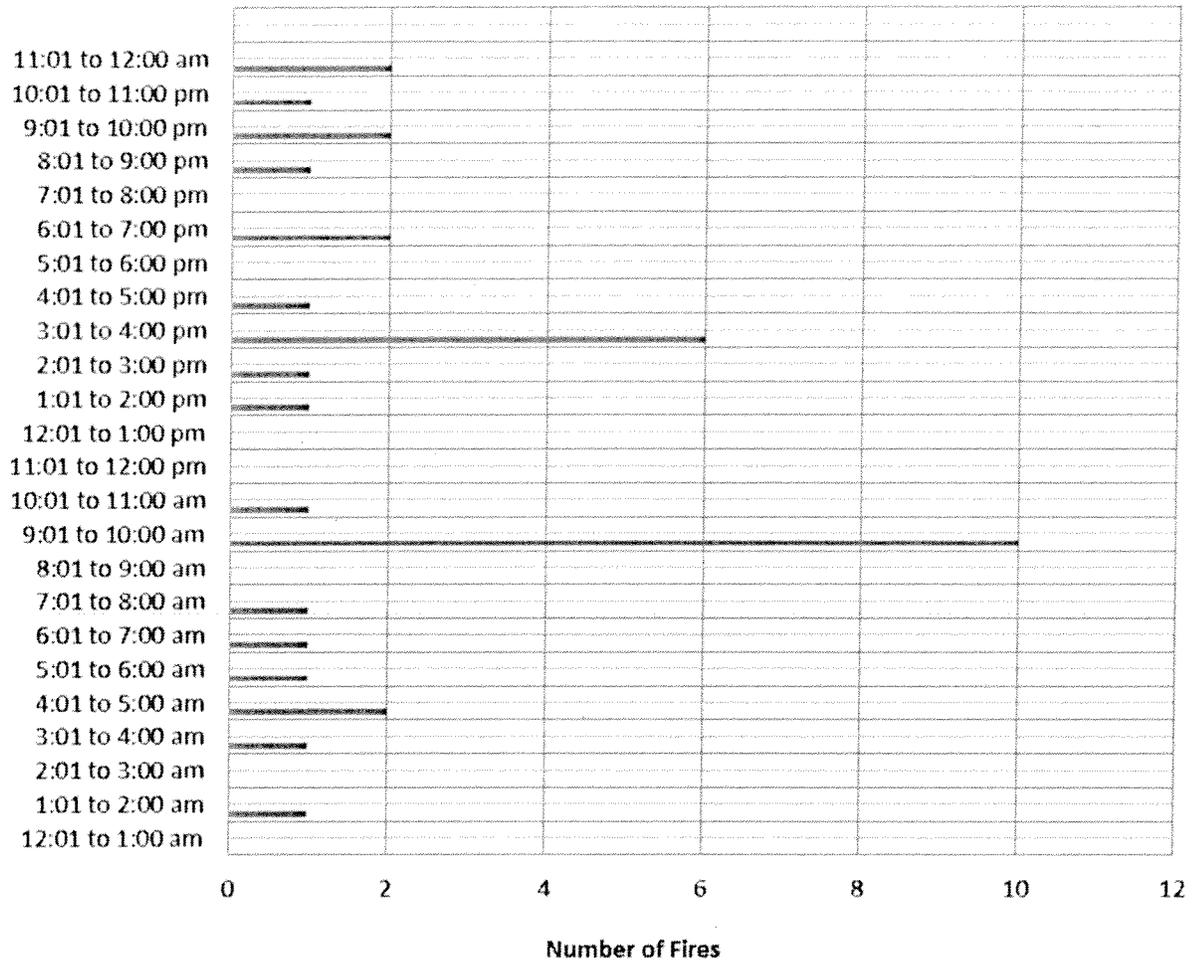


Figure 5

Division of Health Care Facilities and Programs (HCFP)

HCFP is responsible for the licensure and federal Medicare/Medicaid certification activities for all non-LTC health care facilities and programs within the State. Our purpose is to ensure the health, safety and quality of life of all clients served through enforcement, education, training and partnership with the healthcare industry, other government entities and advocates. There are approximately 9,600 licensed/certified non-LTC entities within the State. The various facilities/programs include hospitals, clinical laboratories, ambulatory surgical treatment centers, home health agencies, home services agencies, home nursing agencies, hospices, end stage renal disease facilities, rural health clinics, portable x-rays, outpatient physical therapy/speech pathology/occupational therapy programs, comprehensive outpatient rehabilitation facilities and the various programs under the Alternative Health Care Delivery Act. HCFP is responsible for processing state licenses, federal Medicare/Medicaid certifications, conducting regular and complaint investigations, initials and follow-up surveys, working with a survey staff of registered nurses and complementing support staff.

Division of Long Term Care Quality Assurance (QA)

QA is responsible for processing all surveys conducted by the LTC FO. These activities are performed as prescribed by the Nursing Home Care Act. The structure, format and time frame of certification processing activities also are formalized and regulated by HHS. Staff architects, electrical systems specialists and mechanical/fire protection specialists review initial construction and major remodeling plans to ensure compliance with state licensure rules and the National Fire Protection Association (NFPA) Life Safety Code. Licensure applications for 1,105 facilities are reviewed and processed and Medicare/Medicaid applications are processed by QA staff to assure compliance with the Nursing Home Care Act and federal regulations. QA has staff dedicated to licensure and certification survey activities, including staff assigned to quality review.

Two-year Licenses

The Nursing Home Care Act allows the Department to issue two-year licenses to qualifying facilities. To qualify, a facility cannot have had within the last 24 months:

- a Type "A" violation;
- a Type "B" violation;
- an inspection that resulted in 10 or more administrative warnings;
- an inspection that resulted in an order to reimburse a resident for a violation of Article II (Section 3-305) of the act;
- an inspection that resulted in an administrative warning issued for a violation of improper discharge or transfer (relating to Section 3-401 through 3-413); or
- sanctions or decertification for violations in relation to patient care in a facility under Titles XVIII and XIX of the federal Social Security Act.

During 2013, the Department issued 861 renewal licenses. The two-year license program is cyclical. Statistics show that the number of two-year licenses issued by the

Department is higher in odd-numbered years. Facilities continuing to qualify for the two-year license program maintain this schedule; however, as new facilities are licensed or as facilities change ownership or become disqualified from participation in the two-year program, the number of one-year licenses increases. Since the Department uses the certification survey for licensing and the certification program requires facilities to be surveyed approximately once per year, the certification survey sanctions affect the length of a facility's license. Each facility's certification survey results must be reviewed annually in addition to a review for licensure program sanctions to determine whether the facility meets the two-year license criteria.

<u>Month</u>	<u>1 Year</u>	<u>2 Year</u>	<u>TOTAL</u>
January	49	32	81
February	23	31	54
March	35	30	65
April	29	27	56
May	44	39	83
June	40	39	79
July	37	50	87
August	39	44	83
September	24	40	64
October	36	32	68
November	28	45	73
December	41	27	68
TOTALS	425	436	861

Changes in Licensure

Many LTC facilities experience changes in licensure through a change of the owner/operator of the facility, the addition to an Alzheimer's special care unit, bed increases and/or upgrades not requiring construction/renovation, a decrease in the number of licensed beds or closure of the facility. Table 5 describes the changes in licensure in LTC facilities in Illinois. In 2013, bed changes resulted in skilled care beds increasing by 490 beds, intermediate care beds decreasing by 1,003 beds and sheltered care beds decreasing by 80 beds. In addition, one replacement facility was approved for occupancy and licensed in 2013. Two new facilities were licensed in 2013 adding 146 skilled care beds. Sixteen LTC facilities closed in 2013, resulting in skilled care beds decreasing by 167, intermediate care for developmentally disabled beds decreasing by 408 beds, intermediate care beds decreasing by 239 beds, and sheltered decreasing by 35 beds.

Since the implementation of Public Act 88-278 [210 ILCS 3-212], a mechanism has been in place, through the certification program, to alert the Licensure Section of any federal enforcement action being imposed on facilities certified under Title XVIII or Title XIX of the Social Security Act.

Violations

Professional reviews by QA may yield any combination of "AA", "A" or "B" violations or no violations. When a "B" level violation is found, a facility is required to describe its actions or proposed actions and its plan for correction. When an "AA" or "A" violation is found, the IDPH imposes a conditional license, which is conditioned upon compliance with an imposed accepted plan of correction. If a reinspection indicates that a facility has not corrected a violation after an acceptable plan of correction has been established, a repeat violation may be issued.

**TABLE 7
Total Licensure Violations Initially Issued***

<u>Violation Level</u>	<u>Date</u>		
	<u>2011</u>	<u>2012</u>	<u>2013</u>
"AA" Violation	3	4	8
"A" Violation	118	101	55
Repeat "A" Violation	1	0	0
"B" Violation	399	429	358
Repeat "B" Violation	11	5	1

* Violations issued from all survey types, including annual, complaint, reinspection, etc...

Licensure Action

Based on the number/level of violations, adverse licensure action may be taken as:

Conditional License - Issued for a minimum of six months and up to one year, "conditional" on a facility's complying with an imposed plan of correction. Considered when "A," repeat "B" violations, or multiple or serious "B" violations occur.

License Revocation or Denial - Facility substantially fails to comply with the Nursing Home Care Act or the Department's regulations, including those having to do with staff competence, resident rights or the Nursing Home Care Act; licensee, applicant or designated manager has been convicted of a felony or of two or more misdemeanors involving moral turpitude; the moral character of the licensee, applicant or designated manager is not reputable; or the facility knowingly submits false information or denies access during a survey. Table 8 describes adverse actions.

**TABLE 8
LTC Facility Adverse Licensure Action
2011, 2012 and 2013**

Type of Action	Date		
	2011	2012	2013
Conditional License	92	79	44
Revocation or Denial of License	2	0	0
Suspension	0	0	0

Article III, Part 3 of the Nursing Home Care Act and the ICF/IID Community Care Act authorizes the Department to impose a fine or other penalty on facilities that violate the Acts. Violations are classified as Type AA (the most severe), Type "A", Type "B", and Type "C" (the least severe). The more severe penalties are reserved for facilities that do not correct a Type "AA" or a Type "A" violation within a required time period. In 2013, the Department imposed more than \$1.9 million in licensure fines against facilities and collected \$1, 203,751.41, as compared to \$1,234,740.60 collected in 2012. The amount collected would not necessarily be from those fines imposed in 2012, since most fines are contested by facilities and go through a hearing process before collection.

Article IV, Part 1 of the Specialized Mental Health Act of 2013 authorizes the Department to impose a fine or other penalty on facilities that violate the Act, up to and including license revocation. The Act lists six levels of compliance with the Act, from Level 1 (full compliance) through Level 6 (the most severe). Level 6 means "a licensee's consistent and repeated failure to take necessary corrective actions to rectify documented violations, or the failure to protect clients from situations that produce an imminent risk." Via administrative rule, fines for violations are consistent with Section 3-305 of the Nursing Home Care Act.

Federal Certification Deficiencies in Nursing Homes

Federal enforcement regulations established a classification system for certification deficiencies based on the severity of the problem and the scope, or the number of residents upon whom the non-compliance had or may have an impact. The four levels of severity are: potential for minimal harm, potential for more than minimal harm, actual harm and immediate jeopardy. The scope of deficiencies is classified as isolated, pattern or widespread (e.g., an H-level deficiency would represent a problem where several residents were actually harmed because of the facility's non-compliance with regulations).

The 12 levels of scope/severity are identified using the letters A through L. The following is the scope/severity grid established to classify federal deficiencies:

	<u>Isolated</u>	<u>Pattern</u>	<u>Widespread</u>
Minimal Harm	A	B	C
More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Immediate Jeopardy	J	K	L

Immediate jeopardy deficiencies represent the most serious problems that can occur in LTC facilities. These deficiencies often represent non-compliance that has resulted in serious injury or death to LTC residents. The Illinois LTC survey program has been recognized as a national leader in investigating and identifying non-compliance that puts residents in immediate jeopardy.

Federal Certification Actions

The Nursing Home Care Act allows the Department to use federal certification deficiencies in lieu of licensure violations. Licensure violations and enforcement actions against Medicare and/or Medicaid-certified facilities are pursued only when the licensure standard is stricter than the federal requirement or when the violation is egregious and warrants enforcement action against a facility license.

This enforcement approach is most noticeable in the assessment of fines against non-compliant facilities. The federal formula established in 1995, usually results in a higher fine than would be applied under state licensure except in cases of the most egregious violations. The following statistics illustrate the fines imposed under the authority of the federal regulations.

Federal Certification Civil Money Penalties

- Medicare* and Medicare*/Medicaid Facilities (dually certified) for calendar year 1/1/13 to 12/31/13 - \$1,234,741
- Medicaid Only Facilities for calendar year 1/1/13 to 12/31/13 - \$223,661
- Total CMPs imposed: \$1,458,402

* Medicare portion of Civil Money Penalties assessed against certified facilities is retained by federal CMS. The State receives a portion of Civil Money Penalty from Medicare/Medicaid Facilities (dually certified) based on the number of residents whose care is paid for by Medicaid.

Division of Assisted Living (AL)

The AL oversees approximately 333 licensed establishments. The establishments in Illinois are regulated under the Assisted Living and Shared Housing Establishment Code (77 Illinois Administrative Code 295). Assisted Living establishments provide community-based residential care for at least three unrelated adults (at least 80% of whom are 55 years of age or older) who need assistance with activities of daily living, including personal, supportive, and intermittent health-related services available 24 hours per day to meet the scheduled and unscheduled needs of a resident. This Division is responsible for conducting and processing annual and complaint survey investigations, incident report investigations, and follow-up surveys when applicable. This is a state licensure program with no federal oversight as the residents of these establishments are private pay through an establishment contract. Renewal applications and licensure fees are required yearly.

Division of Long Term Care Field Operations (LTC FO)

LTC FO conducts approximately 860 surveys per month, including annual licensure surveys, complaint investigations, special off-cycle surveys, incident report investigations and follow-up surveys pursuant to deficiencies cited during these inspections. Similar surveys are conducted under the authority of Title XVIII (Medicare) and Title XIX (Medicaid) of the federal Social Security Act. These regulatory activities are commonly called certification surveys. The structure, format and time frame of certification activities are mandated and highly regulated by the U.S. Department of

Health and Human Services (HHS) through the Centers for Medicare and Medicaid Services (CMS). While state licensure is mandatory under the Nursing Home Care Act, federal certification is a voluntary program. Participation allows a facility to admit and to provide care for clients who are eligible to have that care paid for with Medicaid or Medicare resources. Facilities providing LTC that are located within and operated by a licensed hospital are not required to have an additional state license under the Illinois Nursing Home Care Act. Facilities operated as intermediate care facilities for the developmentally disabled by the Illinois Department of Human Services also are not required to have an additional state license under the Illinois Nursing Home Care Act.

LTC FO also is responsible for the Inspection of Care (IOC) program, which was transferred from the Illinois Department of Public Aid to the Department of Public Health in 1994. The IOC program is a federally-mandated reimbursement activity in which field reviews are conducted at facilities for the developmentally disabled to determine if Medicaid-reimbursed health care services are being carried out and to gather data necessary to establish Medicaid reimbursement rates for each participating developmentally disabled individuals facility.

Approximately 1,200 facilities in Illinois are regulated under the Illinois Nursing Home Care Act and/or federal certification requirements for Medicare/Medicaid participation. Of this number, 1,105 are licensed under the Nursing Home Care Act, and 96 are associated with a licensed hospital and are operated as a nursing home under the Hospital Licensing Act. A total of 1,005 (90.95%) of the 1,201 facilities participate in the federal certification program for Medicare and/or Medicaid. A central office staff in Springfield and approximately 186 surveyors headquartered in seven regional offices (Bellwood, Champaign, Edwardsville, Marion, Peoria, Rockford and West Chicago) conduct field survey activities for the 1,201 regulated LTC facilities.

LTC FO Special Investigations Unit (SIU)

Abuse

Resident abuse is the most serious finding that the Department addresses as a survey agency. The elderly residents of nursing homes are highly vulnerable, and the outcome of acts of abuse can be devastating for resident and their families. To address this problem, the Department has significantly increased its investigation of incidents of abuse in Illinois nursing homes through interagency referral and investigation agreements with the Illinois State Police Medicaid Fraud Unit. Working relationships with the Cook County State's Attorney's Office in Chicago and the U.S. Attorney's Office in Springfield also have been established and remain in effect. The Department has established the Abuse Prevention Review Team (APRT). This team provides for an in depth look at any cases where sexual assault is alleged or resident death is alleged in conjunction with a complaint.

A licensing rule was adopted requiring facilities to immediately contact local law enforcement authorities when a resident is the victim of abuse involving physical injury or of any sexual abuse. The intent of the rule is to reduce the incidence of abuse in

Illinois nursing homes by combining the resources of the Department's investigation program with those of criminal law enforcement and prosecution agencies. With improvements in the federal database, new management reports listing various survey statistics are becoming available to state survey agencies. As more reports become available, the Department will use the information to identify trends in the quality of LTC and to help to determine survey program performance.

Monitors

The Division of LTC FO places monitors and/or receivers in facilities to provide additional oversight. The monitor/receiver program must meet requirements, including an understanding of the Nursing Home Care Act and the CMS guidelines. While a Department employee may serve as a monitor when certain conditions exist, the Department generally relies on monitors from companies or individual contractors. The Department also utilizes the placement of monitors as a remedy for federal certification surveys. The process of placement of monitors includes various methods and reasons for requesting a monitor. Placement of monitors is allowed through the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300) or as authorized by the CMS as an enforcement remedy. Conditions justifying placement of monitors include determining whether an emergency exists that threatens the health, safety and welfare of residents.

The Department placed monitors in two facilities in 2013 and continued monitoring five other facilities from 2012. Three of these facilities are licensed and certified to provide intermediate and/or skilled care services, while four of these placements involved Developmentally Disabled facilities. The number of monitor visits per week varies, generally starting with three to four times per week and either increasing or decreasing depending on the facilities progress and correction of the identified problems. Three of these facilities had monitors placed while the facility was pending closure and to assist in the assessment of residents during discharge.

The monitor program continues to expand and be an asset to the IDPH. The IDPH considers the monitors/receivers and their reports as critical components of its ongoing effort to stay in touch with the day-to-day activities occurring at these facilities. The reports are copied and shared, on request, with other agencies in determining ongoing compliance and potential criminal issues. Facilities utilize the monitor placement to recognize deficient practices and areas in need of more in-servicing, staffing and assistance in meeting the regulations to benefit the residents.

Unlicensed Long Term Care Facilities

The Nursing Home Care Act authorizes the IDPH to investigate any location reasonably believed to be operating as a LTC facility without a license. Only those locations that are the subject of a complaint are investigated. When a location is found to be in violation for the first time, the IDPH offers the owner the opportunity to come into compliance with the Nursing Home Care Act. If the owner fails to come into compliance, or is found in violation more than once, the location is then referred to the Office of the Attorney General for prosecution.

Identified Offender Project

P.A. 094-0163 requires facilities to check the Illinois State Police and Department of Corrections sex offender websites on all new admissions. A criminal history check is required on all new and existing residents. If the results of the background check are inconclusive, the facility is required to initiate a fingerprint-based check. In the event a resident's health or lack of potential risk, the facility may apply to the SIU for a waiver for the fingerprint background check. The resident is granted a waiver if the resident is completely immobile as verified by a signed physician explanation, has the existence of severe, debilitating physical condition that nullifies any potential risk. This waiver is valid only while the resident is immobile and the criterion supporting the waiver exists.

P.A. 094-0752 includes permanent rules now being followed by the IDPH requiring a criminal history analysis and report be conducted by the Department but outside the OHCR. The OHCR is responsible for ensuring proper tracking and monitoring of identified offenders is done in LTC facilities. All annual surveys include these extra duties along with complaint and incident investigations including checking the Identified Offender list. The criminal history analysis is to assist the facility in preparing supervision needs for all residents. All convicted or registered sex offenders must reside in a private room.

Abuse, Neglect, Theft in Nursing Homes - Abuse Prevention Review Team Act

Public Act 091-0931 provides for designated review teams appointed to review confirmed cases of sexual assault of a nursing home resident and unnecessary deaths of nursing home residents. The goal of the act is to gain a better understanding of the incidence and causes of sexual assaults against nursing home residents and unnecessary deaths of nursing home residents. The Department is responsible for ensuring that cases meeting the criteria developed in the act are referred to the designated team for review. The team will report their findings to the director and to appropriate agencies, making recommendations in an effort to help reduce the number of sexual assaults on and unnecessary deaths of nursing home residents.

The Department has trained staff to formulate the Special Investigations Unit responsible for implementing and overseeing the review of identified cases. Review teams made up of professionals from multiple disciplines and agencies have been established. Procedures for tracking confirmed sexual assaults, and unnecessary deaths, obtaining death certificates and devising a database as outlined in the statute was established. Secure databases have been established to track the following required by the act:

- Residents who are victims of sexual assaults and LTC residents known to have died at a facility;
- Residents named in quality of care deficiencies, who then are found to have died within six months;
- Residents whose care was the subject of a complaint or incident investigation by the Department involving death/sexual assault.

There are two Abuse Prevention Review Teams that meet quarterly: the Northern Abuse Prevention Review Team reviews deaths and sexual assault cases that occurred in LTC facilities in the geographic area, for the most part, north of I-80 (IDPH Regions 1, 7, 8 and 9); the Southern Abuse Prevention Review Team reviews sexual assault and death cases that occurred in LTC facilities in the geographic area, for the most part, south of I-80 (IDPH Regions 2, 4, 5 and 6).

In 2013, the Department's team logged and reviewed 862 reports of sexual abuse and/or deaths in LTC facilities. Of those, 146 were referred to the APRT:

	2012	2013
Total Cases Reviewed	505	862*
Referred to Teams	150	146
Northern	73	89
Southern	77	57

* In 2013, all incidents related to deaths were reviewed by the Department's APRT staff, not just those that had a related on-site survey completed.

Staff of SIU continues to focus on the prevention, detection and investigation of abuse, neglect and theft in Illinois LTC facilities. With the SIU in place within the Division, the Department was able to put even more emphasis on detection and prevention of abuse and neglect. The unit employs a special investigator who has a law enforcement background with the Illinois State Police (ISP).

The Department renewed its agreement with the Illinois State Police Medicaid Fraud Control Unit (ISP/MFCU) in 2013 to provide greater involvement of ISP/MFCU investigators in the Department, LTC investigations and cross-training of department and ISP/MFCU investigators. The assistance and guidance of the ISP/MFCU has helped the Department increase the number of cases staff is able to investigate, and the additional experience has proven invaluable. The agencies also developed a system to improve communication between ISP agents and IDPH field supervisors.

In 2013, 1,114 incidents and complaints of abuse/neglect, theft and/or fraud were referred to ISP/MFCU, which reviews the reports to determine which referrals to investigate for possible criminal action. Of those, 136 packets were provided to ISP/MFCU at their request for further review. The ISP/MFCU had 16 convictions of LTC abuse, neglect or theft cases. They opened 264 cases for patient abuse, 32 cases for theft, fraud, drug diversion or financial exploitation and 59 for immediate jeopardies.

2013 saw growth in the relationship between the Department, local law enforcement, state's attorneys, the FBI and coroners. The Department requires facilities to immediately contact local law enforcement authorities when a resident is the victim of abuse involving physical injury or sexual abuse. Department staff has attended association meetings, conferences and informational one-on-one meetings to respond to issues and concerns in regard to preventing abuse and neglect in LTC facilities. This

effort continues, and the results have been twofold. The lines of communication have greatly expanded, allowing the Department's focus to be strengthened, and numerous investigations in conjunction with local law enforcement have been conducted. Many one-on-one meetings with local law enforcement have resulted in these entities building relationships with LTC regional staff and allowing direct communication to discuss and share concerns related to incidents and issues of LTC facilities in their jurisdictions. The expanded interaction with law enforcement officials and local prosecutors has resulted in the following benefits:

- Increased awareness of the problem of abuse, neglect and theft in nursing homes. Department staff, along with ISP/MFCU staff, conducted numerous seminars and in-services for LTC providers and the public on abuse, neglect and theft in LTC facilities. Staff from the Division of LTC participates on the U.S. Attorney's Central Illinois Health Care Task Force; a staff member serves on the DuPage County Elder Fatality Review Team.
- The LTC, Special Investigations Unit has a representative on the Illinois State TRIAD Board to improve communications between seniors and law enforcement.
- Better understanding and involvement among law enforcement agencies statewide. Local law enforcement officials are becoming aware of the regulatory requirements of LTC facilities and becoming more comfortable interacting with providers. Some agencies make a routine of "walking a beat" in facilities.
- Improved efficiency in the pursuit of criminal and administrative remedies against identified abusers and against nursing homes that are inadequately protecting their residents from abuse, neglect and theft.

The goal of the Department is a reduction in the incidence of nursing home resident abuse, neglect and theft and, when necessary, prompt and accurate reporting. LTC facilities must be alert to preventing abuse, neglect and theft. Being able to screen prospective employees and residents thoroughly to identify risk factors; to train staff, residents and families; and to investigate reports are all keys to attaining and providing a safer environment for the residents.

Allegations of Aide Abuse, Neglect or Misappropriation of Resident Property

The Nursing Home Care Act and the Abused and Neglected Long-Term Care Facility Residents Reporting Act require that allegations of suspected abuse, neglect or misappropriation of a resident's property by certified nurse aides, developmental disabilities aides and certified child care-habilitation aides (hereafter referred to collectively as aides) be reported to the Department. The Department receives allegations of abuse, neglect or misappropriation of property committed by aides through complaints, incident reports and letters. Documentation from a facility's own complaint investigation is reviewed by the Department to determine whether there is substantial evidence to process an allegation against the aide. If so, the aide is notified by certified letter of the allegation and his or her right to a hearing. If, after a hearing,

the Department finds that the aide abused or neglected a resident or misappropriated resident property in a facility, or if the aide does not request a hearing within 30 days, the finding of abuse, neglect or misappropriation is placed next to the aide's name on the registry. Prospective employers who call the registry to determine an aide's status are informed of the finding. The practical effect is that the aide will not be able to find employment with a LTC facility.

While it cannot be determined whether facilities report all allegations of abuse, neglect or misappropriation of property by aides, in general, information received or requested from facilities is complete. Most facilities have been cooperative in providing the necessary information on such cases, or additional information when requested. Table 9 lists the number and type of findings for 2011, 2012, and 2013.

Allegation type	2011	2012	2013
Division of Legal Services	118	88	87
Cases closed	60	34	18
Cases processed	56	50	61
Abuse	83	40	27
Neglect	18	29	12
Misappropriation of property	15	15	22
Removal of neglect findings	0	0	8

Illinois Department of Human Services – Office of Inspector General

The Abused and Neglected Long-term Care Facility Residents Reporting Act was amended to require the Illinois Department of Human Services, Office of the Inspector General (DHS OIG), to report substantiated findings of physical and sexual abuse and egregious neglect to the Department for posting on the Health Care Worker Registry.

Type	2011	2012	2013
Annual Licensure/Certification Surveys/Follow-up Surveys	6,118	5572	4826
Licensure/Certification Complaint Investigations/Follow-up Investigations	5,448	4482	4569
Medicaid IOC Reviews (DD Only)	306	289	290
Licensure Probationary/Initial Surveys	63	53	47
Certification Initials	2	4	6
Incident Report Investigations	469	489	497
Special Surveys – Licensure/Bed Certification (Off-cycle, After Hours)	348	239	90
TOTAL	12,754	11,128	10,325

Central Complaint Registry (CCR)

The CCR is responsible for investigating the complaints filed against long-term care facilities and facilities operating as unlicensed nursing homes. The complaints are reviewed and logged and sent to the appropriate region for scheduling and subsequent investigation. Complaints are assigned a time frame of 24-hours, seven-days or 30-days. The CCR, operates a 24-hour toll-free nationwide complaint hotline (800-252-4343) as mandated under the Illinois Nursing Home Care Act. The CCR accepts complaints about LTC facilities and other health care facilities. The CCR was established in May 1984, as a result of a legislative mandate to create a central clearinghouse about the quality of care provided to residents of LTC facilities. In 1994, the registry hotline began accepting calls for other health care facilities. The CCR acts as a repository for concerns or complaints concerning more than 29 different programs monitored by the Department. The total number of complaints and the percentage of total complaints received by provider type are as follows:

- Long Term Care – 4,575/86 percent
 - Skilled Nursing Facilities
 - Intermediate Care Nursing Facilities
 - ICF-IID Facilities; Shelter Care Facilities
 - Community Living Facilities
 - Under 22 Facilities
 - State Owned Mental Health Facilities
 - Assisted Living Facilities
- Hospitals - 581/11 percent
- Home Health Agencies - 71/1percent
- Sub-acute Facilities - 1
- Ambulatory Surgical Treatment Centers - 3/<1percent
- End Stage Renal Disease Facilities - 47/<1percent
- Hospice - 17/<1percent
- Rural Health Clinics – 0; Portable X-rays - 0
- Comprehensive Outpatient Facilities - 0
- Outpatient Rehabilitation Facilities - 0
- OPT/SP/OT Outpatient Facilities and Extension Sites - 0
- Home Nursing - 3/<1percent; Home Nursing Placement - 0
- Home Services - 12/<1percent; Home Services Placement - 5/<1percent
- Ambulance Companies – 6; EMS – 0; EMT - 0
- Trauma Centers – 0; Laboratories - 2/<1percent
- Unlicensed Facilities - 13/<1percent

The CCR receives complaints from a variety of entities: Illinois Department on Aging, Illinois Department of Healthcare and Family Services, Illinois Department of Human Services, Illinois Guardianship and Advocacy, Illinois Department of Financial and Professional Regulation, Office of the Attorney General, Illinois Citizens for Better Care, States' attorneys, relatives, patients, staff, friends, visitors and residents. Many persons contacting the CCR do not file a complaint but request information or solutions to problems. These persons are often referred to the Illinois Department on Aging or to a

local area sub-state ombudsman. The CCR received more than 20,275 calls in 2013, which generated 5,336 complaints, with 2,326 of those alleging abuse and/or neglect. Of the 5,336 complaints taken, 4,575 of those were for Long Term Care facilities. The CCR is also the central reporting location for the Abuse and Neglect Long-term Care Facility Residents Reporting Act. In addition to LTC facilities licensed under the Nursing Home Care Act, mental health centers operated by the Illinois Department of Human Services are required to report suspected resident abuse and neglect.

An incident is information provided by a facility to the department regarding a reportable occurrence. The goal of the incident reporting process is to establish a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and clients receiving health care services. The incident management system has three primary objectives which include protective oversight, prevention, and the promotion of efficiency and quality within the health care delivery system.

Incidents are prioritized and investigated based on the seriousness of the allegations. In 2013 there were approximately 64,314 incident reports received. This approximation includes both initial and final reports. These incident reports, broken down into regions and long term care/intellectually disabled, are as follows:

<u>LTC Facilities</u>		<u>ICF/IID Facilities</u>	
Region 1	1,912	Region 1	1,760
Region 2	3,829	Region 2	1,350
Region 4	5,069	Region 4	5,500
Region 5	2,206	Region 5	4,700
Region 6	2,328	Region 6	550
Region 7	8,160	Region 7	4,350
Region 8	8,578	Region 8	2,486
Region 9	<u>7,842</u>	Region 9	<u>3,694</u>
Total	39,924	Total	24,390

Complaints can be received through the toll free hotline number (800-252-4343), e-mail, (DPH.CCR@ILLINOIS.GOV), fax (217-524-8885) or by mail (IDPH-CCR, 525 W. Jefferson St., Ground Floor, Springfield, IL 62761).

Table 11 describes allegations made to the CCR in 2011, 2012, and 2013:

TABLE 11			
Allegations made to the CCR			
2011, 2012 and 2013			
TYPE	2011	2012	2013 *
Total Calls	14,621	19,144	20,275
Total LTC Complaints	3,382	3,950	4,137
Reports of LTC Abuse and Neglect	1,395	2,256	2,326
Physical Abuse	63	101	46
Sexual Abuse	27	60	26

Verbal Abuse	12	19	09
Neglect	668	1125	2040
Mental Abuse	120	188	113
Other Resident Injury	447	669	716
Sexual Assault – Resident to Resident	12	29	20
Verbal Assault	01	01	06
Physical Assault – Resident to Resident	18	37	17
Mental Assault – Resident to Resident	27	27	15

* 2013 statistics were generated from a new database (ACT's) vs. those in 2011/2012 (3270); ACT's will be used moving forward

In reviewing complaints, the IDPH determines the validity of each allegation rather than each complaint. A complaint may have one or more allegations. Table 10 identifies the validity and Table 11 the outcome of complaint allegations. (Note: The total in Table 13 may be less than the total allegations received, since determinations have not yet been made on all allegations received in 2013).

Allegations	2011	2012	2013
Valid	1,811	1,737	1,985
Invalid	4,419	4,928	7,609
Undetermined	0	0	0
Total	6,230	6,665	9,594

Level	2011	2012	2013
"A"	59	62	55
Repeat "A"	0	0	0
"B"	89	156	358
Repeat "B"	0	1	1

Intermediate Care Facility/Individual Intellectually Disabled Specialized Mental Health Rehabilitation (ICF/IID SMHRF) Section

The ICF/IID SMHRF is under the Community Care Act (CCA) and no longer a part of the Nursing Home Care Act. The DD Advisory Board formed and is developing regulatory language that will replace the currently used Illinois Administrative Codes 350 and 390 licensure regulations. The CCA will not impact the 370 code for Community Living Facilities (CLF's) as they have their own statute.

During 2013, the ICF/IID SMHRF Section completed certification, inspection of care and licensure surveys for ICF/IID SMHRF facilities 16 beds or less, 16 beds or more, state operated facilities, skilled pediatric facilities and CLF's for persons with intellectual disabilities, not to be confused with Community Integrated Living Arrangements (CILA's). The ICF/IID SMHRF Section conducted complaint investigations, incident investigations, follow-up surveys, and special certification surveys when necessary. The ICF/IID SMHRF section continues to investigate multiple incidents of abuse and/or neglect in the area of client protections, including allegations of abuse, including sexual, physical and verbal abuse. Neglect is defined as: failure to provide goods and services to meet the needs of the persons served. As this population continues to age, their increased medical needs may impact their lives as much as, or more than the need for active treatment. Client-to-client aggression without sufficient safeguards is an issue resulting in increased deficiencies and/or conditions of participation.

Training during 2013 was provided on an ongoing basis with supervisor follow-up and three full staff meetings. Training focus was on clarification of regulations and survey procedures for added consistency. Increased oversight, direction and feedback of report writing for compliance with federal standards were provided to the surveyors during 2013. Accountability for the surveyor's work has been stressed and follow-up by the supervisor has taken place, including additional training.

Objectives for 2014 include continued supervisory oversight and direction. Surveyors will continue to receive feedback for the work they produce. Focus training will be provided on the Principles of Documentation with individual follow-up to ensure implementation. Consistency between the regions will be monitored in regards to facility compliance with regulations. Provider training will be focused on abuse and neglect investigations as well as client to client abuse and presentation of the top cited Federal deficiencies.

Increased communication with other state agencies providing ICF/IID SMHRF services and provider organizations continue to be an objective for the coming year in order to increase consistency and provision of care. Due to the transitioning of many clients from ICF/IID SMHRF services, downsizing, and the plan to close one of the state operated facilities in 2014, it is imperative that the ICF/IID SMHRF section monitors the transitioning of these clients into alternative placement ensuring their medical and safety needs are met.

**PART II PERFORMANCE OF INSPECTIONS, SURVEYS AND EVALUATION DUTIES
UNDER THE ACT**

Inspections and Surveys

LTC FO conducts state licensure and federal certification surveys and investigations. Because of the similarity of state licensure and federal certification regulations, the mandated, structured certification survey procedures, licensure and certification activities historically have been conducted concurrently in accordance with the federal survey procedures. Both licensure and certification requirements are applied to the deficiencies cited during these combined surveys. The only exceptions to this federal certification-driven survey process are surveys conducted at facilities not participating in the federal Medicare/Medicaid programs, distinct licensure activities (probationary licensure and initial licensure surveys) or instances when state requirements are stricter than federal regulations.

State Survey Performance Standards

As the designated state survey agency (SSA) for conducting federal certification surveys, the LTC program must comply with all federal survey procedures. CMS conducts an extensive auditing for each SSA's performance in conducting the federal survey process. The state survey performance review involves the measurement of state performance standards as follows:

- Frequency 1. **Off-Hour Surveys for Nursing Homes**
No less than 10 percent of standard surveys begin during weekend or "off hours."

References: 42 CFR 488.307, Section 7207B2 of the SOM, and S & C-04-33
- Frequency 2. **Frequency of Nursing Home Surveys**
Standard health surveys are conducted within prescribed time limits. If the maximum number of months between all standard surveys is less than or equal to 15.9 months and the statewide average interval is less than or equal to 12.9 months, the measure is scored as "Met".

References: Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Act and 42 CFR 488.308
- Frequency 3.1 **Frequency of Non-Nursing Home Surveys Tier 1**
Recertification/validation surveys for non-deemed home health agencies (HHA) and intermediate care facilities for the mentally retarded (ICF/IID) and validation surveys for deemed hospitals are conducted within the time frames established by law. If the SA conducts recertifications for non-deemed Home Health Agencies

and ICFs/IID and validation surveys for deemed hospitals according to the Tier 1 Requirements, this Measure is scored as “MET”.

References: HHAs – Section 1891(c)(2)(A) of the Act; ICFs/IID – 42 CFR 442.15, 442.16, and 442.109; Validation Surveys -Sections 1864(c) and 1865 of the Act and 42 CFR 488.7; FY 2013 Survey and Certification Mission and Priority Document; FY 2013 Final State Medicare Allocations Memorandum

Frequency 3.2

Frequency of Non-Nursing Home Surveys Tier 2

If the SA conducts recertification surveys for non-deemed hospices, non-deemed ambulatory surgical centers (ASC), non-deemed hospitals (including non-deemed critical access hospitals- [CAHs]), outpatient physical therapy (OPT), comprehensive outpatient rehabilitation facilities (CORF), rural health clinics (RHC) and end stage renal disease (ESRD) facilities within the time frames established by law, this Measure is scored as “Met”.

References: FY 2013 Survey and Certification Mission and Priority Document; FY 2013 Final State Medicare Allocations Memorandum; FY 2013 Targeted Sample List for ESRD Facilities; FY 2013 Random Sample List for ASCs; FY 2013 Targeted Sample List for Non-Deemed Hospitals

Frequency 3.3

Frequency of Non-Nursing Home Surveys Tier 3

If recertification surveys for non-deemed hospices, non-deemed ASCs, non-deemed hospitals (including non-deemed CAHs), OPTs, CORFs, RHCs and ESRD facilities are conducted within the time frames established by law, this Measure is scored as “Met”.

References: FY 2013 Survey and Certification Mission and Priority Document; FY 2013 Final State Medicare Allocations Memorandum

Frequency 4.

Timeliness of Upload into OSCAR/ODIE of Standard surveys for Non-Deemed Hospitals and Nursing Homes

If the average is less than or equal to 70 calendar days for data entry of both nursing home and non-deemed hospital (including non-deemed CAHs) surveys, this Measure is scored as “Met”.

References: Article II (J) of the 1864 Agreement and SOM Sections 2472C and 7410C

Frequency 5.

Timeliness of Upload into CASPER of Complaint Surveys for Non-Deemed Hospitals and Nursing Homes

If 95% or more of all complaint surveys are uploaded into CASPER in less than 60 calendar days this measure is scored as “Met”.

References: Consistent with forthcoming changes to Chapter 5 of the SOM; Data Source: Quarterly reports provided by CMS Central Office

Quality 1. **Documentation of deficiencies for nursing homes, ESRD facilities, ICF/IID and non-deemed HHAs and hospitals.**

If the score for each requirement for nursing homes and non-nursing homes is greater than or equal to 85%, this Measure is scored as "Met".

References: 42 CFR 488.318, the Principles of Documentation of the SOM, relevant sections of the SOM and applicable Survey and Certification Memoranda related to the documentation of deficiencies (e.g., revised surveyor guidance)

Quality 2. **Q2 Conduct of Nursing Home Health Surveys in Accordance with Federal Standards, as Measured by FOSS Surveys**

Survey teams conduct nursing home surveys in accordance with federal standards, as measured by Federal Oversight/Support (FOSS) surveys.

References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act and 42 CFR 488.318, and the Federal Oversight Support Survey (FOSS) Manual

Quality 3. **Q3 Documentation of Noncompliance in Accordance with Federal Standards for Nursing Home Health FOSS Surveys**

If the unjustified disparity rate is 20% or less, this Measure is scored as "Met"

References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act, 42 CFR 488.318, and the FOSS Manual

Quality 4. **Q4 Identification of Health and Life Safety Code (LSC) Deficiencies on Nursing Home Surveys as Measured by Federal Comparative Survey Results**

If the % Agreement Rate is 90% or higher (without rounding up), this Measure is scored as "Met."

References: Section 1819(g)(3)(A) and 1919(g)(3)(A) of the Act and 42 C.F.R. §488.318

Quality 5. **Implementation of the Nursing Home Quality Indicator Survey**
The Federal Center for Medicare and Medicaid Services (CMS) has not implemented this measure for Illinois.

Quality 6. **Q6 Prioritizing Complaints and Incidents**

CMS guidelines for the prioritization of all federal complaints, regardless of

whether an onsite survey is conducted, and those incidents requiring an onsite survey are followed for nursing homes, non-deemed hospitals, non-deemed CAHs, non-deemed HHA and ESRD facilities. If both Threshold Criteria are scored as "Met," this Measure is scored as "Met."

References: SOM Sections 5070-5075, Exhibit 22 of the SOM

Quality 7. **Q7 Timeliness of Complaint and Incident Investigations**

All complaints triaged as immediate jeopardy and requiring an onsite survey are investigated within the prescribed time limits for nursing homes, ESRD facilities, non-deemed and deemed HHAs, non-deemed and deemed ASCs, non-deemed and deemed hospitals and CAHs, excluding Emergency Medical Treatment and Active Labor Act (EMTALAs). Also includes the timeliness of investigations for all complaints triaged as non-immediate jeopardy for nursing homes and deemed hospitals and CAHS. If all four Threshold Criteria are met, this Measure is scored as "Met."

References: SOM Section 5075

Quality 8. **Quality of EMTALA Investigations**

All complaints and incidents for EMTALA investigations are conducted according to CMS policy. Total score on all requirements must be 90% or above to meet this Measure.

References: Chapter 5 of the SOM, Article II (A)(2) of the 1864 Agreement, and Appendix V

Quality 9. **Quality of Complaint/Incident Investigations for Nursing Homes**

All nursing home complaints and incident reports are investigated according to CMS policy for complaint/incident handling. If the score for each criterion is greater than or equal to 85%, this Measure is scored as "Met."

References: Chapter 5 and Appendix P of the SOM

Quality 10. **Triaging of Deemed Facility Complaints (DEVELOPMENTAL)**

This measure is under development by the Federal Center for Medicare and Medicaid Services (CMS).

Enforcement and Remedy 1

E1 Timeliness of Processing Immediate Jeopardy Cases

Immediate jeopardy cases are processed timely, excluding EMTALA and Medicaid-only providers/suppliers. If the resulting percentage is greater than or equal to 95%, this Measure is scored as "Met."

References: Sections 1819(h)(1)(A) and 1866(b) of the Act, 42 CFR 488.410 and 42 CFR 489.53, and Chapters 3 and 7 of the SOM

Enforcement and Remedy 2.

E2 Timeliness of Mandatory Denial of Payment for New Admissions (DPNA)

Notification for Nursing Homes Enforcement processing time frames for notification of mandatory denial of payment for new admissions in a nursing home are followed. This excludes cases involving Medicaid-only nursing homes. If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met."

References: Section 1819(h)(2)(D) of the Act, 42 CFR 488.417(b)

Enforcement and Remedy 3.

E3 Processing of Termination Cases for Non-Nursing Home Providers/Suppliers

Termination cases for non-nursing home providers/suppliers, except for cases involving deemed providers/suppliers, EMTALA cases and Medicaid-only providers/suppliers, are processed timely. If the resulting percentage is greater than or equal to 80%, this Measure is scored as "Met."

References: Section 1866(b) of the Act, 42 CFR 489.53, and SOM 3012

Enforcement and Remedy 4.

E4 Special Focus Facilities (SFFs) for Nursing Homes

Conduct timely the specified number of special focus surveys of nursing homes. Conduct a standard survey, twice during the fiscal year, of the nursing homes identified as special focus facilities (SFFs). If the SA has conducted the required number of standard surveys for SFFs, this Measure is scored as "Met."

References: S&C-05-13, Admin Info: 08-06, S&C-08-02, and S&C 10-32, the SFF Procedures Guide

Implementation of Federal Certification Enforcement Regulations

The federal CMS regulations impose intermediate sanctions for noncompliance with federal certification requirements. Before these regulations were adopted in 1995, the only enforcement remedy applied to certified facilities was decertification, which was pursued only in cases where facilities were found to be in substantial noncompliance with a significant portion of the certification regulations over an extended period of time. The enforcement regulations establish penalties for noncompliance with a single regulation. These penalties include imposed plans of correction, directed in-service trainings, denial of payment for new admissions, state monitoring and civil money penalties ranging from \$50 per day to \$10,000 per day. In 1999, the CMS added that a civil money penalty could be applied per instance or per deficiency instead of only the per day amounts. The per instance civil money penalty ranges from \$1,000 to \$10,000 per deficiency, but the total amount per survey cannot exceed \$10,000. Sanctions are applied immediately at facilities with poor compliance histories, and for all other facilities if deficiencies are found uncorrected during a revisit or new deficiencies are cited.

Federal Survey Initiatives

The Illinois Department of Public Health continues to work with Telligen, the Medicare Quality Improvement Organization (QIO) for Illinois, under contract with the CMS, an agency of the U.S. Department of Health and Human Services. Telligen is committed to improving individual patient care by working with nursing homes.

The Advancing Excellence in America's Nursing Homes Campaign supports statewide coalitions of stakeholders called Local Area Networks of Excellence (LANEs). The LANE is the central organization within a state to support participating nursing homes in achieving their clinical and organizational goals and help the Campaign succeed. The LANE is comprised of a wide spectrum of long term care stakeholders including representatives of the nursing home associations, IDPH (**state survey agency**), Ombudsman office and the QIO, as well as consumer advocacy organizations.

Advancing Excellence has selected nine goals and developed new resources to help nursing homes get started on their quality improvement projects. The goals are: reducing pressure ulcers, improving pain management, decreasing staff turnover, increasing the use of consistent assignment, reducing hospitalization safely, improving the appropriate use of medications particularly antipsychotic drugs, preventing infections, increasing resident mobility and increasing the use of person-centered care planning and decision making. The website includes national targets for improvement, data gathering tools, and technical assistance resources free of charge for all nursing homes to use. Participating nursing homes choose three of nine goals to work on and set targets for improvement. In collaboration with the stake holders, IDPH participated in the QAPI in Action Workshop held in three different statewide locations. Telephone meetings are conducted monthly with the LANE members. Advancing Excellence data is reviewed as well as promotional updates and enrollment information are shared. Plans are discussed for training needs and working with the provider associations to ensure all nursing homes have the information available.

Additionally, the Department serves as a co-team lead on the Illinois partnership to Improve Dementia Care Coalition. "The Illinois Partnership to Improve Dementia Care Coalition recognizes that the reduction of unnecessary anti-psychotic medication is critical to reducing the risks for adverse events and improving the quality life for Illinois nursing home residents. The Coalition is comprised of many provider, government, activist, behavioral health and aging experts, and is co-chaired by the Illinois Department of Public Health, the Illinois Health Care Association and Telligen. The Coalition recognizes that an inter-disciplinary collaborative approach is needed for rapid improvement and will engage the resources of Coalition members to support educational programs and outreach". CMS launched the national partnership in 2012 with the mission to improve quality of care provided to individuals with dementia living in nursing homes. The partnership promotes rethinking approaches that are utilized in dementia care, reconnecting with people using person-centered care approaches and restoring good health and quality of life in nursing homes. CMS is partnering with federal and state agencies, nursing homes, other providers, advocacy groups, and caregivers to improve dementia care. The partnership promotes a multidimensional approach that includes public reporting, national partnerships and state-based coalitions, research, training for providers and surveyors and revised surveyor guidance.

The Coalition team conducts monthly phone calls as well as participates on the National Dementia Quarterly call with CMS. Illinois' goal is to move from the bottom quartile to the 3rd quartile by December 2014. In 2014, the Coalition will be planning at least 5 webinars to assist to all nursing home disciplines and family members, in addressing the challenges in handling dementia concerns, behaviors, non-pharmacological interventions and medication use.

In an effort to more effectively utilize surveyor resources and maximize on-site survey time, the Centers for Medicare & Medicaid Services (CMS) has undertaken a review of the current LTC survey protocols with a primary goal of optimizing the survey process. Changes in the SOM Appendix P include ensuring the survey sample includes a representative number of residents with dementia who are receiving an antipsychotic medication and revising the number of observations required to calculate the facility medication error rate to a minimum of 25 medication administration opportunities. A new Medication Pass Observation Form CMS-20056 was developed to be used to document the Medication Administration Observation; this replaces CMS Form-677.

Updates to Appendix PP include:

F309- A new section of interpretive guidance related to the review of care and services for a resident with dementia;

F329- Revisions to the antipsychotic medication section of Table 1 and a new severity example at the end of the interpretive guidance at F329

F322 (Feeding Tubes) and F155 (Advanced Directives). This information replaced previous information received in 2012 from CMS.

As a part of a program to improve nursing home quality and safety, Centers for Medicare and Medicaid Services (CMS) developed a Special Focus Facility program in 1998. The purpose of the Special Focus Facility program was to decrease the number of persistently poor performing Skilled and Intermediate Care nursing homes by directing more attention to nursing homes with a record of poor survey performance. State Agencies are required to conduct two standard surveys per year in facilities designated as Special Focus instead of the one required by law. The State Agency must submit monthly reports to CMS concerning the facility compliance status and any remedies imposed by enforcement action are augmented. The facility may contact the State designated Quality Improvement Organization for assistance in achieving compliance.

Illinois has been required by CMS to select seven Medicare and/or Medicaid certified nursing homes for designation of Special Focus Facilities. The facility must graduate from the Special Focus status by demonstrating at two consecutive standard surveys that it has deficiencies cited at a scope and severity level of no greater than „E“ and no intervening complaint-related deficiencies cited greater than “E” or it is terminated from the Medicare /Medicaid certification program.

Because of Federal sequestration in 2013 and 2014, as a nursing home graduates from the Special Focus Facility program an additional home is not selected to maintain the Illinois required number at seven. Of the last seven selected homes that were designated Special Focus Facilities, six have graduated with the required compliance and only one remains on the list and has shown improvement.

Determination to Issue a Notice of Violation

- a) Upon receipt of a report of an inspection, survey or evaluation of a facility, the director or his designee shall review the findings contained in the report to determine whether the report's findings constitute a violation or violations for which the facility must be given notice and which threaten the health, safety or welfare of a resident or residents.
- b) In making this determination, the director or his designee shall consider any comments and documentation provided by the facility within 10 days of receipt of the report.
- c) In determining whether the findings warrant the issuance of a notice of violation, the director or his designee shall base his determination on the following factors:
 - 1) The severity of the finding. The director or his designee will consider whether the finding constitutes a merely technical nonsubstantial error or whether the finding is serious enough to constitute an actual violation of the intent and purpose of the standard.
 - 2) The danger posed to resident health and safety. The director or his designee will consider whether the finding could pose any direct harm to the residents.
 - 3) The diligence and efforts to correct deficiencies and correction of reported deficiencies by the facility.
 - 4) The frequency and duration of similar findings in previous reports and the facility's general inspection history. The director or his designee will consider whether the same finding or a similar finding relating to the same condition or occurrence has been included in previous reports and the facility has allowed the condition or occurrence to continue or to recur.
- d) If the Director or his designee determines that the report's findings constitute a violation or violations which do not directly threaten the health, safety, or welfare of a resident or residents, the *department shall issue an administrative warning* as provided in Section 300.277 (Section 3-303.2(a) of the Act)

- e) *Violations shall be determined under this Section no later than 75 days after completion of each inspection, survey and evaluation. (Section 3-212(c) of the Act)*

(Source: Added at 13 Ill. Reg. 4684, effective March 24, 1989)

Determination of the Level of a Violation*

- a) After determining that issuance of a notice of violation is warranted and prior to issuance of the notice, the Director or his or her designee will review the findings that are the basis of the violation, and any comments and documentation provided by the facility, to determine the level of the violation. Each violation shall be determined to be either a level AA, a level A, a level B, or a level C violation based on the criteria in this Section.
- b) The following definitions of levels of violations shall be used in determining the level of each violation:
 - 1) A "level AA violation" or a "Type AA violation" is *a violation of the Act or this Part which creates a condition or occurrence relating to the operation and maintenance of a facility that proximately caused a resident's death.* (Section 1-128.5 of the Act)
 - 2) A "level A violation" or "Type A violation" is *a violation of the Act or this Part which creates a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that the risk of death or serious mental or physical harm will result therefrom or has resulted in actual physical or mental harm to a resident.* (Section 1-129 of the Act)
 - 3) A "level B violation" or "Type B violation" is *a violation of the Act or this Part which creates a condition or occurrence relating to the operation and maintenance of a facility that is more likely than not to cause more than minimal physical or mental harm to a resident.* (Section 1-130 of the Act)
 - 4) A "level C violation" or "Type C violation" is *a violation of the Act or this Part which creates a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that less than minimal physical or mental harm to a resident will result therefrom.* (Section 1-132 of the Act)
- c) In determining the level of a violation, the Director or his or her designee shall consider the following criteria:
 - 1) The degree of danger to the resident or residents that is posed by the condition or occurrence in the facility. The following factors will be considered in assessing the degree of danger:

- A) Whether the resident or residents of the facility are able to recognize conditions or occurrences that may be harmful and are able to take measures for self-preservation and self-protection. The extent of nursing care required by the residents as indicated by review of patient needs will be considered in relation to this determination.
 - B) Whether the resident or residents have access to the area of the facility in which the condition or occurrence exists and the extent of such access. A facility's use of barriers, warning notices, instructions to staff and other means of restricting resident access to hazardous areas will be considered.
 - C) Whether the condition or occurrence was the result of inherently hazardous activities or negligence by the facility.
 - D) Whether the resident or residents of the facility were notified of the condition or occurrence and the promptness of such notice. Failure of the facility to notify residents of potentially harmful conditions or occurrences will be considered. The adequacy of the method of such notification and the extent to which such notification reduced the potential danger to the residents will also be considered.
- 2) The directness and imminence of the danger to the resident or residents by the condition or occurrence in the facility. In assessing the directness and imminence of the danger, the following factors will be considered:
- A) Whether actual harm, including death, physical injury or illness, mental injury or illness, distress, or pain, to a resident or residents resulted from the condition or occurrence and the extent of such harm.
 - B) Whether available statistics and records from similar facilities indicate that direct and imminent danger to the resident or residents has resulted from similar conditions or occurrences and the frequency of such danger.
 - C) Whether professional opinions and findings indicate that direct and imminent danger to the resident or residents will result from the condition or occurrence.
 - D) Whether the condition or occurrence was limited to a specific area of the facility or was widespread throughout the facility.

Efforts taken by the facility to limit or reduce the scope of the area affected by the condition or occurrence will be considered.

- E) Whether the physical, mental, or emotional state of the resident or residents, who are subject to the danger, would facilitate or hinder harm actually resulting from the condition or occurrence.

(Source: Amended at 35 Ill. Reg. 11419 effective June 29, 2011)

Long-term Care Federal Training
January 1, 2013 through December 31, 2013

TRAINING	LOCATION	DATE (S)	# OF ATTENDEES
ASPEN Basic Training	Longmont, CO	8/5/13	3
Basic ICF/MR Surveyor Training	Madison, WI	4/29/13	5
	Columbus, Ohio	8/5/13	1
Basic LSC Training	Online	9/6/13	3
Basic LTC Surveyor Training	St. Louis, Mo	4/22/13	23
	Springfield, Il	10/21/13	27
Basic Home Health Agency	Baltimore, MD	3/19/13	2
		12/10/13	3
Basic Hospital	San Antonio, TX	4/8/13	2
		12/17/13	6
Basic Hospice	San Diego, CA	2/12/13	3
	Annapolis, MD	9/9/13	1
Basic EMTALA	Online	3/1/13	1
		9/13/13	1
ESRD Annual	Orlando, FL	4/2/13	9
ESRD-Core Conversion	Minneapolis	12/9/13	4
ESRD Basic	Minneapolis, MN	12/3/13	1
		6/10/13	1
		9/9/13	1
ESRD Experienced	Online	6/5/13	5
		9/4/13	3
FSES/HC	Dallas, TX	3/12/13	2
		12/3/13	1
Fundamentals of Patient Safety for Hospital Surveyors-	Online	3/1/13	1
		9/3/13	1
		12/2/13	2
National QIES Technical Training <i>Workbench</i>	Baltimore, MD	6/25/13	2
OASIS	San Antonio, TX	4/23/13	2
OCR Clearance Process-ONLINE	Online	3/1/13	3
		6/13/13	2
RAI Coordinators Conference	NOT HELD		
State Training Coordinators Mtg.	NOT HELD		
Survey & Certification Leadership Summit	Annapolis, MD	4/9/13	3
STAR	Carlsbad, CA	11/18/13	2
State Agency Director	Annapolis	4/8/13	1
Total LMS	Baltimore, MD	4/9/13	1

Administrative Rules Promulgated Under the Authority of the Nursing Home Care Act

[210 ILCS 45]

and

**The Abused and Neglected Long-Term Care Facility Residents Reporting Act
[210 ILCS 30]**

Skilled Nursing and Intermediate Care Facilities Code
(77 Ill. Adm. Code 300)

Sheltered Care Facilities Code
(77 Ill. Adm. Code 330)

Illinois Veterans' Homes Code
(77 Ill. Adm. Code 340)

Central Complaint Registry
(77 Ill. Adm. Code 400)

Long-Term Care Assistants and Aides Training Programs Code
(77 Ill. Adm. Code 395)

Administrative Rules Promulgated Under the Authority of the ID/DD Community Care Act [210 ILCS 47]

Intermediate Care for the Developmentally Disabled Facilities Code
(77 Ill. Adm. Code 350)

Long-Term Care for Under Age 22 Facilities Code
(77 Ill. Adm. Code 390)

Emergency Rules Filed Under the Authority of the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]

Specialized Mental Health Rehabilitation Facilities Code
(77 Ill. Adm. Code 380)

Definition of Facility or Long-term Care Facility

Definition of Facility or Long-term Care Facility

"Facility" or "long-term care facility" means a private home, institution, building, residence, or any other place, whether operated for profit or not, or a county home for the infirm and chronically ill operated pursuant to Division 5-21 or 5-22 of the Counties Code, or any similar institution operated by a political subdivision of the State of Illinois, which provides, through its ownership or management, personal care, sheltered care or nursing for 3 or more persons, not related to the applicant or owner by blood or marriage. It includes skilled nursing facilities and intermediate care facilities as those terms are defined in Title XVIII and Title XIX of the Federal Social Security Act. It also includes homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs. "Facility" does not include the following:

- 1) A home, institution, or other place operated by the federal government or agency thereof, or by the State of Illinois, other than homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs;
- 2) A hospital, sanitarium, or other institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation as organized facilities therefor, which is required to be licensed under the Hospital Licensing Act;
- 3) Any "facility for child care" as defined in the Child Care Act of 1969;
- 4) Any "Community Living Facility" as defined in the Community Living Facilities Licensing Act;
- 5) Any "community residential alternative" as defined in the Community Residential Alternatives Licensing Act;
- 6) Any nursing home or sanatorium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination. However, such nursing home or sanatorium shall comply with all local laws and rules relating to sanitation and safety;
- 7) Any facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act;

- 8) Any "Supportive Residence" licensed under the Supportive Residences Licensing Act;
- 9) Any "supportive living facility" in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01;
- 10) Any assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act, except only for purposes of the employment of persons in accordance with Section 3-206.01;
- 11) An Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act;
- 12) A facility licensed under the ID/DD Community Care Act; or
- 13) A facility licensed under the Specialized Mental Health Rehabilitation Act.

Nursing Home Care Act
[210 ILCS 45/1-113]

Summary of Long-term Care Facility Survey Process

Task 1	Offsite Survey Preparation
1)	Review Quality Measure reports that indicate potential problems or concerns that warrant further investigation.
2)	Review Department files (including previous surveys, incidents, complaints, information on waivers/variances, CASPER 3 and 4) for facility-specific information and make appropriate copies for team members.
3)	Contact the ombudsman.
4)	Pre-select potential residents to be reviewed.
Task 2	Entrance Conference/Onsite Preparatory Activities
1)	Inform administrator of the survey and introduce team members.
2)	Team coordinator conducts entrance conference; other team members proceed to initial tour.
3)	Give copies of the Quality Measure and CASPER 3 & 4 reports and explain.
4)	Inquire about special features of the facility's care and treatment programs, organization, and resident case-mix.
5)	Determine if facility has a functioning quality assessment and assurance committee and its characteristics.
6)	Request information and required forms from facility
7)	Determine if the facility uses paid feeding assistants.
8)	For any survey outside the influenza season (Oct. 1-Mar 31), determine who is responsible for coordination and implementation of the facility's immunization program and a list of current residents who were in the facility during the previous influenza season.
9)	Post signs announcing that a survey is being performed.
10)	Contact the resident council president, provide a list of questions for the council, and arrange for date, time and private meeting space for interview with resident council.
11)	Request a list of residents with diagnosis of dementia and who are receiving antipsychotics or have received a PRN order for antipsychotics over the last 30 days-this is to ensure the sample includes an adequate number of residents who are receiving antipsychotic medication. Also ask the administrator or director of nursing to describe how the facility provides individualized care for resident with dementia. Ask to see policies related to the use of antipsychotic medications in resident with dementia.
Task 3	Initial Tour
1)	Tour facility to allow introduction of surveyors to residents and staff.
2)	Gather information on concerns that were pre-selected; new concerns discovered onsite; and whether residents pre-selected are still present.
3)	Identify resident characteristics and other candidates for the sample.
4)	Get an initial overview of facility care and services and a brief look at the facility's kitchen.
5)	Identify nursing staff on duty.
Task 4	Sample Selection

1)	Perform Final Phase I sample selection of case-mix stratified sample based on current facility census and guidelines established.
2)	Perform Final Phase II sample selection based on concerns noted not yet reviewed, un-reviewed related concerns, and current concerns for which information gathered is inconclusive.
3)	Check facility surety bond when indicated.
4)	Review policies and procedures pertaining to infection control when indicated.
5)	Complete Quality Assessment Assurance Review.
6)	Use list of residents with diagnosis of dementia and who are receiving antipsychotics or have received a PRN order for antipsychotics over the last 30 days-this is to ensure the sample includes an adequate number of residents who are receiving antipsychotic medication.
7)	Ensure that at least one of the residents on the list who is receiving an antipsychotic med is in the Phase 1 sample for a comprehensive or focused record review.
8)	When considering the addition of a resident on the sample, from this list, attempt to select a resident who is representative of areas of concern such as triggering QM's at or above the 75% percentile or other special factors.
Task 5	Information Gathering
Subtask 5A	Observe the facility's environment that may affect the resident's life, health and safety.
Subtask 5B	Assess the facility's food storage, preparation and service.
Subtask 5C	Perform an integrated, holistic assessment of the sampled residents.
Subtask 5D	Assess of residents' quality of life.
Subtask 5E	Observe medication pass and assess the provision of pharmacy services.
Subtask 5F	Assess the facility's Quality Assessment and Assurance program.
Subtask 5G	Perform abuse prohibition review.
Task 6	Information Analysis for Deficiency Determination
1)	Review and analyze information collected to determine whether the facility has failed to meet one or more of the regulatory requirements.
2)	Determine whether to conduct an extended survey.
Task 7	Exit Conference
1)	Invite ombudsman, a member of the resident's council and one or two residents.
2)	Inform the facility of the survey team's observations and preliminary findings.
3)	Provide the facility with the opportunity to discuss and supply additional information pertinent to the identified findings.

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
REPORT OF FIRES IN HEALTH CARE FACILITIES**

Facility Name: _____

Address: _____ City: _____

Provider No. 14: _____ Date of Fire: ____/____/____ Time of Fire: am/pm

Category: Laundry Room, Laundry Dryer, Electrical, Mechanical, HVAC-Exhaust, Kitchen microwave, Cooking Equipment, Smoking Materials, Arson, Spontaneous Combustion Lightning, Gas Leak, Smoke only,

Other _____

Surveyor Description of What Happened: _____
(Use additional sheet to provide additional information as needed to fully describe)

Fire Location: _____
(Provide Sketches/Floor Plan of Facility and Photographs to Show Location and Condition)

Number of Injuries: Residents _____ Staff _____ Firemen _____ Other Responders _____ None _____

Extent of Injuries: Burns _____ Inhalation _____ Other _____

Residents Evacuated From: Room _____ Wing _____ Floor _____ Building _____

Residents Evacuated To: Room _____ Wing _____ Floor _____ Building _____ Outside of Building _____

Were/Are Residents Relocated to Other Facilities as Result of Fire: Yes _____ No _____

Method of Detection: Staff _____ Smoke Detector _____ Heat Detector _____ Sprinkler Head _____ Resident _____

Was fire alarm system activated? Yes _____ No _____

Fire Alarm System Activation Method: Smoke Detector, Heat Detector, Sprinkler Head, Pull Station, Other _____

Extinguishment Method: Extinguisher _____ Sprinkler Head _____ Other _____

Extinguished By: Staff _____ Fire Dept _____ Staff & Fire Dept _____ Others _____ Not Applicable _____

Follow-up call made to Fire Department: Yes _____ No _____ Fire Department responded: Yes _____ No _____

If Fire Extinguisher(s), were extinguisher(s) replaced: Yes _____ No _____

Was fire alarm system restored to normal working condition? Yes _____ No _____

Was sprinkler system restored to normal operating condition? Yes _____ No _____

Was fire reported to Illinois Department of Public Health? Yes _____ No _____

Estimated Cost of Repairs: \$ _____ Surveyor: _____ Report Date: ____/____/____

Offenses That Are Always Disqualifying Except Through the Appeal Process

Illinois Compiled Statutes Citation	Offense	Additional Offense Added Effective
[720 ILCS 5/8-1.1]	Solicitation of Murder	1/1/98
[720 ILCS 5/8-1.2]	Solicitation of Murder for Hire	1/1/98
[720 ILCS 5/9-1]	First-Degree Murder	
[720 ILCS 5/9-1.2]	Intentional Homicide of an Unborn Child	
[720 ILCS 5/9-2]	Second-Degree Murder	
[720 ILCS 5/9-2.1]	Voluntary Manslaughter of an Unborn Child	
[720 ILCS 5/9-3]	Involuntary Manslaughter and Reckless Homicide	
[720 ILCS 5/9-3.1]	Concealment of Homicidal Death	
[720 ILCS 5/9-3.2]	Involuntary Manslaughter and Reckless Homicide of an Unborn Child	
[720 ILCS 5/9-3.3]	Drug Induced Homicide	
[720 ILCS 5/10-1]	Kidnapping	
[720 ILCS 5/10-2]	Aggravated Kidnapping	
[720 ILCS 5/11-6]	Indecent Solicitation of a Child	1/1/98
[720 ILCS 5/11-9.1]	Sexual Exploitation of a Child	1/1/98
[720 ILCS 5/11-9.5]	Sexual Misconduct with a person with a Disability	7/24/06
[720 ILCS 5/11-19.2]	Exploitation of a Child	1/1/98
[720 ILCS 5/11-20.1]	Child Pornography	1/1/98
[720 ILCS 5/12-3.3]	Aggravated Domestic Battery	1/1/04
[720 ILCS 5/12-4]	Aggravated Battery	1/1/98
[720 ILCS 5/12-4.1]	Heinous Battery	
[720 ILCS 5/12-4.2]	Aggravated Battery with a Firearm	
[720 ILCS 5/12-4.2-5]	Aggravated Battery with a Machine Gun or a Firearm Equipped with Any Device or Attachment Designed or Used for Silencing the Report of a Firearm	1/1/04
[720 ILCS 5/12-4.3]	Aggravated Battery of a Child	
[720 ILCS 5/12-4.4]	Aggravated Battery of an Unborn Child	
[720 ILCS 5/12-4.6]	Aggravated Battery of a Senior Citizen	
[720 ILCS 5/12-4.7]	Drug Induced Infliction of Great Bodily Harm	
[720 ILCS 5/12-13]	Criminal Sexual Assault	
[720 ILCS 5/12-14]	Aggravated Criminal Sexual Assault	
[720 ILCS 5/12-14.1]	Predatory Criminal Sexual Assault of a Child	
[720 ILCS 5/12-15]	Criminal Sexual Abuse	
[720 ILCS 5/12-16]	Aggravated Criminal Sexual Abuse	
[720 ILCS 5/12-19]	Abuse and Criminal Neglect of a LTC	

[720 ILCS 5/12-21]	Facility Resident Criminal Abuse or Neglect of an Elderly Person or Person with a Disability	
[720 ILCS 5/16-1.3]	Financial Exploitation of an Elderly Person or a Person with a Disability	
[720 ILCS 5/18-2]	Armed Robbery	
[720 ILCS 5/18-4]	Aggravated Vehicular Hijacking	1/1/98
[720 ILCS 5/18-5]	Aggravated Robbery	1/1/98

Disqualifying Offenses That May be Considered for a Rehabilitation Waiver

Illinois Compiled Statutes Citation	Offense	Additional Offense Added Effective
[720 ILCS 5/16-1]	Theft (as a misdemeanor)	
[720 ILCS 5/16-2]	Theft of Lost or Mislaid Property	1/1/04
[720 ILCS 5/25]	Retail Theft (as a misdemeanor)	
[720 ILCS 5/19-4]	Criminal Trespass to Residence	
[720 ILCS 5/24-1.5]	Reckless Discharge of a Firearm	1/1/98
[225 ILCS 65/10-5]	Practice of Nursing without a License	1/1/04
[720 ILCS 11/53]	Cruelty to Children	1/1/98
[720 ILCS 250/4]	Receiving Stolen Credit Card or Debit Card	1/1/04
[720 ILCS 250/5]	Receiving a Credit or Debit Card with Intent to Use, Sell or Transfer	
[720 ILCS 250/6]	Selling a Credit Card or Debit Card, without the Consent of the Issuer	1/1/04
[720 ILCS 250/8]	Using a Credit or Debit Card with the Intent to Defraud	1/1/04
[720 ILCS 250/17.02]	Fraudulent Use of Electronic Transmission	1/1/04

Disqualifying Offenses That May Be Considered for a Waiver by the Submission of a Waiver Application

Illinois Compiled Statutes Citation	Offense	Additional Offense Added Effective
[720 ILCS 5/10-3]	Unlawful Restraint	
[720 ILCS 5/10-3.1]	Aggravated Unlawful Restraint	
[720 ILCS 5/10-4]	Forcible Detention	
[720 ILCS 5/10-5]	Child Abduction	
[720 ILCS 5/10-7]	Aiding and Abetting Child Abduction	
[720 ILCS 5/12-1]	Assault	
[720 ILCS 5/12-2]	Aggravated Assault	

[720 ILCS 5/12-3]	Battery	
[720 ILCS 5/12-3.1]	Battery of an Unborn Child	
[720 ILCS 5/12-3.2]	Domestic Battery	
[720 ILCS 5/12-4.5]	Tampering With Food, Drugs or Cosmetics	1/1/98
[720 ILCS 5/12-7.4]	Aggravated Stalking	1/1/98
[720 ILCS 5/12-11]	Home Invasion	1/1/98
[720 ILCS 5/12-21.6]	Endangering the Life or Health of a Child	1/1/98
[720 ILCS 5/12-32]	Ritual Mutilation	1/1/98
[720 ILCS 5/12-33]	Ritual Abuse of a Child	1/1/98
[720 ILCS 5/16-1]	Theft	
[720 ILCS 5/16-2]	Theft of Lost or Mislaid Property	1/1/04
[720 ILCS 5/16A-3]	Retail Theft	
[720 ILCS 5/16-30]	Identity Theft	1/1/04
[720 ILCS 5/16-30]	Aggravated Identify Theft	1/1/04
[720 ILCS 5/17-3]	Forgery	1/1/98
[720 ILCS 5/18-1]	Robbery	
[720 ILCS 5/18-3]	Vehicular Hijacking	1/1/98
[720 ILCS 5/19-1]	Burglary	1/1/98
[720 ILCS 5/19-3]	Residential Burglary	
[720 ILCS 5/19-4]	Criminal Trespass to Residence	
[720 ILCS 5/20-1]	Arson	
[720 ILCS 5/20-1.1]	Aggravated Arson	
[720 ILCS 5/20-1.2]	Residential Arson	1/1/04
[720 ILCS 5/24-1]	Unlawful Use of a Weapon	
[720 ILCS 5/24-1.1]	Unlawful Use or Possession of Weapons by Felons or Persons in the Custody of the Department of Corrections Facilities	1/1/04
[720 ILCS 5/24-1.2]	Aggravated Discharge of a Firearm	
[720 ILCS 5/24-1.2-5]	Aggravated Discharge of a Machine Gun or a Firearm Equipped with a Device Designed or Used for Silencing the Report of a Firearm	
[720 ILCS 5/24-1.5]	Reckless Discharge of a Firearm	1/1/98
[720 ILCS 5/24-1.6]	Aggravated Unlawful Use of a Weapon	1/1/04
[720 ILCS 5/24-3.2]	Unlawful Discharge of Firearm Projectiles	1/1/04
[720 ILCS 5/24-3.3]	Unlawful Sale or Delivery of Firearms on the Premises of Any School	1/1/04
[720 ILCS 5/33A-2]	Armed Violence	1/1/98
[225 ILCS 65/10-5]	Practice of Nursing without a License	1/1/04
[720 ILCS 150/4]	Endangering Life or Health of a Child	1/1/98
[720 ILCS 150/5.1]	Permitting Sexual Abuse of a Child	1/1/04
[720 ILCS 115/53]	Cruelty to Children	1/1/98
[720 ILCS 250/4]	Receiving Stolen Credit Card or Debit Card	1/1/04
[720 ILCS 250/5]	Receiving a Credit or Debit Card with Intent To Use, Sell or Transfer	1/1/04
[720 ILCS 250/6]	Selling a Credit Card or Debit Card, Without The Consent of the Issuer	1/1/04

[720 ILCS 250/8]	Using a Credit or Debit Card with the Intent to Defraud	1/1/04
[720 ILCS 250/17.02]	Fraudulent Use of Electronic Transmission	1/1/04
[720 ILCS 550/5]	Manufacture, Delivery or Possession With Intent to Deliver or Manufacture Cannabis	
[720 ILCS 550/5.1]	Cannabis Trafficking	
[720 ILCS 550/5.2]	Delivery of Cannabis on School Grounds	1/1/98
[720 ILCS 550/7]	Delivering Cannabis to a Person under 18	1/1/98
[720 ILCS 550/9]	Calculated Criminal Cannabis Conspiracy	
[720 ILCS 570/401]	Manufacture or Delivery or Possession With Intent to Manufacture or Deliver a Controlled Substance Other Than Methamphetamine, A Counterfeit Substance or a Controlled Substance Analog	
[720 ILCS 570/401.1]	Controlled Substance Trafficking	
[720 ILCS 570/404]	Distribution, Advertisement or Possession with Intent to Manufacture or Distribute a Look-Alike Substance	
[720 ILCS 570/405]	Calculated Criminal Drug Conspiracy	
[720 ILCS 570/405.1]	Criminal Drug Conspiracy	
[720 ILCS 570/407]	Delivering a Controlled, Counterfeit or Look-Alike Substance to a Person Under 18	
[720 ILCS 570/407.1]	Engaging or Employing Person under 18 to Deliver a Controlled, Counterfeit or Look-Alike Substance	
[720 ILCS 646]	Violations under the Methamphetamine Control and Community Protection Act	9/11/05

Section 300.661 Health Care Worker Background Check

- a) The facility shall not *knowingly hire any individual in a position with duties involving direct care for residents* if that person *has been convicted of committing or attempting to commit one or more of the following offenses* (Section 25(a) of the Health Care Worker Background Check Act [225 ILCS 46/25]):
- 1) Solicitation of murder, solicitation of murder for hire (Sections 8-1.1 and 8-1.2 of the Criminal Code of 1961 [720 ILCS 5/8-1.1 and 8-1.2] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 8-1.1 and 8-1.2));
 - 2) Murder, homicide, manslaughter or concealment of a homicidal death (Sections 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3 of the Criminal Code of 1961 [720 ILCS 5/9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3; Ill. Rev. Stat. 1985, ch. 38, par. 9-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 3, 236, 358, 360, 361, 362, 363, 364, 364a, 365, 370, 373, 373a, 417, and 474));
 - 3) Kidnapping or child abduction (Sections 10-1, 10-2, 10-5, and 10-7 of the Criminal Code of 1961 [720 ILCS 5/10-1, 10-2, 10-5, and 10-7] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 10-1, 10-2, 10-5, and 10-7; Ill. Rev. Stat. 1985, ch. 38, par. 10-6; Ill. Rev. Stat. 1961, ch. 38, pars. 384 to 386));
 - 4) Unlawful restraint or forcible detention (Sections 10-3, 10-3.1, and 10-4 of the Criminal Code of 1961 [720 ILCS 5/10-3, 10-3.1, and 10-4] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 10-3, 10-3.1, and 10-4; Ill. Rev. Stat. 1961, ch. 38, pars. 252, 252.1, and 252.4));
 - 5) Indecent solicitation of a child, sexual exploitation of a child, exploitation of a child, child pornography (Sections 11-6, 11-9.1, 11-19.2, and 11-20.1 of the Criminal Code of 1961 [720 ILCS 5/11-6, 11-9.1, 11-19.2, and 11-20.1] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 11-6, 11-19.2, and 11-20.1; Ill. Rev. Stat. 1983, ch. 38, par. 11-20a; Ill. Rev. Stat. 1961, ch. 38, pars. 103 and 104));
 - 6) Assault, battery, heinous battery, tampering with food, drugs or cosmetics, or infliction of great bodily harm (Sections 12-1, 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7 of the Criminal Code of 1961 [720 ILCS 5/12-1,

- 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 12-1, 12-2, 12-3, 12-3.1, 12-3.2, 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.5, 12-4.6, and 12-4.7; Ill. Rev. Stat. 1985, ch. 38, par. 9-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 55, 56, and 56a to 60b));
- 7) Aggravated stalking (Section 12-7.4 of the Criminal Code of 1961 [720 ILCS 5/12-7.4] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-7.4));
 - 8) Home invasion (Section 12-11 of the Criminal Code of 1961 [720 ILCS 5/12-11] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-11));
 - 9) Criminal sexual assault or criminal sexual abuse (Sections 12-13, 12-14, 12-14.1, 12-15, and 12-16 of the Criminal Code of 1961 [720 ILCS 5/12-13, 12-14, 12-14.1, 12-15, and 12-16] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 11-1, 11-2, 11-3, 11-4, 11-5, 12-13, 12-14, 12-15, and 12-16; Ill. Rev. Stat. 1985, ch. 38, pars. 11-1, 11-4, and 11-4.1; Ill. Rev. Stat. 1961, ch. 38, pars. 109, 141, 142, 490, and 491));
 - 10) Abuse and gross neglect of a long-term care facility resident (Section 12-19 of the Criminal Code of 1961 [720 ILCS 5/12-19] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-19));
 - 11) Criminal abuse or neglect of an elderly or disabled person (Section 12-21 of the Criminal Code of 1961 [720 ILCS 5/12-21] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 12-21));
 - 12) Endangering the life or health of a child (Section 12-21.6 of the Criminal Code of 1961 [720 ILCS 5/12-21.6] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2354; Ill. Rev. Stat. 1961, ch. 38, par. 95));
 - 13) Ritual mutilation, ritualized abuse of a child (Sections 12-32 and 12-33 of the Criminal Code of 1961 [720 ILCS 5/12-32 and 12-33] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 12-32 and 12-33));
 - 14) Theft, retail theft (Sections 16-1 and 16A-3 of the Criminal Code of 1961 [720 ILCS 5/16-1 and 16A-3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 16-1 and 16A-3; Ill. Rev. Stat. 1961, ch. 38, pars. 62, 207 to 218, 240 to 244, 246, 253, 254.1, 258, 262, 262a, 273, 290, 291, 301a, 354, 387 to 388b, 389, 393 to 400, 404a to 404c, 438, 492 to 496));
 - 15) Financial exploitation of an elderly person or a person with a disability (Section 16-1.3 of the Criminal Code of 1961 [720 ILCS

5/16-1.3] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 16-1.3));

- 16) Forgery (Section 17-3 of the Criminal Code of 1961 [720 ILCS 5/17-3] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 17-3; Ill. Rev. Stat. 1961, ch. 38, pars. 151 and 277 to 286));
- 17) Robbery, armed robbery (Sections 18-1 and 18-2 of the Criminal Code of 1961 [720 ILCS 5/18-1 and 18-2] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 18-1 and 18-2));
- 18) Vehicular hijacking, aggravated vehicular hijacking, aggravated robbery (Sections 18-3, 18-4, and 18-5 of the Criminal Code of 1961 [720 ILCS 5/18-3, 18-4, and 18-5]);
- 19) Burglary, residential burglary (Sections 19-1 and 19-3 of the Criminal Code of 1961 [720 ILCS 5/19-1 and 19-3] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 19-1 and 19-3; Ill. Rev. Stat. 1961, ch. 38, pars. 84 to 86, 88, and 501));
- 20) Criminal trespass to a residence (Section 19-4 of the Criminal Code of 1961 [720 ILCS 5/19-4] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 19-4));
- 21) Arson (Sections 20-1 and 20-1.1 of the Criminal Code of 1961 [720 ILCS 5/20-1 and 20-1.1] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 20-1 and 20-1.1; Ill. Rev. Stat. 1961, ch. 38, pars. 48 to 53 and 236 to 238));
- 22) Unlawful use of weapons, aggravated discharge of a firearm, or reckless discharge of a firearm (Sections 24-1, 24-1.2, and 24-1.5 of the Criminal Code of 1961 [720 ILCS 5/24-1, 24-1.2, and 24-1.5] (formerly Ill. Rev. Stat. 1991, ch. 38, pars. 24-1 and 24-1.2; Ill. Rev. Stat. 1961, ch. 38, pars. 152, 152a, 155, 155a to 158b, 414a to 414c, 414e, and 414g));
- 23) Armed violence - elements of the offense (Section 33A-2 of the Criminal Code of 1961 [720 ILCS 5/33A-2] (formerly Ill. Rev. Stat. 1991, ch. 38, par. 33A-2));
- 24) Those provided in Section 4 of the Wrongs to Children Act (Section 4 of the Wrongs to Children Act [720 ILCS 150/4] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2354));
- 25) Cruelty to children (Section 53 of the Criminal Jurisprudence Act [720 ILCS 115/53] (formerly Ill. Rev. Stat. 1991, ch. 23, par. 2368));

- 26) Manufacture, delivery or trafficking of cannabis, delivery of cannabis on school grounds, delivery to person under 18, violation by person under 18 (Sections 5, 5.1, 5.2, 7, and 9 of the Cannabis Control Act [720 ILCS 550/5, 5.1, 5.2, 7, and 9] (formerly Ill. Rev. Stat. 1991, ch. 56 1/2, pars. 705, 705.1, 705.2, 707, and 709)); or
 - 27) Manufacture, delivery or trafficking of controlled substances (Sections 401, 401.1, 404, 405, 405.1, 407, and 407.1 of the Illinois Controlled Substance Act [720 ILCS 570/401, 401.1, 404, 405, 405.1, 407, and 407.1] (formerly Ill. Rev. Stat. 1991, ch. 56 1/2, pars. 1401, 1401.1, 1404, 1405, 1405.1, 1407, and 1407.1)).
- b) The facility shall not *knowingly employ or retain any individual in a position with duties involving direct care for residents* if that person *has been convicted of committing or attempting to commit one or more of the offenses listed in subsections (a)(1) to (27) of this Section unless the applicant, employee or employer obtains a waiver pursuant to this Section.* (Section 25(a) of the Health Care Worker Background Check Act)
 - c) A facility shall not *hire, employ, or retain any individual in a position with duties involving direct care of residents if the facility becomes aware that the individual has been convicted in another state of committing or attempting to commit an offense that has the same or similar elements as an offense listed in subsections (a)(1) to (27) of this Section, as verified by court records, records from a state agency, or an FBI criminal history record check. This shall not be construed to mean that a facility has an obligation to conduct a criminal history records check in other states in which an employee has resided.* (Section 25(b) of the Act)
 - d) For the purpose of this Section:
 - 1) "*Applicant*" means an individual seeking employment with a facility who has received a bona fide conditional offer of employment.
 - 2) "*Conditional offer of employment*" means a bona fide offer of employment by a facility to an applicant, which is contingent upon the receipt of a report from the Department Of State Police indicating that the applicant does not have a record of conviction of any of the criminal offenses listed in subsections (a)(1) to (27) of this Section.
 - 3) "*Direct care*" means the provision of nursing care or assistance with feeding, dressing, movement, bathing, or other personal needs.
 - 4) "*Initiate*" means the obtaining of the authorization for a record

check from a student, applicant, or employee. (Section 15 of the Health Care Worker Background Check Act)

- e) For purposes of the Health Care Worker Background Check Act, the facility shall establish a policy defining which employees provide direct care. In making this determination, the facility shall consider the following:
 - 1) The employee's assigned job responsibilities as set forth in the employee's job description;
 - 2) Whether the employee is required to or has the opportunity to be alone with residents, with the exception of infrequent or unusual occasions; and
 - 3) Whether the employee's responsibilities include physical contact with residents, for example to provide therapy or to draw blood.
- f) *Beginning January 1, 1996, when the facility makes a conditional offer of employment to an applicant who is not exempt under subsection (w) of this Section, for a position with duties that involve direct care for residents, the employer shall inquire of the Nurse Aide Registry as to the status of the applicant's Uniform Conviction Information Act (UCIA) criminal history record check. If a UCIA criminal history record check has not been conducted within the last 12 months, the facility must initiate or have initiated on its behalf a UCIA criminal history record check for that applicant. (Section 30(c) of the Health Care Worker Background Check Act)*
- g) *The facility shall transmit all necessary information and fees to the Illinois State Police within 10 working days after receipt of the authorization. (Section 15 of the Health Care Worker Background Check Act)*
- h) The facility may accept an authentic UCIA criminal history record check that has been conducted within the last 12 months rather than initiating a check as required in subsection (f) of this Section.
- i) *The request for a UCIA criminal history record check shall be made as prescribed by the Department of State Police. The applicant or employee must be notified of the following whenever a non-fingerprint-based UCIA criminal history record check is made:*
 - 1) *That the facility shall request or have requested on its behalf a non-fingerprint-based UCIA criminal history record check pursuant to the Health Care Worker Background Check Act.*
 - 2) *That the applicant or employee has a right to obtain a copy of the*

criminal records report from the facility, challenge the accuracy and completeness of the report, and request a waiver in accordance with this Section.

- 3) *That the applicant, if hired conditionally, may be terminated if the non-fingerprint-based criminal records report indicates that the applicant has a record of conviction of any of the criminal offenses enumerated in subsections (a)(1) to (27) of this Section unless the applicant's identity is validated and it is determined that the applicant or employee does not have a disqualifying criminal history record based on a fingerprint-based records check pursuant to subsection (k) of this Section.*
- 4) *That the applicant, if not hired conditionally, shall not be hired if the non-fingerprint-based criminal records report indicates that the applicant has a record of conviction of any of the criminal offenses enumerated in subsections (a)(1) to (27) of this Section unless the applicant's record is cleared based on a fingerprint-based records check pursuant to subsection (k) of this Section.*
- 5) *That the employee may be terminated if the criminal records report indicates that the employee has a record of conviction of any of the criminal offenses enumerated in subsections (a)(1) to (27) of this Section unless the employee's record is cleared based on a fingerprint-based records check pursuant to subsection (k) of this Section. (Section 30(e) and (f) of the Health Care Worker Background Check Act)*
- j) *A facility may conditionally employ an applicant to provide direct care for up to three months pending the results of a UCIA criminal history record check. (Section 30(g) of the Health Care Worker Background Check Act)*
- k) *An applicant or employee whose non-fingerprint-based UCIA criminal history record check indicates a conviction for committing or attempting to commit one or more of the offenses listed in subsections (a)(1) to (27) of this Section may request that the facility or its designee commence a fingerprint-based UCIA criminal records check by submitting any necessary fees and information in a form and manner prescribed by the Department of State Police. (Section 35 of the Health Care Worker Background Check Act)*
- l) *A facility having actual knowledge from a source other than a non-fingerprint check that an employee has been convicted of committing or attempting to commit one of the offenses enumerated in Section 25 of the Act must initiate a fingerprint-based background check within 10 working days after acquiring that knowledge. The facility may continue to employ*

that individual in a direct care position, may reassign that individual to a non-direct care position, or may suspend the individual until the results of the fingerprint-based background check are received. (Section 30(d) of the Health Care Worker Background Check Act)

- m) *An applicant, employee or employer may request a waiver to subsection (a), (b) or (c) of this Section by submitting the following to the Department within five working days after the receipt of the criminal records report:*
 - 1) *A completed fingerprint-based UCIA criminal records check form (Section 40(a) of the Health Care Worker Background Check Act) (which the Department will forward to the Department of State Police); and*
 - 2) *A certified check, money order or facility check made payable to the Department of State Police for the amount of money necessary to initiate a fingerprint-based UCIA criminal records check.*
- n) *The Department may accept the results of the fingerprint-based UCIA criminal records check instead of the items required by subsections (m)(1) and (2) above. (Section 40(a-5) of the Health Care Worker Background Check Act)*
- o) *An application for a waiver shall be denied unless the applicant meets the following requirements and submits documentation thereof with the waiver application:*
 - 1) *Except in the instance of payment of court-imposed fines or restitution in which the applicant is adhering to a payment schedule, the applicant shall have met all obligations to the court and under terms of parole (i.e., probation has been successfully completed); and*
 - 2) *The applicant shall have satisfactorily completed a drug and/or alcohol recovery program, if drugs and/or alcohol were involved in the offense.*
- p) *The Department may grant a waiver based on mitigating circumstances, which may include:*
 - 1) *The age of the individual at which the crime was committed;*
 - 2) *The circumstances surrounding the crime;*
 - 3) *The length of time since the conviction;*

- 4) *The applicant's or employee's criminal history since the conviction;*
- 5) *The applicant's or employee's work history;*
- 6) *The applicant's or employee's current employment references;*
- 7) *The applicant's or employee's character references;*
- 8) *Nurse Aide Registry records; and*
- 9) *Other evidence demonstrating the ability of the applicant or employee to perform the employment responsibilities competently and evidence that the applicant or employee does not pose a threat to the health or safety of residents, which may include, but is not limited to, the applicant's or employee's participation in a drug/alcohol rehabilitation program and continued involvement in recovery; the applicant's or employee's participation in anger management or domestic violence prevention programs; the applicant's or employee's status on nurse aide registries in other states; the applicant's or employee's criminal history in other states; or the applicant's or employee's successful completion of all outstanding obligations or responsibilities imposed by or to the court. (Section 40(b) of the Health Care Worker Background Check Act)*

q) Waivers will not be granted to individuals who have not met the following time frames. "Disqualifying" refers to offenses listed in subsections (a)(1) to (27) of this Section:

- 1) Single disqualifying misdemeanor conviction - waiver consideration no earlier than one year after the conviction date;
- 2) Two to three disqualifying misdemeanor convictions - waiver consideration no earlier than three years after the most recent conviction date;
- 3) More than three disqualifying misdemeanor convictions - waiver consideration no earlier than five years after the most recent conviction date;
- 4) Single disqualifying felony convictions - waiver consideration no earlier than three years after the conviction date;
- 5) Two to three disqualifying felony convictions - waiver consideration no earlier than five years after the most recent conviction date;

- 6) More than three disqualifying felony convictions - waiver consideration no earlier than 10 years after the most recent conviction date.
- r) Waivers will not be granted to individuals who have been convicted of committing or attempting to commit one or more of the following offenses:
- 1) Solicitation of murder, solicitation of murder for hire (Sections 8-1.1 and 8-1.2 of the Criminal Code of 1961 [720 ILCS 5/8-1.1 and 8-1.2]);
 - 2) Murder, homicide, manslaughter or concealment of a homicidal death (Sections 9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3 of the Criminal Code of 1961 [720 ILCS 5/9-1, 9-1.2, 9-2, 9-2.1, 9-3, 9-3.1, 9-3.2, and 9-3.3]);
 - 3) Kidnapping or aggravated kidnapping (Sections 10-1 and 10-2 of the Criminal Code of 1961 [720 ILCS 5/10-1 and 10-2]);
 - 4) Aggravated battery, heinous battery, or infliction of great bodily harm (Sections 12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.6, and 12-4.7 of the Criminal Code 1961 [720 ILCS 5/12-4, 12-4.1, 12-4.2, 12-4.3, 12-4.4, 12-4.6, and 12-4.7]);
 - 5) Criminal sexual assault or aggravated criminal sexual assault (Sections 12-13, 12-14, and 12-14.1 of the Criminal Code of 1961 [720 ILCS 5/12-13, 12-14, and 12-14.1]);
 - 6) Criminal sexual abuse or aggravated criminal sexual abuse (Sections 12-15 and 12-16 of the Criminal Code of 1961 [720 ILCS 5/12-15 and 12-16]);
 - 7) Abuse and gross neglect of a long-term care facility resident (Section 12-19 of the Criminal Code of 1961 [720 ILCS 5/12-19]);
 - 8) Criminal abuse or neglect of an elderly or disabled person (Section 12-21 of the Criminal Code of 1961 [720 ILCS 5/12-21]);
 - 9) Financial exploitation of an elderly person or a person with a disability (Section 16-1.3 of the Criminal Code of 1961 [720 ILCS 5/16-1.3]);
 - 10) Indecent solicitation of a child, sexual exploitation of a child, exploitation of a child, child pornography (Sections 11-6, 11-9.1, 11-19.2, and 11-20.1 of the Criminal Code of 1961 [720 ILCS 5/11-6, 11-9.1, 11-19.2, and 11-20.1]);

- 11) Armed robbery (Section 18-2 of the Criminal Code of 1961 [720 ILCS 5/18-2]); and
 - 12) Aggravated vehicular hijacking, aggravated robbery (Sections 18-4 and 18-5 of the Criminal Code of 1961 [720 ILCS 5/18-4 and 18-5]).
- s) The director of Public Health may grant a waiver to an individual who does not meet the requirements of subsection (o), (q), or (r), *based on mitigating circumstances* (see subsection (p)). (Section 40(b) of the Health Care Worker Background Check Act)
 - t) *An individual shall not be employed in a direct care position from the time that the employer receives the results of a non-fingerprint check containing disqualifying conditions until the time that the individual receives a waiver from the Department. If the individual challenges the results of the non-fingerprint check, the employer may continue to employ the individual in a direct care position if the individual presents convincing evidence to the employer that the non-fingerprint check is invalid. If the individual challenges the results of the non-fingerprint check, his or her identity shall be validated by a fingerprint-based records check in accordance with subsection (k) of this Section.* (Section 40(d) of the Health Care Worker Background Check Act)
 - u) *A facility is not obligated to employ or offer permanent employment to an applicant, or to retain an employee who is granted a waiver.* (Section 40(f) of the Health Care Worker Background Check Act)
 - v) A facility may retain the individual in a direct care position if the individual presents clear and convincing evidence to the facility that the non-fingerprint-based criminal records report is invalid and if there is a good faith belief on the part of the employer that the individual did not commit an offense listed in subsections (a)(1) to (27) of this Section, pending positive verification through a fingerprint-based criminal records check. Such evidence may include, but not be limited to:
 - 1) certified court records;
 - 2) written verification from the State's Attorney's office that prosecuted the conviction at issue;
 - 3) written verification of employment during the time period during which the crime was committed or during the incarceration period stated in the report;
 - 4) a signed affidavit from the individual concerning the validity of the

report; or

- 5) documentation from a local law enforcement agency that the individual was not convicted of a disqualifying crime.

w) This Section *shall not apply to*:

- 1) *An individual who is licensed by the Department of Professional Regulation or the Department of Public Health under another law of this State;*
- 2) *An individual employed or retained by a health care employer for whom a criminal background check is required by another law of this State; or*
- 3) *A student in a licensed health care field including, but not limited to, a student nurse, a physical therapy student, or a respiratory care student unless he or she is employed by a health care employer in a position with duties involving direct care for residents. (Section 20 of the Health Care Worker Background Check Act)*

x) *An employer need not initiate an additional criminal background check for an employee if the employer initiated a criminal background check for the employee after January 1, 1996 and prior to January 1, 1998. This subsection applies only to persons employed prior to January 1, 1998. Any person newly employed on or after January 1, 1998, must receive a background check as required by Section 30 of the Health Care Worker Background Check Act. (Section 25.1 of the Health Care Worker Background Check Act)*

y) *The facility must send a copy of the results of the UCIA criminal history record check to the State Nurse Aide Registry for those individuals who are on the Registry. (Section 30(b) of the Health Care Worker Background Check Act). The facility shall include the individual's Social Security number on the criminal history record check results.*

z) *The facility shall retain on file for a period of 5 years records of criminal records requests for all employees. The facility shall retain the results of the UCIA criminal history records check and waiver, if appropriate, for the duration of the individual's employment. The files shall be subject to inspection by the Department. A fine of \$500 shall be imposed for failure to maintain these records. (Section 50 of the Health Care Worker Background Check Act)*

aa) The facility shall maintain a copy of the employee's criminal history record check results and waiver, if applicable, in the personnel file or other

secure location accessible to the Department.

(Source: Amended at 27 Ill. Reg. 15855, effective September 25, 2003)

Further information is available from the Illinois Department of Public Health

<p>Office of Health Care Regulation 525 W. Jefferson St., 5th floor Springfield, IL 62761 217-782-2913</p>	<p>General long-term care facility issues</p>
<p>Division of LTC Field Operations 525 W. Jefferson St., 5th floor Springfield, IL 62761 217-785-2629</p>	<p>Violations, survey questions, rule interpretations</p>
<p>Division of LTC Quality Assurance 525 W. Jefferson St., 5th floor Springfield, IL 62761 217-782-5180</p>	<p>Plan reviews, licensure, certification</p>
<p>Division of Assisted Living 525 W. Jefferson St., 5th floor Springfield, IL 62761 217-782-2448 217-785-9174</p>	<p>Rule interpretations, establishment compliance history, general licensure questions</p>
<p>Division of Health Care Facilities & Programs 525 W. Jefferson St., 4th floor Springfield, IL 62761 217-782-7412</p>	<p>Non-long term care issues, Home Health, hospitals, dialysis centers</p>
<p>Central Complaint Registry 525 W. Jefferson St., Gr. floor Springfield, IL 62761 800-252-4343</p>	<p>Complaints, reporting resident abuse, neglect</p>
<p>Education and Training Section 525 W. Jefferson St., 4th floor Springfield, IL 62761 217-785-2629 217-785-5132</p>	<p>Nurse Aide training</p>
<p>Division of Administrative Rules & Procedures Health Care Worker Registry 525 W. Jefferson St., 4th floor Springfield, IL 62761 217-785-8851 217-785-5133</p>	<p>Information on accessing rules or recommendations for rule changes; Health Care Worker Registry Background Check Act</p>

