

Illinois Department of Human Services
 Division of Developmental Disabilities
 Children's Residential Waiver
 Setting Observations

Agency _____ Home Address _____

Yes	No	Living Environment
		<p>Is the living environment comfortable and free of hazards?</p> <p>Is the temperature of the house comfortable?</p> <p>Is there a working telephone in the house?</p> <p>Is there a properly charged and inspected fire extinguisher? Is there a carbon monoxide detector?</p> <p>Are the window, window screens and window coverings in good repair?</p> <p>Are household supplies and dangerous items securely stored?</p> <p>Does water drain freely from sinks, showers and stools?</p> <p>Are there cameras in the home? If so, is there an agency policy?</p> <p>Are there alarms on the doors/windows? If so, is there an agency policy?</p>
		<p>Are there hand towels and toilet paper in the bathrooms?</p> <p>Is there hand washing soap available?</p> <p>Are there ample grooming supplies for each person (shampoo, deodorant, toothpaste)?</p>

Yes	No	Observation and Interaction with Staff and Child
		<p>Does the child have their own bedroom?</p> <p>If not, how was the roommate chosen (person, guardian, agency)? Is there a conflict between the roommates, if so, how is it handled?</p> <p>Does the person have enough privacy?</p>
		<p>Are the bedrooms personalized to reflect individual personality, hobbies etc? If so, who chose items?</p>
		<p>Is food available to child at all times? If not, what are the guidelines for availability?</p>
		<p>How is the home daily schedule determined? Do the children have input or does the agency determine daily routine and activities?</p> <p>How is the amount of personal time determined?</p>
		<p>Is there community access for medical appointments, other services as well as activities?</p>

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Agency _____ Home Address _____

		Are there activities available in the home? (board games, sports equipment, computer, craft materials?) Are they able to access and utilize their yard and or neighborhood?
		Is the home physically accessible for all people who live there as well as their visitors?

Employees Present in the Home During the Visit:

Employee Name	Title :DSP, QIDP, Manager, Other	Does the person report being an ADSP?	Does the person have access to medication?
		Yes No	
		Yes No	
		Yes No	
		Yes No	

Other Observations:

Name of the Residents of the Home: First Name Only

	Name	Was this person home during the visit?
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No
_____		Yes No

**Illinois Department of Human Services Division of Developmental Disabilities
FY18 Waiver Performance Measure and Outcome Measure Data Sheet**

Name of Person: _____ Address: _____ City _____ Zip _____

Provider Agency Name: _____ Phone: _____

ISC Agency: _____ Date of Birth: _____

Section I

Provider Agency Date Gathered: _____ Date of meeting with Participant: _____ Reviewer Initials: _____

Has this person expired? Yes ___ No ___ Date of Death _____ Did person expire at agency Yes ___ No ___ If no, Where _____

Has this person been discharged/transferred? If yes, to where? _____

IF THIS IS A SF/SDA record who is responsible for the record? ISC ___ Provider Agency ___

Name of Entity responsible _____

Yes	No	NA		Corrected	Correction Required
			1). Is the ISP updated at least annually? PM -D7 (24Dc) (If the record contains a PCP record on the ISC worksheet #1)		
			2). Are the ISP <u>contents</u> developed in accordance with state requirements addressing all assessed needs per the ISC checklist? PM D5 (24Da) (If the record contains a PCP record on the ISC worksheet #2)		
			3). Does the ISP address all health and safety risks indicated in the assessment? PM D2 (23D) (If the record contains a PCP record on the ISC worksheet #3)		
			4). Does the ISP address all participant needs identified by the assessments? PM D3(21D) (If the record contains a PCP record on the ISC worksheet #4)		
			5). Do the ISP or implementation strategies address all personal goals/outcomes identified by the assessment or discovery? PM D4 (new)		
			6). Are the Implementation strategies updated in a timely manner when there is a change in participants need(s)?		
			7) If the person has restrictive interventions, were all procedures followed as required? PM G7 (36G)		
			8). Does the person receive services in the scope, amount, duration and frequency specified in the plan? PM D10 (28D)		
			9). Does the person receive the coordination and support needed to access healthcare services listed in the plan? PM G8 (34G)		

		10). Is there documentation in the record that the participant (and/or guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver? PM G1 (32G)		
		11). Is the ISP approved by all required entities within the required time frames? PM D6 (24Db) (If the record contains a PCP record on the ISC worksheet #6)		
		12). For all critical incidents reviewed were corrective measures appropriately taken? Note: Other than abuse, neglect and exploitation. PM G6 new		
		13). For those with substantiated incidents of abuse, neglect, or exploitation were corrective actions taken? PM G2 new		
		14). During the course of the review, were there any incidents of alleged abuse, neglect and/or exploitation reported to OIG for this waiver sample person? Describe:		
		<i>Personal Outcome Measures (ADD ONLY)</i> – (Guidance Personal Outcome conversation and decision making worksheet):	<u>Outcome</u> Present – 1 Not Present - 0	<u>Support</u> Present – 1 Not Present - 0
		15). People are connected to natural supports		
		16). People have friends		
		17). People choose where they work		
		18). People choose personal goals		
		19). People participant in the life of the community		
		20). People are safe		
		21). People have the best possible health		
		22). People exercise rights		
		23). People are free from abuse and neglect		

COMPLETE PERSONAL OUTCOME MEASURES WORKSHEET

FY18

Personal Outcome Measures Recommendations to Agency

Based on time spent getting to know the person during the Personal Outcome Measures meeting, make three to five recommendations for the person and his/her planning team:

For the organization AS A WHOLE, what's going well?

Recommendations or considerations for the organization:

Section II: Guardian Interview

Guardian Name: _____ Guardian Address: _____ City, State, Zip _____

Guardian Phone(s): _____ Guardian Relation to Person: Parent ___ Family Relationship) _____

Date of Initial Guardian Contact: _____ Second Attempt Date: _____ Third Attempt Date: _____

Letter Sent Date _____ (Please include Reviewer initials after each entry)

Yes	No	
		1) Are all services that are needed by <i>(name of person)</i> addressed in the ISP/PCP? PM D1 (22D) Comments / Problems Noted:
		2) Are all services listed in the ISP/PCP received by <i>(name of person)</i> ? PM D11 (26D) Comments / Problems Noted:
		3) Does guardian report any issues with neglect, exploitation, restraint, seclusion or restrictive interventions? Is <i>(name of person)</i> free from abuse, neglect or exploitation? Comments / Problems Noted: <i>(use reverse of paper if needed to document)</i> If the guardian reports any issues in any of these areas, follow mandated reporter guidelines. Call Springfield Central office for direction if needed.
		4) Did you receive information or education regarding the new person centered plan process? If no, would you like information? Yes ___ No ___
		Are all environments accessed by <i>(name of person)</i> safe?
		Does <i>(name of person)</i> have the best possible health?
		Does <i>(name of person)</i> have friends and family he/she spends time with?
		Does <i>(name of person)</i> want to work? Does <i>(name of person)</i> have a paying job?
		Does <i>(name of person)</i> make decisions about (his/her) life?
		Does <i>(name of person)</i> contribute to his/her community? Does <i>(name of person)</i> participate in life of his/her community?

Guardian Interview Notes:

WAIVER SAMPLE RECORD: YES ___ NO ___ Check One: Personal Plan ___ Individual Service Plan ___

Check one: ADULT: CILA ___ DT ___ Service Facilitation/SDA ___ OR CHILDREN: (CSW) (service facilitation) ___ CRW Waiver ___

Section III: ISC Agency

ISC Agency: _____ Name of Person: _____

Date Gathered: _____ Reviewer Initials: _____

Provider Agency Name: _____ Date of Review at Provider Agency _____

Yes	No	NA		Corrected	Correction Required
			1). Is the PCP updated at least annually? PM -D7 (24Dc) <i>(not applicable if an ISP was reviewed previously at the person's agency)</i>		
			2). Are the PCP contents developed in accordance with state requirements addressing all assessed needs during the Discovery process? PM D5 (24Da) <i>(not applicable if an ISP was reviewed previously at the person's agency)</i>		
			3). Does the PCP address all health and safety risks indicated in the discovery? PM D2 (23D) <i>(not applicable if an ISP was reviewed previously at the person's agency)</i>		
			4). Does the PCP address all participant needs identified by the Discovery? PM D3(21D)		
			5). Is the PCP updated in a timely manner when there is a change in participants need(s)? PM D8 (25D)		
			6). Is the PCP approved by all required entities within the required time frames? PM D6 (24Db) <i>(not applicable if an ISP was reviewed previously at the person's agency)</i>		
			7). If the record contains a PCP, did person receive at least 2 visits from the ISC during the past 12 months to monitor that services are being delivered in accordance with the services in the plan of care:? PM D9 (27D) <i>(See Guidance/Reference)</i> If the record contains an ISP: A. Most recent visit Date _____ Location _____ Purpose: _____ B. Visit prior to A Date _____ Location: _____ Purpose: _____ C. Visit prior to B: Date _____ Location: _____ Purpose: _____ D. Visit prior to C : Date _____ Location: _____ Purpose: _____ Other Visit Date: Date _____ Location: _____ Purpose: _____		
			8). Was the Level of Care Initial and Redetermination of waiver eligibility completed as required? PM B2 (13B)		
			9). Were both the initial and redetermination forms completed by a QIDP? PM B3 (14B) Request QIDP list from Quality Enhancement Staff and verify if person signing is a QIDP		
			10). Is the person informed annually of the right to choose providers? PM D12 (30D) Date: _____ Date: _____		
			11). Is the form, "Rights of Persons in Medicaid Home and Community-Based Services" (IL462-1201 R-06-17) on file, completed correctly, and signed annually? PM D13 (31D) Date: _____ Date: _____		

WAIVER SAMPLE RECORD: YES ___ NO ___ Check One: Personal Plan ___ Individual Service Plan ___

Check one: ADULT: CILA ___ DT ___ Service Facilitation/SDA ___ OR CHILDREN: (CSW) (service facilitation) ___ CRW Waiver ___

Division of Developmental Disabilities
Bureau of Quality Management

30 days prior to hire and no later than 1 st day in paid status? (Required for all staff as of 7/1/09. Required only for staff working with children hired between 7/1/07 and 7/1/09.)										
Date of the most recent Illinois Sex Offender Registry check?										
Was most recent Illinois Sex Offender Registry check within the past 13 months?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N		
Date HFS OIG Sanction list checked										
HFS OIG Sanctions list checked no sooner than 30 days prior to hire and no later than 1 st day in paid status? (Hired on or after 7/1/08)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N		

Code	Initials	First Name	Last Name
E1			
E2			
E3			
E4			
E5			
E6			
E7			
E8			

Check One: Personal Plan ___ Individual Service Plan ___ Check one: ADULT: CILA ___ DT ___ ASF/SDA ___ OR CHILDREN: CSF/SDA ___

Environmental Checklist

Date:		Time:	Provider Agency:
Site Address:			Check one _____ Agency Controlled _____ Individually Controlled
Review Completed by:			Check one _____ Developmental Training _____ CILA
Yes	No	A. Fire Safety – AGENCY CONTROLLED SITES ONLY	
		1. Is the means of exit suitable for individuals?	
		2. Are smoke detectors present and working?	
		3. Are there appropriate designated outside areas for smoking?	
		4. Is there a properly charged and inspected fire extinguisher?	
Yes	No	B. Physical/Environmental/Maintenance - AGENCY CONTROLLED SITES ONLY	
		1. Are stairs and halls free of obstacles?	
		2. Are all areas in good repair?	
		3. Is the area clean and free of foul odors?	
		4. Are cleaning compounds, pesticides and other chemicals stored properly?	
		5. Is there a working telephone?	
		6. Is the temperature comfortable?	
		7. CILA ONLY: Are there no more than (8) individuals living in the home?	
		8. CILA ONLY: Are there no more than (2) individuals per bedroom?	
		9. CILA ONLY: Does traffic pattern avoid going through other’s bedrooms?	
Yes	No	C. Water Supply/ Sewage Disposal - AGENCY CONTROLLED SITES ONLY	
		1. Does the water drain freely from sinks, tubs, showers, stools?	
		2. Are there toilet paper and hand towels in bathrooms?	
		3. Is water temperature at a safe level?	
		4. CILA ONLY: Is there at least one working bathroom for every 4 individuals in the home?	
Yes	No	D. Food Service Sanitation Hazards - AGENCY CONTROLLED SITES ONLY	
		1. Are foods stored at safe temperatures?	
		2. Are foods properly stored?	
		3. Are food items within the expiration date?	
		4. CILA ONLY: Is there a sufficient supply of food for all individuals being served in the home (i.e. for 2 days)?	
		5. CILA ONLY: Is there sufficient cooking equipment, utensils, and clean dishes?	
Yes	No	E. Emergency/Precautions - AGENCY CONTROLLED SITES ONLY	
		1. Is the Abuse/Neglect reporting number posted?	
		2. Is the Poison Control number posted?	
		3. Is there a posted disaster plan with evacuation?	
Yes	No	F. Health/Safety Issues - AGENCY CONTROLLED SITES ONLY	
		1. Is a first aid kit available?	
		2. Are medications secured?	
		3. Is building free from observable mold?	
		4. Is there adequate staffing to meet needs of persons served with at least 1 fully trained DSP present when persons served are present?	
		5. Is the area free from evidence of roaches, rodents, flies, fleas, etc.?	
		6. If the site used by people with mobility impairments, is it accessible?	

Check One: Personal Plan ___ Individual Service Plan ___ Check one: ADULT: CILA ___ DT ___ ASF/SDA ___ OR CHILDREN: CSF/SDA ___

Environmental Checklist

Yes	No	G. Individual Rights/Quality of Life
		1. Is the site free from any undocumented right's restrictions?
		2. Are meaningful recreational/training activities available?
		3. Is there sufficient opportunity for privacy during personal care activities?

Employees Present in the Home During the Visit:

Employee Name	Title :DSP, QIDP, Manager ,Other	Does the person report being an ADSP?	Does the person have access to medication?
		Yes No	
		Yes No	
		Yes No	
		Yes No	

Other Observations:

Name of the Residents of the Home:

Name	Was this person home during the visit?
	Yes No
	Yes No
	Yes No
	Yes No
	Yes No
	Yes No
	Yes No
	Yes No

For Individually Controlled CILA Sites Only:

Is area safe and appropriate to the needs of the individuals living in the home? ___Yes ___No

If "no," describe problems

noted _____

DEATH

Agency Name: _____ Date of Review: _____

Type of Review: CILA _____ DT _____ CGH _____ ASF _____ CSF _____

Upon arrival at agency, ask for list of deaths that occurred at the agency during FY17.

Requirement	
1. For FY17, Number of deaths at agency _____	
2. For FY17, Number of deaths that occurred upon transfer to hospital or skilled care facility. _____	
3. How many of the Deaths were reported to and documented by OIG or DCFS in the allotted time frame? _____	
+++++	
Reason Death was not reported to required authority in the allotted time frame? (list each death not reported below)	
Death Not Reported (Name)	DOD Reason Not Reported
Percentage Score: Calculate the percentage of deaths reported to the appropriate authorities in the allotted time frame? Divide Number 2 by Number 1 _____	

Reviewed by _____

What deaths are reportable?

It must be reported to OIG if the individual dies on-site in any program that is operated, licensed, certified or funded by DHS, like;

-Residential facilities and CILAs,

-Day treatment and developmental training sites and

-Mental health outpatient programs.

It is also reportable if the individual dies within:
14 calendar days after discharge or transfer, or
24 hours after deflection from a residential program or facility.

What if Deflection?

Deflection is when an individual comes to a facility or agency for admission or services but is not admitted by the staff.

It does not matter why he or she was deflected. If he or she was turned away or sent somewhere else and died within 24 hours, then you must report it to OIG when you become aware of it.

Remember: If a death may have resulted from abuse or neglect, it must be reported to OIG within four hours of initial discovery.

**Overview of Review Plans
FY18**

Division of Developmental Disabilities
Bureau of Quality Management

October 10, 2017

Life Choices Impact on Review Activity

- Rules (115, 116, 119, 120) have not yet “caught up” with new expectations
- BQM will focus on the waiver performance measures and interpret based on whether or not the PCP has occurred for the individual in the sample
 - ISP – rules apply as currently written
 - PP – new expectations apply

**Life Choices Impact on Review
Activities**

- Similar expectations for reviews by BALC and DDD Bureau of Clinical Services (nurses)
 - Specific questions/concerns?
 - Self-medication goals (required after conversion to personal plan only if consistent with the person’s expressed outcomes)

BQM Review Changes from FY17 to FY18

- Minimal changes to data that will be gathered
- Some data previously gathered at provider will be reviewed at ISC agency (if new person-centered planning process has been implemented for the individual in the sample)
- Addition of Personal Outcome Measures interviews with adults (with focus on Division's outcomes)
- Incorporation of mobile application for reviewers

FY18 (continued)

- Post-review feedback will be web-based and anonymous (SurveyMonkey)
- Additional review of deaths that occurred during FY17 for agencies in the sample

FY18 Components

	CILA	DT	Adult SDA/SF	Child SDA/SF	Child Group Home
Waiver Performance Measures	X	X	X	X	X
Environmental Check	X	X			X
National Core Indicators	X	X	X		
Personal Outcome Measures	X	X	X		
Death Worksheet	X	X	X	X	X
Staff Training			X*	X*	X*
Background Checks			X*	X*	X*

* Only if agency does not provide services subject to review by BALC

Sample Selection

- Random selection
- Number of participants is enough to be “representative” of each waiver
- Sample selected in Spring of year prior to initiation of review
 - For FY18, that means selected in March/April of 2017
- Based on billing for July – December prior to selection
 - For FY18, that means bills in July – December 2016)

Sample Participants

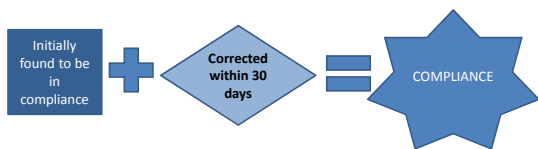
- Specific to the waiver for which they were selected
- Not provider-specific
- If person remains in the same waiver but moved to another provider, review will be done at the NEW provider
- If person left the waiver, review will be done at the LAST recorded provider based on information available at the end of service

FY18

- Adult waiver: 400
- Children’s Support Waiver: 296
- Children’s Residential Waiver: 146
- Total of 165 provider agencies
- All 17 ISC agencies
- No scores issued
- Technical assistance available, as needed

Corrective Action

- Medicaid Home and Community Based Waiver expectations require 100% compliance with waiver performance measures



Corrective Action (continued)

- Correction of the specific finding for the individual in the sample (when possible)
- Correction of systemic issues that will prevent recurrence of the findings
- For FY18
 - submit evidence of correction of the finding for the person(s) in the sample
 - if person no longer receives services, submit evidence of how issue will be systemically addressed

Review of Individual Tools

- FY18 Waiver Performance Measure and Outcome Measure Data Sheet ([DDQR-1000](#))
- Environmental Checklist ([DDQR-2000](#) and [DDQR-2001](#))
- Death Worksheet ([DDQR-3000](#))
- Training and Background Check ([DDQR-1300](#))
- Other documents/worksheets (Entrance Exit form, POM worksheet)

Wrap Up

- Continuing Education Credits for QIDPs
 - <http://www.dhs.state.il.us/page.aspx?item=45329>
- Follow Up Questions
 - Jayma Bernhard Page
jayma.bernhard@illinois.gov
 - Jerry Wood (Central and Southern regions)
Jerry.A.Wood@illinois.gov or 217-782-8286
 - Pamela Manning (Northern, Metro, Cook regions)
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