Buchanan Ingersoll & Rooney PC

Salvatore G. Rotella, Jr.
215 665 5365
salvatore.rotella@bipc.com

Two Liberty Place
50 S. 16th Street, Suite 3200
Philadelphia, PA 19102-2555
T 215 665 8700
F 215 665 8760

January 31, 2020

VIA U.S. MAIL

Mr. Gregg Brandush
Mr. Michael Potjeau
Department of Health and Human Services
Centers for Medicare & Medicaid Services
CMS-Chicago, Survey & Operations Group
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

Re: Northern Illinois Academy (CCN # 14L016)

Dear Mr. Brandush and Mr. Potjeau:

This firm represents Northern Illinois Academy ("NIA") and its ultimate parent company, Sequel Youth and Family Services ("Sequel"). We are writing in response to your January 24, 2020 letter to NIA terminating its CMS Certification Number ("CCN") effective January 24, 2020. *See* Exhibit A (the "Decertification Letter").

The facility has been providing services as NIA since April 11, 2018 and proudly serves a culturally diverse population of young people (between the ages of 6 and 21) who are seeking to live with co-occurring mental illnesses, autism with co-occurring mood disorder, or mental illness combined with neurodevelopmental delays. NIA's stated mission is to "provide creative, individualized care for children and families in a safe, therapeutic environment to prepare for a positive, fulfilling future."

NIA highly values its role as a Joint Commission-certified facility and, at least until just recently, CMS-approved Psychiatric Residential Treatment Facility ("PRTF"). We write today to provide additional facts relevant to CMS' termination decision and in the hopes that we can work collaboratively with your office to reinstate NIA's CCN as soon as possible.

Decertification Decision

We understand from the Decertification Letter – as well as from subsequent phone conversations between Anthony Penn of NIA, Matt Wilburn of Sequel, and Mr. Potjeau – that the primary reason the Centers for Medicare and Medicaid Services ("CMS") is terminating NIA's CCN and prohibiting it from continuing to identify itself as a PRTF is CMS' finding that NIA does not have a Medicaid provider agreement with the Illinois Department of Healthcare and Family Services" ("HFS") or with any other State Medicaid Agency ("SMA").

The Decertification Letter also cites to certain deficiencies in NIA's compliance with the federal restraint and seclusion regulations applicable to PRTFs identified during an Illinois Department of Public Health survey in December 2019 (the "December 2019 Survey"). According to the letter, those deficiencies "constitute a separate basis for termination of" NIA's participation with CMS. Because of NIA's alleged lack of a current provider agreement with an SMA, however, CMS has taken the position that the termination of NIA's CCN is "voluntary." Thus the facility is not entitled to the opportunity CMS and SMAs customarily offer Medicaid provider participants to cure any deficiencies in regulatory compliance identified during the survey process.

NIA's Medicaid Provider Agreements

After additional due diligence, NIA has confirmed that any termination of its CCN on the basis that it does not have an active provider agreement with an SMA is unfounded. That is the case because NIA does in fact have such an agreement with HFS, the SMA in Illinois. NIA included that contract – as signed by NIA, with an effective date of December 21, 2012, and with an indefinite term – as part of a Medicaid enrollment package NIA submitted to HFS in October 2012. *See* Exhibit B (the "NIA/HFS Medicaid Agreement"). While the facility's records do not include a version of the NIA/HFS Medicaid Agreement countersigned by HFS, NIA has at all times thereafter acted in the good faith belief that it is both a PRTF and a participating provider in Illinois Medicaid. More important, HFS and other Illinois state agencies have likewise consistently treated NIA as a Medicaid participant. Finally, neither NIA nor HFS has ever terminated the NIA/HFS Medicaid Agreement.

With respect to NIA's own conduct, we note that, consistent with its PRTF status, it has submitted the CMS-mandated annual attestations to HFS representing compliance with the federal standards governing seclusion and restraint. *See, e.g.*, Exhibit C.

For its part, HFS has repeatedly confirmed NIA's PRTF status, most recently through a recertification survey on July 28, 2016, during which HFS "determined [NIA] to be in compliance with all federal requirements." *See* Exhibit D. The Illinois Division of Mental Health similarly acknowledged and documented NIA's successful enrollment with HFS in Illinois Medicaid via an email on January 8, 2013 anticipating that the facility could begin submitting claims to the program

shortly thereafter. *See* Exhibit E. The Illinois Department of Public Health, in turn, included NIA on its published list of current Illinois PRTFs as recently as October 2, 2019. *See* Exhibit F.[1]

The December 2019 Survey

We understand that an elected official in Oregon has lobbied extensively to prevent NIA from continuing to treat young people from Oregon. We believe those efforts are misguided and unfortunate, and we would like to stress that the official's allegations of improper care at NIA are largely unfounded.

To that end, we certainly acknowledge that the December 2019 Survey determined that a student at NIA was improperly restrained and identified certain other (albeit limited) related training and treatment planning deficiencies. *See* Exhibit H and Exhibit I. We respectfully submit, however, that contrary to their written report, the HFS surveyors in fact never informed NIA that these circumstances rose to the level of Immediate Jeopardy. *See* Exhibit H at 1. Nor did the survey bring to light any systemic quality of care issues that would normally warrant the significant step of terminating a CCN.

Importantly, please note that working in tandem with one of the very surveyors from the Illinois Department of Public Health, NIA's Director of Compliance prepared a corrective action plan that addressed deficiencies related to the aforementioned improper restraint cited during the December 2019 Survey, which the facility submitted to that surveyor on December 16, 2020. *See* Exhibit J. NIA is implementing the actions described in the plan, as well as others to resolve the additional cited deficiencies, and it believes it has eliminated any circumstances that could lead to an ongoing Immediate Jeopardy finding or other ground for decertification.

* * *

For the reasons set forth above, termination of NIA's CCN on the basis that it does not have a provider agreement with an SMA is without merit, as NIA and HFS entered into such an agreement in October 2012 that remains in effect. Because NIA is in fact a participating Medicaid provider in Illinois, moreover, it respectfully requests the opportunity to finish curing the deficiencies noted in the December 2019 Survey that CMS believes could have served as an alternative basis for the decertification if left uncorrected.

I would appreciate the opportunity to discuss this request with you directly and will call you next week to do so. Thank you in advance for your consideration.

---

[1] In addition, NIA has entered into provider agreements of at least limited duration with SMAs in states other than Illinois. NIA, for example, enrolled as a participating provider in the Wyoming Medicaid program effective July 1, 2013, with specific approval to provide PRTF services to Wyoming beneficiaries. *See* Exhibit G.

Sincerely,

Salvatore G. Rotella, Jr.

Enc.

Cc: Via U.S. Mail

Illinois Department of Public Health
525-535 West Jefferson Street
Chicago, IL 62761
ATTN: Ngozi O. Ezike, Director

122 S. Michigan Avenue
Springfield, IL 60603
ATTN: Ngozi O. Ezike, Director

Illinois Department of Health Care & Family Services
88 E. Galena Boulevard, Suite 100
Aurora, IL 60506
ATTN: Marc D. Smith, Acting Director

West Virginia Department of Health and Human Resources, Bureau of Medical Services
350 Capital Street
Charleston, WV 25301
ATTN: Cynthia Beane, Commissioner

Wisconsin Department of Health Services, Office of the Inspector General
1 W. Wilson Street
Madison, WI 53703
ATTN: Anthony Baize, Inspector General

The Joint Commission
1 Renaissance Boulevard
Oak Brook Terrace, IL 60181
ATTN: Lynn Dragisic, Executive Vice President

Via Email

Oregon Health Authority, Sara Fox, sara.b.fox@dhsoha.state.or.us

Washington State Department of Social and Health Services, Michael Campbell, michael.campbell@dcyf.wa.gov

Northern Illinois Academy, Anthony Penn, anthony.penn@sequelyouthservices.com

Sequel Youth and Family Service, Matthew Wilburn, matt.willburn@sequelyouthservices.com

EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS-Chicago, Survey & Operations Group
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 14L016

January 24, 2020

Anthony Penn, Executive Director
Northern Illinois Academy
998 Corporate Blvd.
Aurora, IL 60502

Via Fax: 630-820-8305

Dear Mr. Penn:

The Centers for Medicare & Medicaid Services (CMS) has determined that Northern Illinois Academy (NIA) does not have a Medicaid provider agreement with a State Medicaid Agency (SMA); such agreements are required by Section 1902(a)(27) of the Social Security Act (42 U.S.C. § 1396a(a)(27)). In order to participate as a Psychiatric Residential Treatment Facility (PRTF), a facility must have an active provider agreement with a SMA and attest accurately to that effect. 42 CFR §483.374. CMS has confirmed that NIA does not have a Medicaid provider agreement with the Illinois Department of Healthcare and Family Services (HFS), the SMA for the State of Illinois. Moreover, CMS has verified that NIA lacks a Medicaid provider agreement to participate as a PRTF with any other SMA. Therefore, NIA does not qualify to participate in Medicaid as a PRTF under 42 CFR §440.160 and 42 CFR Part 441 Subpart D.

Furthermore, CMS has received the results of a recertification survey completed on December 16, 2019 by the Illinois Department of Public Health (IDPH). That survey revealed that NIA is not in compliance with 42 CFR Part 483 Subpart G – Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities. We have determined that the deficiencies are so serious they constitute an immediate threat to patient health and safety. Enclosed is a complete listing of all deficiencies cited. This constitutes a separate basis for termination of participation, independent of NIA's lack of a Medicaid provider agreement.

Therefore, under the authority granted to CMS in Section 1902(a)(33)(B) of the Social Security Act (42 U.S.C. § 1396a(a)(33)), CMS is hereby terminating the CMS Certification Number (CCN) for NIA **effective January 24, 2020**. Northern Illinois Academy is prohibited from identifying itself as a PRTF as of January 24, 2020. Ensure that you are not representing your facility as a PRTF in all your communications with the public and other stakeholders.

In accordance with CMS policy and Federal regulation, we are publishing a notice to the public of the termination. Notice can be found by visiting the following website:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html.

Northern Illinois Academy

If you have questions regarding this matter, please contact Michael Potjeau, Acting Branch Manager, at (312) 353-4363.

Sincerely,

Gregg Brandush
Division Director
CMS-Chicago, Survey & Operations Group

Enclosure – CMS Form 2567

cc: Illinois Department of Public Health
Illinois Department of Health Care & Family Services
Oregon Health Authority
Washington State Department of Social and Health Services
West Virginia Department of Health and Human Resources
Bureau of Medical Services
Wisconsin Department of Health Services
Office of the Inspector General
The Joint Commission

EXHIBIT B

State of Illinois
Department of Healthcare and Family Services

AGREEMENT FOR PARTICIPATION
ILLINOIS MEDICAL ASSISTANCE PROGRAM

WHEREAS, Sequel Schools, LLC d/b/a Northern Illinois Academy

Full Legal as well as an Assumed (d.b.a.) name.

364485853001 (HFS Provider Number, if applicable)

hereinafter referred to as ("the Provider") is enrolled with the Illinois Department of Healthcare and Family Services hereinafter referred to as ("the Department") as an eligible provider in the Medical Assistance Program; and

WHEREAS, the Provider wishes to submit claims for services rendered to eligible Healthcare and Family Services clients;

NOW THEREFORE, the Parties agree as follows:

1. The Provider agrees, on a continuing basis, to comply with all current and future program policy and billing provisions as set forth in the applicable Healthcare and Family Services Medical Assistance Program rules and handbooks.

2. The Provider agrees, on a continuing basis, to comply with applicable licensing standards as contained in State laws or regulations. Hospitals are further required to be certified for participation in the Medicare Program (Title XVIII) or, if not eligible for or subject to Medicare certification, must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

3. The Provider agrees, on a continuing basis, to comply with Federal standards specified in Title XIX and XXI of the Social Security Act and with all other applicable Federal and State laws and regulations.

4. The Provider agrees that any rights, benefits and duties existing as a result of participation in the Medical Assistance Program shall not be assignable without the written consent of the Department.

5. The Provider shall receive payment based on the Department's reimbursement rate, which shall constitute payment in full. Any payments received by the Provider from other sources shall be shown as a credit and deducted from charges sent to the Department.

6. The Provider agrees to be fully liable for the truth, accuracy and completeness of all claims submitted electronically or on hard copy to the Department for payment. Provider acknowledges that it understands the laws and handbook provisions regarding services and certifies that the services will be provided in compliance with such laws and handbook provisions. Provider further acknowledges that compliance with such laws and handbook provisions is a condition of payment for all claims submitted. Any submittal of false or fraudulent claim or claims or any concealment of a material fact may be prosecuted under applicable Federal and State laws.

7. The Provider agrees to furnish to the Department or its designee upon demand all records associated with submitted claims necessary to disclose fully the nature and extent of services provided to individuals under the Medical Assistance Program and maintain said records for not less than three (3) years from the date of service to which it relates or for the time period required by applicable Federal and State laws, whichever is longer. The latest twelve months of records must be maintained on site. If a Department audit is initiated, the Provider shall retain all original records until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond the required period.

8. The Provider, if a medical transportation provider, agrees that vehicle operators(s) shall have an appropriate Drivers License and vehicle(s) shall be properly registered.

9. The Provider, if not a practitioner, agrees to comply with the Federal regulations requiring ownership and control disclosure found at 42 CFR Part 455, Subpart B.

10. The Provider agrees to exhaust all other sources of reimbursement prior to seeking reimbursement from the Department.

11. The Provider agrees to be fully liable to the Department for any overpayments, which may result from the Provider's submittal of billings to the Department. The Provider shall be responsible for promptly notifying the Department of any overpayments of which the Provider becomes aware. The Department shall recover any overpayments by setoff, crediting against future billings or by requiring direct repayment to the Department.

12. The Provider (if a hospital, nursing facility, hospice or provider of home health care or personal care services) agrees to comply with Federal requirements, found at 42 CFR Part 489, Subpart I, related to maintaining written policies and providing written information to patients regarding advance directives.

13. The Provider certifies that there has not been a prohibited transfer of ownership interest to or in the provider by a person who is terminated or barred from participation in the Medical Assistance Program pursuant to 305 ILCS 5/12-4.25.

14. The Provider agrees to furnish to the Department or the U.S. Department of Health and Human Services (HHS) on request, information related to business transactions in accordance with 42 CFR 455.105 paragraph (b). The Provider agrees to submit, within 35 days of the date of the request by the Department or HHS, full and complete information about:- (1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

15. The Provider certifies the following owners/stock holders own 5% or more of the stock/shares. If additional space is needed for names, please use separate page. If there is no information to disclose, write NONE on PRINT NAME line. This section MUST be completed for enrollment purposes and an entry is required.

PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP
Sequel CS, Inc.	364-48-5853	100
see attached		
PRINT NAME	SOCIAL SECURITY NUMBER	% OF OWNERSHIP

16. The Provider agrees and understands that knowingly falsifying or willfully withholding information on the Provider Enrollment Application and/or the Agreement for Participation may be cause for termination of participation in the Illinois Medical Assistance Program and such conduct may be prosecuted under applicable Federal and State laws.

17. Requested effective date December 21, 2012 The Provider certifies that all services rendered on or after such date were rendered in compliance with and subject to the terms and conditions of this agreement.

Under penalties of perjury, the undersigned declares and certifies that the information provided in this Agreement for Participation is true, correct and complete.

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

by: _____
(Provider Signature)

Jung Mi Yi
(Print Name of Signature above)

October 30, 2012
Date

by: _____
Division of Medical Programs

Date

Agreement for Participation Illinois Medical Assistance Program, form HFS 1413

Attachment to #15:

Indirect owner of Sequel Schools, LLC:

Name: John F. Ripley
Address: 35481 Troon Court
Round Hill, VA 20141

Name: Adam Shapiro
Address: 412 South 21 Street
Philadelphia, PA 19146

EXHIBIT C

Illinois Department of
Healthcare and Family Services

☐ Annual
☒ Change in Facility Director

ATTESTATION OF COMPLIANCE WITH FEDERAL REQUIREMENTS REGARDING THE USE OF RESTRAINT AND SECLUSION BY FACILITIES PROVIDING INPATIENT PSYCHIATRIC SERVICES TO INDIVIDUALS UNDER 21 YEARS OF AGE

A reasonable investigation, subject to my control, having been conducted in this facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the

Northern Illinois Academy
Name of Facility

364485853
Illinois Medicaid Provider Identification Numbers (FEIN)

Address of the Facility
998 Corporate Ave
Street Address

Aurora IL 60502
City, State, Zip Code

14L016
PRTF I.D. # (To be completed by State Medicaid Agency)

Licensed Beds 87 Total Census 87

# of Out-of-State Residents 5

List of all States that have funded services in this facility.
W Virginia Wisconsin
Oregon

hereby complies with all of the requirements set forth in the federal final rule 42 CFR Part 441 and Part 483 governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under 21 years of age.

I understand the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services and the Illinois Department of Healthcare and Family Services, or their representatives, may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to the *Code of Federal Regulations* and the *Illinois Administrative Code*, have the right to validate that this facility is in compliance with the requirements set forth in the final rule and to investigate serious occurrences as defined under that rule.

An attestation will be completed annually. I will notify the Illinois Department of Healthcare and Family Services immediately if I vacate this position so that an attestation may be submitted by my successor. I will also notify the Illinois Department of Healthcare and Family Services if it is my belief that this facility is out of compliance with the requirements set forth in the final rule.

Signature

10.17.19
Date

Anthony Penn
Printed Name

6309522214
Telephone Number - Voice

Executive Director
Title

8473918001
Telephone Number - Facsimile

Mailing Address (if different than facility address)

anthony.penn@sequelyouthservic
E-Mail Address

Street Address

City, State, Zip Code

EXHIBIT D

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

122 S. Michigan Ave., Suite 2009 • Chicago, Illinois 60603-6152 • www.dph.illinois.gov

August 3, 2016

Carolyn Willandt, M.P.A.
Executive Director
Northern Illinois Academy
998 Corporate Blvd
Aurora, Illinois 60502

Dear Administrator:

On **July 28, 2016** a **recertification** survey was conducted at Northern Illinois Academy by staff of the Illinois Department of Public Health to determine compliance with federal requirements for participation in the Medicare program.

Based on the survey performed, you are determined to be in compliance with all federal requirements.

If you have any questions concerning this notice, please contact the Department by phone at 312-793-2222. You may also telephone the Department's TTY number for the hearing impaired at 1-800-547-0466.

Sincerely,

Annette S. Hodge

Annette Hodge, RN BSN
Field Operations Section Chief
Division of Health Care Facilities and Programs

Copy: File
Enclosure: 2567
4827-1820-4083, v. 1

EXHIBIT E

Jung Mi Yi

From: Jones, Richard E. [Richard.E.Jones@illinois.gov]
Sent: Tuesday, January 08, 2013 4:08 PM
To: Jung Mi Yi
Cc: Kuczora, Christina; Trohalides, Dessie
Subject: HFS Enrollment Packet Submitted

Hi Dr. Yi,
BALC has added your new location to your Medicaid Mental Health Certificate and sent me a copy of the updated BALC certificate. So I submitted the HFS enrollment packet for your new location. I will follow-up with HFS and when they enroll your program, I'll submit the Collaborative Form 2 with the Medicaid ID @ for this new location. Hopefully, you will be able to start submitting claims for this new location in 7-10 days.

Rich Jones, MA
Social Service Program Planner
Division of Mental Health - Office of Community Services
Phone: (217) 782-3052
Fax: (217) 785-3066
Email: Richard.E.Jones@illinois.gov

EXHIBIT F

Illinois Department of Public Health
Division of Health Care Facilities and Programs

Health Facilities Directory

Facility Type: Psychaitric Residential Treatment Facili

License #	Facility Name	Facility Address	City	County	Zip	Contact Person	Expir. Date	Phone #
14-L002	Chestnut Health Systems	2148 Vadalabene Drive	Maryville	Madison	62062	Allen Sender		(618) 281-3100
14-L007	Cornell Interventions Woodridge	2221 64th Street	Woodridge	Du Page	60517	Steve Wenmaler		(630) 986-6477
14-L009	Gateway Foundation	2200 Lake Victoria Drive	Springfield	Sangamon	62703	Kerry Henry		(217) 529-9266
14-L011	Gateway Foundation	1080 East Park Street	Carbondale	Jackson	62901	SteveWeirman		(618) 529-1151
14-L008	Gateway Foundation Lake Villa	25480 West Cedarcrest Lane	Lake Villa	Lake	60046	Patricia Raodriquez		(847) 356-8205
14-L016	Northern Illinois Academy	998 Corporate Blvd	Aurora	Du Page	60502	Carolyn Willardtl		(847) 391-8000
14-L012	Riverside Resolve Center	411 W. Division Street	Manteno	Kankakee	60950	Dr. James Simone		(815) 468-3241
14-L013	Rosecrane, Inc	1601 University Drive	Rockfrod	Winnebago	61109	David Gomel		(815) 391-1000

Psychaitric Residential Treatment Facility 8

EXHIBIT G

Wyoming
Department
of Health

Commit to your health.

JULY 11, 2013

NORTHERN ILLINOIS ACADEMY
PSYCH RESIDENTIAL CENTER
998 CORPORATE BLVD.
AURORA IL 60502-9102

DEAR NORTHERN ILLINOIS ACADEMY:

Welcome to Wyoming Medicaid!

I am pleased that you have chosen to join with those providers who serve the health care needs of our citizens through the Wyoming Medicaid program.

Your commitment to provide high quality Wyoming Medicaid services to clients is important to them and to those of us who administer the program. We are dedicated to making your participation in the program as straightforward and productive as possible.

Enclosed is a sheet that shows the National Provider Identifier (NPI) that you registered with Wyoming Medicaid. Please remember to use your NPI when billing Wyoming Medicaid. This sheet also lists the name and telephone number of the office to call if you encounter a problem or have a question. The office listed is staffed especially to assist you.

The success of the Wyoming Medicaid program is dependent primarily on providers like you who furnish services directly to clients. Thank you for your participation and your efforts to maintain and improve the health of Wyoming citizens.

Sincerely,

Teri Green
State Medicaid Agent/ Wyoming Medicaid Manager
State of Wyoming
Division of Healthcare Financing

P5100RB

Wyoming
Department
of Health

Commit to your health.

JULY 11, 2013

NORTHERN ILLINOIS ACADEMY
PSYCH RESIDENTIAL CENTER
998 CORPORATE BLVD.

AURORA IL 60502-9102

Your enrollment in Wyoming Medicaid is effective from 01/01/13.

The NPI information you registered with Wyoming Medicaid is:

NPI	TAXONOMY
1093735938	323P00000X

You must use your NPI along with one of the taxonomy codes listed above whenever you bill paper or electronic claims to Wyoming Medicaid. The same requirement applies to claims submitted to Medicare if you wish to take advantage of automated cross-over claims. Claims received by Wyoming Medicaid, either directly from providers or via Medicare's automated cross-over process, that are missing taxonomy codes may be denied or rejected.

Below is a list of services and claim types you have been authorized to bill.

Services: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Claim Type(s): UB-04 OR 837I
INPATIENT CROSSOVER

If you have questions or problems about billing matters or claims, please telephone:

Provider Relations
Toll Free Number: 1-800-251-1268

P5100RB

Wyoming Medicaid Provider Manuals

Wyoming Department of Health
Commit to your health.

Please be advised that Wyoming Medicaid is in the process of updating provider manuals. Providers may access the Wyoming Medicaid provider manuals by visiting our website at http://wyequalitycare.acs-inc.com then select "Provider Manuals and Bulletins." From that page select the appropriate manual for your provider type. The provider manuals will continually be updated as policy changes occur.

Wyoming Medicaid offers WINASAP Billing software and Web Portal free of charge to submit your claims electronically. Tutorials for each of these options can be found on the same website by selecting either "WINASAP" or "Web Portal Tutorials."

If you do not have the ability to download, print or access manuals from Wyoming Medicaid website you may mail a written request for a manual on CD or a paper copy. Your request must include your provider number or NPI number and an explanation of why you are unable to obtain the manual from the website. It is the provider's responsibility to maintain a current copy of the provider manual as updates are made.

Please mail these requests to:

Wyoming Medicaid
PO Box 667
Cheyenne, WY 82003-0667

For additional questions regarding billing or covered services, please contact the Wyoming Medicaid Provider Relations Unit at 800-251-1268 or EDI at 800-672-4959. Call center hours are Monday through Friday 9 a.m. to 5 p.m.

EXHIBIT H

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14L016	A. BUILDING _____ B. WING _____	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN ILLINOIS ACADEMY	998 CORPORATE BLVD AURORA, IL 60502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments A recertification survey was conducted on 12/16/19. The Immediate Jeopardy began on 12/10/19 due to the Facility's failure to ensure the appropriate use of emergency safety interventions during a physical hold and escort, resulting in an injury to a resident, and was identified on 12/12/19, at 42 CFR 483.350, Restraint and Seclusion. The IJ was announced on 12/16/19 at 12:20 PM, during a meeting with the Director of Risk (E #1), Executive Director (E #3), and Group Living Director (E #16). The IJ was not removed by the survey exit date of 12/16/19.	N 000		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on document review, observation, and interview, it was determined that the Facility failed to ensure that residents were safe from the improper use of emergency safety interventions by staff. This potentially places all current and future residents at risk for serious harm. As a result, the Condition of Participation, 42 CFR 483.350, Restraint and Seclusion, was not in compliance. Findings include: 1. The Facility failed to ensure that staff used the	N 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14L016	A. BUILDING _____ B. WING _____	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN ILLINOIS ACADEMY	998 CORPORATE BLVD AURORA, IL 60502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 1 appropriate emergency safety intervention techniques for physical holds and escorts. (N-132) An Immediate Jeopardy (IJ) began on 12/10/19, for the Facility's failure to ensure the appropriate use of emergency safety interventions during a physical hold and escort, resulting in an injury to a resident, thus, placing all of the residents at the Facility at risk for serious harm. The IJ was identified and announced on 12/16/19 at 12:20 PM, during a meeting with the Director of Risk (E #1), Executive Director (E #3), and Group Living Director (E #16). The IJ was not removed by the survey exit date of 12/16/19. In addition, the Condition, 42 CFR 483.350, was not met, as evidenced by: 2. The Facility failed to ensure that all direct care staff had current emergency safety intervention training, required annually (N-222 A). 3. The Facility failed to ensure that all direct care staff demonstrated their TCI (Therapeutic Crisis Intervention) competencies on a semiannual basis, as required. (N-222 B.)	N 100		
N 115	INDIVIDUAL PLAN OF CARE CFR(s): 441.155(c) The plan must be reviewed every 30 days by the team specified in §441.156 to- (1) Determine the services being provided are or were required on an inpatient basis, and (2) Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an	N 115		

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NORTHERN ILLINOIS ACADEMY	998 CORPORATE BLVD AURORA, IL 60502

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N 115	Continued From page 2 inpatient. (d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for - [paragraph and subparagraphs (1) and (2) relevant for utilization control hospitals only] This ELEMENT is not met as evidenced by: Based on document review and interview, it was determined that for 1 of 10 (R #4) residents' treatment plans reviewed, the Facility failed to ensure that the treatment plan was reviewed every 30 days, as required. Findings include: 1. The Facility's policy titled, "Treatment Planning" (Reviewed by the Facility on 10/22/19) was reviewed on 12/10/19 and required, "... goals and objectives shall be reviewed at time frames specified by law, regulation, or contract." 2. The clinical record of R #4 was reviewed on 12/10/19. R #4 was admitted on 11/6/2009 with a diagnosis of intellectual developmental disability (difficulty thinking and understanding). The current treatment plan was dated 10/29/19 (due for review by 11/28/19). 2. During an interview on 12/10/19 at approximately 2:00 PM, the Director of Risk (E#1) stated, "The treatment plans need to be reviewed and updated every 30 days. The treatment plan [for R #4] is overdue."	N 115		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b)	N 132		

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N 132	Continued From page 3 Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on document review, observation, and interview, it was determined that for 1 of 1 (R #11) resident in a standing hold, the Facility failed to ensure the emergency safety interventions were performed in a manner that was safe and appropriate. Findings include: 1. The Facility's policy titled, "Restraint Policy" (revised 06/2019) was reviewed on 12/11/19 and required, "... The dignity and privacy of the residents will be preserved to the greatest extent during the implementation and monitoring of the restraint...Definitions: ...Physical hold (restraint): A physical hold means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body... Each restraint will:... Be monitored by trained [Facility] staff in the use of emergency safety interventions who continually assess and monitor the physical and psychological well-being of the resident and the safe use of the restraint throughout the duration of the emergency safety intervention... Staff must record the intervention which is placed in the resident's clinical record. That documentation	N 132		

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N 132	Continued From page 4 must be completed by the end of the shift in which the restraint occurred..." 2. On 12/12/19, the "TCI [Therapeutic Crisis Intervention] Standing Restraint" (Therapeutic Crisis Intervention Student Workbook, Sixth Edition, Cornell University, 2009 - therapeutic crisis intervention technique used by the Facility) was reviewed and included that staff should have, "slid their own inside arms (arms nearest child) under the child's armpits, being careful not to grasp the child's upper arms. Both adults gently bring the child's arms across the plane of their bodies, securing the child's arms against their chests, the child's hand at the adult's waist ...The workers stand hip to hip to the child, staying as close to the child as possible ... If the child continues to be violent, the adults continue with the standing restraint. 2. Pivot and hold: ...both workers pivot and step behind the young person ... standing hip to hip, they grab their own upper arms with their inside hands ... Once in position, workers make sure that their heads are away from the young person's head, to avoid getting hit in the face ... They should maintain a balanced stance, and assess the young person's level of aggression ... CAUTION: The worker's arm should not be jammed into the young person's axilla (armpit) ... risking shoulder subluxation (dislocation). Keep the young person's arm in a natural or neutral position ..." 3. The clinical record of R #11 was reviewed on 12/12/19 at approximately 10:20 AM. R #11 was admitted on 8/20/19 with diagnoses of disruptive mood dysregulation disorder DMDD (frequent severe temper outbursts), ADHD (attention deficit hyperactivity disorder - impulsiveness), and high-level autism (disorder that impairs ability to	N 132		

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N 132	Continued From page 5 communicate and interact). R #11's clinical record included a "Physical Hold/Seclusion Form", dated 12/11/19, which indicated that, on 12/10/19, R #11 was being provoked by peers in the classroom; began to kick chairs and tables over; and began to kick at staff and peers around him. R #11 was placed in a standing hold against the wall in the hallway outside of the classroom at approximately 12:55 PM on 12/10/19. - The Nurse's note, dated 12/11/19 at 9:19 PM (the day after the physical hold), included, " ...Youth had many abrasions and bruising to the left upper side of back and a few scratches towards center upper back area as well ... Youth reports this injury occurred while he was being held against the wall after being removed from classroom for being aggressive and after hitting a peer. Youth also expresses that one of three staff intentionally was gripping and scratching him ..." 4. On 12/12/19 at approximately 11:00 AM, the video surveillance of R #11's physical hold was reviewed in the presence of the Director of Risk (E #1). - The standing hold showed that there were three Resident Counselors (RCs - E #11, E #12, E #13)) and the A.M. Supervisor (Supervisor from 7:00 AM - 3:00 PM - E #14) physically holding R #11 against the wall with R #11's back to the wall for approximately 5 minutes. - During the hold, the 4 staff were facing R #11, who had his back against the wall. - E #11 was holding R #11's left arm with his right hand (E #11's left arm was holding R #11's left side but exact placement of E #11's arm was not visible on camera.) - E #12 was in front of and facing R #11 with both of E #12's arms holding R #11 (exact hand placement not visible).	N 132		

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N 132	Continued From page 6 - E #13 was holding R #11's right arm and side (exact hand placement not visible). - E #14 was standing between E #13 and E #12 to the front and facing R #11. - E #14 intermittently reached his arm into the hold to grab R #11's chest/shoulder area (exact hand placement not visible). - Video surveillance review of the escort of R #11 from the hallway to his room after the hold included the 3 RCs (E #11, E #12, and E #13) and the A.M. Supervisor (E #14) physically carrying R #11 (E #11 and E #12 holding R #11's arms, and E #12 and E #14 holding R #11's legs) down the hallway and into his room. - The hold and the escort were not in accordance with the TCI technique. A physical escort should be the use of a light grip to escort the resident to the desired location. Five RC's were visible in the video witnessing R #11's standing hold. 5. On 12/12/19 at approximately 1:00 PM, an interview was conducted with the Director of Risk (E #1). E #1 stated that the hold and escort technique used in R #11's hold on 12/10/19 was not proper TCI technique. E #1 stated that E #11, E #12, E #13, and E #14 were placed on administrative leave, pending termination, as soon as this incident was identified (12/12/19 on arrival to the Facility). 6. On 12/12/19 at approximately 1:20 PM, an interview was conducted with the Executive Director (E #3). E #3 stated that an improper hold and escort was done during R #11's physical hold and escort on 12/10/19. E #3 stated that this should have been reported by staff who witnessed the improper hold as soon as it occurred. E #3 stated that R #11 was sent out to the hospital for X-rays (radiologic test to check for	N 132		

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N 132	Continued From page 7 broken bones) the morning of 12/12/19. 7. On 12/16/19 between approximately 9:35 AM and 9:45 AM, interviews were conducted with 2 (E #17 and E #18) of the RC's who witnessed R #11's hold on 12/10/19. E #17 and E #18 were not able to identify that improper hold techniques were used during R #11's hold.	N 132		
N 144	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on document review and interview, it was determined that for 1 of 7 (R #1) records reviewed for residents in physical holds, the Facility failed to ensure the resident was kept in a physical hold for no longer than 1 hour, per policy. Findings include: 1. The Facility's policy titled, "Use of Physical Holds with Children and Youth" (reviewed by the Facility 10/13/19) was reviewed on 12/10/19 and included, "[The Facility] prohibits the use of ... physical holds for more than one hour in duration." 2. The clinical record of R #1 was reviewed on	N 144		

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N 144	Continued From page 8 12/10/19. R #1 was admitted on 6/5/18 with a diagnosis of post traumatic stress disorder (PTSD - mental and emotional stress as a result of injury or severe psychological shock). R #1's clinical record included an "Unusual Incident Report", dated 11/12/19 at 9:25 PM, included, "Resident was in an extended restraint. Due to her continued escalation and because the demonstrated behaviors were different from her regular reactions, Medical Director and EMS [emergency medical services] called. Resident was transported by ambulance to the local ED [emergency department] for psychiatric assessment. Resident was admitted to [Hospital's Behavioral Unit]. No injuries to resident or staff." Documentation included that R #1's physical hold was initiated on 11/12/19 at 7:25 PM and discontinued on 11/12/19 at 9:25 PM (2 hours). R #1's clinical record included physician's (MD #1's) orders for physical hold for 15 minutes every 15 minutes from 7:25 PM to 9:25 PM. 3. During an interview on 12/11/19 at approximately 3:00 PM, the Executive Director (E#3) stated, "At no time should a physical hold be continued for more than an hour." E#3 stated that, after one hour of using a physical hold, the Psychiatrist, Executive Director and Program Director should be notified to discuss the best course of treatment to stop the physical hold. Usually sending the resident to the hospital for evaluation is what is recommended. E#3 stated, "The facility is trying to get away from using any kind of restraint at all."	N 144		
N 148	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3)	N 148		

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N 148	Continued From page 9 [Each order for restraint or seclusion must include] the emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use. This ELEMENT is not met as evidenced by: Based on document review and interview, it was determined that for 4 of 7 (R #1, R #5, R #6 and R #8) clinical records reviewed for restraint application, the Facility failed to ensure that each order for restraints included the length of time the Physician authorized its use. Finding include: 1. The Facility's policy titled, "Use of Physical Holds [restraints] with Children and Youth (reviewed 10//13/19)" was reviewed on 12/10/19 and required, "Each physical hold will be limited to 15 minutes per order ... Each order will contain: ... The emergency safety intervention ordered, including the length of time the Physician authorized its use." 2. The clinical record of R #1 was reviewed on 12/10/19. R #1 was admitted on 6/5/18 with a diagnosis of post traumatic stress disorder (PTSD - mental and emotional stress as a result of injury or severe psychological shock). The following Physician's physical hold restraint orders lacked an authorized time frame for its use: 11/11/19 at 4:44 PM, 11/11/19 at 4:59 PM, 11/11/19 at 5:14 PM, and 11/11/19 at 5:29 PM. 3. The clinical record of R #5 was reviewed on 12/10/19. R #5 was admitted on 3/13/19 with a diagnosis of PTSD. A Physician's physical hold	N 148		

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N 148	Continued From page 10 restraint order, dated 11/5/19 at 7:02 PM, lacked an authorized time frame for its use. 4. The clinical record of R #6 was reviewed on 12/10/19. R #6 was admitted on 10/17/16 with a diagnosis of bipolar I disorder (periods of severe mood episodes from mania to depression). The following Physician's physical hold restraint orders lacked inclusion of an authorized time frame for its use: 9/20/19 at 1:45 PM, 10/1/19 at 4:45 PM, and 10/1/19 at 5:00 PM. 5. The clinical record of R #8 was reviewed on 12/10/19. R #8 was admitted on 6/20/17 with a diagnosis of reactive attachment disorder (unable to form a secure healthy emotional bond with primary caregivers). The following Physician's physical hold restraint orders lacked inclusion of an authorized time frame for it use: 10/17/19 at 6:28 PM, 10/17/19 at 6:43 PM, 10/17/19 at 6:58 PM, 10/17/19 at 7:55 PM, and 10/17/19 at 8:10 PM. 6. During an interview on 12/10/19 at approximately 2:00 PM, the Director of Risk (E#1) stated that all orders for physical holds are required to have a length of time for its use, and the physical hold orders for R #5, R #6, and R #8 should have included the length of time for the holds.	N 148		
N 218	EDUCATION AND TRAINING CFR(s): 483.376(b) Certification in the use of cardiopulmonary resuscitation, including periodic recertification, is required.	N 218		

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N 218	Continued From page 11 This ELEMENT is not met as evidenced by: A. Based on document review and interview, it was determined that for 4 of 15 Resident Counselors (RC's - E #10, E #15, E #18, and E #20), the Facility failed to ensure direct care staff were CPR (cardiopulmonary resuscitation) certified. Findings include: 1. On 12/12/19, the Job Description for the Resident Counselor was reviewed. There was no requirement for CPR certification in the job description. 2. On 12/12/19, E #10, E #15, E #18 and E #20's employee files were reviewed. E #10, E #15, E #18 and E #20's employee files lacked documentation of current CPR certification. 3. On 12/12/19 at 3:00 PM, an interview was conducted with E #1 (Director of Risk). E #1 stated that she was not aware that all staff need to be CPR certified.	N 218		
N 222	EDUCATION AND TRAINING CFR(s): 483.376(f) Staff must demonstrate their competencies as specified in paragraph (a) of this section on a semiannual basis and their competencies as specified in paragraph (b) of this section on an annual basis. This ELEMENT is not met as evidenced by: A. Based on document review and interview, it was determined that for 6 of 24 (E #6, E #7, E #9, E #10, E #11, and E #19) direct care staff personnel files reviewed, the Facility failed to	N 222		

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N 222	Continued From page 12 ensure TCI (Therapeutic Crisis Intervention) training was completed annually, as required. This has the potential to affect all current (86 residents) and future residents at the Facility. Findings include: 1. On 12/12/19, the Facility's Job Description for Residential Counselor, Registered Nurse, Shift Supervisor and Team Lead lists the following as an essential duty "...Utilizes Therapeutic Crisis Intervention (TCI) skills and physical restraining techniques according to training guidelines..." 2. The Facility's policy titled, "Restraint Policy" (revised 06/2019) was reviewed on 12/12/19 and required, "...Education and training: a. [Facility] requires staff to have ongoing education, training, and demonstrated knowledge of:... The use of non-physical intervention skills... The safe use of restraint... Competency is assessed..." The policy lacked the frequency of TCI training. 3. The personnel files for 6 direct care staff were reviewed on 12/12/19 and lacked current, annual TCI training. E #6, E #7, E #10, and E #11 were Resident Counselors (RC's). E #9 was a Shift Supervisor. And E #19 was a Team Leader. 4. On 12/12/19 at 3:00 PM, an interview was conducted with the Director of Risk (E #1). E #1 stated that employees should receive TCI training upon hire and annually. E #1 did not know why these employees had not had the annual training. B. Based on document review and interview, it was determined that the Facility failed to ensure that all direct care staff demonstrated their TCI	N 222		

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N 222	Continued From page 13 (Therapeutic Crisis Intervention) competencies on a semiannual basis, as required. This has the potential to affect all current (86 residents) and future residents at the Facility. Findings include: 1. On 12/12/19, the Facility's Job Description for Residential Counselor, Registered Nurse, Shift Supervisor and Team Lead lists the following as an essential duty "...Utilizes Therapeutic Crisis Intervention (TCI) skills and physical restraing techniques according to training guidelines..." 2. The Facility's policy titled, "Restraint Policy" (revised 06/2019) was reviewed on 12/12/19 and required, "...Education and training: a. [Facility] requires staff to have ongoing education, training, and demonstrated knowledge of:... The use of non-physical intervention skills... The safe use of restraint... Competency is assessed..." The policy lacked the frequency of demonstration of competencies. 3. On 12/12/19, a sample of all direct care staff's (15 Resident Counselors, 5 Registered Nurses, 2 Shift Supervisors, 1 Team Lead, and 1 teacher) peronnel files were reviewed for TCI training. The files lacked documentation of semiannual TCI competency. 4. On 12/12/19 at 3:00 PM, an interview was conducted with the Director of Risk (E #1). E #1 stated that employees receive TCI training upon hire and as a refresher TCI class every year. E #1 stated that there was no semiannual demonstration by direct care staff required by the Facility.	N 222		

EXHIBIT I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments The Emergency Preparedness requirements were evaluated, in conjunction with the recertification survey, on 12/16/19. The Facility was not in compliance with Standards for Establishment of the Emergency Preparedness Program, 42 CFR 441.184, as evidenced by:	E 000		
E 039	EP Testing Requirements CFR(s): 441.184(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based	E 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14L016	A. BUILDING _____ B. WING _____	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN ILLINOIS ACADEMY	998 CORPORATE BLVD AURORA, IL 60502

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E 039	Continued From page 1 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional	E 039		

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E 039	Continued From page 2 exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared	E 039		

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E 039	Continued From page 3 questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or	E 039		

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E 039	Continued From page 4 prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039		

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E 039	Continued From page 5 emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop	E 039		

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E 039	Continued From page 6 exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, it was determined that the Facility failed to ensure participation in a full-scale exercise that is community based or when community based exercise is not available, an individual Facility based exercise to test the Emergency Plan annually. Findings include: 1. The Facility's "Emergency Management Plan" (2019) was reviewed on 12/9/19 and required, "...Exercises/Drills:...semi-annual exercises and drills are conducted. Each department/unit conducts 2 drills per shift per quarter..." The	E 039		

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E 039	Continued From page 7 "Emergency Management Plan" lacked the required participation in a full-scale community-based or Facility-based exercise to test the Emergency Plan. 2. On 12/9/19 at approximately 10:30 AM, an interview was conducted with the Facility's Operations Manager (E #2). E #2 stated that fires, tornados, and blizzards are the Facility's highest hazardous risks, and drills are conducted frequently to test the Facility's response to these emergencies. E #2 stated that the Facility had not requested to participate in a community-based full scale exercise and had not conducted a Facility based exercise to test the Emergency Plan.	E 039		

EXHIBIT J

Northern Illinois Academy Answer to Protection of Residents 12.16.19:

Noncompliance:

Resident became escalated inside his classroom where he hit a peer. Resident was escorted to the hallway by two staff where he was placed in a standing hold. Upon review of the restraint, an unapproved Therapeutic Crisis Intervention (TCI) technique was utilized.

Approximately five minutes after the restraint was initiated, resident was escorted from the hallway to his unit. During that transition, the resident was able to free himself from staff. Resident was on the floor where staff attempted to assist the resident to stand. When unsuccessful with that move, staff members took resident's arms (two staff) and resident's legs (one staff) and transported him through the unit to his bedroom. This also was not an approved technique.

Beginning on 12.16.19, all staff are required to attend mandatory meetings – attendance taken at each meeting. Additional meetings are planned for the 17th, 18th, and 19th with an Overnight staff meeting taking place on the 18th. Though the meetings are mandatory, NIA understands there can be incidences where staff are unable to attend. For those individuals, written notices of the meeting contents will be provided.

During the scheduled mandatory meetings, training staff will demonstrate the proper techniques for standing, seated, small child and supine restraints. In addition, training staff will demonstrate the proper way to escort a resident with reminders that when a safety issue is not present, an escort may not be the proper response. Beginning early next year, all staff will demonstrate on a twice yearly basis, their proficiency with the physical TCI techniques.

The roles of the Witness and the attending RN will be reviewed so that all staff are aware that these two individuals have the right to discontinue a restraint due to safety concerns or improper technique. And though general conversation is discouraged with the exception of the one individual communicating with the resident, staff will be informed that any member in the hold or any observer is encouraged to tell participants in the hold if they see something that may be improper.

It is Northern Illinois' commitment to reduce the number of restraints which is measured by percentage utilizing Patient Care Days (PCD) with the Average Daily Census (ADC). In support of that commitment, NIA is training staff on UKERU – a de-escalation tool focusing on trauma-based care. In addition, NIA established a Staff Support Intervention Specialist role with the purpose of working with staff to improve de-escalation with residents based on a knowledge of individual residents' triggers. In the past two months, NIA's restraints are at a six year low based on PCD.

Serious injury and Need for Immediate Action:

Resident complained of pain and was examined by nursing who noted bruising and scratches the next day. Resident was sent to the hospital for x-ray; results negative.

Multiple staff witnessed the improper hold and escort.

During the scheduled mandatory meetings, staff will receive training showing the proper TCI techniques for the restraints utilized by NIA. (NOTE: NIA prohibits the use of prone restraint.) By reviewing the techniques, through practice and return demonstration, staff will be able to notice a physical

intervention that does not follow protocol. Staff will be expected to say something at the time of the restraint and/or to report the hold/escort/other physical intervention to their supervisor or others in an administrative role for the facility. Staff have the opportunity to report anonymously as well in a drop box outside of the compliance office. Likewise, residents have the ability to report utilizing the same drop box.

Complaints will be reviewed by group living/compliance/executive director/designee immediately.

NIA utilizes cameras throughout the facility as a proactive means of observation. A required number of observations occur each week by NIA's program managers. In addition, Sequel, the parent company, also complete camera reviews of NIA reporting any issues and best practices. This allows ongoing reviews of physical interventions and staff/resident interactions.

NIA staff will demonstrate their competency of the TCI restraints in January. In the meantime, Supervisors on Duty and nursing staff will monitor all physical interventions to ensure the correctness of those interventions. Any physical intervention considered inappropriate or not following protocol will be discontinued at once.

Further Notes:

The scheduled mandatory meetings will cover the following (not all inclusive):

- *Discuss seclusion/time out reports*
- *Complaint/Allegation/Abuse policies*
- *TCI trainer will demonstrate appropriate supine, seated, small child, and standing restraints*
- *TCI trainer will demonstrate an appropriate escort*
- *Review documentation needed to support the need for a supine restraint (more detailed descriptions of unsafe behaviors)*
- *Review that SOD and nurse are allowed to discontinue restraints*
- *Remind staff about making adjustments during a restraint to ensure the safety of all involved.*