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Long-term Care Report to the Illinois General Assembly

July 2015



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April 27, 2015

Dear Members of the General Assembly,

Thank you for the opportunity to present the 2015 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.

Regards,

Nirav D. Shah, M.D., J.D.
Director of Public Health



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April 27, 2015

Dear Members of the General Assembly,

The Illinois Department of Public Health is pleased to submit its 2015 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,

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

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

Nursing Home Care Act

(210 ILCS 45/3-804) (Ch. 111 1/2, par. 4153-804) (Sec. 3-804)

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. (Source: P.A. 97-135, eff. 7-14-11.)
<http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1225&ChapterID=21>

Abused and Neglected Long-Term Care Facility Residents Reporting Act

(210 ILCS 30) (Ch. 111 1/2, par. 4166) (Sec. 6)

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. (Source: P.A. 97-38, eff. 6-28-11; 97-227, eff. 1-1-12; 97-813, eff. 7-13-12; 98-104, eff. 7-22-13.)
<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapterID=21>

ID/DD Community Care Act

(210 ILCS 47/3-804) (Sec. 3-804)

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. (Source: P.A. 96-339, eff. 7/1/10)
<http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=3127&ChapterID=21>

Community Living Facilities Licensing Act

(210 ILCS 35) (Ch. 111 1/2, par. 4181) (Sec. 1)

The purpose of this Act is to authorize the Department to license Community Living Facilities (CLFs) using standards appropriate to this type of residential setting. The CLF is a transitional residential setting which provides guidance, supervision, training and other assistance to persons with a mild or moderate developmental disability with the goal of eventually moving these persons into more independent living arrangements. The Act authorizes the Department to establish minimum standards, rules and regulations consistent with the philosophy and purpose of CLFs while insuring the protection of residents' rights and general welfare. (Source: P.A. 88-380.)
<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1223&ChapterID=21>

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PART I OVERVIEW

The Nursing Home Care Act authorizes the Illinois Department of Public Health (IDPH) to establish different levels of care:

- Skilled Nursing Care Facility (SNF)
- Intermediate Care Facility (ICF)
- Sheltered Care Facility (SC)
- Veterans' Home

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

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, 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 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.

Facilities for Individuals with Intellectual Disabilities

The Intellectual Disabilities/Developmental Disabilities (ID/DD) Community Care Act provides for licensure of Intermediate Care Facility for the Intellectually Disabled (ICF/ID) and Long-term Care Facility for those under Age 22.

The ID/DD Community Care Act provides the following definition for both 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 are examples of persons who live in such facilities:

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.

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.

Community Living Facility (CLF)

The Community Living Facility Licensing Act (210/ILCS 35/) provides the following definition:

"Community Living Facility" (CLF) means a transitional residential setting which provides guidance, supervision, training and other assistance to ambulatory or mobile adults with a mild or moderate developmental disability with the goal of eventually moving these persons to more independent living arrangements. Residents are required to participate in day activities, such as vocational training, sheltered workshops or regular employment. A CLF shall not be a nursing or medical facility and shall house no more than 20 residents, excluding staff.

Residents of a community living facility must have the goal of eventually moving to more independent living arrangements and are required to participate in day activities, such as vocational training or supported employment. In order to help residents make progress toward the goal of independent living, the facility must offer services and programs that provide experience in working and performing daily living tasks. The facility must also provide evening and weekend training programs that help residents to develop independent living skills. These include assistance with personal grooming, socialization skills, communication skills, clothing, finances, food, transportation, and leisure-time activities. The facility must also provide or arrange vocational training to help develop work skills.

Specialized Mental Health Rehabilitation Facility (SMHRF)

The Specialized Mental Health Rehabilitation Act of 2013 [(210 ILCS 49/1-102) Article 1. Sec. 1-102. Definitions. (Source: P.A. 98-104, eff. 7/22/16)] defines a facility as:

“Facility” means 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 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 an institute for mental disease under the federal definition of the term.

Size and Variety of Facilities

Long-term care facilities range from four (4) beds to 551 beds (e.g., 4 bed ICF/IID facility; 551 bed VA facility). Some offer only one level of care, while others provide two or more levels of care. Tables 1 and 2 describe the number of licensed facilities and beds by level of care provided. Facilities certified, but not licensed, still require inspections and investigations. There are 93 certified-only and hospital-based facilities with more than 3,850 additional beds in Illinois.

TABLE 1	
Number and Type of Licensed and/or Certified LTC Facilities - 2014	
Type	Number
SNF Only	495
SNF/ICF	145
SNF/ICF/SC	23
SNF/ICF/ICF-DD	2
SNF/SC	35
SNF and SNF/22 and Under	1
22 and Under Only	9
ICF Only	46
ICF/IID Only	22
16 or Fewer Bed Only	217
ICF/SC	6
SC Only	46
CLF only	28
Hospital-based LTC units	30
Swing Beds	56
Supportive Residences	1
State Mental Health LTC units	7
TOTAL FACILITIES	1,169

TABLE 2	
Number and Type of Licensed and/or Certified LTC Facility Beds - 2014	
Type of Facility	Number of Licensed and/or Certified LTC Beds
SNF	81,352
ICF	16,884
ICFDD	5,121
22 and Under	932
CLF	397
SC	6,182
TOTAL BEDS	110,868

Office of Health Care Regulation Structure

The Department's Office of Health Care Regulation (OHCR) is comprised of 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: Long-Term Care Field Operations (LTC FO), Quality Assurance (QA), and Assisted Living (AL). The LTC FO is comprised of three sections: the Special Investigations Unit (SIU), which includes the Central Complaint Registry (CCR); the Intermediate Care Facility/Individual Intellectually Disabled and Specialized Mental Health Rehabilitation Section (ICF/IID and SMHRF); and seven (7) regional offices located in Rockford, West Chicago, Peoria, Champaign, Edwardsville, Marion, and Bellwood.

Budget and Fiscal Section

The Budget and Fiscal Section is responsible for OHCR fiscal transactions. This includes advising the OHCR Deputy Director on budget and personnel matters; accounting transactions (travel vouchers, payroll, vendor payments, contracts, ordering of supplies and equipment); information technology requests (ESRs); audit compliance; organizing federal training requests; and monitoring inventory, which includes furniture and equipment.

Education and Training Section

The Education and Training section coordinates and assists with training OHCR staff, other agency staff involved in long-term care issues, long-term care 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. Training for OHCR and other agency staff also may be held to meet the requirements of the Centers for Medicare and Medicaid Services (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 IDPH's response to certain situations, or introduce new regulations and/or procedures or technical material; it also provides a forum for exchanging information.

The Section provides continuing education opportunities for staff through various outside training programs. Some of the specific trainings include: Illinois Pioneer Coalition Annual Summit; Illinois Environmental Health Association seminars; and the Illinois Food Safety Symposium. Computer based learning for continuing education units (CEs) mandated, is available for all disciplines from the Care2Learn System. These "CEs" are for State license renewals for select disciplines. CMS provides satellite broadcasts and Web-based training for surveyor disciplines. Information regarding federal surveyor training and education continues to be maintained in the centralized database called the Total Learning Management System.

The Section Chief facilitates statewide Town Hall meetings where providers hear regulatory updates and information regarding the region's most frequently cited deficiencies. The goal of these informational meetings is to assist providers in their provision of necessary care and services that improve resident outcomes. The locations are geographically selected to provide easy access for the providers throughout the state. IDPH continues its collaborative effort with associations, to provide educational opportunities related to regulatory updates, and processes to provide necessary care and services. The Section Chief has made over ten (10) presentations to professional groups and providers about the survey process.

Long-Term Care Surveyor Training

The Section coordinates the three-week State Basic Surveyor Orientation Training Program (BSO). Forty-eight (48) new surveyors were provided an overview of the federal and state requirements for nursing facilities to assist in surveying for compliance and to complete the Survey Minimum Qualifications Test (SMQT). The SMQT deems surveyors qualified to survey long-term care facilities. Topics covered during orientation include:

- State Operations Manual Appendices P, PP, Q
- Chapters 5 & Survey Tasks 1-7
- Pressure ulcers
- 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
- Federal Oversight Support Surveys (FOSS) & Federal Monitoring Surveys (FMS)
- SMQT
- Infection Control
- Pharmacy Tags and Medication Pass
- Environmental and Nutritional Requirements
- Enforcement
- MDS/RAI
- Food Service Sanitation
- Administrative Hearing Process
- Culture Change
- Role of the Surveyor
- ASPEN and ACTS federal survey databases
- Healthcare Worker Background Checks
- Findings of Abuse, Neglect and Misappropriation of Funds
- Legal Issues and Department on Aging Ombudsman program

During the first session of the year, 16 new surveyors attended BSO training in Springfield. Due to the number of new employees hired, to comply with Senate Bill 326, IDPH added more training locations and dates. This plan included the addition of two more locations to accommodate the new surveyors, allow supervisors to participate as instructors, as well as assist with managing the cost. The second session, conducted in the Peoria Regional Office included 13 new surveyors. Bellwood Regional Office hosted the third training with 19 new surveyors completing the training in December.

IDPH continues to implement a plan to hire additional surveyors in order to comply with Senate Bill 326 [Public Act 096-1372: SB0326 (20 ILCS 2310/2310-130)]. IDPH will continue to hire and train surveyors according to SB 326 as long as hiring and budget constraints do not limit efforts to fulfill the mandate of SB 326. Increase in staffing will allow IDPH to comply with state and federal laws to ensure surveys are conducted within the required timeframes and to ensure the minimum standards of nursing home care.

Mandatory training for all surveyor staff included the 2014 updates to Appendix P and PP as received from the Centers for Medicare and Medicaid (CMS) in Survey and Certification (S&C) notifications, Administrative Memos (Admin InFo) and Transmittals. Training included:

- Clarification of Terms Implicating the Spousal Relationship in Regulations and Guidance for Medicare and Medicaid-certified Providers and Suppliers;
- Implementation of the Survey and Certification Group Emergency Preparedness Email Mailbox to facilitate communication between the Survey Agency, Regional Office and CMS Central Office;
- F371 guidance revision-Sanitary Conditions and Preparation of Eggs in Nursing Homes;
- F441- guidance revision-Single-Use Device Reprocessing; and
- Changes in the State Operations Manual P and PP with all the Survey and Certification letters received from October 2003-December 2014.

CMS is in the process of posting a new Appendix P and PP update complete with all the revisions from May 2003 to December 2014. The last complete CMS update was in 2010. Education and Training purchased several volumes of the completed update of Appendices P and PP. This was necessary to ensure surveyors have the tools needed to follow and complete the survey process as mandated.

Nurse Aide Training and Competency Evaluation Program (NATCEP)

This Section also administers the Nurse Aide Training Program, which is authorized and operated in accordance with the Nursing Home Care Act and federal certification requirements. Staff 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.

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. Other criteria to meet the equivalency for becoming a CNA in Illinois include: 1) a nursing student who has completed an introductory nursing theory class and clinical experience; 2) military personnel who completed a hospital corpsman or medical training specialist course; or 3) completed a RN or LPN nursing course in a foreign country.

All Basic Nursing Assistant Training programs are approved by Education and Training staff. Rules governing Basic Nursing Assistant Training programs in Illinois are found in the 77 Illinois Administrative Code, Part 395, Rules for Basic Nurse Aide Training Programs. These training programs are sponsored by various entities including community colleges, long-term care facilities, home health agencies, hospitals, 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.

All instructors and evaluators teaching in training programs must be approved by IDPH prior to instructing students. In 2014, 551 instructors and 155 evaluators were approved. In addition, eighteen (18) new Basic Nursing Assistant Training Programs were approved in 2014, bringing the total number of active programs to 299.

Breakdown of sponsors for current programs - 2014			
Community colleges	107	Nursing homes	11
Vocational schools	87	Hospitals	2
High schools	85	Home health agencies	7
Total number of active Basic Nursing Assistant Training programs			299

Nurse Aide Training programs are monitored and evaluated by IDPH staff to ensure compliance with stated program plans. IDPH conducted 17 monitor visits in 2014.

In 2014, all training programs had to submit verification stating they were in compliance with the revised 77 Illinois Administrative Code, Part 395 Rules for Basic Nurse Aide Training Programs. The revised Code was adopted in June, 2013 and included new requirements for instructors, evaluators and program curriculum. A new requirement for program instructors is to complete a Train the Trainer Refresher course every five (5) years. These courses were developed in 2014 and are available online through three (3) Community Colleges. Instructors began completing courses in November, 2014.

The CNA Career Ladder/CNA II proposed Administrative Code and curriculum were developed in response to Illinois Statute ILCS 2310/2310-225 and 227, which requires IDPH and numerous agencies to conduct a study to determine incentive programs necessary to attract and retain CNA's to work in long term care facilities. As a result,

IDPH implemented a nurse assistant incentive program. Development of the incentive program began in 2007 and completed in 2010. The Project could not be continued until new Basic Nurse Aide Training Program rules were approved. In response to the Statute 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, have been updated and are complete. The next step is the final IDPH legal review prior to publishing the rules for public comment.

Division of Administrative Rules and Procedures (ARP)

ARP maintains three sets of administrative rules written under the authority of the Nursing Home Care Act; two sets of rules written under the authority of the ICF/IID Community Care Act; and one rule under the authority of the Specialized Mental Health Rehabilitation Act of 2013 (see Appendix D.) ARP also administers the Health Care Worker Background Check Act and the Health Care Worker Registry (HCWR).

Legislative Actions for the Office of Health Care Regulation

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, IDPH, working with stakeholders and partnering State 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. Emergency rules were filed on May 22, 2014. Permanent rules were adopted on November 21, 2014, and Subpart T of Part 300 was repealed. Under the new rules, the SMHRFs will be licensed and certified under the new Act. OHCR staff, working with stakeholders representing both the industry and residents, has drafted preliminary language on distressed facilities from Public Act 96-1372. The language is nearly complete and will be reviewed by both the Long-Term Care (LTC) Facility Advisory Board and the Developmentally Disabled (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). IDPH's LTC Facility Advisory Board, continues to work with stakeholders and other state agencies to make extensive changes to Subpart S.

IDPH collaborated with the DD Facility Advisory Board 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 First Notice once reviewed and approved by the Developmentally Disabled Facility Advisory Board. Similar amendments will be drafted for LTC for Under Age 22 Facilities Code (77 Ill. Adm. Code 390).

Administrative Rules

Public Act 96-1372 also mandated an overhaul of 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. IDPH's LTC Facility Advisory Board, has worked with stakeholders and other state agencies to make extensive changes to Subpart S. The advisory board will meet to review the rules and vote on them. IDPH hopes to propose the amendments before the end of 2015.

IDPH, working with residents and stakeholders representing the industry, has drafted preliminary language to implement statutory requirements for distressed facilities, from Public Act 96-1372. The language will be reviewed by the LTC Facility Advisory Board and the DD Facility Advisory Board.

IDPH has been working with a Developmentally Disabled 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 Intellectual Disability/Developmental Disability (ID/DD) Community Care Act. The rules will be proposed for First Notice once 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).

To implement the Specialized Mental Health Rehabilitation Act of 2013, the Department, filed emergency rules filed on May 22, 2014. Permanent rules were adopted on November 21, 2014, and Subpart T of Part 300 was repealed.

On October 3, 2014, the Department proposed amendments to the three rules under the Nursing Home Care Act and the ID/DD Community Care Act to implement Public Act 98-0271, which removed language from those respective Acts that limited the administration of pneumococcal vaccination to residents aged 65 or older. Those amendments were adopted in February, 2015.

Health Care Worker Registry (HCWR)

The HCWR's principal responsibility is to provide information to health care employers about unlicensed health care workers. The responsibilities include information about CNA certification; 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 Developmentally Disabled aide training. The HCWR provides applications, forms and instructions needed to assist health care workers seeking to be certified as an Illinois nurse aide or who are seeking to be granted a waiver for disqualifying convictions that are revealed on their Illinois background check. The HCWR supports a public and a private website, has a Registry call center and answers e-mail inquiries.

Licensed health care employers or certified long-term care facilities must check the registry before employing a non-licensed individual who either will have or may have

contact with residents or have access to the resident's living quarters, financial, medical or personal records. For the facility to hire the individual, a fingerprint-based fee applicant (Fee_App) background check must be conducted by an approved IDPH Livescan vendor. The individual may not work with disqualifying convictions unless the individual has been granted a waiver of those convictions. If the individual is to be hired as a CNA, the facility must verify the individual has met proper training and competency test requirements. The individual cannot have any administrative findings of abuse, neglect or theft. Once a Fee_App background check is in place for an individual on the Registry, the Illinois State Police automatically sends any new convictions to the Registry. If a new disqualifying conviction is received for an individual working on a waiver, the waiver is automatically revoked and the facility is notified that the person must be terminated. The public can check the registry by visiting the website at <https://hcwrpub.dph.illinois.gov/Search.aspx> or by calling the toll free number 844-789-3676. Facilities can access IDPH's HCWR Web portal at <http://portalhome.dph.illinois.gov>.

TABLE 3		
Health Care Worker Registry Statistics, 2014		
CNA competency testing		
	Passed	14,630
	Failed	2,884
	No show	1,033
	Total registered to test	18,547
Direct service personnel added		6,330
Total number of CNAs on the registry as of 12/31/2014		261,161
Total number of direct service personnel as of 12/31/2014		98,294

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 allegations of suspected abuse, neglect or misappropriation of a resident's property by CNAs, DD aides and Habilitation aides be reported to IDPH. After these allegations have been investigated and processed through an administrative hearing, those who have a final order of abuse, neglect or theft are published on the registry.

Table 4	
Administrative Findings Statistics, 2014	
Abuse	59
Neglect	8
Misappropriation of property	13
Total administrative findings	80

Background Checks and Disqualifying Convictions

The Health Care Worker Background Check Act requires 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 must initiate a criminal history records check for 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 the individual receives a waiver, if one is granted by IDPH.

IDPH 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

IDPH's goal in evaluating waivers is to continue prohibiting the employment of those individuals who might pose a threat to the clients of health care employers. If specific criteria are met, the individual may be granted a rehabilitation waiver without submitting a waiver application.

Background checks added to the registry	14,882
Total Background checks on the registry	145,676
Waivers	
Granted	1,433
Denied	455
Total waivers processed	1,888
Waivers revoked*	106

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

Division of Life Safety and Construction (LSC)

LSC conducts plan reviews and inspections of licensed and certified health care facilities, and develops and updates physical plant rules. LSC conducts onsite investigations regarding complaints or incidents at licensed/certified facilities. Facility types the LSC oversees include hospitals (acute care, critical access, rehabilitation, psychiatric, long term acute care, and pediatric), ambulatory surgery centers, long-term care facilities, assisted living, hospice, end stage renal dialysis facilities, free standing birthing centers, and free standing emergency centers. LSC is comprised of two sections: Design and Construction (plan reviews and licensure surveys for all facility types and certification surveys for non-long term care facilities) and Field Services (certification surveys for long term care facilities).

Construction/Renovation/Addition Plans – Design and Construction Section

Health Facility Plan Review Fund [Public Act 90-0327] - (210 ILCS 45/) Nursing Home Care Act, Sec. 3-202.5. (210 ILCS 85/) and Hospital Licensing Act, Sec. 8 and (210 ILCS 5/) Ambulatory Surgical Treatment Center Act, Sec. 8]

The Facility Plan Review Fund allows IDPH to charge a fee for facility plan reviews. The Nursing Home Care Act and Ambulatory Surgical Treatment Center Act require a fee for major construction projects with an estimated cost greater than \$100,000. The Hospital Licensing Act requires a fee for major construction projects with an estimated cost greater than \$500,000. The difference between fees paid for plan review and the estimated amount required to support the process comes from the general revenue fund.

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.

The Acts require acceptable plan review submissions completed within 30 days for design development and 60 days for construction/working. Item-to-item responses must be reviewed within 45 days after receipt. Most projects require onsite surveys prior to use or occupancy and must be completed within 15 working days to 30 calendar days after acceptance of the facility's project completion certifications depending on facility type. Some projects require inspection by architectural, mechanical, electrical and clinical disciplines. In 2014, LSC conducted 140 licensure construction inspections of LTC facilities and 331 of non-LTC facilities.

The Design and Construction Section completed desk reviews of bed upgrades for LTC facilities. These beds were upgraded from sheltered and intermediate to skilled nursing beds. LSC approved 13 requests for upgrades, resulting in 460 beds upgraded from sheltered or intermediate to skilled nursing beds.

In 2014, LSC reviewed 96 long-term care projects with plan review fees totaling \$347,737.36 for total project costs of \$107,883,499.90 and 393 non-long-term care projects with plan review fees totaling \$1,406,743.16 for total project costs of \$927,029,682.62.

The Field Services Section conducts the annual life safety code nursing home surveys and life safety code/physical environment complaint surveys on behalf of the Centers for Medicare and Medicaid Services (CMS). Field Services conducted annual surveys of 1,075 LTC facilities and issued 14,745 deficiencies (an average of 13.5 per facility).

Summary of Fire Situations

IDPH received 24 fire incident reports for LTC facilities in 2014. During this reporting period, no resident deaths occurred. The severity of fires in nursing homes remain at a minimal level due to IDPH's enforcement of life safety code standards that focus on early detection, extinguishment systems, staff education (fire drills) and effective maintenance programs.

Categories used for graphic purposes:

- 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

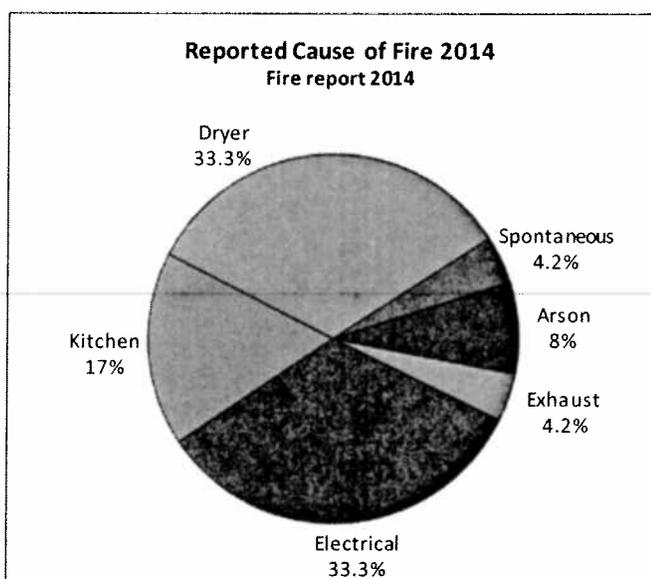


Figure 1

Major causes of fires were electrical (8 or 33%), dryer (8 or 33%), and kitchen (4 or 17%), Figure 1. The number of arson fires decreased in 2014 from five in 2013 to two. In both arson fires, the residents were identified as the perpetrators. This supports the importance of resident assessment and subsequent planning of care and resident supervision. The reductions in number and severity can also be attributed, in part to, the maintenance of smoke and fire detection systems, fire extinguishment systems, and the practice of fire drills, as part of staff education.

Electrical 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 continuing staff education and preventative maintenance programs for cooking, laundry, cooling, heating, ventilation and electrical systems.

The most successful means of detection was facility staff (15 or 62%), Figure 2. This illustrates the importance of staff education to include properly conducted fire drills. The 2nd most successful means of detection was the fire alarm system (8 or 33%). This demonstrates the importance of properly maintaining and testing all components of the fire alarm system.

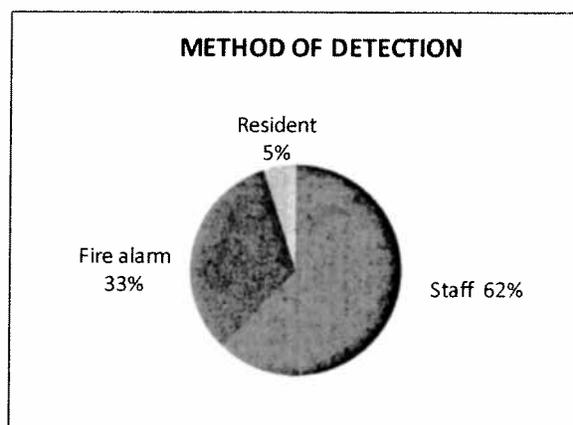


Figure 2

Staff continues to be an important part of fire extinguishment. Staff members extinguished 17 fires. The fire department extinguished five fires, a resident extinguished one fire and the sprinkler system extinguished one fire.

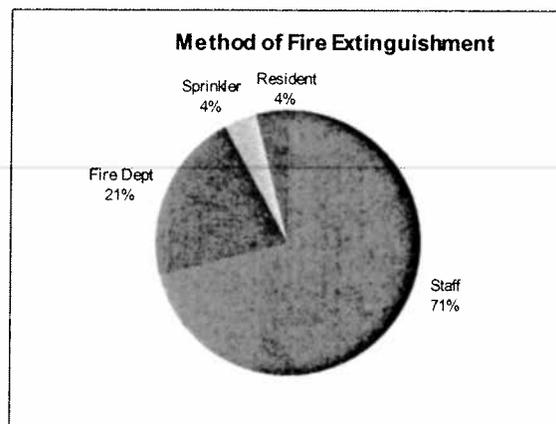


Figure 3

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 1st shift - 7 a.m. to 3 p.m., 2nd shift, 3 p.m. to 11 p.m., 3rd shift, 11 p.m. to 7 a.m. The greatest number of fires (15 or 62%) occurred during 2nd shift. The 2nd highest number of fires (5 or 37%) occurred during 1st shift. The specific hourly periods of occurrence are shown in Figure 5.

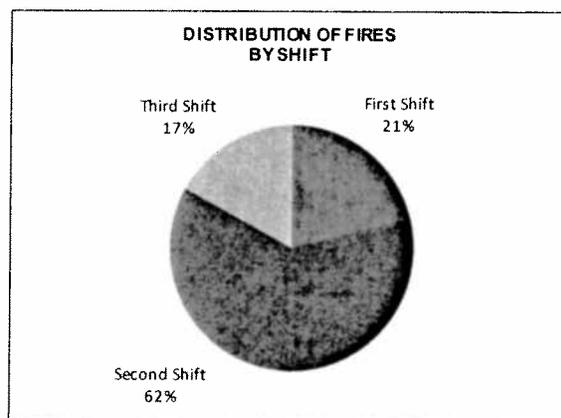


Figure 4

Distribution of Fire by Shifts

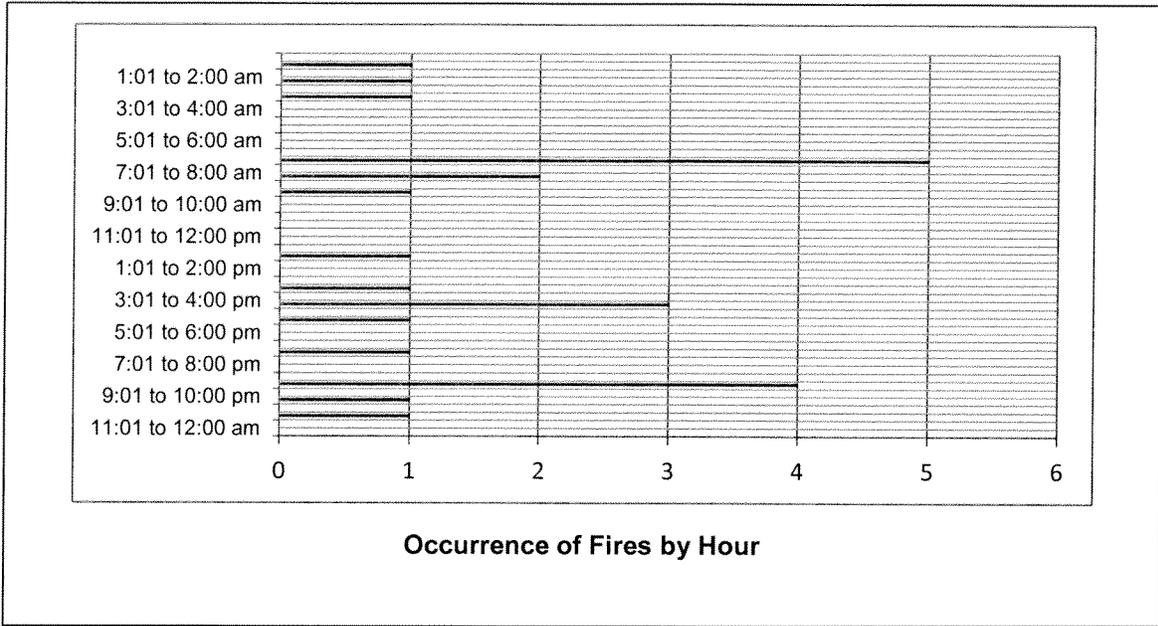


Figure 5

Bureau of Long-Term Care

Division of Long-Term Care Field Operations (LTC FO)

Approximately 1,169 facilities are regulated under the Illinois Nursing Home Care Act and/or federal requirements for Medicare (Title XVIII) and/or Medicaid (Title XIX) participation. Of the 1,169 facilities, 1,083 are licensed under the Nursing Home Care Act, and 86 are associated with a licensed hospital operated as a nursing home under the Hospital Licensing Act. A total of 1,082 (92.56%) of the 1,169 facilities participate in the federal certification program for Medicare and/or Medicaid. Springfield office staff and approximately 260 surveyors headquartered in seven regional offices (Bellwood, Champaign, Edwardsville, Marion, Peoria, Rockford and West Chicago) conduct field survey activities for the 1,169 regulated long-term care facilities.

LTC FO conducts approximately 833 certification 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 inspections. Similar surveys are conducted under the authority of Medicare and Medicaid of the federal Social Security Act. The structure, format and time frame of certification activities are mandated and 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 for Medicaid or Medicare. Facilities providing long-term care 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 (IDHS) (i.e., State Operated Developmental Centers) also are not required to have an additional state license under the Illinois Nursing Home Care Act.

LTC FO is also responsible for the Inspection of Care (IOC) program, which was transferred from the Illinois Department of Healthcare and Family Services to IDPH 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 DD facility.

Table 6
Surveys/Investigations/Inspection of Care - 2014

Annual Licensure/Certification Surveys/Follow-up Surveys	4,623
Licensure/Certification Complaint Investigations/Follow-up Investigations	4,848
Medicaid IOC Reviews (DD only)	290
Licensure Probationary/Initial Surveys	41
Certification Initials	7
Incident Report Investigations	358
Special Surveys – Licensure/Bed Certification (off-cycle, after hours)	127
TOTAL	10,294

LTC FO Special Investigations Unit (SIU)

Abuse – 210 ILCS 28

Resident abuse is one of the most serious findings IDPH addresses. Residents of nursing homes are highly vulnerable and abuse can be devastating for residents and their families. To address this problem, IDPH has significantly increased its investigation of incidents of abuse through interagency referral and investigation agreements with the Illinois State Police Medicaid Fraud Unit. IDPH also established working relationships with the Cook County State's Attorney's Office and the U.S. Attorney's Office in Springfield.

A licensing rule (Nursing Home Care Act 210 ILCS 45/3-6610a) was adopted requiring facilities to immediately contact local law enforcement authorities when a resident is the victim of abuse involving physical injury or sexual abuse. The intent of the rule is to reduce the incidence of abuse in nursing homes by combining the resources of IDPH's investigation program with those of criminal law enforcement and prosecution agencies. With improvements in the federal database, IDPH can use the information to identify trends in the quality of long-term care and to help to determine survey program performance. The new management reports list various survey statistics and are becoming available to state survey agencies.

Identified Offender Project

Public Act 094-0163 requires facilities to check the Illinois State Police and the Illinois Department of Corrections sex offender websites on new admissions. A criminal history check is required on 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 Special Investigations Unit for a waiver of the fingerprint background check. The resident is granted a waiver if the resident is completely immobile as verified by a signed physician explanation or has the existence of a 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.

Public Act (P.A.) 094-0752 mandates a criminal history analysis and report conducted by IDPH to be completed at annual surveys, complaint, and incident investigations. The criminal history analysis assists the facility in preparing supervision needs for residents. Convicted or registered sex offenders must reside in private rooms. The Identified Offender Program is responsible for ensuring proper tracking and monitoring of identified offenders in long-term care facilities.

Abuse Prevention Review Team Act – 210 ILCS 28

Public Act (P.A.) 091-0931 mandates designated appointed teams made up of professionals from multiple disciplines (Nursing, Social Services, Attorneys, Police investigators, ombudsman, and coroner) and agencies (IDPH, ISP, IDHS, State's Attorney Office, Department of Financial & Professional Regulation) to review

confirmed or alleged cases of sexual assault and unnecessary deaths of nursing home residents. The goal of the APRT Act is to gain a better understanding of the incidence and causes of sexual assaults and unnecessary deaths such as deaths related to abuse and/or neglect. IDPH has established the Abuse Prevention Review Team (APRT), which conducts an in depth review of cases where sexual assault is alleged/confirmed or resident death is alleged in conjunction with a complaint. IDPH is responsible for ensuring cases meeting the criteria developed in the Act are referred to the designated team for review. IDPH established procedures for tracking confirmed sexual assaults and unnecessary deaths, obtaining death certificates and developing a database, all outlined in the statute. The team will report its findings to the OHCR Deputy Director and to the appropriate agencies such as Illinois State Police and Department of Professional Regulations, and will include recommendations to help reduce the number of sexual assaults on and unnecessary deaths of nursing home residents.

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

Secure databases have been established to track the following required by the Act:

- Residents who are victims of sexual assaults;
- Residents known to have died at a facility;
- Residents cited in quality of care deficiencies, who then died within six months;
- Residents whose care was the subject of a complaint or incident alleging death and/or sexual assault

Staff of SIU continues to focus on the prevention, detection and investigation of abuse, neglect and theft in long-term care facilities. With the SIU in place, 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.

In 2014, SIU staff reviewed 711 reports of sexual abuse and/or deaths. Of those, 111 were referred to the APRTs:

Total Cases Reviewed	711
Referred to Teams	111
Northern	71
Southern	40

* In 2014, all incidents related to deaths were reviewed by the IDPH's APRT staff, not just those that had a related on-site survey completed.

In 2014, IDPH renewed its agreement with the Illinois State Police Medicaid Fraud Control Unit (ISP/MFCU) to provide greater involvement of ISP/MFCU investigators in IDPH investigations and cross-training of IDPH and ISP/MFCU investigators. The assistance and guidance of the ISP/MFCU has helped IDPH 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 2014, 1,765 incidents and complaints of abuse/neglect, theft and/or fraud were referred by the APRT to ISP/MFCU, which then reviews the reports to determine which referrals to investigate for possible criminal action. Of those, 47 packets were provided to ISP/MFCU at their request for further review. The ISP/MFCU had 18 convictions of long-term care abuse, neglect or theft cases. They opened 192 cases for patient abuse, 42 cases for theft, fraud, drug diversion or financial exploitation, and 54 for immediate jeopardies.

In 2014, there was continued growth in the relationship between IDPH, local law enforcement, state's attorneys, the FBI and coroners. IDPH requires facilities to contact local law enforcement authorities immediately when a resident is the victim of physical injury or sexual abuse. IDPH 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 long-term care facilities. The 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.
- Local law enforcement officials continue to be aware of the regulatory requirements of long-term care facilities and becoming more comfortable interacting with providers.

IDPH's goal is to reduce the incidence of abuse, neglect, and theft and, when necessary, to report those incidences promptly and accurately. Long-term care 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 – 210 ILCS 45/3-206.01

IDPH's goal is to reduce the incidence of abuse, neglect and theft and, when necessary, to report those incidences promptly and accurately. Long-term care facilities must prevent 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.

The Nursing Home Care Act and Abused and Neglected Long-Term Care Facility Residents Reporting Act require 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 as aides) be reported to IDPH. IDPH 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 IDPH to determine whether there is substantial evidence to process an allegation against the aide. If so, the aide is notified by certified letter and right to a hearing. If, after a hearing, IDPH finds 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 desired effect is that the aide will not be able to find employment with a long-term care 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 7 lists the number and type of findings for 2014.

Division of Legal Services	69
Cases closed	33
Cases processed	29
Abuse	45
Neglect	17
Misappropriation of property	20
Removal of neglect findings	10

Monitors and/or Receivers – 210 ILCS 45/3-5

Monitors and/or receivers are placed in facilities to provide additional oversight at least three (3) times a week of their day to day operations. The placement of monitors is determined when the health, safety and welfare of residents is threatened. The monitor/receiver program must have an understanding of the Nursing Home Care Act and the CMS guidelines. While an IDPH employee may serve as a monitor when certain conditions exist, IDPH generally relies on monitors from companies or individual contractors. Although Monitors do not have any specific qualifications, the Special Investigations Unit reviews all potential monitor resume's. Generally the Monitor is a Registered Nurse, Registered Dietician, former Nursing Home Administrator, etc. The selection of the monitor is based on the facility's deficiencies and the appropriate professional is selected, i.e., if the facility is deficient in nursing care, a Registered

Nurse would be assigned. IDPH also utilizes the placement of monitors as a remedy for federal certification surveys. 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.

IDPH placed monitors in three (3) facilities in 2014 and continued the monitoring of three (3) others from 2013. Five (5) of these facilities are licensed and certified to provide intermediate and/or skilled care services; the remaining placements involved a developmentally disabled facility. The number of monitor visits per week varies, generally starting with 3-4 times per week and increasing or decreasing depending on the facility's progress and correction of identified problems. One (1) had a monitor placed as the facility was pending closure and to assist in the assessment of residents during discharge.

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 in the monitored 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 – 210 ILCS45/3-102.1

The Nursing Home Care Act authorizes IDPH to investigate any location reasonably believed to be operating as a long-term care 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, 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.

Illinois Department of Human Services (IDHS) – Office of Inspector General

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

Central Complaint Registry (CCR) – 210 ILCS 30-13,14

The CCR is a 24-hour toll-free nationwide complaint hotline mandated under the Illinois Nursing Home Care Act. The CCR reviews/logs and sends complaints to the appropriate region for scheduling and subsequent investigation. Complaints are assigned a time frame of 24-hours, seven-days or 30-days. Complaints can be received through the toll free hotline (800-252-4343), e-mail, (DPH.CCR@ILLINOIS.GOV), fax (217-524-8885) or mail (IDPH-CCR, 525 W. Jefferson St., Ground Floor, Springfield, IL 62761).

The CCR was established in May 1984, as a result of a legislative mandate to create a central clearinghouse for reports on the quality of care provided to residents of long-term care 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 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 22,000 calls, faxes and emails in 2014, which generated 5,909 complaints, with 2,922 of those alleging abuse and/or neglect. Of the 5,909 complaints taken, 4,906 of these were for long-term care facilities (including ICF/IIDs). Of the ICF/IID complaints, 1,063 were anonymous, leaving 3,842 as actual trackable complaints. There were 4,758 complaints filed against certified facilities which resulted in 1,790 complaints being substantiated and 2,940 being unsubstantiated. There are an additional 28 complaints from the original 4,758 that are still in the investigative process at the time of this report and have yet to be identified as substantiated or unsubstantiated. Table 8 shows the number of complaints and percentage of complaints received by provider type.

Long-term Care	4,740/80 percent
○ Skilled Nursing Facilities	
○ Intermediate Care Nursing Facilities	
○ Shelter Care Facilities	
○ Community Living Facilities	
Hospitals	630/10.6 percent
ICF-IID/Under 22/State Owned Mental Health Facilities	166/2.8 percent
Assisted Living Facilities	172/2.9 percent
Home Health Agencies	94/<1.59 percent
Ambulatory Surgical Treatment Centers	6/<1 percent
Hospice	14/<1 percent
Portable X-rays	1/<1 percent
Home Nursing	2/<1 percent
Home Services	13/<1 percent
Ambulance Companies/EMS/EMT	13/<1 percent
Laboratories	6/<1 percent
Unlicensed Facilities	10 /< 1 percent
Total	5,909/100 percent

Long-term Care received the greatest amount of complaints, 80% (4,740), in 2014 and Hospitals with the second greatest amount at 10.6% (630). CCR received a total of 5909 complaints in 2014.

The CCR is also the central reporting location for the Abuse and Neglect Long-term Care Facility Residents Reporting Act. In addition to long-term care facilities licensed under the Nursing Home Care Act, intellectual centers operated by IDHS are required to report suspected resident abuse and neglect incidents.

An incident is information provided by a facility to IDPH 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: 1) protective oversight; 2) prevention; and 3) promotion of efficiency and quality within the health care delivery system.

Incidents are prioritized and investigated based on the seriousness of the allegations. In 2014 there were approximately 64,780 incident reports received, including both initial and final reports. Table 9 shows these incident reports, broken down by region and provider type facilities:

Table 9			
Incident Reports by Region and Provider Type - 2014			
LTC Facilities		ICF/IID Facilities	
Region 1 - Rockford	2,568	Region 1 - Rockford	1,833
Region 2 - Peoria	6,234	Region 2 - Peoria	1,222
Region 4 - Edwardsville	4,877	Region 4 - Edwardsville	5,555
Region 5 - Marion	2,434	Region 5 - Marion	4,914
Region 6 - Champaign	2,771	Region 6 - Champaign	585
Region 7 - West Chicago	6,896	Region 7 - West Chicago	3,830
Region 8 - Chicago	9,214	Region 8 - Chicago	1,666
Region 9 - Bellwood	9,538	Region 9 - Bellwood	4,090
Total	44,532	Total	20,248

Region 9 has the largest amount of incident reports for Long Term Care Facilities. Region 4 has the largest amount for IID Facilities. All together Central Office reviewed 64,780 incident reports in 2014.

TABLE 10	
Allegations made to the CCR - 2014	
Reports of LTC Abuse and Neglect	2,922
Physical Abuse	73
Sexual Abuse	59
Verbal Abuse	11
Neglect	2,909

TABLE 10	
Allegations made to the CCR - 2014	
Mental Abuse	175
Other Resident Injury	1,412
Sexual Assault – Resident-to-Resident	28
Verbal Assault	4
Physical Assault – Resident-to-Resident	40
Mental Assault – Resident-to-Resident	32
Total Calls	21,268
Total LTC Complaints	4,906

* 2014 statistics were generated from a new database, the Aspen Complaint Tracking System (ACTS) compared to prior years. ACTS will be used moving forward.

In reviewing complaints, IDPH determines the validity of each allegation rather than each complaint. A complaint may have one or more allegations. Table 11 identifies the validity and Table 12 the outcome of complaint allegations. (Note: The total in Table 12 may be less than the total allegations received, because determinations have not yet been made on all allegations received in 2014).

Table 11	
Validity of Allegations - 2014	
Valid	2,346
Invalid	10,578
Undetermined	0
Total	12,924

An allegation is valid if what is stated on the complaint is found to be true; however, if the facility was in compliance a deficiency will not be cited. A complaint can be founded, but if the facility did nothing wrong, then there will be no findings against the facility. The allegation would be found invalid if it was found to not be occurring. An allegation would be considered undetermined if the complaint could not be investigated due to the facility not being Long-Term Care.

TABLE 12			
Violation Levels for Allegations - 2014			
Level	2012	2013	2014
"A"	62	55	99
Repeat "A"	0	0	0
"B"	156	358	413
Repeat "B"	1	1	0

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)

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)

A Repeat Violation is for purposes of assessing fines under Section 3-305 of the Act, a violation that has been cited during one inspection of the facility for which a subsequent inspection indicates that an accepted plan of correction was not complied with, within a period of not more than 12 months from the issuance of the initial violation. A repeat violation shall not be a new citation of the same rule, unless the licensee is not substantially addressing the issue routinely throughout the facility. (Section 3-305(7) of the Act).

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

The ICF/IID program became regulated under the Community Care Act and not the Nursing Home Care Act, effective 1/1/12. IDPH's DD Advisory Board is developing regulatory language that will replace the currently used Illinois Administrative Codes 350 and 390 licensure regulations. These changes will not affect the 370 code for Community Living Facilities (CLF's) as they have their own statute.

During 2014, staff completed certification, inspection of care and licensure surveys for ICF/IID facilities, State Operated Developmental Centers, Long-Term Care Facilities for those Under Age 22, and Community Living Facilities (CLFs). Staff also conducted complaint investigations, incident investigations, follow-up surveys and special certification surveys. Staff investigated incidents of abuse (sexual, physical and mental) and neglect in the area of client protections. Neglect is defined as the failure to provide goods and services to meet the needs of the persons served. As this population continues to age, increased medical needs affect their lives as much as, or more than the need for services focused on improving an individual's daily functional skills.

Training during 2014 was provided on an ongoing basis with supervisor follow-up and three full staff meetings. The training focused on the clarification of regulations and survey procedures for added consistency, and on the use of psychotropic medication in the IID population. Increased oversight, direction and feedback of report writing for compliance with federal standards were provided to the surveyors. The supervisor has stressed that the survey must take accountability for his/her work and will follow up with additional training, if necessary.

Specialized Mental Health Rehabilitation Facilities (SMHRFs)

The Specialized Mental Health Rehabilitation Act of 2013 provided for licensure of long-term care facilities that were federally designated as institutions of the mentally diseased (n = 24) on the effective date of the Act (7/22/13) and specialized in providing services to individuals with a serious mental illness.

On November 21, 2014 IDPH adopted the Specialized Mental Health Rehabilitation Facilities Code (77 Ill. Adm. Code 380) and repealed Subpart T of the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300). The six (6) Subparts of 77 Ill. Adm. Code 380 address general provisions, facility programs, program personnel, administration, support services and environment, and licensure requirements of the 24 facilities. The Act and Rule defined four specialized units and programs to serve different consumers in different states of illness, including:

1. Non-residential triage centers, with a length of stay no more than 23 hours, for short-term crisis assessment and disposition;
2. Crisis stabilization units that serve consumers for no more than 21 days;
3. Recovery and rehabilitation support units that address longer-term consumer mental health rehabilitation needs and training; and
4. Transitional living units that prepare consumers for community transition within 120 days following admission.

Division of Long Term Care Quality Assurance (QA)

QA is responsible for processing licensure and certification surveys conducted by LTC Regional Field Operations, as mandated by the Nursing Home Care Act. The U.S. Department of Health and Human Services (HHS) formalized and regulated the structure, format and time frame of certification processing activities. Licensure applications for 1,169 facilities were reviewed and processed and Medicare/Medicaid applications were processed 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 IDPH 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 Medicare and Medicaid of the federal Social Security Act.

During 2014, IDPH issued 759 renewal licenses. The two-year license program is cyclical. Statistics show that the number of two-year licenses issued by IDPH 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 IDPH 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.

TABLE 13
2014 License Renewal Information

Month	1 Year	2 Year	TOTAL
January	40	29	69
February	32	21	53
March	34	24	58
April	33	34	67
May	35	36	71
June	36	16	52
July	37	31	68
August	42	27	69
September	28	31	59
October	23	47	70
November	21	21	42
December	46	35	81
TOTALS	407	352	759

Changes in Licensure

Many long-term care 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. In 2014, bed changes resulted in skilled care beds increasing by 718, intermediate care beds decreasing by 730 and sheltered care beds decreasing by 65. Four (4) new facilities were licensed in 2014 that added 313 skilled-care beds. Thirty-two long-term care facilities closed in 2014, resulting in skilled-care beds decreased by 287, intermediate care for developmentally disabled beds decreased by 392, and intermediate care beds decreased by 118.

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 Medicare or Medicaid.

Violations

Professional reviews may yield any combination of "AA", "A" or "B" violations or no violations. When a "B" 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, IDPH imposes a conditional license, which is conditioned upon compliance with an imposed accepted plan of correction. If a reinspection indicates a facility has not corrected a violation after an acceptable plan of correction has been established, a repeat violation may be issued. Table 14 shows Licensure Violations issued.

"AA" Violation	4
"A" Violation	99
Repeat "A" Violation	0
"B" Violation	413
Repeat "B" Violation	0

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

Licensure Action

Based on the number and/or 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 IDPH'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 15 describes adverse actions.

Conditional License	90
Revocation or Denial of License	0
Suspension	0

Article III, Part 3 of the Nursing Home Care Act and the ICF/IID Community Care Act authorizes IDPH 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 2014, IDPH imposed more than \$1.9 million in licensure fines against facilities and collected \$1,067,595.91, as compared to \$1,203,751.41 collected in 2013. The amount collected would not necessarily be from those fines imposed in 2014, since most fines are contested by facilities and go through a hearing process before collection.

Article IV, Part 1, Specialized Mental Health Rehabilitation Act of 2013 authorizes IDPH to impose a fine or penalty on facilities that violate the act, up to and including license revocation. The act lists six levels of compliance 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 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>Severity</u>	<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 (IJ) deficiencies represent the most serious problems that can occur in long-term care facilities. These deficiencies often represent non-compliance that has the potential or high likelihood of serious injury or death to residents. IDPH's long-term care survey program has been recognized as a national leader in investigating and identifying non-compliance that places residents in immediate jeopardy.

Federal Certification Actions

The Nursing Home Care Act allows IDPH to use federal certification deficiencies in lieu of licensure violations. Licensure violations and enforcement actions against Medicare and/or Medicaid-certified facilities are pursued 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 (CMP's) for calendar year 1/1/14 – 12/31/14

- Medicare* and Medicare*/Medicaid Facilities (dually certified): \$1,033,813.84
- Medicaid Only Facilities: \$37,570.00
- Total CMPs imposed: \$1,071,383.84

* Medicare portion of CMP's assessed against certified facilities is retained by federal CMS. The state receives a portion of CMP's from Medicare/Medicaid facilities (dually certified) based on the number of residents whose care is paid for by Medicaid.

Monitors and Receivership [Part 5. (210 ILCS 45/3-518) Sec. 3-518. Fines.]

Beginning in 2014, and each year thereafter, IDPH shall submit to the General Assembly, an accounting of all federal and State fines received by IDPH in the preceding *fiscal year* by the fund in which they have been deposited. For each fund, the report shall show the source of all moneys deposited into each fund and the purpose and amount of all expenditures from each fund. (Source: P.A. 98-85, eff. 7-15-13.)

FY13 Fines Received (7/1/12 – 6/30/13):

- Long-Term Care Monitor/Receivership: \$1,179,805 (Fund 285)
- Federal Medicaid Only Fines Received: \$161,237 (Fund 063/371)
- Federal Medicaid/Medicare Fines Received: \$1,264,510 (Fund 063/371)

FY13 Expenditures (7/1/12 – 6/30/13):

- Civil Monetary Penalties: \$452,090 (Monitoring of problem nursing homes)
- Long-Term Care Monitor/Receivership: \$2,636,684 (Public Health staff salaries, fringe benefits and travel)
- Equity and LTC Quality Fund: \$0 (371)

FY14 Fines Received (7/1/13 – 6/30/14):

- Long-Term Care Monitor/Receivership: \$905,538 (Fund 285)
- Federal Medicaid Only Fines Received: \$256,895 (Fund 063/371)
- Federal Medicaid/Medicare Fines Received: \$1,329,866 (Fund 063/371)

FY14 Expenditures (7/1/13 – 6/30/14):

- Civil Monetary Penalties: \$337,778 (Monitoring of problem nursing homes)
- Long-Term Care Monitor/Receivership: \$13,796,844 (Public Health staff salaries, fringe benefits and travel)
- Equity and LTC Quality Fund: \$0 (371)

The amounts that are shown for Fund 063 and 371 are split 50/50 between the funds.

Division of Assisted Living (AL)

The Division of Assisted Living oversees 357 licensed establishments regulated by the Assisted Living and Shared Housing Establishment Code (77 Illinois Administrative Code. 295). AL 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. Personal, supportive and intermittent health-related services are available 24-hours per day to meet the scheduled and unscheduled needs of all residents. AL 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 pay privately through an establishment contract. Renewal applications and licensure fees are required yearly.

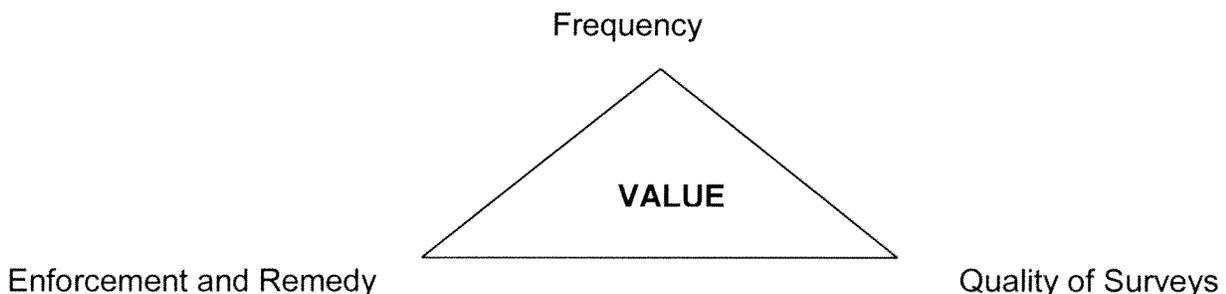
PART II PERFORMANCE OF INSPECTIONS, SURVEYS AND EVALUATION DUTIES UNDER THE ACT

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 (SPSS)

In 2001, CMS established a set of standards to determine whether the State Survey Agencies (SSAs) were meeting the requirements for the survey and certification program and to identify areas for improvement in management. In 2006, the State Performance Standards System (SPSS), as illustrated below, was redesigned in order to emphasize that the value of the survey program stems not only from completing surveys timely, but also from the quality of the surveys themselves, the proper identification of deficiencies, and the enforcement and remedy of identified problems in Medicare/Medicaid – certified providers/suppliers, preferably through systemic change.



The SPSS is intended to evaluate whether the SSAs are meeting selected key areas of the State survey and certification program. This evaluation does not restrict the CMS Regional Offices (ROs) from performing other oversight activities, to assure that the SSAs are meeting the terms of the 1864 Agreement. Furthermore, the SPSS neither creates new policy for the SSAs, nor does it nullify Federal law, regulations, the State Operations Manual, or formal policy provided by CMS.

The performance review involves the measurement of the following:

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 and 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 state agency conducts recertifications for non-deemed Home Health Agencies, ICF/IIDs 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 percent 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/IIDs and Non-deemed HHA's and Hospitals.

If the score for each requirement for nursing homes and non-nursing homes is greater than or equal to 85 percent, 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 percent 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 percent Agreement Rate is 90 percent 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 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**
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 and non-deemed and deemed hospitals and CAHs, excluding Emergency Medical Treatment and Active Labor Act (EMTALAs). Includes timeliness of investigations for 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**

Complaints and incidents for EMTALA investigations are conducted according to CMS policy. Total score on all requirements must be 90 percent 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 percent, 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 percent, 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 of mandatory denial of payment for new admissions in a nursing home. This excludes cases involving Medicaid-only nursing homes. If the resulting percentage is greater than or equal to 80 percent, 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 percent, 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

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

Within the Federal fiscal year, the State agency must conduct two standard surveys for each Special Focus facility. If the state survey agency has conducted the required number of standard surveys for SFFs, this measure is scored as “Met.”

Revised total SFF Slots: Effective April 2014, the number of designated slots and candidates were adjusted so states can resume selecting and replacing nursing homes for SFF designation. As outlined by CMS, regions and states will continue with the Programmatic and Operational Adjustment by conducting the 18 month “last chance” onsite survey and reviewing the progress of all facilities that have been on the SFF list for more than 12 months.

Implementation of Federal Certification Enforcement Regulations

CMS regulations impose intermediate sanctions for noncompliance with federal certification requirements. Before these regulations were adopted in 1995, decertification was the only enforcement remedy option, and it 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, 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

IDPH continues to work with Telligen, the Medicare Quality Improvement Organization (QIO) for Illinois, under contract with CMS. Telligen is committed to improving the quality of health care for consumers and providers by working with nursing homes.

The QIO supports the Advancing Excellence in America's Nursing Homes and serves as convener of Local Area Networks of Excellence (LANE). LANE is the central organization within a state to support participating nursing homes in achieving clinical and organizational goals. LANE is comprised of a wide spectrum of long-term care stakeholders, including representatives from the nursing home associations, IDPH (state survey agency), ombudsman office, the QIO and consumer advocacy. This collaborative effort assists nursing homes in their Quality Assurance Performance improvement (QAPI) initiatives.

Nine goals support long-term care facilities' quality improvement projects.

Organizational goals include:

- Consistent assignment
 - helps to strengthen relationships between caregivers and both residents and their family members
- Reduce hospitalizations
 - frequently nursing home residents are transferred to acute care settings upon a change in their condition
- Promote person centered care
 - resident choices in their daily lives; promotes purpose
- Achieve staff stability
 - residents like having caregivers they know

Clinical Outcome Goals:

- Infections
 - strategies to reduce spread of infections among residents
- Medications
 - appropriate use with a focus on antipsychotic medications
- Mobility
 - part of daily care and helps to maintain physical and psychological well being

- Pain
 - addresses issues related to pain and providing appropriate and adequate pain management
- Pressure ulcers
 - approaches to addressing and assessing a resident's skin risk to reduce incidence and severity of pressure ulcers

One Quality Improvement project which continued in 2014 was the Critical Access Nursing Home Project. This project also aligns with the Quality Assurance Performance Improvement (QAPI) initiative. Participants learn to construct a performance improvement plan. This collaborative learning purpose is to share best practices among facilities and help facilities that are struggling with staff retention, absenteeism and primary assignments. Facilities are selected based on their Five Star Rating and survey scores listed on the Nursing Home Compare website. Six (6) nursing homes are participating in the project.

Telephone meetings are conducted monthly with the LANE members. Advancing Excellence data is reviewed, and promotional updates and enrollment information are shared. Plans are discussed for training needs and working with the provider associations to ensure nursing homes have the information available.

IDPH serves as co-team lead on the Illinois partnership to Improve Dementia Care Coalition (The Coalition). The Coalition recognizes that the reduction of unnecessary anti-psychotic medication is critical to reducing the risks for adverse events and improving the quality of 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 IDPH, 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 is about rethinking approaches 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. Coalition activities include webinars that address the use of antipsychotics and benzodiazepines with the dementia population and minimizing the use of Antipsychotic Medication. IDPH provided information and opportunity for focused training for surveyors related to training on antipsychotics and the person centered care process for those with dementia. This included a review of the "Hand in Hand" training video created by CMS. It involves a continual process of listening, testing new approaches, and changing routines and

organizational approaches in an effort to individualize and de-institutionalize the care environment.

In June 2014, IDHS and IDPH announced the Prescription Monitoring Program (PMP) Long-Term Care (LTC) initiative. This collaborative effort came about from concerns regarding a high use of behavioral health medications within the nursing home population. IDHS and IDPH entered into an interagency agreement to reduce the use of chemical restraints and improve the quality of care. The goal of the interagency agreement is to work with the long-term care industry to develop reports that will assist medical directors, nursing directors, consultant pharmacists and facility directors in evaluating the care they are providing to their patients.

IDPH'S Office of Health Care Regulation's Phase I process has been completed and included training for Regional supervisors on how to access PMP data and maintain confidentiality of the data. The supervisors examined a running report of facility information specific to their region.

Phase II in process, training the survey team members on how to access information and utilize the information as part of the offsite survey prep and survey process.

Phase III includes IDPH working with its IT department with plans to include monthly data and graphs on the IDPH website. This would allow facilities to view how they compare regionally and a portal access for each facility would allow them to view their specific data. Facilities could then review how they are doing relative to their regional summary and statewide summary. This would allow the facility and the survey office to graph the overall trends within facility, region and state. The facility would have access to the same information the survey agency would utilize in its offsite survey preparation.

CMS developed a Special Focus Facility program in 1998 to improve nursing home quality and safety. 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.

In 2014, CMS required Illinois to select four (4) Medicare and/or Medicaid certified nursing homes for designation of Special Focus Facilities (SFFs). 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.

The four (4) Special Focus Facilities were selected in July of 2014. IDPH is surveying and reviewing the compliance progress of these facilities. CMS is expecting that States will continue the process to speed up final resolution of the issues with these nursing homes where serious problems have persisted for a considerable time. Resolution of the facility's Special Focus Status is expected within eighteen months of selection.

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)

Administrative 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

"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]

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 findings contained in report to determine whether the 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) The director or his designee shall consider comments and documentation provided by the facility within 10 days of receipt of the report.
- c) In determining whether findings warrant issuance of a notice of violation, the director or his designee shall base the determination on the following:
 - 1) The severity of the finding. The director or his designee will consider whether the finding constitutes a 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 direct harm to the resident(s).
 - 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 similar finding relating to the same condition or occurrence was included in previous reports and the facility allowed the condition or occurrence to continue or to recur.
- d) If the director or his designee determines the report's findings constitute a violation(s), which do not directly threaten the health, safety, or welfare of a resident(s), *IDPH 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 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)

Appendix E

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, CASPER 3 and 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 (October 1 – March 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 residents 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 medication 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 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.

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, 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 the applicant or employee does not pose a threat to the health or safety of residents, which may include, but 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 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 1/1/1996 and prior to 1/1/1998. This subsection applies only to persons employed prior to 1/1/1998. 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).

APPENDIX G

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 Facility Resident	
[720 ILCS 5/12-21]	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	1/1/04

	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] [720 ILCS 550/5]	Fraudulent Use of Electronic Transmission Manufacture, Delivery or Possession With Intent to Deliver or Manufacture Cannabis	1/1/04
[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] [720 ILCS 570/401]	Calculated Criminal Cannabis Conspiracy 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] [720 ILCS 570/404]	Controlled Substance Trafficking Distribution, Advertisement or Possession with Intent to Manufacture or Distribute a Look-Alike Substance	
[720 ILCS 570/405] [720 ILCS 570/405.1] [720 ILCS 570/407]	Calculated Criminal Drug Conspiracy Criminal Drug Conspiracy 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

APPENDIX H

Long-Term Care Federal Training
January 1, 2014 through December 31, 2014

TRAINING	LOCATION	DATE (S)	# OF ATTENDEES
ASPEN Basic Training	Denver, CO	8/4/14	2
Basic LSC Training	Online	9/19/14	1
Basic LTC Surveyor Training	Texas	7/14	16
	Baltimore MD	11/17/14	13
	Baltimore MD	12/1/14	19
RAI Coordinators Conference	Baltimore, MD	5/27/14	2
State Training Coordinators Meeting	Baltimore, MD	7/78/14	2
SETI conference	Annapolis, MD	4/14/14	2
Lesbian, Gay, Bisexual and Transgender	Online	11/13/14	11

APPENDIX I

Further information is available from the Illinois Department of Public Health	
Division of LTC Field Operations 525 W. Jefferson St., 5 th floor Springfield, IL 62761 217-782-2913 217-785-2629	Violations, survey questions, general long-term care facility issues
Division of LTC Quality Assurance 525 W. Jefferson St., 5 th floor Springfield, IL 62761 217-782-5180	Licensure applications, status for licensure, filing complaint, hearing request, rule interpretation
Division of Assisted Living 525 W. Jefferson St., 5 th floor Springfield, IL 62761 217-782-2448 217-785-9174	Rule interpretation, establishment compliance history, general licensure questions
Division of Health Care Facilities & Programs 525 W. Jefferson St., 4 th floor Springfield, IL 62761 217-782-7412	Non-long term care issues, Home Health, hospitals, dialysis centers, ambulatory surgery centers, CLIA, Home Services, Home Nursing Services, Home Placement, Hospice, rural health centers, healthcare credentialing; Sexual Assault Survivors Emergency Treatment Act
Central Complaint Registry 525 W. Jefferson St., Ground floor Springfield, IL 62761 800-252-4343	Complaints, reporting resident abuse, neglect
Education and Training Section 525 W. Jefferson St., 4 th floor Springfield, IL 62761 217-785-5132 or 217-785-5569	Nurse Aide training, Resident Attendant training, MDS, approval for instructors of Nurse Aide Training programs
Division of Administrative Rules & Procedures Health Care Worker Registry 525 W. Jefferson St., 4 th floor Springfield, IL 62761 Toll free number 844-789-3676 https://hcwrpub.dph.illinois.gov/Search.aspx	Information on accessing rules or recommendations for rule changes; Health Care Worker Registry Background Check Act, CNA waivers
Division of Life Safety & Construction 525 W. Jefferson St., 4 th floor Springfield, IL 62761 217-782-7412	Physical Plant plan reviews, new construction, building modification, Life Safety Code interpretation