Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

...b) All persons seeking admission to a nursing facility must be screened to determine the need for nursing facility services prior to being admitted, regardless of income, assets, or funding source. (Section 2-201.5(a) of the Act) A screening assessment is not required provided one of the conditions in Section 140.642(c) of the rules of the Department of Healthcare and Family Services titled Medical Payment (89 Ill. Adm. Code 140.642(c)) is met.

... d) Screening shall be administered through procedures established by administrative rule by the agency responsible for screening. (Section 2201.5(a) of the Act) The Illinois Department on Aging is responsible for the screening required in subsection (b) of this Section for individuals 60 years of age or older who are not developmentally disabled or do not have a severe mental illness. The Illinois Department of Human Services is responsible for the screening required in subsection (b) of this Section for all individuals 18 through 59 years of age and for individuals 60 years of age or older who are developmentally disabled or have a severe mental illness. The Illinois Department of Healthcare and Family Services or its designee is responsible for the screening required in subsection (c) of this Section.

e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident’s name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

Section 300.625 Identified Offenders

g) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:

...l) The facility shall incorporate the Criminal History Analysis Report into the identified offender’s care plan. (Section 2-201.6(f) of the Act)

Section 300.662 Resident Attendants

...g) As part of the comprehensive assessment (see Section 300.1220), each resident shall be evaluated to determine whether the resident may or may not be fed, hydrated or provided
personal hygiene by a resident attendant. Such evaluation shall include, but not be limited to, the resident’s level of care; the resident’s functional status in regard to feeding, hydration, and personal hygiene; the resident’s ability to cooperate and communicate with staff.

Section 300.1220 Supervision of Nursing Services

...b) The DON shall supervise and oversee the nursing services of the facility, including:

...2) Overseeing the comprehensive assessment of the residents’ needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident’s comprehensive assessment, individual needs and goals to be accomplished, physician’s orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident’s condition. The plan shall be reviewed at least every three months.

Section 300.7010 Admission Criteria [Alzheimer’s Special Care]

... c) Unit staff shall complete a comprehensive evaluation of the resident before the resident is admitted. The evaluation shall include, but not be limited to, the prospective resident’s health status, life-style, behavior, interests, and history. In addition to appropriate medical, behavioral, and social service professionals, the resident, the resident’s family, the resident’s representative, and the resident’s most recent care giver shall have the opportunity to provide information for this evaluation. This information shall be available to staff before admission and shall be used in the assessment process after admission.

d) A resident may be admitted to the unit without a comprehensive evaluation in situations where a sudden change in circumstances renders the primary care giver unable to continue to provide care (e.g., death or incapacitating illness of the care giver; treatment and release of the prospective resident from a hospital emergency room). A plan shall be put in place prior to admission to meet the resident’s needs on admission. In these situations, a comprehensive evaluation shall be initiated within 24 hours after admission and shall be completed within seven days after admission.
a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident’s abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.

1) Assessments shall include at least a behavioral and a functional assessment, as well as direct observations of the resident. The facility shall attempt to interview the resident, the resident’s family, the resident’s representative, and recent and current direct care givers. This attempt shall be documented.

2) Assessments shall include at least the following:

A) daily routine;

B) dining, mealtime approaches, and non-mealtime nutrition and hydration needs;

C) dressing, toileting, grooming, preference in bathing (e.g., bathing, showering, a.m./p.m.) and other personal care abilities;

D) ambulation and transferring abilities;

E) behavior triggers; effective calming approaches; and an analysis of each of the resident’s patterns of dementia-related behaviors, such as wandering, agitation, anxiety, and safety issues; and

F) adaptive equipment or activities that allow the resident to function at the highest practical level.

3) Assessments shall be conducted by a nurse, physical therapist, occupational therapist, social worker or unit director who has at least two years of experience working with residents with dementia and who has training in conducting behavioral or functional assessments.

4) The assessment process shall be ongoing by direct care staff or other professionals, as needed, and shall include the assessment components in subsection (a)(2).

b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident’s admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident’s needs, the resident, the resident’s representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident’s direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident.

1) The care plan shall be ability centered in focus (see Section 300.7030) and shall define how the identified abilities, strengths, interests, and preferences will be encouraged and used by addressing the resident’s physical and mental well-being; dignity, choice, security, and safety; use of retained skills and abilities; use of adaptive equipment; socialization and interaction with others; communication, on whatever level possible (verbal and nonverbal); healthful rest; personal expression; ambulation and physical exercise; and meaningful work.
2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan.

3) The resident's care plan shall be reviewed by the unit director 30 and 60 days after the initial care plan’s development and shall be modified, as needed, with the participation of the interdisciplinary team.

4) The care plan shall be reviewed at least quarterly.

5) All appropriate staff shall have access to and shall use the information in the care plan in order to integrate the care plan into the daily care of the resident.

6) The care plan shall be implemented and followed by staff who care for the resident.

7) Revisions may be made to the care plan at any time, with input from the resident, resident’s family, and resident’s representative, the care coordinator, and, if appropriate, the physician.

8) The resident and the resident's representative shall be given the opportunity to participate in care plan development and modification. If they are unable to attend, a copy or summary of the care plan or modifications shall be provided to the resident and resident’s representative.

c) The facility shall include the resident's family (other than the resident's representative) in the interdisciplinary team and in care planning and shall provide information to the family about the resident and the resident's care plan, with the consent of the resident or, as appropriate, the resident's representative.

d) When a resident is moved within the facility or different direct care staff are newly assigned, discharging and receiving staff shall communicate verbally and with written documentation to the newly assigned staff about the care plan and the needs of the resident.

e) The unit shall have and follow a written plan for communicating information within departments, between shifts, between units, and with resident’s family and resident’s representative.

f) The unit shall have a procedure that is implemented and monitored for safeguarding residents’ adaptive equipment, such as hearing aids, glasses, dentures, and feeding and ambulation equipment.

(Source: Added at 28 Ill. Reg. 14623, effective October 20, 2004)

Section 300.7030 Ability-Centered Care [Alzheimer's Special Care]

a) Ability-centered care programming, also called activity-focused programming, recognizes the resident’s abilities and competencies in care planning. Tasks are adapted and modified to provide for the resident's involvement at the maximum level of the resident's ability. Ability-centered care programming embraces the following concepts: activities are every event, encounter, and exchange with a staff member, volunteer, relative, or other
individuals; activities are redefined as traditional (i.e., work related, recreational) and nontraditional (i.e., bathing, eating, walking); both independent and structured events are used.

b) Flexibility is allowed in traditional staff roles and staff are encouraged to develop relationships with residents. The use of staff in nontraditional roles shall be documented in the unit’s policies and procedures. Non-licensed staff who are not certified nursing assistants shall not provide nursing or personal care but are limited to assisting with activities of daily living and providing verbal cueing, for which the staff have been trained.

c) Unit directors and activity professionals for units established before January 1, 2005 shall participate in ability-centered care training before July 1, 2005. Unit directors and activity professionals for units established after January 1, 2005 shall have had course work in ability-centered care programming.

d) The unit shall use a distinct approach to resident care that is designed for persons with Alzheimer’s disease and related dementia. The use of ability-centered care is recommended. If the facility uses an alternative approach, this approach shall be reviewed by the Department to determine if the care goals of the ability-centered care have been satisfied. Alternative methodologies shall not be implemented until the Department has approved them.

e) Dining and mealtime approaches shall address the special needs of individuals with dementia.

(Source: Added at 28 Ill. Reg. 14623, effective October 20, 2004)