SUPPORTIVE LIVING PROGRAM
CERTIFICATION REVIEW
DEMENTIA CARE SETTING PROGRAM

TABLE OF CONTENTS OF
SUPPORTIVE LIVING FACILITY
CERTIFICATION AND REVIEW PROCESSES
DEMENTIA CARE SETTING

I. ENTRANCE CONFERENCE

ILLINOIS DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PRGRAM CERTIFICATION/REVIEW TOOL
DEMENTIA CARE SETTING

Provider_____ ID #_____

Address_____ Freestanding ( )

City_____ Zip Code_____

Phone #_____ Fax #_____

Is the Dementia Care Setting (DCS) connected to an operational SLP building? Yes ( ) No ( )

DCS Occupancy Information

# of Single Occupancy Apts.		Current Medicaid Census	
# of Double Occupancy Apts.		Current Private Pay Census	
Total # of Apts.		**Total** Current Census	
Maximum Potential Occupancy			

Is the private pay rate higher then the Medicaid rate? Yes ( ) No ( )

If yes, is SLP Medicaid occupancy at 25% or more, or is the SLP provider reserving at least 25% of its apartments for Medicaid? 146.215(d) Yes ( ) No ( )

Type of Certification Review (complete only one)	**Entrance Date**	**Exit Date**
Final		
Annual		

REVIEW FINDINGS: YES ( ) NO ( )

Ombudsman was notified on _____ about the date of the review.
Ombudsman participated in review: Yes ( ) No ( )

Manager/Designee Signature/Date _____

Review Team's Signature/Date _____

_____

Regional Supervisor Signature/Date _____

Area Manager Signature/Date _____

Bureau Chief Signature/Date _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
SUPPORTIVE LIVING PROGRAM DCS CERTIFICATION/REVIEW TOOL

1. **Required Certifications/License**
Does the SLP provider have documentation to verify compliance with the following during the past year?

Certification/License	Yes	No	N/A	Comment
Fire 146.210(a)(1)				
Local Health and Food Preparation 146.215(c)(5)				
Elevator (freestanding 2 or more levels = 1 for 75 or < units/2 for 76 or > units				
Other (list)				

General Policies 146.230 and 146.310	Yes No Comments
2. Is there a policy addressing potential resident inquiry and application for admission? 146.215(c)(4)(S)	N/A FY20. Reviewed by central office
3. Is there a Non-Discrimination policy? 146.215(c)(4)(T)	N/A FY20. Reviewed by central office
4. Is there a policy addressing resident rights? 146.215(c)(4)(H)	[ ] [ ] [ ]
5. Is there a policy(ies) that supports residents' choice of services that meet their needs and preferences? **NOTE:** Examples include residents rights, involvement in assessment and service planning.	[ ] [ ] [ ]
6. Does the resident discharge policy include relocation assistance? 146.215(c)(4)(I) and 146.255(i)	[ ] [ ] [ ]
7. Are activities for residents of the DCS carried out no less than 3 times per day? 146.640(c)(2)	[ ] [ ] [ ]
4. If the SLP provider manages residents' funds, is there a surety bond equal to or more than the amount of funds managed? 146.310(b) **NOTE:** Mark **N/A** if SLP provider is not providing this service. **[ ] NOT APPLICABLE**	[ ] [ ] [ ]

General Policies 146.230 and 146.310	Yes	No	Comments
5. If the SLP provider manages resident funds, are they kept in an account that is separate from provider funds? **NOTE:** resident funds may ONLY be maintained in an account with other residents' funds. This applies to managed resident funds and direct-deposit of resident income. 146.310(a)(7) and 146.310(c) **NOTE:** Mark **N/A** if SLP provider is not providing this service. [ ] NOT APPLICABLE	[ ]	[ ]	[ ]
6. Are any residents identified sex offenders? 146.630(b) **NOTE: If yes, notify central office ASAP.**	[ ]	[ ]	[ ]

Comments: _____

_____

_____

Community Setting Validation	Yes	No	Comments
1. Is the SLP building connected or adjacent to a nursing home, hospital, clinic, or other institution? OR part of a multi-setting campus? OR located on the grounds of, or immediately adjacent to a public institution?	[ ]	[ ]	[ ]

If "Yes", check the following that apply:

☐ SLP building has a separate entrance

☐ SLP building has a separate outdoor signage

☐ SLP building has a clearly defined physical separation, such as a wall, door or parking lot

☐ SLP building has separate licensure

2. Does the SLP provider use delayed egress devices or have secured perimeters only in accordance with individually approved plans of care? 146.250(e)(9) and 146.610(a)(3)	[ ]	[ ]	[ ]

Comments: _____

_____

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_____

Double Occupancy	**Yes**	**No**	**Comments**
1. Does the building have apartments certified for double occupancy? If no, mark "N/A" and skip the rest of this section.	[ ]	[ ]	[ ]
☐ **N/A, all apartments are single occupancy.**			
2. Do residents have a choice/option for a private apartment?	[ ]	[ ]	[ ]
3. Do residents have a choice regarding roommates or a private apartment? **NOTE:** Current vacancies and affordability should not be taken into consideration.	[ ]	[ ]	[ ]
4. Is there a process for changing roommates or acquiring other accommodations if desired by the resident? 146.250(e)(13)	[ ]	[ ]	[ ]

Comments: _____

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II. TOUR

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
GENERAL OBSERVATIONS OF THE DCS

Common Areas 146.210, 146.230, 146.610, 146.640, 146.700	**Yes**	**No**	**Comments**
1. Is the dementia care setting located on the 1st or 2nd story of the building? 146.610(a)(2)	[ ]	[ ]	[ ]
2. Does each dementia care setting have alarmed doors exiting the unit with delays requiring a resident to hold the push bar for several seconds before it opens? 146.610(a)(3)	[ ]	[ ]	[ ]
3. Is there at least one common area for socialization for every ten residents? (Dining room can be one.) 146.610 (d)(1)	[ ]	[ ]	[ ]
4. Are areas separate from those used by the conventional population of the operational SLP building available? 146.610(d)(3) **NOTE:** Mark N/A if dementia unit is freestanding [ ] NOT APPLICABLE	[ ]	[ ]	[ ]
5. Are private or public outdoor recreation areas available to residents in the dementia care unit that are secure? 146.610 (d)(2)	[ ]	[ ]	[ ]
6. Are areas accessible for wheelchair use and furnished to meet residents' needs? 146.210(j)(2)	[ ]	[ ]	[ ]
7. Are all common areas physically accessible to residents? 146.210(j)(2)	[ ]	[ ]	[ ]
8. Are residents observed in common areas, both inside and outside of the building (as weather permits)?	[ ]	[ ]	[ ]
9. Is each common area equipped with a working emergency call system? 146.230(m)(2) **NOTE:** ALL common area call buttons must be checked.	[ ]	[ ]	[ ]
10. Emergency call system provides direct notification to staff OR is manned by staff 24 hours/day for transmission to available staff for assistance? 146.230(m)(3)	[ ]	[ ]	[ ]
11. Is there a handicapped accessible phone that allows residents to have private conversations? 146.210(l) **NOTE:** Does not have to be located in a common area, but must be made available to residents at their request.	[ ]	[ ]	[ ]
12. Is there a refrigerator for snacks and ice ? 146.610(c)(2)	[ ]	[ ]	[ ]

General Observations

Common Areas 146.210, 146.230, 146.610, 146.640, 146.700

13. Is there accessible drinking water in at least one common area? 146.210(r)(4) [ ] [ ] [ ]

14. Are there individual locked mailboxes inside the building? 146.210(d)(4) and 146.210(e)(5)
NOTE: For SLP providers approved after 1/1/05 [ ] [ ] [ ]

15. Does the SLP provider supply mail delivery by staff to the dementia unit or arrange for a specific time for residents to pick up their mail with staff supervision? 146.640(d) [ ] [ ] [ ]

16. Is there night lighting for corridors? 146.210(c) [ ] [ ] [ ]

17. Is at least one Department Complaint Poster with the hotline complaint number displayed on the dementia care unit in a location that is accessible to all residents? 146.700(a) [ ] [ ] [ ]

18. Is at least one Long Term Care Ombudsman Program poster displayed on the dementia care unit in a location accessible to all residents? 146.700(b) [ ] [ ] [ ]

Comments: _____

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Baths/Restrooms 146.210 and 146.230	**Yes**	**No**	**Comments**
1. Common Bath – If applicable, does the common bath have a toilet with grab bars sufficient to meet the needs of the residents, bathtub and roll-in shower which is wheelchair accessible, non-skid surface, transfer seat with grab bars, and lockable door, that is kept clean and orderly, and has a working emergency call system? 146.210(j)(5) and 146.230(m)(2) **NOTE:** Common bathing rooms are optional in SLP buildings. [ ] NOT APPLICABLE	[ ]	[ ]	[ ]
2. Public Restrooms – Is there at least one public restroom that is handicapped accessible, clean, has soap, toilet tissue, waste receptacles, and non-reusable hand drying means and that has a working emergency call system? **NOTE:** Mark "Yes" if part of an operational conventional SLP building and the public restroom is located in the conventional area.146.210(k)(1-3) and 146.230(m)(2)	[ ]	[ ]	[ ]

General Observations

Baths/Restrooms 146.210 and 146.230	**Yes**	**No**	**Comments**

Comments: _____

_____

_____

_____

Kitchen 146.210 and 146.230	**Yes**	**No**	**Comments**
1. Is food prepared daily onsite? 146.210(n)(2)	[ ]	[ ]	[ ]
2. The dementia care setting is contained within an operational conventional SLP that has a centralized kitchen separate from the dementia care setting that provides meals.	[ ]	[ ]	[ ]

NOTE: If question #2 is "Yes", mark N/A below and skip questions 3-9
[ ] NOT APPLICABLE.

3. Is the kitchen locked when dietary staff are not present in order to prevent dementia resident access?	[ ]	[ ]	[ ]
4. Is there storage space for both non-perishable and perishable foods? 146.210(n)(3)(A)	[ ]	[ ]	[ ]
5. Do food preparation areas have cleanable surfaces? 146.210(n)(3)(B)	[ ]	[ ]	[ ]
6. Is there capability for food distribution at the appropriate temperatures? 146.210(n)(3)(C)	[ ]	[ ]	[ ]
7. Is kitchenware washing space available to meet food service needs? 146.210(n)(3)(D)	[ ]	[ ]	[ ]
8. Are hand washing areas separate from food washing areas? 146.210(n)(3)(E)	[ ]	[ ]	[ ]

NOTE: Responses for 9-11 should be based on kitchen and dining room observations, ie; is food in refrigerator covered, labeled and dated? Are potentially hazardous foods (ex. raw meat) thawed away from prepared foods? Are food supplies stored up off of the floor? Are there any cross contamination concerns, such as using the same cutting board for uncooked meat and vegetables. Does staff wash their hands?

9. Is food stored, prepared, distributed, and served in a manner to prevent contamination and spoilage and at safe and palatable temperatures? 146.230(e)(7)	[ ]	[ ]	[ ]
10. Are kitchen and dining areas neat and clean with adequate supply of eating, drinking and cooking utensils? 146.230(e)(8)	[ ]	[ ]	[ ]

General Observations

Kitchen 146.210 and 146.230	**Yes**	**No**	**Comments**
11. Are food staples adequate and meet the requirements of the menu? (staples for a one week period and perishables for a 2 day period) 146.230(e)(5)	[ ]	[ ]	[ ]
12. Are there areas to store and clean garbage cans and carts? 146.210(n)(3)(F)	[ ]	[ ]	[ ]

Comments: _____

Waste Removal 146.210	**Yes**	**No**	**Comments**
1. Are there lids on trash cans and dumpsters? 146.210(s)(3)	[ ]	[ ]	[ ]
2. Are garbage removal plans being followed? 146.210(s)(5)	[ ]	[ ]	[ ]
3. Are sharps placed in containers that are rigid and leak-resistant and disposed of properly? 146.210 (s)(6)(A-C) **NOTE:** Mark N/A if no sharps in facility. [ ] NOT APPLICABLE	[ ]	[ ]	[ ]

Comments: _____

Meals/Dining 146.210 and 146.230	**Yes**	**No**	**Comments**
1. Is the dining area of the dementia care setting separate from the dining area of the conventional SLP building? 146.610(c) **NOTE:** Mark N/A if a freestanding SLP dementia care setting. [ ] NOT APPLICABLE	[ ]	[ ]	[ ]
2. Is the dining area handicapped accessible? 146.210(o)(1)	[ ]	[ ]	[ ]
3. Do meal schedules allow for some flexibility in eating times? **NOTE:** Examples include the ability to change seating times, and staggered arrival. 146.250(e)(10)	[ ]	[ ]	[ ]

General Observations

Meals/Dining 146.210 and 146.230	**Yes**	**No**	**Comments**
4. Does the SLP provider offer three meals or two meals plus a breakfast bar per day? 146.230(e)(l)	[ ]	[ ]	[ ]
5. Are choices for therapeutic diets provided as needed? 146.230(e)(1) **NOTE:** Mark N/A if no residents have MD ordered therapeutic diets. [ ] NOT APPLICABLE	[ ]	[ ]	[ ]
6. Are beverages and snack foods available at no additional cost to the residents? 146.230(e)(2)	[ ]	[ ]	[ ]
7. Are all residents offered the same menu except for therapeutic diets? 146.230(e)(3)	[ ]	[ ]	[ ]

Mark question8-10 N/A if the dementia care setting is contained within an operational conventional SLP building that has a centralized kitchen to provide meals.

8. Are served menus kept on file for at least six months? 146.230(e)(4)	[ ]	[ ]	[ ]
9. Are food purchase records kept on file for at least six months? 146.230(e)(6)	[ ]	[ ]	[ ]
10. Are residents provided with menus, menus are not repeated in the same week, and residents have input into selection and preparation of food? 146.230(e)(9)	[ ]	[ ]	[ ]

Comments: _____

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Laundry/Laundry Rooms 146.210 and 146.230	**Yes**	**No**	**Comments**
For resident use:			
1. Is there at least one washer and dryer, separate from the staff laundry room, and detergent and fabric softener provided for resident use at no cost? 146.210(p)(1)(A)	[ ]	[ ]	[ ]
2. Does the resident laundry room have a sink for hand washing? 146.210(p)(1)(B)	[ ]	[ ]	[ ]
3. Does the resident laundry have a working emergency call system? 146.210(p)(1)(C)	[ ]	[ ]	[ ]

Laundry/Laundry Rooms 146.210 and 230 | **Yes** | **No** | **Comments**

4. Is the laundry room locked so that dementia residents do not have access to the room without staff supervision? **NOTE:** Mark N/A if laundry room is not located in the dementia care setting.
   [ ] NOT APPLICABLE [ ] [ ] [ ]

For SLP provider laundry rooms where laundry is done onsite:

5. Is the SLP provider laundry room separate from the resident laundry room? 146.210(p)(2)(A) [ ] [ ] [ ]

Mark questions 6-9 N/A if the dementia care setting is contained within an operational conventional SLP building that has a staff laundry room used for dementia care setting residents.

6. If laundry is done onsite, does the SLP provider laundry room have provisions for processing laundry soiled with body secretions separately? 146.210(p)(2)(B) [ ] [ ] [ ]
7. Is there a hand washing sink separate from a sink used for laundry rinsing in the staff laundry room? 146.210(p)(2)(C) [ ] [ ] [ ]
8. Are laundry services, excluding dry cleaning, provided at least weekly if requested? 146.230(f)(1-4) [ ] [ ] [ ]

Comments: _____

Housekeeping Maintenance 146.210 and 146.230 | **Yes** | **No** | **Comments**

1. Is there at least one lockable janitor's closet with hot and cold running water? **NOTE:** Mark N/A for dementia care settings without a janitor's closet that are part of an operational conventional SLP building. 146.210(q) [ ] [ ] [ ]
   [ ] NOT APPLICABLE
2. Are the dementia care setting's building and grounds clean, free of hazard and in good working order? 146.230(h)(2) [ ] [ ] [ ]

General Observations

Housekeeping Maintenance 146.210 and 146.230 **Yes No Comments**

Comments:

Water Services 146.210 **Yes No Comments**

1. Does the dementia care setting have hot and cold running water with adequate water pressure? 146.210(r)(3) page 17 [ ] [ ] [ ]

2. Does the SLP provider have a policy in place for checking water temperatures and is the policy followed? 146.210(r)(5)(A-C) [ ] [ ] [ ]

NOTE: Hot water temperatures must be between 95-120 degrees in resident apartments and any other areas of the building that are accessible to residents. Temperature checks must be completed at least monthly and include a random sample of resident apartments. The SLP provider shall document steps taken to correct temperatures not found to be within the required range. If no, explain in comments below. If over 120 degrees, notify supervisor IMMEDIATELY.

Comments:

General Observations

Activities 146.230 and 640	**Yes**	**No**	**Comments**
1. Does the SLP provider offer residents the opportunity to participate in on-site and off-site activities at least three times daily? 146.640(b)(2) NOTE: Please review a random 3 months of activity calendars since the last review.	[ ]	[ ]	[ ]
2. Does the SLP provider offer residents health promotion and exercise programs at least three times per week? 146.230 (l)(2) NOTE: Please review a random 3 months of activity calendars since the last review	[ ]	[ ]	[ ]
3. Does the SLP provider make available information about community resources and make community integration part of recreational, socialization and vocational activities? 146.230(i)(4) **NOTE:** Review activity calendars, newsletters or other communication.	[ ]	[ ]	[ ]
4. Does the SLP provider allow both on-site and off-site services? Are residents given the opportunity to interact with the larger community without SLP staff? 146.250(e)(10) **NOTE:** Examples include physician appointments, activities and family visits not arranged by the SLP provider.	[ ]	[ ]	[ ]
4. Does the SLP provider offer daily activities that are based on individuals' needs and preferences? **NOTE:** Interview staff to learn how activities are identified and how residents are involved. Review applicable policies.	[ ]	[ ]	[ ]

Comments: _____

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IV. QUALITY ASSURANCE PLAN

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
QUALITY ASSURANCE PLAN

Review the facility's Quality Assurance Plan.

146.270(a) – (h)	Yes	No	Comments
Does the quality assurance plan include the following?			
a) Results and responses to the resident satisfaction survey?	[ ]	[ ]	[ ]
b) Evaluation of care and services?	[ ]	[ ]	[ ]
c) Tracking of improvements based on care outcomes?	[ ]	[ ]	[ ]
d) A system of quality indicators measuring:			
1) Quality of services provided?	[ ]	[ ]	[ ]
2) Resident rating of services, including food service?	[ ]	[ ]	[ ]
3) Cleanliness and furnishings of the common areas?	[ ]	[ ]	[ ]
4) Service availability?	[ ]	[ ]	[ ]
5) Adequacy of service provision and coordination?	[ ]	[ ]	[ ]
6) Provision of a safe environment?	[ ]	[ ]	[ ]
7) Socialization activities?	[ ]	[ ]	[ ]
8) Resident autonomy which includes:			
A) Protection of resident rights?	[ ]	[ ]	[ ]
B) Provision of appropriate oversight for vulnerable residents?	[ ]	[ ]	[ ]
C) Resident exercise of personal autonomy and choice?	[ ]	[ ]	[ ]
e) Procedures for preventing, detecting, and reporting resident neglect and abuse?	[ ]	[ ]	[ ]
f) Development of objectives for improving service quality, including the service quality indicators and measures to determine when objectives are met?	[ ]	[ ]	[ ]

146.270(a) – (h)	**Yes**	**No**	**Comments**
g) Evidence of ongoing quality improvements as a result of the quality review data?	[ ]	[ ]	[ ]
h) A committee to complete reviews for both health care and social service providers or to serve in a contractual relationship with the SLP provider which shall include:			
1) A regular schedule for review?	[ ]	[ ]	[ ]
2) A system to evaluate the care given by specific providers following the service plan developed by the SLP provider licensed nursing staff and approved by the resident?	[ ]	[ ]	[ ]

Comments:

V. RESIDENT REVIEW

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
SLP RESIDENT REVIEW DCS

LAG ADMISSION REVIEW

Provider Name: _____

Resident Name: _____ **Apartment Number:** _____

RIN: _____ **Admit Date to DCS:** _____ **DOB:** _____

Date of Most Recent DON or Conversion Screen: _____ **DON Score:** _____

Previous Residence: ☐ Private home ☐ Assisted Living ☐ SLP provider--adjoining

☐ SLP--other than adjoining ☐ Nursing Facility ☐ Senior Indep. Living Apt.
☐ Other _____

Lag Admission Instructions

TO BE COMPLETED FOR ALL RESIDENTS ON THE SAMPLE LIST unless an exception is approved by central office.

NOTE. For residents admitted directly from the DCS' adjoining operational conventional SLP building, answer questions 5-8 and mark questions 1-4 N/A.

Hospitalized residents—Answer all questions.

Discharged residents—Answer questions 1, 2 and 8. Mark questions 3-7 N/A.

Medicaid conversion and not a new admission—Note the date of the conversion screening and the score. Answer questions 1, 2 & 8. Mark questions 3-7 N/A.

Resident Participation Requirements 146.220, 146.240	**Yes**	**No**	**N/A**	**Comments**
1. Was the DON completed **prior to admission?** **OR** was it an allowable post-screen **OR** did the resident transfer directly from another SLP provider or a NF **OR** did the resident receive a Medicaid conversion screening? 146.220(a)(2) **NOTE:** Mark "Yes" if **ANY** of the above applies.	[ ]	[ ]	[ ]	[ ]

2. Was the most recent HFS 2536 Interagency Screening Results form completed as required?
   ☐ N/A Resident was admitted directly from a NF or another SLP provider and the 2536 form was not available OR resident was admitted directly from the adjoining conventional SLP building.

OR Check all that apply:
☐ Resident name ☐ Date of screening
☐ Screening score noted (> or < 29 is acceptable) ☐ Screener's signature & date
If any boxes above are NOT checked, fax or scan to central office and include a copy with this record review.
NOTE: This question should not to be used for determining findings of non-compliance.

Lag Resident Review (2 of 2) Resident Name: _____

Resident Participation Requirements 146.220, 146.240	**Yes**	**No**	**N/A**	**Comments**
3. Was the resident evaluated by a DHS DDD ISC or DHS DMH PAS screening agent and determined to be able to have their needs met in the SLP setting? 146.220(a)(3)	[ ]	[ ]	[ ]	[ ]
4. Did the resident have his/her name checked against the three identified sex offender websites (Illinois State Police, Department of Corrections and U.S. Department of Justice Dru Sjodin National Offender Public Website) prior to admission? 146.220(a)(4) **NOTE:** Date of admit acceptable. ***NOTE:** Registered sex offenders CANNOT be admitted to a dementia care setting.	*[ ]	[ ]	[ ]	[ ]
5. Record contains a physician diagnosis of Alzheimer's disease, related form of dementia or conditions of internal pathological changes to the brain? 146.630 (a) & 4/2/13 Informational Notice for dementia providers. NOTE: The type of documentation is not prescribed by the Department.	[ ]	[ ]		[ ]
6. Elopement Risk Assessment completed or co-signed by the RN prior to occupancy? Date: _____	[ ]	[ ]		[ ]
7. Elopement Risk Assessment determined the resident required alarmed/delayed exit doors as a safety intervention? **NOTE:** If "No", notify Regional Supervisor ASAP.	[ ]	[ ]		[ ]
8. Resident contract signed by the SLP provider and resident or their designated representative? 146.240 (a) NOTE: Date of signature does not apply to this question.	[ ]	[ ]		[ ]

Comments: _____

_____

_____

Reviewer Signature: _____

Date of Review: _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
SLP RESIDENT REVIEW DCS

Provider Name: _____

Resident Name: _____ **Apartment Number:** _____

RIN: _____ **Admit Date to DCS:** _____ **DOB:** _____
Payment Status: ☐ Private Pay ☐ Medicaid
Date of Most Recent DON or Conversion Screen: _____ **DON Score:** _____

NEW ADMISSION REVIEW ONLY

New Admission Instructions

TO BE COMPLETED FOR ALL RESIDENTS ON THE SAMPLE LIST unless an exception is approved by central office.
Hospitalized residents-- Answer all questions.
Discharged residents—Answer questions 1, 2, & 13. Mark the remaining questions N/A.
Medicaid Conversions— Note the date of the conversion screening and the score. Answer questions 1, 2, 13, 15-40 & Management of Funds. Mark remaining questions N/A.
NOTE. For residents admitted since the last review directly from the DCS' adjoining operational conventional SLP building, mark questions1-7 N/A and answer the remaining questions, included manag. of funds.

Previous Residence: ☐ Private home ☐ Assisted Living ☐ Nursing Facility
☐ SLP provider--adjoining ☐ SLP--other than adjoining ☐ Senior Indep. Living Apt.
☐ Other _____

Resident Participation Requirements 146.215, 220, 245, 630	**Yes**	**No**	**N/A**	**Comments**
1. Was the DON completed **prior to admission?** **OR** was it an allowable post-screen **OR** did the resident transfer directly from another SLP provider or a NF **OR** did the resident receive a Medicaid conversion screening? 146.220(a)(2) **NOTE:** Mark "Yes" if **ANY** of the above applies.	[ ]	[ ]	[ ]	[ ]

2. Was the most recent HFS 2536 Interagency Screening Results form completed as required?
   ☐ N/A Resident was admitted directly from a NF or another SLP provider and the 2536 form was not available OR resident was admitted directly from the adjoining conventional SLP provider.

OR Check all that apply:
☐ Resident name ☐ Date of screening
☐ Screening score noted (> or < 29 is acceptable) ☐ Screener's signature & date
If any boxes above are NOT checked, fax or scan to central office and include a copy with this record review.
NOTE: This question should not to be used for determining findings of non-compliance.

SLP Resident Review (2 of 7) Resident Name: _____

Resident Participation Require. 146.215, 220, 240, 245 & 630	**Yes**	**No**	**N/A**	**Comments**
3. Was the resident evaluated by a DHS DDD ISC or DHS DMH PAS screening agent and determined to be able to have their needs met in the SLP setting? 146.220(a)(3)	[ ]	[ ]	[ ]	[ ]
4. TB screening test performed or documentation provided in accordance with the Control of Tuberculosis Code and no active TB noted? 146.220(c) **NOTE:** Refer to TB Testing Resource Guide for testing requirements. If applicable: 1st Step Mantoux Date given: _____ Date read: _____ 2nd Step Mantoux Date given: _____ Date read: _____ **OR** Date blood drawn: _____ Result: _____	[ ]	[ ]	[ ]	[ ]
5. Checklist of Signs & Symptoms of TB Disease completed within 7 days after admission? 146.220(c) Date: _____	[ ]	[ ]	[ ]	[ ]
6. Resident/family/designated representative informed of Advanced Directives including, the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate? 146.215(o)	[ ]	[ ]	[ ]	[ ]
7. Had name checked against the three identified sex offender (Illinois State Police, Department of Corrections, and U.S. Department of Justice Dru Sjodin National Offender Public Website) prior to admission AND was **NOT** included on any registry? 146.630 (b) and 146.220(a)(4)	[ ]	[ ]	[ ]	[ ]
8. Record contains a physician diagnosis of Alzheimer's disease, related form of dementia or conditions of internal pathological changes to the brain? 146.630 (a) & 4/2/13 Informational Notice for dementia providers. NOTE: The type of documentation is not prescribed by the Department.	[ ]	[ ]	[ ]	[ ]
9. Standardized interview geared toward the resident's service needs at or before the time of occupancy? 146.245(a) Date: _____	[ ]	[ ]	[ ]	[ ]
10. Elopement Risk Assessment completed or co-signed by the RN prior to occupancy? Date: _____	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (3 of 7) Resident Name: _____

Resident Participation Require. 146.215, 220, 240, 245 & 630	**Yes**	**No**	**N/A**	**Comments**
11. Elopement Risk Assessment determined the resident required alarmed/delayed exit doors as a safety intervention? **NOTE:** If "No", notify Regional Supervisor ASAP.	[ ]	[ ]	[ ]	[ ]
12. Initial assessment and service plan completed by or co-signed by an LPN or RN within 24 hours after admission? 146.245(b) Date: _____	[ ]	[ ]	[ ]	[ ]
13. Resident contract signed by the SLP provider and resident or their designated representative? 146.240 (a)	[ ]	[ ]	[ ]	[ ]
14. Was the resident oriented to the emergency plans within ten days after admission? 146.295(e) **NOTE:** Orientation includes assisting the resident in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.	[ ]	[ ]		[ ]

NOTE: A Medicaid SLP resident cannot participate in another federal Home and Community Based Services Waiver program. 146.220(d)

Assessment/Support Plan/Quarterly Evaluation 146.245 & 670	**Yes**	**No**	**N/A**	**Comments**
15. Comprehensive assessment: ☐ Completed by or co-signed by an RN? ☐ Signed/co-signed by RN within **7-14 days after admission**? OR ☐ New assessment completed prior to admission if admitted directly from the adjoining operational SLP provider? **NOTE:** Does not apply to a freestanding DCS. 146.245(c) & 146.670(a) Date of comprehensive assessment: _____	[ ]	[ ]	[ ]	[ ]
16. Comprehensive assessment is thoroughly completed (no areas left blank)? 146.245(c)	[ ]	[ ]	[ ]	[ ]
17. Comprehensive assessment is accurate? 146.245(c) **NOTE:** Staff should compare the assessment with the ISP. If there is a conflict, review SLP provider documentation of services, interview staff and resident, etc. to determine if the assessment is correct. Changes in condition that are not significant and/or changes in residents' preferences do not require the assessment to be revised. In these instances, it is acceptable for the assessment not to match the ISP.	[ ]	[ ]	[ ]	[ ]

SLP New Resident Review (4 of 7) Resident Name: _____

Assessment/Support Plan/Quarterly Evaluation 146.245	**Yes**	**No**	**N/A**	**Comments**
18. SLUMS or MOCA completed within 7-14 days after admission? 146.670(b) Date of assessment: _____ Check One: ☐ SLUMS ☐ MOCA	[ ]	[ ]	[ ]	[ ]
19. Assessment of resident's safe use of sink and appliances within apartment completed at or prior to occupancy 146.610(b)(2) Date: _____	[ ]	[ ]		[ ]
20. Individual Support Plan (ISP) Development: ☐ Developed by or co-signed by an RN? ☐ Signed/co-signed by RN w/in 7 days of completing the comprehensive assessment? OR ☐ New ISP completed prior to admission if admitted directly from the adjoining operational SLP building? **NOTE:** Does not apply to a freestanding DCS. Date: _____ **NOTE:** The timeliness of the assessment is not relevant for this question.	[ ]	[ ]	[ ]	[ ]
21. ISP reviewed/signed by the resident or his/her designated representative and any others included by the resident? 146.245 (d)	[ ]	[ ]	[ ]	[ ]
22. Did the resident/designated representative initial the ISP to indicate he/she chose to receive services from the SLP provider?	[ ]	[ ]	[ ]	[ ]
23. If the resident/designated representative did not choose to receive services from the SLP provider, did the resident/ designated representative initial that he/she received referral information?	[ ]	[ ]	[ ]	[ ]
24. Did the resident/designated representative initial that he/she received a copy of the SLP's resident rights? **NOTE:** If initials are missing, answer the question "No" and remediate while on-site.	[ ]	[ ]	[ ]	[ ]
25. Does the ISP include areas important to the resident, such such as goals, interests, preferences or choices? 146.245(d)	[ ]	[ ]	[ ]	[ ]
26. If applicable, does the ISP include coordination and inclusion of services being delivered to the resident by an outside entity? 146.245(d) **NOTE:** This includes services provided by family.	[ ]	[ ]	[ ]	[ ]

SLP New Resident Review (5 of 7) **Resident Name:** _____

Assessment/Support Plan/Quarterly Evaluation 146.245	**Yes**	**No**	**N/A**	**Comments**
27. Is the ISP individualized to the resident's preferences and assessed needs? 146.245(d) **NOTE:** Compare with assessment, MD orders, nursing notes, etc. Assessment may differ from ISP if there has not been a significant change in condition or if there has been a preference change by the resident since the assessment was completed. This is acceptable.	[ ]	[ ]	[ ]	[ ]
28. Does the ISP identify safety concerns that impact the resident's options or choices? 146.245(d) **NOTE:** Examples include a medication lock box or escorts during outings in the community due to cognition.	[ ]	[ ]	[ ]	[ ]
29. If the resident declined any services, are they noted on the service plan? 146.245(d)	[ ]	[ ]	[ ]	[ ]
30. Quarterly evaluations: ☐ Completed by or co-signed by an RN? ☐ Completed every 92 days? 146.245(e) Date(s) of last 3: _____ **NOTE:** The length of time between the 3rd quarterly assessment and the annual RAI can be greater than 92 days.	[ ]	[ ]	[ ]	[ ]
31. Elopement Risk Assessment: ☐ Completed by or co-signed by an RN? ☐ Completed every 92 days? Date(s) of last 3: _____ **NOTE:** The length of time between the 3rd ERA and the annual, or 4th quarter, can be greater than 92 days.	[ ]	[ ]	[ ]	[ ]
32. Elopement Risk Assessments determined the resident required alarmed/delayed exit doors as a safety intervention? **NOTE:** If "No", notify Regional Supervisor ASAP.	[ ]	[ ]	[ ]	[ ]
33. Was a significant change of condition addressed in a comprehensive assessment update? 146.245(c) If yes, date:_____ **NOTE:** The completion of a new assessment is acceptable.	[ ]	[ ]	[ ]	[ ]
34. Was a significant change of condition addressed in an ISP update? 146.245(d)	[ ]	[ ]	[ ]	[ ]

Services 146.215 and 230	**Yes**	**No**	**N/A**	**Comments**
35. Was the significant change of condition included in the quarterly assessment? 146.245(e)	[ ]	[ ]	[ ]	[ ]
36. Was a serious or life-threatening situation reported to the physician and the resident's designated representative immediately? 146.245(h) **NOTE:** Resident can refuse notification. Mark N/A with a comment.	[ ]	[ ]	[ ]	[ ]
37. Does the SLP provider perform well-being checks on the resident at least three times/day; at least once per shift? 146.640(c) **NOTE:** Review documentation from 3 random months since the last. If resident was admitted less than three months ago, check since the time of admission.	[ ]	[ ]		[ ]
38. Is there **any** documentation of services provided to the resident? **NOTE:** This is data for a SLP waiver performance measure. This question should not be used to determine findings of non-compliance. Examples of documentation could include well-being checks, medication management services or housekeeping, maintenance and/or bathing logs. <u>As long as at least one provision of service is documented, answer "yes".</u>	[ ]	[ ]		[ ]
39. If the resident speaks limited English, does the SLP provider ensure that the resident has meaningful and equal access to benefits and services? 146.215(n) **NOTE:** If resident speaks English, mark "N/A" **NOTE:** This includes bilingual staff, interpreters and alternative methods of communication such as Braille, large print, picture boards, etc.)	[ ]	[ ]	[ ]	[ ]
40. Is the resident supervised while smoking? 146.640(d) **NOTE:** Mark N/A if resident does not smoke.	[ ]	[ ]	[ ]	[ ]
41. Have Concerning Activity Logs been completed and reviewed by licensed nursing staff at least weekly required? 146.690(c) NOTE: Mark N/A if resident has not exhibited any concerning behaviors.	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (7 of 7) Resident Name: _____

NOTE: Reviewer should attempt to observe service delivery wherever possible during the course of the review. Record any service observations in the comment section below.

Comments: _____

_____

_____

_____

_____

_____

Reviewer Signature: _____

Date of Review: _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
SLP RESIDENT REVIEW DCS

Provider Name: _____

Resident Name: _____ **Apartment Number:** _____

RIN: _____ **Admit Date to DCS:** _____ **DOB:** _____
Payment Status: ☐ Private Pay ☐ Medicaid
Date of Most Recent DON or Conversion Screen: _____ **DON Score:** _____

RESIDENT REVIEW

Resident Review Instructions

- To be completed for **ALL** residents in the 20% Medicaid and Private Pay samples.
- If a resident is in the hospital or has been discharged, an alternate must be selected.

Assessment/Support Plan/Quarterly Eval. 146.245, 670 and 690	**Yes**	**No**	**N/A**	**Comments**
1. Comprehensive assessment: ☐ Completed by or co-signed by an RN? ☐ Signed/co-signed by RN **within 366 days** of the previous assessment? 146.245(c) Dates of last two comprehensive assessments: _____ **NOTE:** Include the date of the assessment completed within 7-14 days of admission if there has only been one annual completed.	[ ] [ ]		[ ]	
2. Comprehensive assessment is thoroughly completed (no areas left blank)? 146.245(c)	[ ] [ ] [ ]		[ ]	
3. Comprehensive assessment is accurate? 146.245(c) **NOTE:** Staff should compare the assessment with the ISP. If there is a conflict, review SLP provider documentation of services, interview staff and resident, etc. to determine if the assessment is correct. Changes in condition that are not significant and/or changes in residents' preferences do not require the assessment to be revised. In these instances, it is acceptable for the assessment not to match the ISP.	[ ] [ ] [ ]		[ ]	
4. SLUMS or MOCA completed within 366 days of the previous SLUMS or MOCA? 146.670(b) Dates of last two annual assessments: _____ _____ Check One: ☐ SLUMS ☐ MOCA	[ ] [ ] [ ]		[ ]	

SLP Resident Review (2 of 10) Resident Name: _____

Assessment/Support Plan/Quarterly Eval. 146.245, 670 and 690	**Yes**	**No**	**N/A**	**Comments**
5. Assessment of resident's safe use of sink and appliances within the apartment completed within 366 days of the previous assessment? 146.610(b)(2) Dates of the last two annual assessment: _____ _____ NOTE: Annual requirement effective 7/1/12.	[ ]	[ ]	[ ]	[ ]
6. Individual Support Plan (ISP) Development: ☐ Developed by or co-signed by an RN? ☐ Signed/co-signed by RN w/in 7 days of completing the comprehensive assessment? Date: _____ **NOTE:** The timeliness of the assessment is not relevant for this question.	[ ]	[ ]	[ ]	[ ]
7. Is the ISP reviewed/signed by the resident or his/her designated representative and any others included by the resident? 146.245 (d)	[ ]	[ ]	[ ]	[ ]
8. Did the resident/designated representative initial the ISP to indicate he/she chose to receive services from the SLP provider?	[ ]	[ ]	[ ]	[ ]
9. If the resident/designated representative did not choose to receive services from the SLP provider, did the resident/ designated representative initial that he/she received referral information?	[ ]	[ ]	[ ]	[ ]
10. Did the resident/designated representative initial that he/she received a copy of the SLP's resident rights? **NOTE:** If initials are missing, answer the question "No" and remediate while on-site.	[ ]	[ ]	[ ]	[ ]
11. Does the ISP include areas important to the resident, such such as goals, interests, preferences or choices? 146.245(d)	[ ]	[ ]	[ ]	[ ]
12. If applicable, does the ISP include coordination and inclusion of services being delivered to the resident by an outside entity? 146.245(d) **NOTE:** This includes services provided by family.	[ ]	[ ]	[ ]	[ ]
13. Is the ISP individualized to the resident's preferences and assessed needs? Including any identified behaviors and intervention by staff 146.245(d)	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (3 of 10) **Resident Name:** _____

Assessment/Support Plan/Quarterly Eval. 146.245, 670 & 690	**Yes**	**No**	**N/A**	**Comments**
14. If the resident declined any services, are they noted on the ISP? 146.245(d)	[ ]	[ ]	[ ]	[ ]
15. Quarterly evaluations: ☐ Completed by or co-signed by an RN? ☐ Completed every 92 days? 146.245(e) Date(s) of last 3: _____ **NOTE:** The length of time between the 3rd quarterly assessment and the annual RAI can be greater than 92	[ ]	[ ]	[ ]	[ ]
16. Elopement Risk Assessment: ☐ Completed by or co-signed by an RN? ☐ Completed every 92 days? Date(s) of last 3: _____ **NOTE:** The length of time between the initial ERA and the 1st quarterly AND the 3rd ERA and the annual, or 4th quarterly, can be greater than 92 days.	[ ]	[ ]	[ ]	[ ]
17. Elopement Risk Assessments determined the resident required alarmed/delayed exit doors as a safety intervention? **NOTE:** If "No", notify Regional Supervisor ASAP.	[ ]	[ ]	[ ]	[ ]
18. Was a significant change of condition addressed in a comprehensive assessment update? 146.245(c) If yes, date:_____	[ ]	[ ]	[ ]	[ ]
19. Was a significant change of condition addressed in an ISP update? 146.245(d)	[ ]	[ ]	[ ]	[ ]
20. Was the significant change of condition included in the quarterly assessment? 146.245(e)	[ ]	[ ]	[ ]	[ ]
21. Was a serious or life-threatening situation reported to the physician and the resident's designated representative immediately? 146.245(h) **NOTE:** Resident can refuse notification. Mark N/A with a comment.	[ ]	[ ]	[ ]	[ ]
22. Does the SLP provider perform well-being checks on the resident at least three times/day, at least once per shift? 146.640(c) **NOTE:** Review documentation from 3 random months since the last annual review. If resident was admitted less than three months ago, check since the time of admission.	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (4 of 10) Resident Name: _____

Assessment/Support Plan/Quarterly Eval. 146.245, 670 & 690 Yes No N/A Comments

23. Is there **any** documentation of services provided to the resident?
    NOTE: This is data for a SLP waiver performance measure. This question should not be used to determine findings of non-compliance. Examples of documentation could include well-being checks, medication management services or housekeeping, maintenance and/or bathing logs. As long as at least one provision of service is documented, answer "yes". [ ] [ ] [ ] [ ]

24. If the resident speaks limited English, does the SLP provider ensure that the resident has meaningful and equal access to benefits and services? 146.215(n)
    NOTE: If resident speaks English, mark "N/A" [ ] [ ] [ ] [ ]
    NOTE: This includes bilingual staff, interpreters and alternative methods of communication such as Braille, large print, picture boards, etc.)

25. Is the resident supervised while smoking? 146.640(d)
    NOTE: Mark N/A if resident does not smoke. [ ] [ ] [ ] [ ]

26. Have Concerning Activity Logs been completed and reviewed by licensed nursing staff at least weekly required? 146.690(c)
    NOTE: Mark N/A if resident has not exhibited any concerning behaviors. [ ] [ ] [ ] [ ]

NOTE: Reviewer should attempt to observe service delivery wherever possible during the course of the review. Record any service observations in the comment section below.

Comments: _____

Reviewer Signature: _____

Date of Review: _____

MANAGEMENT OF RESIDENT FUNDS REVIEW

Management of Resident Funds 146.310	Yes	No	N/A	Comments
1. Does the SLP provider manage the resident's funds? **NOTE:** This includes managing a resident's personal needs Allowance and/or any available assets. ☐ **N/A SLP provider is NOT managing the resident's funds. SKIP THE REST OF THIS SECTION.**	[ ]	[ ]		[ ]
2. Did the resident, resident's guardian, representative or immediate family give written authorization to the SLP provider to manage resident's funds? 146.310(a)	[ ]	[ ]		[ ]
3. Was this authorization witnessed by someone who has no pecuniary interest in the SLP provider or its operations and who is not connected in any way to personnel or the manager? 146.310(a)	[ ]	[ ]		[ ]
4. If resident's funds are in excess of $50.00, are the funds held in an interest bearing account? 146.310 (a)(1)	[ ]	[ ]	[ ]	[ ]
5. Is there a separate, written record of the resident's account? 146.310(a) (2)	[ ]	[ ]		[ ]
6. Does the SLP provider provide a written record of the account at least quarterly to the resident or authorized representative included on the account? 146.310(a)(3)	[ ]	[ ]	[ ]	[ ]
7. Did the SLP provider notify DHS of any changes in resident's circumstance or lump sum payments received? 146.310(a)(5) and (6)	[ ]	[ ]	[ ]	[ ]
8. Did the SLP provider notify the resident when the amount in the resident's account reached $200 less than the asset limit ($2,000 for one person or $3,000 for a couple)? **NOTE:** Only applies to Medicaid eligible residents. 146.310(a)(8)	[ ]	[ ]	[ ]	[ ]
9. Does the SLP provider maintain signed receipts of deposits and withdrawals to the resident's account? 146.310 (a)(2)	[ ]	[ ]		[ ]
10. Has the SLP provider maintained records of the resident's managed funds for the last 12 months on-site? 146.310(a)(4)	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (6 of 10) **Resident Name:** _____

Comments: _____

_____

_____

_____

_____

Reviewer Signature: _____

Date of Review: _____

MEDICATION MANAGEMENT REVIEW

Medication Management Services 146.230

1. Level of medication management service received (check box of **highest** level received).

☐ **NONE**. Resident does **NOT** receive any of the medication management services **listed below** from the **SLP provider**. **(SKIP THE REST OF THIS SECTION)** **NOTE:** DCS residents are not allowed to be independent with medication.

☐ Reminders **ONLY** (staff only provide verbal reminder to resident)

OR

☐ Reminders **AND** any of the below medication management services
Check ALL that apply:

- ☐ Handing medication from where it is stored
- ☐ Opening or uncapping medication container
- ☐ Removal of medication from container and assisting resident in consuming or applying it (BLTC staff: confirm this is done by licensed nursing staff)

Review medication management documentation from the past 90 days for residents receiving medication management.

	Yes	No	N/A	Comments
2. Does the SLP provider maintain a correct list of the resident's medication, including resident's name, name of medication, dosage, directions and route of administration? 146.230(d)(3)(B-C) and 146.230(d)(4)(B-C) **NOTE:** Examples may include: physician order sheet, medication management record, medication administration record.	[ ]	[ ]		[ ]
3. Does SLP provider staff initial and document date and time medication management services were provided in the form of verbal reminders, assistance with medication container(s) and/or medication administration? 146.230(d)(3)(D-E) and 146.230(d)(4)(E-F)	[ ]	[ ]	[ ]	[ ]
4. Does SLP provider staff document medications refused by the resident? 146.230 (d)(4)(E) **NOTE:** Mark N/A if no medications refused.	[ ]	[ ]	[ ]	[ ]
5. Was/were a medication error report(s) completed? 146.265(c) **NOTE:** Mark N/A if no errors occurred.	[ ]	[ ]	[ ]	[ ]

SLP Resident Review (8 of 10) Resident Name: _____

Medication Management Services 146.230	**Yes**	**No**	**N/A**	**Comments**
6. Was/were a medication error resulting in hospitalization reported to the Department within 24 hours? 146.265(c) **NOTE:** Mark N/A if no errors requiring hospitalization occurred.	[ ]	[ ]	[ ]	[ ]

Comments: _____

APARTMENT OBSERVATIONS

Apartment Observations 146.210, 230, 610 and 640	Yes	No	Comments
1. All doors, including entrance doors, are wheelchair accessible? 146.210(h)(1)	[ ]	[ ]	[ ]
2. Entrance doors open onto a public corridor? 146.210(h)(3)	[ ]	[ ]	[ ]
3. Entrance doors have locking devices that are accessible to the outside? 146.210(h)(2)	[ ]	[ ]	[ ]
4. All entrance doors lock from the inside? 146.210(d)(3)(A) or 146.210(e)(4)(A)	[ ]	[ ]	[ ]
5. Each apartment entrance door equipped with an "eye view"? 146.210(h)(4)	[ ]	[ ]	[ ]
6. Apartment has individually controlled systems to maintain comfortable temperatures? 146.210(b)(1), 146.210(d)(3)(D), 146.210(e)(4)(D)	[ ]	[ ]	[ ]
7. A full bathroom that provides privacy, is equipped with toilet with grab bars sufficient to meet the needs of the resident, bathtub and/or shower stall with grab bars sufficient to meet the needs of the resident, sink, hot and cold water? 146.210(f)(1)	[ ]	[ ]	[ ]
8. A working emergency call device in each bathroom and each bedroom OR a portable emergency home response system is provided to residents in place of one located in the bedroom? 146.210(d)(3)(C), 146.210(e)(4)(C) and 146.230(m)(1) **NOTE:** An emergency call device must ALWAYS be located in each bathroom.	[ ]	[ ]	[ ]
9. An individual locked mailbox inside the building? 146.210(d)(4) or 146.210(e)(5) NOTE: For providers approved after 1/1/05	[ ]	[ ]	[ ]
10. Does the SLP provider offer for mail delivery by staff to the dementia care setting or arrange for a specific time for residents to pick up their mail with staff supervision? 146.640 (d)	[ ]	[ ]	[ ]

SLP Resident Review (10 of 10) Resident Name: _____

Apartment Observations 146.210, 230, 610 and 640

11. Wiring for private phone, cable TV, satellite, or master antenna with access to at least 10 channels? 146.210(d)(3)(F) or 146.210(e)(4)(F) [ ] [ ] [ ]

12. A sink, microwave and refrigerator with separate freezer? 146.610(b)(a) [ ] [ ] [ ]

13. Closet for each resident of the apartment? 146.210(g)(1) [ ] [ ] [ ]

14. Closet(s) with a door? 146.210(g)(2) [ ] [ ] [ ]

15. Double occupancy apartments have a door on each bedroom? 146.210(h)(5)
NOTE: Applies to all SLPs approved after 8/1/09.
[ ] NOT APPLICABLE [ ] [ ] [ ]

16. Each apartment has windows with transparent glass (except bathroom) that are large enough to permit viewing to the outside of the facility and at least one window permits viewing from a seated position. 146.210(i) [ ] [ ] [ ]

17. Apartment in good maintenance and repair? 146.230(h)(1) [ ] [ ] [ ]

18. Apartment appears to be receiving regular housekeeping services?
NOTE: Take into consideration individual preferences.
NOTE: if resident refuses housekeeping services. [ ] [ ] [ ]

19. If applicable, are sharps placed in containers that are rigid and leak-resistant and disposed of properly? 146.210 (s)(6)(A-C)
NOTE: Mark N/A if resident does not require.
[ ] NOT APPLICABLE [ ] [ ] [ ]

Comments: _____

_____

_____

_____

_____

Reviewer Signature: _____

Date of Review: _____

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
GUIDE FOR INDIVIDUAL RESIDENT INTERVIEW

Resident Name: _____

NOTES FOR COMPLETION:

- If a resident has a negative response to a question, or raises a concern/problem, or the reviewer identifies an area of concern, this should be discussed with the manager or designee. Document the communication and outcome in the comments section.
- If a resident experiences difficulty completing the interview due to their cognitive condition, complete as many questions as possible. Make a note in the comment section regarding the resident's cognitive status.
- Staff should make several attempts to try and interview residents who are unavailable due to illness, medical appointments, social activities, etc. **If an interview cannot be completed, make a note in the comment section, including dates and times attempts were made.** A minimum of two attempts should be made on separate days/times.
-

146. 230 and 250	**Yes**	**No**	**Comments**
1. Do you feel safe living here? 146.250(e)(1)	[ ]	[ ]	[ ]
2. Do the people who take care of you here treat you nicely? 146.250(e)(1) and (14)	[ ]	[ ]	[ ]
3. Do you get help from the people who work here with the things you need? 146.230 and 146.640	[ ]	[ ]	[ ]
4. Do you get to make choices for yourself? 146.250(e)(10), (15) and (16)	[ ]	[ ]	[ ]
5. Are you satisfied with the care you receive here?	[ ]	[ ]	[ ]

HFS Staff Observations:
NOTE: OBSERVATIONS MUST BE RECORDED FOR Q6 AND Q7 EVEN IF RESIDENT REFUSES THE INTERVIEW.

6. Is the resident free from restraints? 146.250(e)(9) **NOTE:** If no, contact Regional Supervisor **immediately**.	[ ]	[ ]	[ ]
7. Is the resident clean, well-groomed, free of odor and dressed appropriately for the season? 146.230(c) **NOTE:** Take into consideration individual preferences. If "no" is marked and the resident is independent with some or all of their personal care, include a comment. If the resident receives personal care services from the SLP provider, but refuses them as documented in the record, include a comment.	[ ]	[ ]	[ ]

Resident Interview

Resident Name: _____

COMMENTS: _____

COMMUNICATION DIFFICULTIES:
If a resident is unable to complete the interview due to communication problems (ie, he/she is extremely hard of hearing or is aphasiac), note how staff effectively communicates with the resident.

Reviewer Name: _____ **Date of Interview:** _____

VI. STAFF REQUIREMENTS

Staffing 146.235, 265 and 660	Yes	No	N/A	Comments

NOTE: If the dementia unit is part of an operational SLP provider and employees transfer to the dementia unit, they are not treated as new employees in regards to background checks, TB testing and required conventional SLP provider employee training. If any of these employees are new hires to the operational SLP provider since the last annual review, verify the above requirements are in compliance.

NOTE: Complete the staff worksheets to assist with answering questions in this section. Worksheets must be completed and submitted with the annual review packet.

1.	Is there documented training of staff which takes place no later than 30 days after beginning employment? (Review documentation and/or discuss with employee.) 146.235(e)(1)(A) and 146.305(c)	[ ]	[ ]	[ ]	[ ]
2.	Are there 4 hours of training documented for all staff specific to working with persons with Alzheimer's disease or related dementia within 7 days of beginning work in the dementia unit? (Review documentation and/or discuss with employee.) 146.660(e)(1-8)	[ ]	[ ]	[ ]	[ ]
3.	Is training completed by qualified individuals? 146.235(e)(1)(C)	[ ]	[ ]		[ ]
5.	Is there evidence of semi-annual training in areas related to employment? 146.235(e)(1)(A)	[ ]	[ ]		[ ]
6.	Does staff orientation, and at least annual training cover, resident rights, infection control, crisis intervention, prevention and notification of abuse, neglect and financial exploitation, behavior intervention, and encouraging independence, potential resident inquiry and admission application policy, non-discrimination policy, tuberculosis identification, prevention, control and reporting? 146.235(e)(1)(B) and 146.305 (c) **NOTE:** Annual training required 1x/calendar year.	[ ]	[ ]		[ ]
7.	Do staff annually receive 12 hours of training annually regarding Alzheimer's disease and other related dementia? 146.660(f)(1-9) **NOTE:** Annual training required 1x/calendar year.	[ ]	[ ]		[ ]

8. Did the SLP provider arrange required training for employees?
NOTE: This is data for a SLP waiver performance measure. This question should not be used to determine findings of non-compliance. Timeliness is not considered when answering this question. Mark "No" if the provider did not provide training for all required topics. [ ] [ ] [ ]

9. Is there at least one CNA on all shifts for every 10 residents? 146.660(c)
NOTE: Do NOT include roommates without dementia to determine the 1:10 ratio. [ ] [ ] [ ]

Mark questions 10-11 N/A for dementia units contained within an operational conventional SLP building.

10. Does a dietician come on-site at least twice per quarter for a period of not less than a cumulative total of eight hours? 146.235(g)(3)
NOTE: Calendar year quarters should be used to calculate. Only the quarters since the last review need to be checked. [ ] [ ] [ ] [ ]

11. Is the dietician licensed under the Dietetic and Nutrition Services Practice Act? 146.235(g)(1) [ ] [ ] [ ] [ ]

12. Does the 24 hour response staff possess current certification in emergency resuscitation? 146.235(i) [ ] [ ] [ ]
NOTE: Training must include in-person demonstration.

13. Are all nurses licensed by the State of Illinois? 146.235(j) [ ] [ ] [ ]

14. Is there at least one licensed nurse available at all times on-site or on-call? 146.660(b) [ ] [ ] [ ]

15. Have all nursing assistants been certified by completing a nursing assistant training course or a Department of Public Health approved equivalent training and competency evaluation no later than 120 days after employment? 146.235(f)(1) [ ] [ ] [ ]

16. Have all staff been checked against the Health Care Worker Registry for record of previous background checks and disqualifying convictions prior to beginning work? 146.235(l)
NOTE: Only new hires since the last review need to be checked. The provider must have copies of employee Registry profile OR "No Worker Found" screens.
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

Staffing 146.235, 265 and 660 cont'd	Yes	No	N/A	Comments

NOTE: All questions related to the Health Care Worker Background Check Act (146.235 (l) do NOT apply to licensed staff.

QUESTIONS 17-26 TO BE USED FOR FINGERPRINT BACKGROUND CHECKS

17. Were employees checked on the website registries required by IDPH prior to beginning work? 146.235(l)
NOTE: The provider must print the IDPH verification screen which includes the date this was done. This is required for all new hires, even people who have had a fingerprint check completed previously.
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ] [ ] [ ]

18. If a new employee was included on the Registry, but only had a UCIA background check listed, was a fingerprint check initiated? 146.235(l)
NOTE: Only applies to new employees already listed on the Registry who have not undergone a fingerprint check.
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

19. Were Disclosure and Authorization forms completed and signed by all employees prior to beginning work? 146.235(l)
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

20. If employees were conditionally hired, were finger prints collected by a Livescan vendor within 10 working days of the authorization? 146.235(l)
NOTE: Does not apply to SLP provider that do not hire employees until fingerprint check results are received.
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

21. If hired conditionally AND fingerprints were NOT collected within 10 days, was the employee suspended? 146.235(l)
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

22. If hired conditionally AND fingerprints were NOT collected within 30 days, was the employee terminated? 146.235(l)
NOTE: Not required for hires directly from a related SLP building, assisted living building or nursing facility. [ ] [ ][ ] [ ]

Staffing 146.235, 265 and 660 cont'd	Yes	No	N/A	Comments
23. If hired conditionally and the fingerprints were not collected within 30 days, did the SLP provider withdraw the application for fingerprint check from the Registry? 146.235(l) **NOTE**: SLP provider should print this screen. **NOTE:** Not required for hires directly from a related SLP building, assisted living building or nursing facility.	[ ]	[ ]	[ ]	[ ]
24. Was the Registry updated within 30 days of employees beginning employment? 146.235(l) **NOTE:** The provider must have copies of the employee Registry profile screens.	[ ]	[ ]	[ ]	[ ]
25. Did the SLP Provider update the employee profiles on the Registry annually? 146.235(l) **NOTE:** Annually=Once every calendar year. **NOTE: Not reviewed for Bi-annual [ ] N/A**	[ ]	[ ]		[ ]
26. Did any staff who had fingerprints collected have a disqualifying conviction identified? 146.235(l) **NOTE**: Mark N/A if no disqualifying convictions.	[ ]	[ ]	[ ]	[ ]
27. If staff had a disqualifying conviction and did not already have a waiver from IDPH, was he/she immediately terminated or suspended pending a waiver? **NOTE**: Mark N/A if no disqualifying convictions OR if there was already a waiver granted by IDPH.	[ ]	[ ]	[ ]	[ ]
28. Did the SLP provider receive any waivers from IDPH for staff who have a disqualifying conviction? If yes, list the key identifier number of the staff below. 146.235(l) **NOTE**: Mark N/A if no waivers requested.	[ ]	[ ]	[ ]	[ ]
29. TB screening test performed or documentation provided in accordance with the Control of Tuberculosis Code? 146.235(m) **NOTE:** Not required for hires directly from a related SLP building, assisted living building or nursing facility.	[ ]	[ ]	[ ]	[ ]
30. Checklist of Signs & Symptoms of TB Disease completed for new employees with a documented positive TB skin test. 146.235(m) **NOTE:** Not required for hires directly from a related SLP building, assisted living building or nursing facility.	[ ]	[ ]	[ ]	[ ]

Comments:

STAFF WORKSHEET—NEW HIRES

(Make additional copies of form as needed)

PROVIDER:_____

TB = Dates of 2-Step Mantoux & S&S

Name & Title	**Start Date**	**Lic #**	**Completion of CNA course & competencies** (Y or N)	**TB** Dates given & read OR doc of + reactor & S/S date S&S only required if a documented positive reactor.	**HCW Registry** Checked prior to start date (can be same day as long as before shift) for all UNLICENSED hires. Note any waivers.	**Registry Websites** Six required Registries checked for ALL UNLICENSED hires prior to starting first shift. (Y or N)	**Fingerprint Check** Authorization signed prior to first shift and prints taken w/in 10 working days of signature. **UNLICENSED staff** (Y or N)	**Registry Employment Verification w/in 30 days** Completion on the day of hire acceptable **UNLICENSED staff**
Example: Fred Jones, CNA	7/1/10		Y	7/2/10-7/4 N 7/21/10-7/23 N S/S 7/5/10	7/7/11—LATE	Y	Y	7/25/10

NOTE:

--ALL new unlicensed employees must have documentation of a HCW Registry check prior to the time they start their first shift.

--ALL new unlicensed employees must have a fingerprint check.

--If an employee was already listed on the HCW Registry with a UCIA background check, a fingerprint check MUST be completed.

-- If an employee was already listed on the HCW Registry with a fingerprint check, a new one does NOT have to be completed.'

--The six required Registries must be checked for ALL new hires, even if they have had a fingerprint check completed.

NOTE: The above clarifications do not apply to staff hired directly from a related SLP building, assisted living building or nursing facility. Mark N/A.

STAFF WORKSHEET—NEW HIRES

PROVIDER:_____

COMMENTS:

Signature of HFS staff completing: _____ **Date:** _____

STAFF TRAINING WORKSHEET

Complete for ALL employees

(Make additional copies of form as needed)

PROVIDER: _____

NOTE: Training in 146.235 (e)(1)(B) must be completed within 30 days of beginning employment and annually thereafter. The training must take place sometime during the calendar year. Additionally, semi-annual training must be provided in areas related to employment.

*At least one staff person on each shift must have current CPR certification.

Mark with and "X" if was completed training timely. If not timely, note dates. See example below. Make additional copes if necessary.

	*CPR Certif.	Behav. Interv.	Crisis Interv	Infect. Cont.	TB	Encour. Indep.	Resid. Rights	Abuse & Neglect	Non-Discrim	Resid Inquiry & App	Emerg Plan	Fire Exting.	Employ-ment	Disab Sensitiv.
Staff Name			Orientation & annually										Orient & semi-annual	22-64 SLPs only
EXAMPLE Fred Jones	N/A	X	X	X	X	X	7/1/10 None for 2011	X					Start Date 7/1/10 T= 7/2/10 & 2/17/11	N/A
									N/A FY20 CO rev.	N/A FY20 CO rev.				
									N/A FY20 CO rev.	N/A FY20 CO rev.				
									N/A FY20 CO rev.	N/A FY20 CO rev.				
									N/A FY20 CO rev.	N/A FY20 CO rev.				
									N/A FY20 CO rev.	N/A FY20 CO rev.				
									N/A FY20 CO rev.	N/A FY20 CO rev.				

STAFF TRAINING WORKSHEET

PROVIDER: _____

COMMENTS:

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Signature of HFS staff completing: _____ **Date:** _____

STAFF DEMENTIA TRAINING WORKSHEET

Complete for ALL employees

(Make additional copies of form as needed)

PROVIDER: _____

NOTE: Four hours of training as listed in 146.660 (e) must be completed **within 7 days of beginning employment**. 146.660 (f) requires a minimum of 12-hours of dementia training annually thereafter. The training must take place sometime within the following calendar year; it does not need to be exactly 366 days from the previous training date.

Mark with and "X" if was completed training timely. If not timely, note dates. See example below. Make additional copes if necessary.

	Dementia	Communication	Behavior	Activities	Min. Safety Risks	Personal Care	Partnering with others	12 hours of annual training related to dementia
Staff Name	Four hours total within 7 days of beginning employment.							
EXAMPLE Fred Jones	N/A	X	X	X	X	X	Start Date 7/1/10 T= 8/25/10	10 hours

ANNUAL HCW REGISTRY VERIFICATION WORKSHEET

(Must be completed for ALL unlicensed staff employed by the facility for >1 year)
Make additional copies of form as needed

PROVIDER : _____

NOTE: Verification is required once each calendar year; it can be >366 days. The facility can choose to complete the verifications for all employees on the same date instead of individually for each employee based on their hire date. If the SLP provider completes the task in this manner, make a copy of the Registry print out and note any verifications that were not completed timely. The table below does not need to be completed if the Registry print out is attached.

Name	Start Date or Date of previous update	Annual HCW Registry Verification Date	Name	Start Date or Date of Previous update	Annual HCW Registry Verification Date

ANNUAL HCW REGISTRY VERIFICATION WORKSHEET

PROVIDER: _____

Comments:

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Signature of HFS staff completing: _____ **Date:** _____

VII. GRIEVANCE PROCEDURES

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
GRIEVANCE PROCEDURES

Grievance Procedure 146.260	Yes	No	Comments
1. Is there a grievance procedure in place? 146.260(a)	[ ]	[ ]	[ ]
2. Are residents and/or their designated representatives made aware of grievance procedures? 146.260(a)	[ ]	[ ]	[ ]
3. Does the SLP provider maintain records on written grievances and responses? 146.260(b)	[ ]	[ ]	[ ]

Comments:

VIII. EMERGENCY CONTINGENCY PLAN

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

BUREAU OF LONG TERM CARE
EMERGENCY CONTINGENCY PLAN

Emergency Contingency Plan 146.295 and 146.305	Yes	No	N/A	Comments
1. Is there a written plan included in the SLP provider's Quality Assurance Plan that protects all persons in the event of an emergency and for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building whenever necessary? 146.295(a)	[ ]	[ ]	[ ]	[ ]
2. Does the plan address the physical and cognitive needs of residents and include special staff response, including the procedures needed to ensure the safety of any resident? 146.295(a)(1)	[ ]	[ ]	[ ]	[ ]
3. Is the plan amended or revised whenever any resident with unusual needs is admitted? 146.295(a)(1)	[ ]	[ ]	[ ]	[ ]
4. Does the plan provide for the temporary relocation of residents for any emergency requiring relocation? 146.295(a)(2)	[ ]	[ ]	[ ]	[ ]
5. Does the plan provide for the movement of residents to safe locations within the SLP building in the event of a tornado warning or severe thunder storm warning issued by the National Weather Service? 146.295(a)(3)	[ ]	[ ]	[ ]	[ ]
6. Does the plan provide for the health, safety, welfare and comfort of all residents when the heat index-apparent temperature, as established by the National Oceanic and Atmospheric Administration, inside the residents' living, dining, activities, or sleeping areas if the SLP building exceeds a heat index/apparent temperature of 80°F, or falls below 55°F for 12 hours or more? 146.295(a)(4)	[ ]	[ ]	[ ]	[ ]
7. Does the plan address power outages, including how residents call for help, how resident safety is monitored and how food spoilage is checked? 146.295(a)(5)	[ ]	[ ]	[ ]	[ ]
8. Does the plan include contingencies in the event of flooding, if located on a flood plain? 146.295(a)(6)	[ ]	[ ]	[ ]	[ ]

Emergency Contingency Plan 146.295 cont'd	Yes	No	N/A	Comments
9. Are all personnel employed on the premises instructed in the emergency contingency plan and the use of fire extinguishers? 146.295(b)	[ ]	[ ]	[ ]	[ ]
10. Is a diagram of emergency evacuation route(s) posted in at least all corridors and common areas? 146.295(c)	[ ]	[ ]	[ ]	[ ]
11. Are all personnel employed on the premises aware of the route? 146.295(c)	[ ]	[ ]	[ ]	[ ]
12. Does the SLP provider have a means of notification when the National Weather Service issues a tornado warning covering the area in which the building is located other than commercial radio or television? 146.295(d) **NOTE**: Notification measures include being within range of local tornado warning sirens, an operable National Oceanic and Atmospheric Administration weather radio in the building, or arrangements with local public safety agencies (police, fire, ESDA) to be notified if a warning is issued.	[ ]	[ ]	[ ]	[ ]
13. Does the SLP provider conduct at least two drills per year that include residents, staff and other persons in the SLP building? 146.295(f) & (h) **NOTE:** One drill each for fire and tornado.	[ ]	[ ]	[ ]	[ ]
14. Does the SLP provider have a process in place to evaluate the effectiveness of emergency plans, procedures and training? 146.295(g)	[ ]	[ ]	[ ]	[ ]
15. Do drills include making a general announcement throughout the SLP building that a drill is being conducted or sounding an emergency alarm? 146.295(i)	[ ]	[ ]	[ ]	[ ]
16. Do the drills involve the actual evacuation of residents to an assembly point as specified in the emergency plan and provide residents with experience using various means of escape? 146.295(j)	[ ]	[ ]	[ ]	[ ]
17. Is a written evaluation of each drill submitted to the SLP manager and the Quality Assurance Committee and maintained for one year from the date of the drill? 146.295(k) **NOTE:** The evaluation must include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation.	[ ]	[ ]	[ ]	[ ]

18. If the SLP provider had an incident of physical, sexual or financial abuse, exploitation or neglect by a staff member, family member, visitor, another resident or individual, did the SLP provider contact local law enforcement authorities immediately? 146.305(b) [ ] [ ] [ ] [ ]

19. If the SLP provider had an incident of a crime or death other than by disease processes occur to a resident as the result of actions by a staff member, family member, visitor, another resident or individual, did the SLP provider contact local law enforcement authorities immediately? 146.305(b) [ ] [ ] [ ] [ ]

20. If the SLP provider had an occurrence of any emergency requiring hospital service, police, fire department or coroner, and/or loss of electrical power in excess of an hour, did the SLP manager or designee provide an Incident Report to the Department within 24 hours after the occurrence? 146.265(d) page 52, 146.295(l) & 146.305(e) [ ] [ ] [ ] [ ]

NOTE: For question 20, an emergency is defined as physical abuse involving physical injury, sexual abuse, a crime, or death of a resident that occurs as the result of actions by a staff member, visitor or another resident or an event, as a result of a mechanical failure or natural force such as water, wind, fire or loss of electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the SLP building.

Comments: _____

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IX. TB PLAN

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE

REVIEW OF TB PLAN

Control of TB 146.215 (c)(4)(R), 146.220(c), 146.235(m)	Yes	No	Comments
1. Does the SLP have a written plan for the screening and management of tuberculosis infection and disease?	[ ]	[ ]	[ ]
2. Does the plan specify who is responsible for seeing that the TB Code and the facility's written plan is followed? (who is going to keep track of TB information in the and by using what methods)	[ ]	[ ]	[ ]
3. Has the plan been updated within the last 12 months including an annual risk assessment (TB screening risk classification) with evidence of collaboration with the local TB authority?	[ ]	[ ]	[ ]
4. Does the plan include protocols for screening, diagnosis and reporting suspected or confirmed TB disease? (This would include: baseline 2-step Mantoux, frequency of retesting (if any), who and how often signs & symptoms checklist are completed, what are the indications for chest x-ray, and medical evaluation.)	[ ]	[ ]	[ ]
5. Does documentation include data collection and evaluation? (Screening results, signs and symptoms checklist results, results of any diagnostic testing, information gathered from local TB authority regarding TB occurrences in the area etc.)	[ ]	[ ]	[ ]
6. Does the plan address how the SLP provider will respond if a resident, healthcare worker, or volunteer develops active TB disease? (Where will residents be discharged to, what will be done to decrease the risk of transmission to other residents or staff until the resident with suspected or confirmed TB disease is discharged)	[ ]	[ ]	[ ]
7. Does the plan include and is there documentation of education programs (initially and annually) for employees that includes tuberculosis identification, prevention, and control as well as reporting requirements?	[ ]	[ ]	[ ]
8. Is the plan followed (DPH 696.130(a))?	[ ]	[ ]	[ ]
9. Is an annual signs and symptoms checklist completed annually for residents and employees who have had a positive skin test?	[ ]	[ ]	[ ]

Control of TB 146.215 (c)(4)(R), 146.220(c), 146.235(m) pages 22,27, and 38

Comments:

X. EXIT CONFERENCE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
BUREAU OF LONG TERM CARE
EXIT CONFERENCE

1. Review team will discuss outcome of review with SLP manager or designee. If no findings, manager or designee and review team signs page 4 of the review packet.

2. If there are findings that require correction, the review team will leave or send Supportive Living Program (SLP) Response to On-Site Review Findings" (See page 85) with the provider describing the finding(s). Signatures of SLP provider manager should be obtained at the time findings are presented. The signature page may be faxed to the SLP provider. All members of the review team must sign and date page 4 (this may be done prior to the exit).

3. A copy of the completed Tool **CANNOT** be left with the SLP provider. The review team may leave a copy of the signature page (page 4).

4. A copy of the LOCD Tool should be printed and mailed to the SLP provider or e-mailed with the password provided in a separate e-mail.

XI. REVIEW PROCEDURES

SUPPORTIVE LIVING PROGRAM
REVIEW PROCEDURES

ON-SITE REVIEW PREPARATION

The BLTC regional supervisor, working with the area manager, will plan dates and team composition. For final and annual certification reviews, regional staff should notify central office at least 3 weeks prior to the review date and request a resident sample.

NOTE: The interim and final certification processes outlined below may be conducted simultaneously for existing facilities that already have residents.

INTERIM CERTIFICATION PROCESS

1. Applicants are given 24 months from the date of the approval of application to notify BLTC that the facility is ready for an onsite certification review. An extension of the 24-month timeframe may be granted by BLTC central office based upon a written request by the applicant.

2. When BLTC is notified that the facility is ready for an onsite review (notification may be made directly to the regional office or through central office), the BLTC regional supervisor will schedule and conduct an onsite review as soon as operating needs allow.

3. An interim certification review includes review of the building, documents and staffing to confirm that the facility is ready to do business. This review will include completion of the Supportive Living Facility Interim Certification Review Tool. This includes: General Observations of the Facility, Staff Requirements, Staff Worksheet-new hire, Staff Training Worksheet, Emergency Contingency Plan, Facility TB Plan, and Apartment Review Worksheet.

4. The supervisor should be updated on the progress throughout the review and notified immediately of any concerns regarding health and safety issues. This includes, but is not limited to: malfunctioning emergency call lights, malfunctioning fire alarm or sprinkler systems, elevators not operating, water temperatures in excess of 120 degrees, nursing staff and dieticians without current Illinois licensure or certification and staff without a fingerprint check completed within the required time period.

5. Refer to the Presentation of Review Results and Follow-up Review sections for the procedures related to findings of non-compliance, exit procedures and follow-up reviews.
6. Once the SLP provider passes the onsite interim or interim/final review, an interim (or final, if done simultaneously) certificate will be issued by BLTC central office. An SLP provider cannot begin admitting residents until it receives the certificate from BLTC central office. In some cases, BLTC central office may request verbal confirmation of "No Findings" and request the BLTC regional supervisor and area manager sign Page 4 of the certification tool and fax it to central office so the certificate can be issued.

7. When the certification review is complete, BLTC central office will send an enrollment packet to the facility. The enrollment packet includes the Medicaid provider agreement, payment to corporate owner form, power of attorney form and other forms that will be used in the operation of the program.

8. Upon receipt of the completed enrollment packet from the facility, BLTC central office will provide information to the Provider Participation Unit (PPU) for enrollment on the system.

9. Upon notification by PPU that the facility is enrolled, BLTC central office sends a copy of the executed provider agreement to the facility.

10. BLTC central office notifies the BLTC area manager, BLTC regional office and DHS local office that the facility has been enrolled and is now authorized to receive Medicaid payments from HFS. The effective date listed on the notification reflects the date the facility was certified.

FINAL CERTIFICATION PROCESS

1. Prior to the issuance of a final certificate, onsite resident reviews must be conducted. Determination of when the onsite resident review is conducted is based upon the following:
   - At least 90 days has passed from the effective date of the interim certification;
   - For SLP buildings with a maximum occupancy of 75 persons or less, the resident reviews shall be conducted when two-thirds of the maximum occupancy has been reached;
   - For SLP building with a maximum occupancy of 76 persons or more, the resident reviews shall be conducted when one-half of the maximum occupancy has been reached;
   - No resident reviews shall be conducted later than 180 days, regardless of census, after the effective date of the interim certification.
   - The onsite resident review can be scheduled at any point between 90 and 180 days that the applicable census is reached.
   - The regional supervisor is to track the census during this period to determine when to schedule the onsite resident review.

2. Central office will generate a sample list of residents for review. This will include the names of a random 20% of the residents in the Medicaid population (a minimum of 10 residents) and at least 5 private pay residents. A record review, medication management review, management of resident funds, apartment observation, and interview must be completed for all residents identified in the 20% Medicaid and private pay samples. Additionally, since all of the residents are new admissions, the New Admission, Resident Review and Management of Resident Funds sections will need to be completed for all Medicaid residents. If a resident is no longer in the facility or is temporarily in the hospital, a record review should not be completed. The reviewer should make a note on the front page of the record review form indicating the resident is no longer at the facility. Then the first resident from the appropriate alternate sample list should be reviewed to replace the individual from the original sample.

   SLP providers with dementia units certified by the Department will receive 100% record review for Medicaid residents.

3. The final certification review requires completion of the Supportive Living Facility Certification Review Tool. This includes: General Observations of the Facility, Resident Satisfaction Survey, Quality Assurance Plan, Resident Review for each resident identified in the samples, Resident Funds Review, Medication Management Review, Apartment Observation, Individual Resident Interview, Staff Requirements, Staff Worksheet, Staff Training Worksheet, Grievance Procedures, Emergency Contingency Plan and TB plan.

4. The supervisor should be updated on the progress throughout the review and notified immediately of any concerns regarding health and safety issues. This includes, but is not limited to: malfunctioning emergency call lights, malfunctioning fire alarm or sprinkler systems, elevators not operating, water temperatures in excess of 120 degrees, nursing staff and dieticians without current Illinois licensure or certification, staff without a fingerprint check completed within the required time period, inadequate food supplies, possible life threatening situations involving residents and suspected resident abuse or neglect.

5. Refer to the Presentation of Review Results and Follow-up Review sections for the procedures related to findings of non-compliance, exit procedures and follow-up reviews.

6. Once the SLP provider passes the onsite final review and the review packet is received by BLTC central office, a final certificate will be issued.

ANNUAL CERTIFICATION PROCESS

1. An annual certification review must be initiated within 60 days **after** the certification date for each SLP provider. The interim certification date is used to determine when the annual certification is due. BLTC central office must approve an annual review outside of this time period.

2. BLTC central office will generate a sample list of residents for review. This will include all new admissions since the last annual review. New admissions require a record review and management of resident's funds review. Lag admissions will also be identified, which are residents who were new at the time of the previous final/annual review, but due to caseworker lag, were not identified in the Medicaid sample. Lag admissions require a section of the New Admission review to be completed. In addition, the names of a random 20% of the residents in the Medicaid population (a minimum of 10 residents) and at least 5 private pay residents will be compiled. Review of these residents will include: a record review, medication management, management of resident funds, apartment observations, and interview. If a resident is no longer in the facility or is temporarily in the hospital, a record review should not be completed. The reviewer should make a note on the front page of the record review form indicating the resident is no longer at the facility. The first resident from the appropriate alternate sample list should be reviewed to replace the individual from the original sample.

   SLP provider with dementia units certified by the Department will receive 100% record review for Medicaid residents.

3. All Medicaid residents require a Level of Care Determination (LOCD) within 365 of the last LOCD. All Medicaid residents admitted since the last review will also have an LOCD completed. Central office will prepare an automated LOCD Tool for each review. Residents in the 20% Medicaid sample will have modified LOCDs completed that include information regarding services provided by the SLP. A copy of the completed LOCD tool must be printed and mailed to the SLP OR it can be e-mailed if the password protection feature is left in place.

4. The supervisor should be updated on the progress throughout the review and notified immediately of any concerns regarding health and safety issues. This includes, but is not limited to: malfunctioning emergency call lights, fire alarm or sprinkler systems, elevators not operating, water temperatures in excess of 120 degrees, nursing staff and dieticians without current Illinois licensure or certification, staff without a fingerprint check completed within the required time period, inadequate food supplies, possible life threatening situations involving residents and suspected resident abuse or neglect.

5. Refer to the Presentation of Review Results and Follow-up Review sections for the procedures related to findings of non-compliance, exit procedures and follow-up reviews.

CHANGE OF OWNERSHIP (CHOW) REVIEW

1. When an SLP provider changes ownership, an on-site review must be completed no later than at the date of the next annual certification review or within three months after the effective date of the CHOW, whichever is earlier. Unless it is unavoidable due to staffing assignments, it is suggested that a CHOW review not occur until at least 30 days after the CHOW effective date. This will allow time for staff and residents to respond to questions asked during the review about changes that may have been made as a result of the new ownership.

2. Unless done in conjunction with an annual review, record reviews do not have to be completed during a CHOW review. The CHOW review requires completion of the Supportive Loving Program CHOW Facility Review Tool: This includes general questions posed to staff and a sample of residents to ensure that major changes have not occurred due to the CHOW. Central office will provide a sample of residents that includes 10% of the Medicaid population (at least 5 residents) and one private pay resident. Only the manager the manager or designee needs to be interviewed to complete the general questions.

DEMENTIA CARE UNIT REVIEW

The Dementia Care Unit shall be reviewed for compliance of the SLP rules as they pertain to these areas on an annual basis.

GENERAL FINDINGS

If rule non-compliance that impacts health and safety of residents and/or staff is found during an informal visit to an SLP provider or during the course of a follow-up review for other findings of non-compliance, general findings may be written. Refer to the Presentation of Review Results and Follow-up Review sections for the procedures related to findings of non-compliance, exit procedures and follow-up reviews.

PRESENTATION OF REVIEW RESULTS

1. The SLP provider manager or designee and the BLTC review team must sign Page 4 of the review tool on the day the onsite portion of the review is completed. A copy of page 4 can be provided to the SLP provider.

2. The team leader for the review must submit a summary report of issues of non-compliance identified during the review and also any areas of concern to the BLTC regional supervisor in accordance with the supervisor's instructions. The report must include any issues that were remediated while BLTC staff was onsite. A copy of the summary report should NOT be given to the SLP provider.

3. The BLTC regional supervisor will review the summary and provide recommendations to the BLTC area manager and SLP coordinator. Staff will collaborate to determine the final outcome of the review.

4. **If there are NOT any findings of non-compliance**, BLTC review staff will conduct an exit within **10 working days** of the completion of the review (the date the BLTC regional supervisor notifies the reviewer of the final decision regarding the results). The exit may be done onsite or by phone at the discretion of the BLTC regional supervisor. A copy of page 4 of the review tool can be left with the SLP provider, but not any other portions of the tool.

5. **If there are findings of non-compliance**, the BLTC reviewer will complete the Response to Onsite Review Findings (RORF) form (see Writing Findings section). The BLTC area manager or central office will inform the regional supervisor if the ID key can be released to the SLP provider. The RORF must be provided to the SLP provider within **10 working days** after the completion of the review (the date the BLTC regional supervisor notifies the reviewer of the final decision regarding the results). The signature of the SLP provider manager should be obtained at the time the findings are presented. Written findings should identify the rule cite found to be out of compliance and a detailed description of the findings that includes employee/resident ID numbers. The exit may take place in person or via phone as determined by the regional supervisor. If the exit is done via phone, the RORF can be e-mailed to the SLP provider. The SLP provider manager will need to sign the second page and fax to review staff. Information with resident identifiers (resident keys) should not be e-mailed.

6. The SLP provider must complete and return the RORF form with a plan of correction (POC) to the BLTC regional supervisor within **14 calendar days** of the exit. The SLP provider's response must include dates of correction for each finding. The POC cannot simply state compliance with rule site (example, "All RSPs will be completed within 7 days of the RAI"). It must address how the facility will ensure future compliance and also who is responsible for the POC. Returning an inadequate plan of correct does not stop the time clock.

7. Extensions of the 14 day response or 30 day compliance can only be granted through Central Office. The Department shall provide a written decision to the facility within **10 working days** after receipt of the request for extension.

8. When it is determined the SLP provider has passed the review and is in compliance, the completed review packet is forwarded by the BLTC reviewer for signature to the regional supervisor within **5 working days** of exit. The regional supervisor will forward the packet to the area manager for signature, who will send it to central office for Bureau Chief sign-off.

WRITING FINDINGS

- The rule cites out of compliance should be listed.
- There should be a general statement identifying how the facility was out of compliance. For example, The RSP was not individualized for 3 out of 7 residents reviewed.
- The R key should be used to identify specific residents. For example: The RSP was not individualized for 3 out of the 7 residents reviewed. R2, R4, R6,
- Specific examples should be cited when possible. For example: The RSP was not individualized for 3 out of the 7 residents reviewed. R2, R4, R6,
  As evidence by the following:
  R2-RSP dated 1/1/13 did not address the resident's need for monitoring of side effects related to the Coumadin.
  R4-RSP dated 1/2/13 did not address the resident's need for assistance applying TED hose as identified in the nursing notes.
  R6-RSP dated 1/3/13 did not address the resident's need for assistance arranging transportation to dialysis and monitoring of the shunt as identified in the POS.

FOLLOW-UP REVIEWS

1. Review staff will initiate an onsite follow-up review within **10 working days** after the 30 calendar day correction period. A follow-up visit may occur earlier only if the SLP provider requests and it is approved by the BLTC regional supervisor. At the follow-up visit, review staff will determine if the SLP provider is in compliance with the previously cited areas.

2. The information/documentation reviewed during the follow-up should be related to the specific areas of non compliance noted in the findings. The process should include a general review to determine if the interventions identified in the facility's written POC have been implemented. In addition, the residents and/or staff identified in the initial findings should be reviewed to determine if the areas cited were corrected where applicable. Examples include a RSP that was not individualized or a staff person who did not have required training. In addition, a sampling of resident and/or staff documentation should be reviewed related to the issues noted. Interviews and observation should be done as needed. If an in-service was part of the POC, review staff should look at the training materials and sign-in sheet to verify the training took place and that all applicable staff were included.

3. The look back timeframe for review of documentation will vary based on the type of finding. In most instances, the review will focus on information/documentation after the 30 calendar days allowed for implementation of the POC. Some areas of non-compliance may require review of documentation prior to the implementation of the POC. Examples include a RSP not being individualized or no current quarterly completed. Another area that would

allow for review of information within the 30 day timeframe is documentation of medication delivery. BLTC central office, area manager and regional supervisor will make this determination and instruct review staff.

4. If the BLTC reviewer finds the SLP provider is in compliance, this can be indicated by writing "ok", signature/initials and the date, in the Correction Date column on the RORF form for each finding. If the SLP provider is not in compliance with one or more areas, the areas of non-compliance can be indicated with a "no", signature/initials and the date, in the Correction Date column on the RORF form.

5. The BLTC reviewer must submit a summary report to the BLTC regional supervisor in accordance with the supervisor's instructions. The write up should address each issue originally cited, including issues with specific employees/residents and the information/documentation reviewed to determine compliance. It should also include the facility's response to interventions identified in the POC. A copy of the summary report should NOT be given to the SLP provider.

6. The BLTC regional supervisor will review the summary and provide recommendations to the BLTC area manager and central office. Staff will collaborate to determine the final outcome of the follow-up review.

7. If the SLP provider continues to be out of compliance after the **first follow-up**, a second RORF Form must be completed and left with the facility (refer to Presentation of Review Results section). The facility **does not** have to complete a new POC.

8. A **second onsite** follow-up review is performed by HFS staff within **10 working days** after the second 30 calendar day correction period. Refer to procedures listed in #1-5 above.

9. If the second follow-up continues to show non-compliance, the BLTC regional supervisor should notify the area manager and central office as soon as possible. A written summary report and RORF should be completed and sent to the regional supervisor. A formal exit by BLTC reviewers will not occur. Central office will notify the SLP provider that non-compliance still remains after the second onsite follow-up review and that the Department is imposing one or more sanctions in accordance with 89 Ill. Adm. Code 146.280, Termination or Suspension of SLP Provider Agreement. The RORF Form from the second follow-up visit will be included with the notification letter sent by central office.

10. The facility does not need to submit a POC for a sanction. If the sanction in a mandatory in-service or directed plan of correction, the facility will have 30 calendar days from the date of the sanction letter to complete. Documentation must be submitted to BLTC central office by the 31st day after date of the sanction letter.

11. BLTC review staff will complete a follow-up review within **10 working days** after the 30 calendar day correction period. A written summary of the review must be provided to the BLTC regional supervisor as soon as possible. If the facility is still not in compliance, a stronger sanction may be issued by central office. Refer to #8-9 for the sanction process.

REFUTE OF FINDINGS

1. A facility may refute findings of non-compliance within **14 calendar days** of exit (5 calendar days in the case of an immediate jeopardy). Refutations must be submitted in writing to central office and should include supporting documentation.

2. Once a refutation is received, the timeline for the POC is placed on hold until the Department issues a written response. The timeline for the POC begins again once the written response from the Department is sent. Central Office will notify the regional supervisor and area manager when a refutation is received and when the written response is sent to the facility by the Department.

IMMEDIATE JEOPARDY

1. Immediate Jeopardy means a situation in which a provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death and should be reported **immediately** to the BLTC regional supervisor. Examples include but are not limited to: malfunctioning emergency call lights, malfunctioning fire alarm or sprinkler systems, elevators not operating, water temperatures in excess of 120 degrees, nursing staff and dieticians without current Illinois licensure or certification, staff without a fingerprint check completed within the required time period, inadequate food supplies, possible life threatening situations involving residents and suspected resident abuse or neglect.

2. The BLTC reviewer must submit a written summary report of the suspected immediate jeopardy issue(s) identified during the review (e-mail is acceptable) while still onsite at the facility. A copy of the summary report should NOT be given to the SLP provider.

3. In the event it is determined that findings of non-compliance result in an immediate jeopardy that poses a current risk to the health and safety of the residents, BLTC central office shall notify the facility by phone immediately. Central office shall provide a written notice and RORF form to the SLP provider. BLTC reviewers may be required to stay onsite until the area(s) of non-compliance have been abated.

4. For non-compliance involving immediate jeopardy where health and safety of resident is **not** currently at risk, BLTC central office shall provide a written notice and the RORF form to the SLP provider within **5 working days** after the conclusion of the onsite review.

5. The SLP provider shall have **5 calendar days** from receipt of the written notice to refute the findings (refer to Refute of Findings section) or submit a POC. All POCs involving immediate jeopardy must be reviewed with the BLTC area manager, regional supervisor and central office.

6. If no refutation is submitted, the SLP provider shall have **10 calendar days** from receipt of the written notice to correct the non-compliance issue(s). No extension of the 10 day period shall be granted. If a refutation is submitted, the 10 day correction period is stayed until a Department decision is made.

7. Department staff shall conduct a follow-up review within **10 working days** after the conclusion of the 10 calendar day correction period to verify compliance.

8. The information/documentation reviewed during the follow-up should be related to the area(s) specific to the immediate jeopardy. The BLTC reviewer must submit a summary report to the BLTC regional supervisor in accordance with the supervisor's instructions. A copy of the summary report should NOT be given to the SLP. BLTC central office will notify the facility in writing of the results of the follow-up review. If the immediate jeopardy remains, central office will take action to suspend or terminate the facility's provider agreement.

9. The documentation and report summary(ies) for the immediate jeopardy should be included in the review packet.

ON-SITE REVIEW COMPLETION GUIDE

INITIAL REVIEW				
	Review	Exit	Plan of Correction	Follow-up Review
Summary of Review	Discuss review with regional supervisor and/or area manager and/or central office to determine if there are findings of non-compliance.			
Review Outcome	**NO FINDINGS:** Complete cover sheet and signature page of Response to On-Site Review Findings (RORF) form.	Exit with SLP provider within 10 working days of completion of the on-site review by completing the RORF (can be done via phone and fax). Obtain signatures of team leader and SLP provider representative on RORF. Forward completed review packet to regional supervisor within 5 working days of exit.		
	FINDINGS: Complete Response to On-Site Review Findings (RORF) form. **NOTE:** all examples of non-compliance must be listed.	Exit with SLP provider within 10 working days of completion of the on-site review by completing the RORF (can be done via phone and fax). Obtain signatures of team leader and SLP provider representative on RORF.	Written plan of correction (POC) due within 14 calendar days of exit. Implementation date of any correction not to be any later than 30 calendar days after exit.	Due within 10 working days of implementation of the POC. **NOTE:** This can occur sooner than 30 calendar days after exit if the facility's POC states the correction period is sooner.

1st FOLLOW UP REVIEW				
	Review	Exit	Plan of Correction	Follow-up Review
Summary of Review	Discuss review with regional supervisor and/or area manager and/or central office.			
Review Outcome	**NO FINDINGS:** Update RORF form cover sheet with date(s) of 1st follow up. Indicate findings were corrected by writing "OK", initialing and dating in the 3rd column (Correction Date) of the RORF. Include a written summary separate from the RORF regarding the f/u review. Resident and staff names should be included, along with a description of what was reviewed.	Exit with SLP provider within 10 working days of completion of the on-site review by completing the RORF (can be done via phone and fax). Do NOT obtain a new signature page or complete a new coversheet for the RORF. Add follow-up review date (s) and mark "yes" box on the RORF to indicate findings were corrected. Forward completed review packet to regional supervisor within 5 working days of exit.		
	FINDINGS: Complete RORF form for all areas that remain out of compliance. **NOTE:** All examples of non-compliance must be listed. For any area(s) cleared, include a written summary separate from the RORF.	Exit with SLP provider within 10 working days of completion of the on-site review by completing the RORF (can be done via phone and fax). Complete a new coversheet and obtain signatures for the RORF. Add follow-up review dates and outcome	Another written POC is **not** required. SLP provider has another 30 calendar days from the date of exit to come into compliance.	Due within 10 working days after the 30 day correction period.

2ND FOLLOW UP REVIEW				
	Review	Exit	Plan of Correction	Follow-up Review
Summary of Review	Discuss review with regional supervisor and/or area manager and/or central office.			
	NO FINDINGS: Update RORF form cover sheet with date(s) of 2nd follow up. Indicate findings were corrected by writing "OK", initialing and dating in the 3rd column (Correction Date) of the RORF. Include a written summary separate from the RORF regarding the f/u review. Resident and staff names should be included, along with a description of what was reviewed.	Exit with SLP provider within 10 working days of completion of the on-site review by completing the RORF (can be done via phone and fax). Do NOT obtain a new signature page or complete a new coversheet for the RORF. Add follow-up review date (s) and mark "yes" box on the RORF to indicate findings were corrected.		
	FINDINGS: Regional supervisor/Area manager to contact central office immediately. Submit a summary of the review, including all examples of non-compliance to central office.	No formal exit by regional staff occurs.		

SANCTION

	Review	Exit	Plan of Correction	Follow-up Review
		Central office sends a sanction letter and RORF form to the SLP provider.		Determined by central office.
Follow-up Review	Provide a written summary to regional supervisor and central office.	Central office will send a written letter to the SLP provider.		Determined by central office. Another 30 day correction period can be given and/or a new sanction issued.

REFUTE OF FINDINGS

An SLP provider may refute findings of non-compliance within 14 calendar days of the exit (5 days in the case of an immediate jeopardy). Refutations must be submitted in writing to central office and should include supporting documentation.

Once a refutation is received, the timeline for the plan of correction is placed on hold until the Department issues a written response to the refutation. The timeline for the plan of correction begins again once the written response from the Department is sent. Central office will notify the regional supervisor and area manager when a refutation is received. Staff will be asked to review the refutation and offer input for the Department's response. Central office will notify the regional supervisor and area manager when the written response is sent to the SLP provider.

IMMEDIATE JEOPARDY **(Non-compliance that poses a current risk to the health and safety of residents)**

	Review	Exit	Plan of Correction	Follow-up Review
Summary of Review	IMMEDIATELY discuss with regional supervisor and/or area manager. Central office should be notified by the regional supervisor or area manager. If it is determined an immediate jeopardy exits, submit a written summary, including all examples of the IJ to central office.	Central office may require regional staff to stay on-site until the immediate jeopardy is corrected. Central office sends a letter identifying the immediate jeopardy and RORF form to the SLP provider within 5 working days.	Written plan of correction (POC) due within 5 calendar days of receipt the Department's letter. Implementation date of any correction not to be any later than 10 calendar days of receipt of the Department's letter. NOTE: in cases of immediate jeopardy, the SLP provider has five calendar days to refute the findings.	Due within 10 working days after the 10 day correction period.

Guidance for Resident Record Review

Initial admission documentation (Lag and New Admissions) :

- DON assessment
- TB screening & signs and symptoms
- Dementia diagnosis
- Advance directive information
- Sex offender checks
- Standardized interview
- Elopement Risk Assessment
- Initial assessment and service plan
- Signed resident contract
- Orientation to emergency plan

Comprehensive Resident Assessment (Assessment) (New Admissions & 20% Resident Review)

- Dates of the last two Assessments must be noted OR initial assessment and last Assessment if fewer than 2 annuals have been completed.
- Annual Assessments must be completed within 366 days.
- ALL sections of the Assessment must be completed and identified needs must correspond with the ISP.
- When *significant changes in condition are updated on the Assessment, the changes should include staff initials and date(s).
- If a resident returns from a nursing home stay that was >30 days, a new Assessment should be completed. IF the stay was <30 days, the Assessment should be updated to include any changes in condition. The updates must be signed and dated within 24 hours of return to SLP building.

Individual Support Plan (ISP) (New Admissions & 20% Resident Review)

- ISP should include ALL services being provided to the resident, including outside providers such as: home health care, family, legal guardian, Veterans' Administration, hospice, etc., as well as resident's goals.
- Make sure all needs/preferences identified on the Assessment are addressed in the ISP.
- *Significant changes in condition were updated on the ISP. Changes to the ISP should include staff initials and date(s).
- If a resident returns from a nursing home stay that was >30 days, a new ISP should be completed. IF the stay was <30 days, the ISP should be updated to include any changes in condition. The update is to be within 24 hours of return to the SLP building and must be signed and dated.
- A new ISP form does NOT need to be completed each year. Staff can indicate it was reviewed on a specific date and no changes were required. New staff and resident signatures must still be obtained.
- Home health care services (HHC)—private pay residents can receive any service. Medicaid eligible residents CANNOT receive any service that is already required to be provided by the SLP provider in section 146.230. Examples of the most common

allowable HHC services include: PT, OT, speech therapy, wound care. IV's and lab draws.

Quarterly Evaluation (New Admissions & 20% Resident Review)

- Quarterly assessments are due every 92 days. Due dates are determined by the Assessment date or the previous quarterly, whichever is later. A quarterly may be completed <92 days.
- Significant changes in condition should be noted on the quarterly.
- Make sure any incidents such as falls and hospitalizations were included on quarterly.

*"Significant Change" means that there has been a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and the decline or improvement impacts more than one area of the resident's health status and requires revision of the Service Plan.

Medication Management Services Review

Review timeframe

- Medication management documentation from the past 90 days should be reviewed. It may be necessary to review documentation prior to this time if a problem is identified.

Medication listing

- The resident's list of medication(s) is not required to be included on the medication management services form used by the SLP provider. A separate list such as, a physician order sheet, medication administration record, or other similar documents are acceptable, as long as it includes: resident's name, name of medication, dosage, directions & route of administration.

Medication Management Services Documentation

- Medication management services documentation must include at a minimum:
  - resident's name
  - date and time of service
  - notation if medication(s) was refused or missed
  - staff signature/initials
- When a resident's medication is set-up in a pill caddy or other pre-packaged format by a licensed nurse or pharmacy, it is acceptable for the CNA to document the above for a specific date and time (ex. a.m., Noon are acceptable) and NOT note each individual medication. For example, the documentation should indicate the resident was given their bubble pack containing their 8:00 a.m. medications. The resident's list of medications should identify which medications are given at 8:00 a.m. If a licensed nurse is administering medication, a specific time must be documented.
- If a resident's medications are NOT set-up, meaning the medication is maintained in a resident's apartment in individual bottles/containers, the resident can ONLY receive verbal reminders from a CNA. The resident must be assessed by the facility and found to be able to identify their medication and know the correct dosage

Medication Error Reporting

- These questions should be marked N/A if a medication error was not discovered during medication management services review.

Management of Resident Funds (20% Resident Review)

- Must be completed for residents who have their funds managed by the SLP provider. This does NOT include residents who have their monthly income deposited into the SLP provider's account for payment of room & board and Medicaid services.
- If a resident's funds are not being managed by the SLP provider, mark #1 N/A and skip the rest of this section.
- Review records to verify:
    - Signed authorization that is witnessed by someone with no pecuniary witness.
    - Funds >$50.00 are held in an interest bearing account.
    - There is a separate written record of each resident's account.
- Facility documentation should include:
    - Quarterly account information provided to the resident/representative.
    - Notification of resident/representative when account reached $200 less than the allowable asset amount (for Medicaid eligible residents ONLY).
    - Signed receipts of deposits and withdrawals.
- SLP providers are required to maintain records of the resident's account for 3 years. If the facility has been managing the resident's funds for <3 years, mark "Yes" with a comment.

Guidance for Review of Management of Resident Funds

1. Does the facility manage the resident's funds? NOTE: This includes managing a resident's personal needs allowance and/or any available assets.
Questions 4 & 5 on page 5 of the SLP Tool will help determine if the facility is managing resident funds. BLTC staff may also ask the manager. If the facility is managing resident funds, a listing of residents who receive this service should be requested.

2. Did the resident, resident's guardian, representative or immediate family give written authorization to the facility to manage a resident's funds?
Look for signed documentation in the resident's file, or request the documentation from the facility if it is maintained in another location. **NOTE:** if this was confirmed during a previous on-site review, BLTC staff may check N/A with a comment.

3. Was this authorization witnessed by someone who has no pecuniary interest in the facility or its operations and who is not connected in any way to facility personnel or the manager?
This question is asking if the witness is related to the facility or facility staff in any capacity. BLTC staff should review the signature of the witness to make sure it is not that of an employee, or someone affiliated with the SLP provider. **NOTE:** if this was confirmed during a previous on-site review, BLTC staff may check N/A with a comment.

4. If resident's funds are in excess of $50.00, are the funds held in an interest bearing account?
Review facility bank statements for the residents' fund account to confirm that interest is being earned.

5. Is there a separate, written record of the resident's account?
Request to see the SLP provider's individual record keeping for each resident's funds.

6. Does the facility provide a written record of the account at least quarterly to the resident or authorized representative included on the account? What is the most recent statement amount?
Review the last 4 quarterly records, or those distributed since the last on-site review. Electronic versions are acceptable.

7. Did the facility notify DHS of any changes in the resident's circumstance or lump sum payments received?
If a quarterly record reflects a deposit that is out of the ordinary (for example, a deposit of $1,000 is shown one month, when the resident's usual pension check is $600), request to see the HFS 1156 Long Term Care Facility Notification form that the SLP provider should have forwarded to the DHS caseworker.

8. Did the facility notify the resident when the amount in the resident's account reached $200 less than the asset limit ($2,000 for one person, $3,000 for a couple)? NOTE: Only applies to Medicaid eligible residents.
If a quarterly record indicates a resident's funds, were $1,800+ or a couple's was $2,800+, ask to see documentation that the resident(s) or their designated representative were informed.

9. Does the facility maintain signed receipts of deposits and withdrawals to the resident's accounts?
Review facility documentation of transactions.

10. Has the facility maintained records of the resident's managed funds for the last 12 months on-site?
Make sure at least 12 months of documentation is maintained on-site at the facility.

XII. DOCUMENTATION/COMMENTS

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUPPORTIVE LIVING PROGRAM (SLP)
RESPONSE TO ON-SITE REVIEW FINDINGS

SLP PROVIDER NAME: _____

CHECK ONE:

( ) INTERIM CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) FINAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) ANNUAL CERTIFICATION REVIEW FINDINGS: YES ☐ NO ☐
( ) BI-ANNUAL CERTIFICATION (Dementia Units ONLY)

ENTRANCE DATE: _____ EXIT DATE: _____

( ) CHANGE OF OWNERSHIP REVIEW FINDINGS: YES ☐ NO ☐

ENTRANCE DATE: _____ EXIT DATE: _____

( ) GENERAL FINDINGS (Use for findings noted during informal visits to SLP)
Findings should be written under this section for non-compliance of rules that impact the health and safety of facility residents and/or staff.

BEGIN DATE: _____ EXIT DATE: _____

( ) COMPLAINT REVIEW DATE OF COMPLAINT: _____

REFERRAL DATE: _____ **REVIEW FINDINGS:** YES ☐ NO ☐

BEGIN DATE: _____ END DATE: _____

( ) FIRST FOLLOW-UP REVIEW ( ) SECOND FOLLOW-UP REVIEW

(1st) BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

(2nd)BEGIN DATE: _____ END DATE: _____

FINDINGS CORRECTED: YES ☐ NO ☐

For non-compliance found during an interim review or interim/final completed simultaneously-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider must complete and return the Response to On-site Review Findings form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. The SLP provider's response must include dates of correction for each finding.

For non-compliance involving immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within five working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within five calendar days from the date it was received from the review team. The SLP provider has ten working days from the date it was received from the review team to correct the non-compliance. No extension of the ten-day period will be granted. BLTC staff must conduct a follow-up review within ten working days after the conclusion of the ten-day immediate jeopardy correction period. If the follow-up continues to show immediate jeopardy, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to suspend or terminate the SLP provider agreement.

For non-compliance involving non-immediate jeopardy-

The Response to On-Site Review Findings form must be provided to the SLP provider within ten working days after the conclusion of the on-site review. The SLP provider should complete and return the form to the BLTC regional supervisor within 14 calendar days from the date it was received from the review team. Initially, no correction date is to be later than 30 days from the date that the findings were presented to the SLP provider unless there is justification documented by the SLP provider. Within those 30 days, the SLP provider is responsible for notifying the regional supervisor the status of the corrections or that the corrections have been completed. The regional supervisor or designated staff will make a follow-up visit to the SLP provider within 10 working days of the SLP provider's notification or take other appropriate steps to determine if all corrective action has been taken. If the first 30-day follow-up review continues to show non-compliance, the facility is granted a second 30-day period to correct the non-compliance issues. If the second follow-up continues to show non-compliance, the regional supervisor should notify the area manager and BLTC central office. BLTC central office will take action to apply one or more of the sanctions allowed depending on the severity of the non-compliance.

_____ _____

Signature of SLP Provider Representative Date

_____ _____

Signature of Bureau of Long Term Care HFSN Date

_____ _____

Signature of Bureau of Long Term Care Regional Supervisor Date

_____ _____

Signature of Bureau of Long Term Care Area Manager Date

RESPONSE TO ON-SITE REVIEW FINDINGS **PAGE ____ OF _____**

PROVIDER NAME: _____ REFERRAL DATE: _____

First Follow-up ( ) Second Follow-up ( )

Note: Due to privacy concerns, resident and employee names cannot be used in the Complaint/Finding Description or in the SLP Response. Use a resident and/or employee identifier key (R-1, R-2, etc. for residents and E-1, E-2, etc. for employees). Submit the corresponding identifier key with this form.

COMPLAINT/FINDING DESCRIPTION (Must include rule cite)	**SLP RESPONSE**	**CORRECTION DATE**

Signature of SLP Provider Representative_____Date_____

RESIDENT/STAFF IDENTIFIER KEY

R-1 Name:
Private Pay/Medicaid:
Apartment #:

R-2 Name:
Private Pay/Medicaid:
Apartment #:

R-3 Name:
Private Pay/Medicaid:
Apartment #:

R-4 Name:
Private Pay/Medicaid:
Apartment #:

E-1 Name:
Staff Position:

E-2 Name:
Staff Position:

E-3 Name:
Staff Position:

E-4 Name:
Staff Position:

TEAM LEADER'S ON-SITE REVIEW SUMMARY AND RECOMMENDATION

1. Are residents' age appropriate for the SLP (65+)?

   If no, list names(s)_____

2. Do all residents have a DON date prior to admission, or were an allowable post-screen?

   If no, list name(s)_____

3. Do any residents have a primary or secondary diagnosis of DD or serious and persistent MI and were NOT determined to be appropriate for an SLP according to the screening completed by a DHS DDD ISC or DHS DMH PAS screening agent?

   If yes, list name(s) _____

2. Did all residents have a TB test or documentation of a TB test in accordance with the Control of Tuberculosis Code?

   If no, list name(s)_____

3. Was a Checklist of Signs & Symptoms of TB Disease completed within 7 days after admission?
   If no, list name(s)_____

6. Were all residents and/or their designated representative informed of advanced directives, including the Durable Power of Attorney for Health Care, Statement of Illinois Law on Advance Directives, Living Will, Declaration for Mental Health Treatment and Do Not Resuscitate?
   If no, list names(s) _____

7. Were all residents checked against all three of the identified sex offender websites prior to admission (Illinois State Police, Department of Corrections and U.S. Department of Justice Dru Sjodin National Offender Public Website) and NO sex registered offenders were admitted?
   If no, list names(s)_____

8. Did all residents have documentation of a MD diagnosis of Alzheimer's disease, related dementia or conditions of internal pathological changes to the brain?

   If no, list names(s)_____

7. Did all residents have an Elopement Risk Assessment completed prior to admission and quarterly thereafter?

   If no, list names(s) _____

8. Were all residents given a standardized interview at or prior to admission?

   If no, list names(s) _____

11. Do all residents have an initial assessment completed or co-signed by an RN within 24 hours after admission ?

    If no, list name(s) _____

12. Do all residents have a housing and service contract signed by the facility and resident or their designated representative?

    If no, list name(s) _____

13. Do all residents have a comprehensive assessment(s) completed or co-signed by an RN in place within 14 days of admission and/or completed within 366 days of previous CRA?

    If no, list name(s) _____

14. Do all residents have a comprehensive assessment that is completed thoroughly?

    If no, list name(s) _____

15. Do all residents a comprehensive assessment that is completed accurately?

    If no, list name(s) _____

16. Do all residents have a MOCA or SLUMS assessment completed within 7-14 days of admission or completed within 366 days of the previous one?

    If no, list name(s) _____

17. Do all residents have a service plan developed or co-signed by an RN in place within 7 days of completing the comprehensive assessment?

    If no, list name(s)_____

18. Are all service plans reviewed/signed by the resident or his/her designated representative?

    If no, list name(s)_____

19. Are all service plans individualized to each resident's needs?

    If no, list name(s)_____

20. Do service plans include coordination and inclusion of services for residents who receive services delivered by an outside entity?

If no, list name(s)_____

21. Are resident declined services noted on the service plan?

If no, list name(s)_____

22. Did residents have a significant change in condition that was not addressed in the service plan?

If yes, name(s) _____

23. Do all residents have quarterly evaluations completed co-signed by a RN at least every 92 days?

If no, list name(s) _____

24. Did residents have a significant change of condition that was not addressed in the quarterly assessment??

If yes, name(s) _____

25. Was the resident, designated family representatives and physician notified when change in the resident's mental or physical status was noted by SLP provider staff? This includes the requirement to report serious or life-threatening situations within 24 hours.

If no, list name(s) _____

26. Were Concerning Activity Logs completed on all applicable residents and reviewed by a nurse at least weekly?

If no, list name(s) _____

27. Was there a correct list of the resident's medication, including resident's name, name of medication, dosage, directions, and route of administration??

If no, name(s) _____

28. Was there documentation of date and time medication management services were provided in the form of verbal reminders, assistance with medication container(s) and /or medication administration that was initialed by staff?

If no, name(s) _____

29. Are resident medication refusals documented by the staff?

If no, name(s) _____

30. Were Medication Error Reports completed for identified medication errors?

If no, name(s) _____

31. Were identified medication errors resulting in hospitalization reported to the Department within 24 hours?

If no, list names(s) _____

32. Were any minor areas of non-compliance remediated while still on-site? Includes rule cite(s) and specific examples(s) and also the remediation (how SLP provider corrected).

_____
_____
_____
_____
_____

NOTE: Before exiting, leave a supply of the Department's SLP brochure on how to file a complaint with the Department to report suspected abuse, neglect and exploitation.

List any other issues and concerns found during the review and the team leader's recommendation.

_____
_____
_____
_____
_____ _____

Team Leader Signature Date

SUMMARY/COMMENT/RECOMMENDATION SHEET

Submit completed packet to regional supervisor. Supervisor should review for accuracy and document comments/recommendations where appropriate. Supervisor submits packet to Area Manager for review and determination of compliance.

1. # of Record Reviews completed: Medicaid_____Private Pay_____

N/A ( )=Empty building review

2. # of Residents Interviewed: Medicaid_____Private Pay_____

N/A ( )=Empty building review ( ) =Unit expansion review

3. Occupied building review converting to a SLP building with only private pay residents: Yes ( ) No ( ) (If Yes, a minimum of 10 record reviews and resident interviews are to be completed.)

4. The record review_____and/or resident interview_____was expanded (N/A_____) by 10% ____or more_____ due to the following:

_____

_____

_____

5. The justification to expand the sample was approved by the Area Manager or representative.

Name, and title of representative and date:_____

6. Was this review initiated in proper timeframes? Yes ( ) No ( )

If no, document why:_____

_____

7. Have any waivers been granted to this SLP provider? Yes ( ) No ( )

If yes, document date and reason for waiver(s)_____

_____

8. This review resulted in _____finding(s) and all follow-up reviews have been completed and are included in this packet. **NOTE:** Findings=# of administrative rule cites, NOT the number of specific individual examples of non-compliance.

For Annual Reviews Only:

Level of Care Determinations (LOCD) are to be completed on ALL Medicaid residents who were not admitted since last annual review.

9. _____of_____LOCD required additional documentation to justify SLP LOC.
Note: Do NOT perform LOCD reviews on private pay residents.

10. _____LOCD could not justify SLP LOC and was discussed with Area Manager or representative.

Name and title of representative and date:_____

11. Identify resident(s) by key who did not qualify for the SLP.

LOC:_____,_____,_____.

The RAI and/or additional documentation justifying reason(s) for not qualifying for SLP LOC is attached to the individual record review.

12. Additional issues/concerns: Yes ( ) See attached page. No ( )

13. Based on the results of this review, including all follow-up reviews, it is recommended that SLP certification be approved_____not approved_____. If not, see attached page for justification.

_____ _____

Regional Supervisor Signature Date