

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH

CHAPTER I: DEPARTMENT OF PUBLIC HEALTH

SUBCHAPTER c: LONG-TERM CARE FACILITIES

PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE

The General Assembly's Illinois Administrative Code database includes only those rulemakings that have been permanently adopted. This menu will point out the Sections on which an emergency rule (valid for a maximum of 150 days, usually until replaced by a permanent rulemaking) exists. The emergency rulemaking is linked through the notation that follows the Section heading in the menu.

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AUTHORITY: Implementing and authorized by the Nursing Home Care Act [210 ILCS 45].

SOURCE: Emergency rules adopted at 4 Ill. Reg. 10, p. 1066, effective March 1, 1980, for a maximum of 150 days; adopted at 4 Ill. Reg. 30, p. 311, effective July 28, 1980; emergency amendment at 6 Ill. Reg. 3229, effective March 8, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 5981, effective May 3, 1982; amended at 6 Ill. Reg. 6454, effective May 14, 1982; amended at 6 Ill. Reg. 8198, effective June 29, 1982; amended at 6 Ill. Reg. 11631, effective September 14, 1982; amended at 6 Ill. Reg. 14550 and 14554, effective November 8, 1982; amended at 6 Ill. Reg. 14684, effective November 15, 1982; amended at 7 Ill. Reg. 285, effective December 22, 1982; amended at 7 Ill. Reg. 1972, effective January 28, 1983; amended at 7 Ill. Reg. 8579, effective July 11, 1983; amended at 7 Ill. Reg. 15831, effective November 10, 1983; amended at 7 Ill. Reg. 15864, effective November 15, 1983; amended at 7 Ill. Reg. 16992, effective December 14, 1983; amended at 8 Ill. Reg. 15599, 15603, and 15606, effective August 15, 1984; amended at 8 Ill. Reg. 15947, effective August 17, 1984; amended at 8 Ill. Reg. 16999, effective September 5, 1984; codified at 8 Ill. Reg. 19766; amended at 8 Ill. Reg. 24186, effective November 29, 1984; amended at 8 Ill. Reg. 24668, effective December 7, 1984; amended at 8 Ill. Reg. 25102, effective December 14, 1984; amended at 9 Ill. Reg. 132, effective December 26, 1984; amended at 9 Ill. Reg. 4087, effective March 15, 1985; amended at 9 Ill. Reg. 11049, effective July 1, 1985; amended at 11 Ill. Reg. 16927, effective October 1, 1987; amended at 12 Ill. Reg. 1052, effective December 24, 1987; amended at 12 Ill. Reg. 16811, effective October 1, 1988; emergency amendment at 12 Ill. Reg. 18477, effective October 24, 1988, for a maximum of 150 days; emergency expired March 23, 1989; amended at 13 Ill. Reg. 4684, effective March 24, 1989; amended at 13 Ill. Reg. 5134, effective April 1, 1989; amended at 13 Ill. Reg. 20089, effective December 1, 1989; amended at 14 Ill. Reg. 14950, effective October 1, 1990; amended at 15 Ill. Reg. 554, effective January 1, 1991; amended at 16 Ill. Reg. 681, effective January 1, 1992; amended at 16 Ill. Reg. 5977, effective March 27, 1992; amended at 16 Ill. Reg. 17089, effective November 3, 1992; emergency amendment at 17 Ill. Reg. 2420, effective February 3, 1993, for a maximum of 150 days; emergency expired on July 3, 1993; emergency amendment at 17 Ill. Reg. 8026, effective May 6, 1993, for a maximum of 150 days; emergency expired on October 3, 1993; amended at 17 Ill. Reg. 15106, effective September 3, 1993; amended at 17 Ill. Reg. 16194, effective January 1, 1994; amended at 17 Ill. Reg. 19279, effective October 26, 1993; amended at 17 Ill. Reg. 19604, effective November 4, 1993; amended at 17 Ill. Reg. 21058, effective November 20, 1993; amended at 18 Ill. Reg. 1491, effective January 14, 1994; amended at 18 Ill. Reg. 15868, effective October 15, 1994; amended at 19 Ill. Reg. 11600, effective July 29, 1995; emergency amendment at 20 Ill. Reg. 567, effective January 1, 1996, for a maximum of 150 days;

emergency expired May 29, 1996; amended at 20 Ill. Reg. 10142, effective July 15, 1996; amended at 20 Ill. Reg. 12208, effective September 10, 1996; amended at 21 Ill. Reg. 15000, effective November 15, 1997; amended at 22 Ill. Reg. 4094, effective February 13, 1998; amended at 22 Ill. Reg. 7218, effective April 15, 1998; amended at 22 Ill. Reg. 16609, effective September 18, 1998; amended at 23 Ill. Reg. 1103, effective January 15, 1999; amended at 23 Ill. Reg. 8106, effective July 15, 1999; amended at 24 Ill. Reg. 17330, effective November 1, 2000; amended at 25 Ill. Reg. 4911, effective April 1, 2001; amended at 26 Ill. Reg. 3113, effective February 15, 2002; amended at 26 Ill. Reg. 4846, effective April 1, 2002; amended at 26 Ill. Reg. 10523, effective July 1, 2002; emergency amendment at 27 Ill. Reg. 2181, effective February 1, 2003, for a maximum of 150 days; emergency expired June 30, 2003; emergency amendment at 27 Ill. Reg. 5452, effective March 25, 2003, for a maximum of 150 days; emergency expired August 21, 2003; amended at 27 Ill. Reg. 5862, effective April 1, 2003; emergency amendment at 27 Ill. Reg. 14204, effective August 15, 2003, for a maximum of 150 days; emergency expired January 11, 2004; amended at 27 Ill. Reg. 15855, effective September 25, 2003; amended at 27 Ill. Reg. 18105, effective November 15, 2003; expedited correction at 28 Ill. Reg. 3528, effective November 15, 2003; amended at 28 Ill. Reg. 11180, effective July 22, 2004; amended at 28 Ill. Reg. 14623, effective October 20, 2004; amended at 29 Ill. Reg. 876, effective December 22, 2004; emergency amendment at 29 Ill. Reg. 11824, effective July 12, 2005, for a maximum of 150 days; emergency rule modified in response to JCAR Recommendation at 29 Ill. Reg. 15101, effective September 23, 2005, for the remainder of the maximum 150 days; emergency amendment expired December 8, 2005; amended at 29 Ill. Reg. 12852, effective August 2, 2005; amended at 30 Ill. Reg. 1425, effective January 23, 2006; amended at 30 Ill. Reg. 5213, effective March 2, 2006; amended at 31 Ill. Reg. 6044, effective April 3, 2007; amended at 31 Ill. Reg. 8813, effective June 6, 2007; amended at 33 Ill. Reg. 9356, effective June 17, 2009; amended at 34 Ill. Reg. 19182, effective November 23, 2010.

Section 300.110 General Requirements

- a) This Part applies to the operator/licensee of facilities, or distinct parts thereof, that are to be licensed and classified to provide intermediate care or skilled nursing care. Any license issued and in effect prior to March 1, 1980, pursuant to the Nursing homes, sheltered care homes, and homes for the aged Act (Ill. Rev. Stat. 1977, ch. 111½, par. 35.16 et seq.) shall remain valid and subject to the terms and conditions of the Nursing Home Care Act (the Act) (Ill. Rev. Stat. 1991, ch. 111½, par. 4151-101 et seq.) and all regulations promulgated thereunder until the expiration date shown on the face of such license.
- b) The license issued to each operator/licensee shall designate the licensee's name, facility name, address, the classification by level of service authorized for that facility, the number of beds authorized for each level, the date the license was issued and the expiration date. Such licenses shall be issued for a period of *not less than six months nor more than 18 months*. The Department will set the period of the license based on the license expiration dates of the facilities in the geographical area surrounding the facility *in order to distribute the expiration dates* as evenly as possible *throughout the calendar year*. (Section 3-110 of the Act)
- c) An applicant may request that the license issued by the Department of Public Health

(the Department) have distinct parts classified according to levels of services. The distinct part must satisfactorily meet the applicable physical plant standards based on a level of service classification sought for that distinct part. If necessary to protect the health, welfare and safety of residents in a distinct part requiring higher standards, the Department shall require compliance with whatever additional physical plant standards are necessary in any distinct part, to achieve this protection as required by the highest level of care being licensed. Administrative, supervisory, and other personnel may be shared by the entire facility, if so doing does not adversely affect meeting the total needs of the residents of the facility.

- d) *The operator may not admit residents in excess of the licensed capacity of the facility.* (Section 2-209 of the Act) (B)
- e) An intermediate care facility licensed and classified under the Act shall not use in its title or description "Hospital", "Sanitarium", "Sanatorium", "Rehabilitation Center", "Skilled Nursing Facility", or any other word or description in its title or advertisements which indicates that a type of service is provided by the facility which the facility is not licensed to provide or, in fact, does not provide. A skilled nursing facility may use in its title or advertisement the words or description: "Nursing Home", "Intermediate Care", "Skilled Nursing Facility".
- f) Any person constructing or modifying a long-term care facility or portion thereof without obtaining the required permit from the Health Facilities Planning Board shall not be eligible to apply for licensure for that facility or portion thereof (Ill. Rev. Stat. 1991, ch. 111½, par. 1163.1).
- g) *The licensee shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than ten percent of the residents. Such notice shall be given to the Department, to any residents who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The licensee shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under the Act.* (Section 3-423 of the Act) (A, B)
- h) Licensure for more than one level of care.
 - 1) A facility may be licensed for more than one level of care. The licensee must designate the level of care that will be provided in each bedroom. Bedrooms of like licensed level of care must be contiguous to each other within each "nursing unit" as defined in Section 300.330. Each nursing unit may have up to two levels of care and must meet the construction standards

for the highest licensed level of care in the nursing unit.

- 2) If a licensee wishes to designate a portion of its licensed beds as either Intermediate Care for the Developmentally Disabled or Long-Term Care for Under Age 22, the licensed beds must be located in a distinct part (as defined in Section 300.330) of the facility.

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.120 Application for License

- a) Any person acting individually or jointly with other persons who proposes to build, own, establish, or operate an intermediate care facility or skilled nursing facility shall submit application information on forms provided by the Department. The Department shall be furnished a written description of the proposed program to be provided, and other such information as it may require in order to determine the appropriate level of care for which the facility should be licensed. Application forms and other required information shall be submitted and approved prior to surveys of the physical plant or review of building plans and specifications.
- b) An application for a new facility shall be accompanied by a permit as required by the Illinois Health Facilities Planning Act [20 ILCS 3960].
- c) *Application* for a license to establish or *operate* an intermediate care facility or skilled nursing facility shall be made in writing and submitted, with other such information as the Department may require, *on forms* provided by the Department. (Section 3-103(1) of the Act)
- d) *All license applications shall be accompanied with an application fee of \$995. The fee for a 2-year license shall be double the fee for the annual license.* (Section 3-103(2) of the Act)
- e) *The application shall be under oath and the submission of false or misleading information shall be a Class A misdemeanor. The application shall contain the following information:*
 - 1) *The name and address of the applicant if an individual, and if a firm, partnership, or association, of every member thereof, and in the case of a corporation, the name and address thereof and of its officers and its registered agent, and in the case of a unit of local government, the name and address of its chief executive officer;*
 - 2) *The name and location of the facility for which a license is sought;*
 - 3) *The name of the person or persons under whose management or supervision the facility will be conducted;*

- 4) *The number and type of residents for which maintenance, personal care, or nursing is to be provided; and*
 - 5) *Such information relating to the number, experience, and training of the employees of the facility, any management agreements for the operation of the facility, and of the moral character of the applicant and employees as the Department may deem necessary. (Section 3-103(2) of the Act)*
- f) **Ownership Change or Discontinuation**
- 1) The license is not transferable. It is issued to a specific licensee and for a specific location. The license and the valid current renewal certificate immediately become void and shall be returned to the Department when the facility is sold or leased; when operation is discontinued; when operation is moved to a new location; when the licensee (if an individual) dies; when the licensee (if a corporation or partnership) dissolves or terminates; or when the licensee (whatever the entity) ceases to be.
 - 2) A license issued to a corporation shall become null, void and of no further effect upon the dissolution of the corporation. The license shall not be revived if the corporation is subsequently reinstated. A new license must be obtained in such cases.
- g) *Each initial application shall be accompanied by a financial statement setting forth the financial condition of the applicant and by a statement from the unit of local government having zoning jurisdiction over the facility's location stating that the location of the facility is not in violation of a zoning ordinance. An initial application for a new facility shall be accompanied by a permit as required by the Illinois Health Facilities Planning Act. After the application is approved, the applicant shall advise the Department every six months of any changes in the information originally provided in the application. (Section 3-103(3) of the Act)*
- h) *The Department may issue licenses or renewals for periods of not less than six months nor more than 18 months for facilities with annual licenses and not less than 18 months nor more than 30 months for facilities with 2-year licenses in order to distribute the expiration dates of such licenses throughout the calendar year. The fees for such licenses shall be pro-rated on the basis of the portion of the year for which they are issued. (Section 3-110 of the Act)*

(Source: Amended at 30 Ill. Reg. 1425, effective January 23, 2006)

Section 300.130 Licensee

- a) The licensee is the corporate body, political subdivision, individual, or individuals responsible for the operation of the facility and upon whom rests the responsibility for meeting the licensing requirements. The licensee does not have to own the building being used.

- b) If the licensee does not own the building, a lease or management agreement between the licensee and the owner of the building is required. A copy of the lease or management agreement shall be furnished to the Department. The Department shall also be provided with a copy of all new lease agreements or any changes to existing agreements within 30 days of the effective date of such changes.
- c) If the licensee is not a corporation or a political subdivision of the State of Illinois, each person responsible for the operation of the facility and upon whom rests the responsibility for meeting the licensing Minimum Standards shall be at least 18 years of age.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.140 Issuance of an Initial License for a New Facility

- a) *Upon receipt and review of an application for a license and inspection of the applicant facility, the Director shall issue a probationary license if he finds:*
 - 1) *The applicant is a person responsible and suitable to operate or to direct or participate in the operation of a facility by virtue of financial capacity, appropriate business or professional experience, a record of compliance with lawful orders of the Department and lack of revocation of a license during the previous five years;*
 - 2) *The facility is under the supervision of an administrator who is licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1991, ch. 111, par. 3651 et seq.) [225 ILCS 70]; and*
 - 3) *The facility is in substantial compliance with the Act and this Part. (Section 3-109 of the Act)*
- b) The Department will issue a probationary license for 120 days from the date of issuance.
- c) *Within 30 days prior to the termination of a probationary license, the Department shall fully and completely inspect the facility and, if the facility meets the applicable requirements for licensure, shall issue a license under Section 3-109 of the Act. (Section 3-116 of the Act) If the facility is not in compliance and satisfactory progress toward compliance is not being made, the Department will allow the probationary license to expire.*
- d) *If the Department finds that the facility does not meet the requirements for licensure but has made substantial progress toward meeting those requirements, the license may be renewed once for a period not to exceed 120 days from the expiration date of the initial probationary license. (Section 3-116 of the Act) Under no condition may more than two successive probationary licenses be issued.*

- e) The licensee shall qualify for issuance of a two-year license if the licensee has met the criteria contained in Section 3-110(b) of the Act for the last twenty-four consecutive months.

(Source: Amended at 18 Ill. Reg. 1491, effective January 14, 1994)

Section 300.150 Issuance of an Initial License Due to a Change of Ownership

- a) *Upon receipt and review of an application for a license the Director shall issue a probationary license if he finds:*
 - 1) *The applicant is a person responsible and suitable to operate or to direct or to participate in the operation of a facility by virtue of financial capacity, appropriate business or professional experience, a record of compliance with lawful orders of the Department and lack of revocation of a license during the previous five years;*
 - 2) *The facility is under the supervision of an administrator who is licensed under the Nursing Home Administrators Licensing and Disciplinary Act; and*
 - 3) *The facility is in substantial compliance with the Act and this Part.*
(Section 3-109 of the Act)
- b) *Whenever ownership of a facility is transferred from the person named in a license to any other person, the transferee must obtain a new probationary license. The transferee shall notify the Department of the transfer and apply for a new license at least 30 days prior to final transfer. (Section 3-112 of the Act)*
- c) *The transferor shall notify the Department at least 30 days prior to final transfer. The transferor shall remain responsible for the operation of the facility until such time as the license is issued to the new transferee. (Section 3-112 of the Act)*
- d) *The license granted to the transferee shall be subject to any plan of correction submitted by the previous owner and approved by the Department and any conditions contained in a conditional license issued to the previous owner. If there are outstanding violations and no plan of correction has been submitted by the facility and approved by the Department, the Department may issue a conditional license and plan of correction as provided in Sections 3-311 through 3-317 of the Act in place of a probationary license. (Section 3-113 of the Act)*
- e) *The transferor shall remain liable for all penalties assessed against the facility which are imposed for violations occurring prior to transfer of ownership.*
(Section 3-114 of the Act)
- f) The Department will issue a probationary license for 120 days from the date of issuance.

- g) *Within 30 days prior to the termination of a probationary license, the Department shall fully and completely inspect the facility and, if the facility meets the applicable requirements for licensure, shall issue a license under Section 3-109 of the Act.*(Section 3-116 of the Act) If the facility is not in compliance and satisfactory progress toward compliance is not being made, the Department will allow the probationary license to expire.
- h) *If the Department finds that the facility does not meet the requirements for licensure but has made substantial progress toward meeting those requirements, the license may be renewed once for a period not to exceed 120 days from the expiration date of the initial probationary license.* (Section 3-116 of the Act) Under no condition may more than two successive probationary licenses be issued.
- i) The issuance date of the probationary license to the new owner will be the date the last licensure requirement is met as determined by the Department.
- j) The licensee shall qualify for issuance of a two-year license if the licensee has met the criteria contained in Section 3-110(b) of the Act for the last twenty-four consecutive months.

(Source: Amended at 18 Ill. Reg. 1491, effective January 14, 1994)

Section 300.160 Issuance of a Renewal License

At least 120 days but not more than 150 days prior to license expiration, the licensee shall submit an application for renewal of the license in such form and containing such information as the Department requires. If the application is approved, and the facility is in compliance with all other licensure requirements, the license shall be renewed in accordance with Section 3-110 of the Act. The renewal application shall not be approved unless the applicant has provided to the Department an accurate disclosure document in accordance with the Alzheimer's Special Care Disclosure Act [220 ILCS 4] and Section 300.163 of this Part, if applicable. (Section 3-115 of the Act)

(Source: Amended at 24 Ill. Reg. 17330, effective November 1, 2000)

Section 300.163 Alzheimer's Special Care Disclosure

A facility that offers to provide care for persons with Alzheimer's disease through an Alzheimer's special care unit or center shall disclose to the Department or to a potential or actual client of the facility the following information in writing on request of the Department or client:

- a) *The form of care or treatment that distinguishes the facility as suitable for persons with Alzheimer's disease;*
- b) *The philosophy of the facility concerning the care or treatment of persons with Alzheimer's disease;*
- c) *The facility's pre-admission, admission, and discharge procedures;*

- d) *The facility's assessment, care planning, and implementation guidelines in the care and treatment of persons with Alzheimer's disease;*
- e) *The facility's minimum and maximum staffing ratios, specifying the general licensed health care provider to client ratio and the trainee health care provider to client ratio;*
- f) *The facility's physical environment;*
- g) *Activities available to clients at the facility;*
- h) *The role of family members in the care of clients at the facility; and*
- i) *The costs of care and treatment under the program or at the center.* (Section 15 of the Alzheimer's Special Care Disclosure Act)

(Source: Added at 23 Ill. Reg. 1103, effective January 15, 1999)

Section 300.165 Criteria for Adverse Licensure Actions

- a) Adverse licensure actions are determinations to deny the issuance of an initial license, to deny the issuance of a renewal of a license, or to revoke the current license of a facility.
- b) A determination by the Director or his designee to take adverse licensure action against a facility shall be based on a finding that one or more of the following criteria are met:
 - 1) The facility has *substantially failed to meet any of the minimum standards set forth in the act or this Part*. For purposes of this provision, substantial failure is a failure to meet the requirements of this Part which is other than a variance from strict and literal performance which results only in unimportant omissions or defects given the particular circumstances involved. (Sections 3-117(1) and 3-119(a)(1) of the Act)
 - 2) *The licensee or applicant, or the person designated to manage or supervise the facility has been convicted of any of the following crimes during the previous five years. Such convictions shall be verified by a certified copy of the record of the court of conviction.*
 - A) *A felony.*
 - B) *Two or more misdemeanors involving moral turpitude.* (Sections 3-117(2) and 3-119(a)(2) of the Act)
 - 3) *The moral character of the licensee, administrator, manager, or supervisor of the facility is not reputable.* Evidence to be considered will include verifiable statements by residents of a facility, law enforcement officials, or other persons with knowledge of the individual's character. In

addition, the definition afforded to the terms "reputable," "unreputable," and "irreputable" by the circuit courts of the State of Illinois shall apply when appropriate to the given situation. For purposes of this Section, a manager or supervisor of the facility is an individual with responsibility for the overall management, direction, coordination, or supervision of the facility or the facility staff. (Section 3-117(2) and 3-119(a)(2) of the Act)

- 4) The facility is operating (or, for an initial applicant, intends to operate) *with personnel which are insufficient in number or unqualified by training or experience to properly care for the number and type of residents* in the facility. Standards in these rules concerning personnel, including Sections 300.810, 300.820, 300.830, 300.1220, 300.1230 and 300.1240, will be considered in making this determination. (Sections 3-117(3) and 3-119(a)(3) of the Act)
 - 5) The facility has available *insufficient financial or other resources to operate the facility in accordance with this Part*. Financial information and changes in financial information provided by the facility under Section 300.120(f) and under Section 3-208 of the Act will be considered in making this determination (Section 3-208 of the Act)
 - 6) *The facility is not under the direct supervision of a full-time administrator* as required by Section 300.510. (Sections 3-117(6) and 3-119(a)(5) of the Act)
 - 7) The facility has violated the rights of residents of the facility by any of the following actions:
 - A) A pervasive pattern of cruelty or indifference to residents has occurred in the facility.
 - B) The facility has appropriated or converted for its use the property of a resident without his written consent or the consent of his legal guardian.
 - C) The facility has secured property, or a bequest of property, from a resident by undue influence.
 - 8) The facility knowingly submitted false information either on the licensure or renewal application forms or during the course of an inspection or survey of the facility.
 - 9) The facility has refused to allow an inspection or survey of the facility by agents of the Department to occur.
- c) The Director or his designee shall consider all available evidence at the time of the determination, including the history of the facility and the applicant in complying with the Act and this Part, notices of violations which have been issued to the facility and the applicant, findings of surveys and inspections, and

any other evidence provided by the facility, residents, law enforcement officials and other interested individuals.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.170 Denial of Initial License

- a) A determination by the Director or his designee to deny the issuance of an initial license shall be based on a finding that one or more of the criteria outlined in Section 300.165 or the following criteria are met.
 - 1) *The applicant, any member of the firm, partnership, or association which is the applicant, any officer or stockholder of the corporation which is the applicant, or the person designated to manage or supervise the facility has been convicted of any of the following crimes during the previous five years. Such convictions shall be verified by a certified copy of the record of the court of conviction.*
 - A) *A felony.*
 - B) *Two or more misdemeanors involving moral turpitude. (Section 3-117(2) of the Act)*
 - 2) Prior license revocation. Both of the following conditions must be met:
 - A) *The license of a facility under this Act has been revoked during the past five years, which was owned or operated by the applicant, by a controlling owner of the applicant, by a controlling combination of owners of the applicant, or by an affiliate who is a controlling owner of the applicant. Operation for the purposes of this provision shall include individuals with responsibility for the overall management, direction, or supervision of the facility.*
 - B) *Such prior revocation renders the applicant unqualified or incapable of maintaining a facility in accordance with the minimum standards set forth in the act or in this Part. This determination will be based on the applicant's qualifications and ability to meet the criteria outlined in Section 300.165(b) as evidenced by the application and the applicant's prior history. (Section 3-117(5) of the Act)*
- b) The Department shall notify an applicant *immediately upon denial of any application*. Such notice shall be *in writing* and shall include:
 - 1) *A clear and concise statement of the basis of the denial. The statement shall include a citation to the provisions of Section 3-117 of the Act and the provisions of this Part under which the application is being denied.*

- 2) A description of *the right of the applicant to appeal the denial of the application* and the right to a hearing. (Section 3-118 of the Act)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.175 Denial of Renewal of License

- a) Application for renewal of a license of a facility shall be denied and the license of the facility shall be allowed to expire when the Director or his designee finds that a condition, occurrence, or situation in the facility meets any of the criteria specified in Section 300.165(b). Pursuant to Section 10-65 of the Illinois Administrative Procedure Act (Ill. Rev. Stat. 1991, ch. 127, par. 1010-65) [5 ILCS 100/10-65], licensees who are individuals are subject to denial of renewal of licensure if the individual is more than 30 days delinquent in complying with a child support order.
- b) When the Director or his designee determines that an application for renewal of a license of a facility is to be denied, the Department shall notify the facility. The notice to the facility shall be in writing and shall include:
 - 1) *A clear and concise statement* of the basis of the denial. The statement shall include a citation to the provisions of the Act and this Part on which the application for renewal is being denied.
 - 2) A statement of the date on which the current license of the facility will expire as provided in subsection (c) of this Section and Section 3-119(d) of the Act.
 - 3) *A description of the right of the applicant to appeal the denial of the application for renewal and the right to a hearing.* (Section 3-119(b) of the Act)
- c) The effective date of the nonrenewal of a license shall be as provided in Section 3-119(d) of the Act.
- d) The current license of the facility shall be *extended by the Department* when it finds that such extension is necessary *to permit orderly removal and relocation of residents.* (Section 3-119(d)(3) of the Act)

(Source: Amended at 17 Ill. Reg. 19279, effective October 26, 1993)

Section 300.180 Revocation of License

- a) The license of a facility shall be revoked when the Director or his designee finds that a condition, occurrence or situation in the facility meets any of the criteria specified in Section 300.165(b). In addition, the license of a facility will be revoked when the facility fails to abate or eliminate a level A violation as provided in Section 300.282(b). Pursuant to Section 10-65 of the Illinois Administrative Procedure Act, licensees who are individuals are subject to

revocation of licensure if the individual is more than 30 days delinquent in complying with a child support order.

- b) When the Director or his designee determines that the license of a facility is to be revoked, the Department shall notify the facility. The notice to the facility shall be in writing and shall include:
 - 1) *A clear and concise statement of the basis of the revocation. The statement shall include a citation to the provisions of the Act and this Part on which the license is being revoked.*
 - 2) *A statement of the date on which the revocation will take effect as provided in subsection (c) of this Section and Section 3-119(d) of the Act.*
 - 3) *A description of the right of the facility to appeal the revocation of the license and the right to a hearing. (Section 3-119(b) of the Act)*
- c) The effective date of the revocation of a license shall be as provided in Section 3-119(d) of the Act.
- d) The effective date of the revocation shall be *extended by the Department* when it finds that such extension is necessary *to permit orderly removal and relocation of residents.* (Section 3-119(d)(3) of the Act)

(Source: Amended at 17 Ill. Reg. 19279, effective October 26, 1993)

Section 300.190 Experimental Program Conflicting With Requirements

- a) Any facility desiring to conduct an experimental program or do research which is in conflict with this Part shall submit a written request to the Department and secure prior approval. The Department will not approve experimental programs which would violate residents rights under the Act. Such approval will be granted only if the request will not create an unnecessary and unusual threat to the health, welfare, or safety of the residents or staff. (A, B)
- b) The Department may grant to a facility special permission to provide day care when it has adequate facilities and staff to satisfactorily provide such services based on the requirements in Section 300.3710.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.200 Inspections, Surveys, Evaluations and Consultation

The terms survey, inspection and evaluation are synonymous. These terms refer to the overall examination of compliance with the Act and this Part.

- a) All facilities to which this Part applies shall be subject to and shall be deemed to have given consent to annual inspections, surveys or evaluations by properly identified personnel of the Department, or by such other properly identified

persons, including local health department staff, as the Department may designate. *An inspection, survey or evaluation, other than an inspection of financial records, shall be conducted without prior notice to the facility. A visit for the sole purpose of consultation may be announced.* The licensee, or person representing the licensee in the facility, shall provide to the representative of the Department access and entry to the premises or facility for obtaining information required to carry out the Act and this Part. In addition, representatives of the Department *shall have access to and may reproduce or photocopy at its cost any books, records, and other documents maintained by the facility*, the licensee or their representatives *to the extent necessary to carry out the Act and this Part.* A facility may charge the Department for such photocopying at a rate determined by the facility not to exceed the rate in the Department's Freedom of Information Code (2 Ill. Adm. Code 1126). Sections 3-212 and 3-213 of the Act)

- b) *In determining whether to make more than the required number of unannounced inspections, surveys and evaluations of a facility, the Department shall consider one or more of the following:*
- 1) *previous inspection reports;*
 - 2) *the facility's history of compliance with the Act and this Part:*
 - A) *correction of violations;*
 - B) *penalties or other enforcement actions;*
 - 3) *the number and severity of complaints received about the facility;*
 - 4) *any allegations of resident abuse or neglect;*
 - 5) *weather conditions;*
 - 6) *health emergencies;*
 - 7) *other reasonable belief that deficiencies exist; and*
 - 8) *requirements pursuant to the "1864 Agreement" (42 U.S.C.A. 1395aa) between the Department and U.S. Health and Human Services (HHS) (e.g., annual and follow-up certification inspections, life safety code inspections and any inspections requested by the secretary of HHS). (Section 3-212(b) of the Act)*
- c) *The Department shall not be required to determine whether a facility certified to participate in the Medicare program under Title XVIII of the Social Security Act, or the Medicaid Program under Title XIX of the Social Security Act, and which the Department determines by inspection to be in compliance with the certification requirements of Title XVIII or XIX, is in compliance with any requirement of the Act that is less stringent than or duplicates a federal*

certification requirement. (Section 3-212(b-1) of the Act, see P.A. 88-278, effective August 10, 1993)

- d) *The Department shall, in accordance with Section 3-212(a) of the Act, determine whether a certified facility is in compliance with requirements of the Act that exceed federal certification requirements.* (Section 3-212(b-1) of the Act, see P.A. 88-278, effective August 10, 1993)
- e) *If a certified facility is found to be out of compliance with federal certification requirements, the results of the inspection conducted pursuant to Title XVIII or XIX of the Social Security Act* (Section 3-212(b-1) of the Act, see P.A. 88-278, effective August 10, 1993) shall be reviewed to determine which, if any, of the results shall be considered licensure findings, as follows:
 - 1) The result identifies potential violations of the Nursing Home Care Act and this Part; and
 - 2) The result, based on available information, would likely represent a Type A or Type B violation if tested against the factors described in Sections 300.272 and 300.274.
- f) All results of an inspection conducted pursuant to Title XVIII or XIX of the Social Security Act that the Department considers licensure findings shall be provided to the facility at the time of exit or by mail in accordance with subsection (g) of this Section.
- g) *Upon the completion of each inspection, survey and evaluation, the appropriate Department personnel who conducted the inspection, survey or evaluation shall submit a copy of their report to the licensee or their representative upon exiting the facility or upon considering results of an inspection conducted pursuant to Title XVIII or XIX of the Social Security Act as licensure findings. A copy of the information gathered during a complaint investigation will not be provided upon exiting the facility. Comments or documentation provided by the licensee which may refute findings in the report, which explain extenuating circumstances that the facility could not reasonably have prevented, or which indicate methods and timetables for correction of deficiencies described in the report shall be provided to the Department within ten days of receipt of the copy of the report.* (Section 3-212(c) of the Act)
- h) Consultation consists of providing advice or suggestions to the staff of a facility at their request relative to specific matters of the scope of regulation, methods of compliance with the Act or this Part, or general matters of patient care.

(Source: Amended at 19 Ill. Reg. 11600, effective July 29, 1995)

Section 300.210 Filing an Annual Attested Financial Statement

- a) *Each licensee shall submit an annual attested financial statement to the Department. This financial statement shall be filed in a prescribed format on forms supplied by the Department. The forms will be developed in conjunction with the Illinois Department of Public Aid. The time period covered in the financial statement shall be a period determined by the Department for the initial filing, and shall thereafter coincide with the facility's fiscal year or the calendar year. (Section 3-208 of the Act)*
- b) *The Department may require any facility to file an audited financial statement, if the Department determines that such a statement is needed. (Section 3-208 of the Act)*
- c) *The Department may require any or all facilities to submit attested or audited financial statements more frequently than annually, if the Department determines that more frequent financial statements are needed. The frequency and time period of such filings shall be as determined by the Department for each individual facility. (Section 3-208 of the Act)*
- d) The financial statement shall be filed with the Department within 90 days following the end of the designated reporting period. The financial statement will not be considered as having been filed unless all sections of the prescribed forms have been properly completed. Those sections which do not apply to a particular facility shall be noted "not applicable" on the forms.
- e) The information required to be submitted in the financial statement will include at a minimum the following:
 - 1) Facility information, including: facility name and address, licensure information, type of ownership, licensed bed capacity, date and cost of building construction and additions, date and cost of acquisition of buildings, building sizes, equipment costs and dates of acquisition.
 - 2) Resident information, including: number and level of care of residents by source of payment, income from residents by level of care.
 - 3) Cost information by level of care, including:
 - A) General service costs; such as dietary, food, housekeeping, laundry, utilities, and plant operation and maintenance.
 - B) Health care costs; such as medical director, nursing, medications, oxygen, activities, medical records, other medical services, social services, and utilization reviews.
 - C) General Administration; such as administrative salaries, professional services, fees, subscriptions, promotional, insurance, travel, clerical, employee benefits, license fees, and inservice training and education.

- D) Ownership; such as depreciation, interest, taxes, rent, and leasing.
- E) Special Service cost centers; such as habilitative and rehabilitative services, therapies, transportation, education, barber and beauty care, and gift and coffee shop.
- 4) Income information, including operating and nonoperating income.
- 5) Ownership information, including balance sheet and payment to owners.
- 6) Personnel information, including the number and type of people employed and salaries paid.
- 7) Related organization information, including related organizations from which services are purchased.
- f) The new owner or a new lessee of a previously licensed facility may file a projection of capital costs at the time of closing or signing of the lease.
 - 1) A facility which is licensed for the first time (a newly constructed facility) must file a projection of capital costs.
 - 2) Each of the above must file a full cost report within nine months after acquisition (covering the first six months of operation). Each must also file a cost report within 90 days of the close of its first complete fiscal year.
- g) *No public funds shall be expended for the maintenance of any resident in any facility which has failed to file this financial statement, and no public funds shall be paid to, or on behalf of, a facility which has failed to file the statement.*
(Section 3-208(b) of the Act)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.220 Information to Be Made Available to the Public By the Department

- a) *The Department shall respect the confidentiality of a resident's record and shall not divulge or disclose the contents of a record in a manner which identifies a resident, except upon a resident's death to a relative or guardian, or under judicial proceedings. This Section shall not be construed to limit the right of a resident or a resident's representative to inspect or copy the resident's records.*
(Section 2-206(a) of the Act)
- b) *Confidential medical, social, personal or financial information identifying a resident shall not be available for public inspection in a manner which identifies a resident.* (Section 2-206(b) of the Act)

- c) *The following information is subject to disclosure to the public from the Department or the Department of Public Aid:*
- 1) *Information submitted under Section 3-103 and 3-207 of the Act, except information concerning the remuneration of personnel licensed, registered, or certified by the Department of Professional Regulation and monthly charges for an individual private resident;*
 - 2) *Records of license and certification inspections, surveys, and evaluations of facilities, other reports of inspections, surveys, and evaluations of resident care, and reports concerning a facility prepared pursuant to Titles XVIII and XIX of the Social Security Act (42 U.S.C.A. 1395 et seq. and 1396 et seq.)subject to the provisions of the Social Security Act (42 U.S.C.A. 301 et seq.)*
 - 3) *Cost and reimbursement reports submitted by a facility under Section 3-208 of the Act reports of audits of facilities, and other public records concerning the cost incurred by, revenues received by, and reimbursement of facilities; and*
 - 4) *Complaints filed against a facility and complaint investigation reports, except that a complaint or complaint investigation report shall not be disclosed to a person other than the complainant or complainant's representative before it is disclosed to a facility under Section 3-702 of the Act, and, further, except that a complainant or resident's name shall not be disclosed except under Section 3-702 of the Act. (Section 2-205 of the Act)*
- d) *The Department shall disclose information under this Section in accordance with provisions for inspection and copying of public records required by the Freedom of Information Act (Ill. Rev. Stat. 1987, ch. 116, par. 201 et seq.).*
- e) *However, the disclosure of information described in subsection (1) shall not be restricted by any provision of the Freedom of Information Act. (Section 2-205 of the Act)*
- f) *Copies of reports available to the public may be obtained by making a written request to the Department in accordance with the Department's Freedom of Information Rules – 2 Ill. Adm. Code 1126. However, access to cost reports shall be governed by Department of Public Aid rule "Access to Cost Reports" (89 Ill. Adm. Code 140.544). The Department may, at its discretion, waive this fee if the party requesting the material is involved in legal action with the Department.*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.230 Information to Be Made Available to the Public By the Licensee

- a) *Every facility shall conspicuously post or display in an area of its offices accessible to residents, employees, and visitors the following:*
- 1) *Its current license;*
 - 2) *A description, provided by the Department of complaint procedures established under the Act and the name, address, and telephone number of a person authorized by the Department to receive complaints;*
 - 3) *A copy of any order pertaining to the facility issued by the Department or a court; and*
 - 4) *A list of the material available for public inspection under subsection (b) of this Section and Section 3-210 of the Act. (Section 3-209 of the Act)*
- b) *A facility shall retain the following for public inspection:*
- 1) *A complete copy of every inspection report of the facility received from the Department during the past five years;*
 - 2) *A copy of every order pertaining to the facility issued by the Department or a court during the past five years;*
 - 3) *A description of the services provided by the facility and the rates charged for those services and items for which a resident may be separately charged;*
 - 4) *A copy of the Statement of Ownership required by Section 3-207 of the Act;*
 - 5) *A record of personnel employed or retained by the facility who are licensed, certified or registered by the Department of Professional Regulation; and*
 - 6) *A complete copy of the most recent inspection report of the facility received from the Department. (Section 3-210 of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.240 Municipal Licensing

- a) Municipalities which have adopted a licensing ordinance as provided under Section 3-104 of the Act and this Part shall adopt this Part by complying with Article I, Division 3, of the Illinois Municipal Code (Ill. Rev. Stat. 1987, ch. 24, pars. 1-3-1 et seq.).
- b) Municipalities shall issue licenses so that the expiration dates are distributed throughout the calendar year. The month the license expires shall coincide with

the date of original licensure of the licensee. During the 24 month period following the effective date of the Act, the municipality may issue renewal licenses for a period of less than one year in order to distribute the expiration date of such licenses throughout the calendar year.

- c) The municipality shall notify the Department within ten days from the date of issuance or denial of a license that the municipal license has been issued or denied. If the license is issued, the notice will include the facility name, address, the date of issuance, and the number of beds by level of care for which the license was issued. If the license is denied, the notice will indicate reason for denial and the current status of licensee's (applicant's) application for municipal license.
- d) *The municipality shall use the same licensing classifications as the Department; and a facility may not be licensed for a different classification by the Department than by the municipality.*
- e) *The Department and the municipality shall have the right at any time to visit and inspect the premises and personnel of any facility for the purpose of determining whether the applicant or licensee is in compliance with the Act, this Part or with the local ordinances which govern the regulation of the facility. The Department may survey any former facility which once held a license to insure that the facility is not again operating without a license. Municipalities may charge a reasonable license or renewal fee for the regulation of facilities, which fees shall be in addition to the fees paid to the Department.*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.250 Ownership Disclosure

- a) *As a condition of the issuance or renewal of the license of any facility, the applicant shall file a statement of ownership. The applicant shall notify the Department of any change in the information required in the statement of ownership within ten days of the Change. (Section 3-207(a) of the Act)*
- b) A statement of ownership shall include the following:
 - 1) The name, address, Social Security Number, telephone number, occupation or business activity, business address, business telephone number, and the percent of direct or indirect financial interest of those persons who have a direct or indirect financial interest of five percent or more in the legal entity designated as the operator/licensee of the facility which is the subject of the application or license;
 - 2) The name, address, Social Security Number, telephone number, occupation or business activity, business address, business telephone number, and the percent of direct or indirect financial interest of those persons who have a direct or indirect financial interest of five percent or more in the legal entity that owns the building in which the

operator/licensee is operating the facility which is the subject of the application or license; and

- 3) *The name and address of any facility, wherever located, in which the applicant has any ownership interest. (Section 3-207(b) of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.260 Issuance of Conditional Licenses

- a) *The Director may issue a conditional license under Section 3-305 of the Act to any facility if the Director finds that either a Type "A" or Type "B" violation exists in such facility. The issuance of a conditional license shall revoke any license held by the facility. (Section 3-311 of the Act)*
- b) *Prior to the issuance of a conditional license, the Department shall review and approve a written plan of correction. The Department shall specify the violations which prevent full licensure and shall establish a time schedule for correction of the deficiencies. Retention of the license shall be conditional on the timely correction of the deficiencies in accordance with the plan of correction. (Section 3-312 of the Act)*
- c) *Written notice of the decision to issue a conditional license shall be sent to the applicant or licensee together with the specification of all violations of the Act and this Part which prevent full licensure and which form the basis for the Department's decision to issue a conditional license and the required plan of correction. The notice shall inform the applicant or licensee of its right to a full hearing under Section 3-315 of the Act to contest the issuance of the conditional license. (Section 3-313 of the Act)*
- d) *If the applicant or licensee desires to contest the basis for issuance of a conditional license, or the terms of the plan of correction, the applicant or licensee shall send a written request for hearing to the Department within ten (10) days after receipt by the applicant or licensee of the Department's notice and decision to issue a conditional license. The Department shall hold the hearing as provided under Section 3-703 of the Act. The terms of the conditional license shall be stayed pending the issuance of the Final Order at the conclusion of the hearing, and the facility may operate in the same manner as with an unrestricted license. (Section 3-315 of the Act)*
- e) *A conditional license shall be issued for a period specified by the Department, but in no event for more than one year. The effective date of the conditional license shall not begin until such time as the applicant or licensee has had the opportunity to request a hearing pursuant to subsection (d) of this Section, and if a hearing is requested in a timely manner, then the terms of the conditional license shall be stayed as provided for in subsection (d) of this Section. The Department shall periodically inspect any facility operating under a conditional license. If the Department finds substantial failure by the facility to timely correct the violations*

which prevented full licensure and formed the basis for the Department's decision to issue a conditional license in accordance with the required plan of correction, the conditional license may be revoked as provided under Section 3-119 of the Act. (Section 3-316 of the Act)

(Source: Amended at 17 Ill. Reg. 15106, effective September 3, 1993)

Section 300.270 Monitor and Receivership

- a) *The Department may place an employee or agent to serve as a monitor in a facility when any of the following conditions exist:*
 - 1) *The facility is operating without a license;*
 - 2) *The Department has suspended, revoked or refused to renew the existing license of the facility;*
 - 3) *The facility is closing or has informed the Department that it intends to close and adequate arrangements for relocation of residents have not been made at least 30 days prior to closure;*
 - 4) *The Department determines that an emergency exists, whether or not it has initiated revocation or nonrenewal procedures, if because of the unwillingness or inability of the licensee to remedy the emergency the Department believes a monitor is necessary; as used in this subsection, "emergency" means a threat to the health, safety or welfare of a resident that the facility is unwilling or unable to correct; or*
 - 5) *The Department receives notification that the facility is terminated or will not be renewed for participation in the federal reimbursement program under either Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act. (Section 3-501 of the Act)*

- b) *The monitor shall meet the following minimum requirements:*
 - 1) *be in good physical health as evidenced by a physical examination by a physician within the last year;*
 - 2) *have an understanding of the needs of long-term care facility residents as evidenced by one year of experience in working, as appropriate, with elderly or developmentally disabled individuals in programs such as patient care, social work, or advocacy;*
 - 3) *have an understanding of the Act and this Part which are the subject of the monitors' duties as evidenced in a personal interview of the candidate;*

- 4) not be related to the owners of the involved facility either through blood, marriage or common ownership of real or personal property except ownership of stock that is traded on a stock exchange;
 - 5) have successfully completed a baccalaureate degree or possess a nursing license or a nursing home administrator's license; and
 - 6) have two years full-time work experience in the long-term care industry of the State of Illinois.
- c) The monitor shall be under the supervision of the Department; shall perform the duties of a monitor delineated in Section 3-502 of the Act; and shall accomplish the following actions:
- 1) visit the facility as directed by the Department;
 - 2) review all records pertinent to the condition for such monitor's placement under subsection (a) of this Section;
 - 3) provide to the Department written and oral reports detailing the observed conditions of the facility; and
 - 4) be available as a witness for hearings involving the condition for placement as monitor.
- d) All communications, including but not limited to data, memoranda, correspondence, records and reports shall be transmitted to and become the property of the Department. In addition, findings and results of the monitor's work done under this Part shall be strictly confidential and not subject to disclosure without written authorization from the Department or by court order subject to disclosure only in accordance with the provisions of the Freedom of Information Act, subject to the confidentiality requirements of the Act.
- e) The assignment as monitor may be terminated at any time by the Department.
- f) Through consultation with the long-term care industry associations, professional organizations, consumer groups and health-care management corporations, the Department shall maintain a list of receivers. Preference on the list shall be given to individuals possessing a valid Illinois Nursing Home Administrator's License, experience in financial and operations management of a long-term care facility and individuals with access to consultative experts with the aforementioned experience. To be placed on the list, individuals must meet the following minimum requirements:
- 1) be in good physical health as evidenced by a physical examination by a physician within the last year;
 - 2) have an understanding of the needs of long-term care facility residents and the delivery of the highest possible quality of care as evidenced by one

- year of experience in working with elderly or developmentally disabled individuals in programs such as patient care, social work, or advocacy;
- 3) have an understanding and working knowledge of the Act and this Part, as evidenced in a personal interview of the candidate;
 - 4) have successfully completed a baccalaureate degree or possess a nursing license or a nursing home administrator's license; and
 - 5) have two years full-time working experience in the Illinois long-term care industry.
- g) Upon appointment of a receiver for a facility by a court, the Department shall inform the individual of all legal proceedings to date which concern the facility.
- h) The receiver may request that the Director of the Department authorize expenditures from monies appropriated, pursuant to Section 3-511 of the Act, if incoming payments from the operation of the facility are less than the costs incurred by the receiver.
- i) In the case of Department ordered patient transfers, the receiver may:
- 1) assist in providing for the orderly transfer of all residents in the facility to other suitable facilities or make other provisions for their continued health;
 - 2) assist in providing for transportation of the resident, his medical records and his belongings if he is transferred or discharged; assist in locating alternative placement; assist in preparing the resident for transfer; and permit the resident's legal guardian to participate in the selection of the resident's new location;
 - 3) unless emergency transfer is necessary, explain alternative placements to the resident and provide orientation to the place chosen by the resident or resident's guardian.
- j) *In any action or special proceeding brought against a receiver in the receiver's official capacity for acts committed while carrying out the aforesaid powers and duties, the receiver shall be considered a public employee under the Local Governmental and Governmental Employees Tort Immunity Act [745 ILCS 10]. A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts or breach of fiduciary duty. (Section 3-513 of the Act)*

(Source: Amended at 19 Ill. Reg. 11600, effective July 29, 1995)

Section 300.271 Presentation of Findings

- a) If it is probable that findings will be presented that could be issued as violations of regulations which represent a direct threat to the health, safety or welfare of residents, surveyors shall notify the administrator or designee during the course of the survey of such possible findings.
- b) The Department shall conduct an exit conference with the administrator or other facility designee at the conclusion of each on-site inspection at the facility, whether or not the investigation has been completed. If the investigation has been completed, findings shall be presented during the exit conference. If the investigation has not been completed at the time of the facility exit, the Department shall inform the facility administrator or designee that the investigation is not complete and that findings may be presented to the facility at a later date. Presentation of any additional findings may be conducted at the facility, at the Department's regional office, or by telephone.
- c) With the assistance of the administrator, surveyors shall schedule a time and place for the exit conference to be held at the conclusion of the survey.
- d) At the exit conference, surveyors shall present their findings and resident identity key and identify regulations related to the findings. The facility administrator or designee shall have an opportunity at the exit conference to discuss and provide additional documentation related to the findings. The Department's surveyors conducting the exit conference may, in their discretion, modify or eliminate any or all preliminary findings in accordance with any facts presented by the facility to the Department during the exit conference.
- e) Additional comments or documentation may be submitted by the facility to the Department during a 10-day comment period as allowed by the Act.
- f) If the Department determines, after review of the comments submitted pursuant to subsection (d) of this Section, that the facility may have committed violations of the Act or this Part different than or in addition to those presented at the exit conference and the violations may be cited as either Type A or repeat Type B violations, the Department shall so inform the facility in writing. The facility shall then have an opportunity to submit additional comments addressing the different or additional Sections of the Act or this Part. The surveyors will be advised of any code changes made after their recommendations are submitted.
- g) The facility shall have 5 (five) working days from receipt of the notice required by subsection (f) of this Section to submit its additional comments to the Department. The Department shall consider such additional comments in determining the existence and level of violation of the Act and/or this Part in the same manner as the Department considers the facility's original comments.
- h) If desired by the facility, an audio-taped recording may be made of the exit conference provided that a copy of such recording is provided, at facility expense, to the surveyors at the conclusion of the exit conference. No video-taped recording shall be allowed.

- i) Surveyors shall not conduct an exit conference for the following reason:
 - 1) The facility administrator or designee requests that an exit conference not be held;
 - 2) During a scheduled exit conference, facility staff and/or their guests create an environment that is not conducive to a meaningful exchange of information.

(Source: Added at 17 Ill. Reg. 15106, effective September 3, 1993)

Section 300.272 Determination to Issue a Notice of Violation or Administrative Warning

- a) Upon receipt of a report of an inspection, survey or evaluation of a facility, the Director or his designee shall review the findings contained in the report to determine *whether the report's findings constitute a violation or violations of which the facility must be given notice and which threaten the health, safety, or welfare of a resident or residents*. All information, evidence and observations made during an inspection, survey or evaluation shall be considered findings or deficiencies. (Section 3-212(c) of the Act)
- b) In making this determination, the Director or his designee shall consider *any comments and documentation provided by the facility* within ten days of receipt of the report in accordance with Section 300.200(c). (Section 3-212(c) of the Act)
- c) In determining whether the findings warrant the issuance of a notice of violation, the Director or his designee shall base his determination on the following factors:
 - 1) *The severity of the finding*. The Director or his designee will consider whether the finding constitutes a merely technical non-substantial error or whether the finding is serious enough to constitute an actual violation of the intent and purpose of the standard.
 - 2) *The danger posed to resident health and safety*. The Director or his designee will consider whether the finding could pose any direct harm to the residents.
 - 3) *The diligence and efforts to correct deficiencies and correction of reported deficiencies by the facility*. Consideration will be given to any evidence provided by the facility in its comments and documentation that steps have been taken to reduce noted findings and to insure a reduction of deficiencies.
 - 4) *The frequency and duration of similar findings in previous reports and the facility's general inspection history*. The director or his designee will consider whether the same finding or a similar finding relating to the same condition or occurrence has been included in previous reports and the

facility has allowed the condition or occurrence to continue or to recur.
(Section 3-212(c) of the Act)

- d) If the Director or his designee determines that the report's findings constitute a violation or violations which do not directly threaten the health, safety, or welfare of a resident or residents, the *department shall issue an administrative warning* as provided in Section 300.277 (Section 3-303.2(a) of the Act)
- e) *Violations shall be determined under this Section no later than 60 days after completion of each inspection, survey and evaluation.* (Section 3-212(c) of the Act)

(Source: Added at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.274 Determination of the Level of a Violation

- a) After determining that issuance of a notice of violation is warranted and prior to issuance of the notice, the Director or his designee will review the findings which are the basis of the violation and any comments and documentation provided by the facility to determine the level of the violation. Each violation shall be determined to be either a level A or level B violation based on the criteria outlined in this Section.
- b) The following definitions of levels of violations shall be used in determining the level of each violation:
 - 1) A "level A violation" or "type A violation" is *a violation of the act or these rules which creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that death or serious mental or physical harm will result therefrom.* (Section 1-129 of the Act)
 - 2) A "level B violation" or "type B violation" is *a violation of the act or these rules which creates a condition or occurrence relating to the operation and maintenance of a facility directly threatening to the health, safety or welfare of a resident* (Section 1-130 of the Act)
- c) In determining the level of a violation, the Director or his designee shall consider the following criteria:
 - 1) The specific requirements of this Part which have been violated and the designated level of violation for those provisions.
 - A) The designated level of violation is indicated by the letter or letters in parentheses following specific provisions. The presence of more than one letter following a specific provision indicates that the provision may be applicable to different levels of violation. The absence of any letter following a specific provision indicates

that no designated level of violation applicable to that provision has been determined.

- B) The designated level of violation will be considered in conjunction with the other criteria contained in subsections (c)(2) and (c)(3) of this Section which may increase or decrease the level of violation cited for a specific violation, except that no violation will be cited as a level B violation unless there is a direct threat to the health, safety or welfare of a resident, or as a level A violation unless there is a substantial probability of the death of a resident or serious mental or physical harm to a resident.
- 2) The degree of danger to the resident or residents which is posed by the condition or occurrence in the facility. The following factors will be considered in assessing the degree of danger:
- A) Whether the resident or residents of the facility are able to recognize conditions or occurrences which may be harmful and are able to take measures for self-preservation and self-protection. The extent of nursing care required by the residents as indicated by review of patient needs will be considered in relation to this determination.
 - B) Whether the resident or residents have access to the area of the facility in which the condition or occurrence exists and the extent of such access. A facility's use of barriers, warning notices, instructions to staff and other means of restricting resident access to hazardous areas will be considered.
 - C) Whether the condition or occurrence was the result of inherently hazardous activities or negligence by the facility.
 - D) Whether the resident or residents of the facility were notified of the condition or occurrence and the promptness of such notice. Failure of the facility to notify residents of potentially harmful conditions or occurrences will be considered. The adequacy of the method of such notification and the extent to which such notification reduced the potential danger to the residents will also be considered.
- 3) The directness and imminence of the danger to the resident or residents by the condition or occurrence in the facility. In assessing the directness and imminence of the danger, the following factors will be considered:
- A) Whether actual harm, including death, physical injury or illness, mental injury or illness, distress, or pain, to a resident or residents resulted from the condition or occurrence and the extent of such harm.

- B) Whether available statistics and records from similar facilities indicate that direct and imminent danger to the resident or residents has resulted from similar conditions or occurrences and the frequency of such danger.
- C) Whether professional opinions and findings indicate that direct and imminent danger to the resident or residents will result from the condition or occurrence.
- D) Whether the condition or occurrence was limited to a specific area of the facility or was widespread throughout the facility. Efforts taken by the facility to limit or reduce the scope of the area affected by the condition or occurrence will be considered.
- E) Whether the physical, mental, or emotional state of the resident or residents, who are subject to the danger, would facilitate or hinder harm actually resulting from the condition or occurrence.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.276 Notice of Violation

- a) *Each notice of violation shall be in writing and shall contain the following information:*
 - 1) A description of *the nature of the violation*.
 - 2) A citation of the specific *statutory provision or rule* which the Department believes has been violated. (Section 3-301 of the Act)
 - 3) A statement of the level of the violation as determined pursuant to Section 300.274.
 - 4) One of the following requirements for corrective action:
 - A) For level A violations, a statement that necessary corrective action to *abate or eliminate* the violation must be taken *immediately* or within a specific *fixed period of time not exceeding 15 days*. In setting this period, the Department will consider whether harm to residents of the facility is imminent, whether necessary precautions can be taken to protect residents before the corrective action is completed, and whether delay would pose additional risks to the residents.
 - B) For level B violations, a *request* that the facility submit a *plan of correction within ten days of the receipt of the notice of violation* pursuant to Section 3-303 of the Act and Section 300.278 of this Part. (Section 3-301 of the Act)

- 5) A statement that the Department may take additional action under the Act, including assessment of penalties or licensure action.
 - 6) A description of the licensee's right to appeal the notice and its right to a hearing.
- b) Each notice of violation shall be sent to the facility and the licensee or served personally at the facility *within ten days* after the Director or his designee determines that issuance of a notice of violation is warranted under Section 300.272. (Section 3-301 of the Act)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.277 Administrative Warning

- a) Each administrative warning shall be in writing and shall include the following information:
 - 1) A description of the nature of the violation.
 - 2) A citation of the specific statutory provision or rule which the Department believes has been violated.
 - 3) A statement that the *facility shall be responsible for correcting the situation, condition, or practice.* (Section 3-303.2(a) of the Act)
- b) Each administrative warning shall be sent to the facility and the licensee or served personally at the facility within ten days after the Director or his designee determines that issuance of an administrative warning is warranted under Section 300.272.
- c) The facility is not required to submit a plan of correction in response to an administrative warning.
- d) If the Department finds, during *the next on-site inspection which occurs more than 90 days after the issuance of the administrative warning*, that the facility has *not corrected the situation, condition, or practice which resulted in the issuance of the administrative warning*, the Department shall notify the facility of the finding. The facility must then *submit a written plan of correction* as provided in Section 300.278. The Department will consider the plan of correction and take any necessary action in accordance with Section 302.78. (Section 3-303.2(b) of the Act)

(Source: Added at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.278 Plans of Correction

- a) *A facility shall have ten days after receipt of notice of violation for a Type B violation, or after receipt of a notice under Section 300.277(d) of failure to correct a situation, condition, or practice which resulted in the issuance of an administrative warning, to prepare and submit a plan of correction to the Department. (Section 3-303(b) of the Act)*
- b) Within the ten-day period, a facility may request additional time for submission of the plan of correction. The Department will extend the period for submission of the plan of correction for an additional 30 days, when it finds that corrective action by a facility to abate or eliminate the violation will require *substantial capital improvement*. The Department will consider the extent and complexity of necessary physical plant repairs and improvements and any impact on the health, safety, or welfare of the residents of the facility in determining whether to grant a requested extension. (Section 3-303(b) of the Act)
- c) Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences which are the basis of the violation and an evaluation of the practices, policies, and procedures which have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:
 - 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
 - 2) A description of the steps which will be taken to avoid future occurrences of the same and similar violations.
 - 3) A specific date by which the corrective action will be completed.
- d) Submission of a plan of correction shall not be considered an admission by the facility that the violation has occurred.
- e) The Department shall review each plan of correction to insure that it provides for the abatement, elimination, or correction of the violation. The Department shall reject a submitted plan only if it finds any of the following deficiencies:
 - 1) The plan does not appear to address the conditions or occurrences which are the basis of the violation and an evaluation of the practices, policies, and procedures which have caused or contributed to the conditions or occurrences.
 - 2) The plan is not specific enough to indicate the actual actions the facility will be taking to abate, eliminate, or correct the violation.
 - 3) The plan does not provide for measures which will abate or eliminate, or correct the violation.

- 4) The plan does not provide steps which will avoid future occurrences of the same and similar violations.
- 5) The plan does not provide for timely completion of the corrective action, considering the seriousness of the violation, any possible harm to the residents, and the extent and complexity of the corrective action.
- f) When the Department rejects a submitted plan of correction, it shall notify the facility. The notice of rejection shall be in writing and shall specify *the reason for the rejection. The facility shall have ten days after receipt of the notice of rejection in which to submit a modified plan.* (Section 3-303(b) of the Act)
- g) If a facility fails to submit a plan or modified plan meeting the criteria in subsection (c) of this Section within the prescribed time periods in subsection (a) or (b) of this Section, or anytime the Department issues a Type A or repeat B violation, an approved plan of correction will be imposed by the Department.
- h) The Department shall verify the completion of the corrective action required by the plan of correction within the specified time period during subsequent investigations, surveys and evaluations of the facility.

(Source: Amended at 17 Ill. Reg. 15106 effective September 3, 1993)

Section 300.280 Reports of Correction

- a) In lieu of submission of a plan of correction, a facility may submit a report of correction if the corrective action has been completed. The report of correction must be submitted within the time periods required in Section 300.278 for submission of a plan of correction.
- b) Each report of correction shall be based on an assessment by the facility of the conditions or occurrences which are the basis of the violation and an evaluation of the practices, policies, and procedures which have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each report of correction shall include:
 - 1) A description of the specific corrective action the facility has taken to abate, eliminate, or correct the violation cited in the notice.
 - 2) A description of the steps which have been taken to avoid future occurrences of the same and similar violations.
 - 3) The specific date on which the corrective action was completed.
 - 4) A signed statement by the administrator of the facility that the report of correction is true and accurate, which shall be considered an oath for the purposes of any legal proceedings.

- c) Submission of a report of correction shall not be considered an admission by the facility that the violation has occurred.
- d) The Department shall review and approve or disapprove the report of correction based on the criteria outlined in Section 300.278(d) for review of plans of correction. If a report of correction is disapproved, the facility shall be subject to a plan of correction imposed by the Department as provided in Section 300.278.
- e) The Department shall verify the completion of the corrective action outlined in the report of correction during subsequent investigations, surveys and evaluations of the facility.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.282 Conditions for Assessment of Penalties

The Department shall consider the assessment of a monetary penalty against a facility under the following conditions:

- a) When a notice of violation for a level A violation is issued.
 - 1) The penalty to be assessed for this violation shall be the greater of the following:
 - A) An amount *not less than* \$5000 as determined by the Director or his designee considering the factors outlined in Section 300.286(a), or
 - B) The total of the following:
 - i) \$5 *per resident in the facility, plus*
 - ii) \$.20 *per resident for each day of the violation, commencing on the day on which the notice of violation is served under Section 3-301 of the Act and ending on the date the violation is corrected, or*
 - C) *When death, serious mental or physical harm, permanent disability, or disfigurement results, a fine of not less than \$10,000 as determined by the Director or his designee considering the factors outlined in Section 300.286(a). (Section 3-305(1) of the Act)*
 - 2) The facility shall also be issued a conditional license for a period of six months as provided in Section 300.260.

- b) When a facility fails to abate or eliminate a level A violation immediately or within the period set by the Department in the notice of violation pursuant to Section 300.276(a)(4)(A).
 - 1) The facility shall be cited for a repeat violation.
 - 2) The penalty to be assessed shall be three times the penalty computed under subsection (a)(1) of this Section.
 - 3) The license of the facility shall be revoked as provided in Section 300.180.
- c) When a notice of violation for a level B violation is issued.
 - 1) The penalty to be assessed for this violation shall be the greater of the following:
 - A) An amount *not less than* \$500 as determined by the Director or his designee considering the factors outlined in Section 300.286(a), or
 - B) The total of the following:
 - i) \$3 *per resident in the facility, plus*
 - ii) \$.15 *per resident for each day of the violation, commencing on the date a notice of violation is served under Section 3-301 of the Act and ending on the date the violation is corrected.* (Section 3-305(2) of the Act)
 - 2) Upon acceptance of a plan of correction by the Department, assessment of the penalty shall be suspended by the Department. No additional penalty shall be imposed for days during which the plan of correction is in effect.
- d) When a facility fails to correct a level B violation within the time period specified in the plan of correction approved by the Department.
 - 1) The facility shall be cited for a repeat violation.
 - 2) The penalty to be assessed shall be computed in accordance with subsection (c)(1) of this Section. Days during which the plan of correction was in effect shall be included in the calculation of the penalty.
 - 3) The facility shall also be issued a conditional license for a period of at least six months as provided in Section 300.260.
- e) *When a notice of violation is issued for a violation of Article II of the Act with regard to the rights of a particular resident of the facility, the Department shall order the facility to reimburse the residents for any injuries incurred or if the*

amount of the injuries is less than \$100, the Department shall order the facility to pay \$100 to the resident. (Section 3-305(7) of the Act)

(Source: Amended at 18 Ill. Reg. 1491, effective January 14, 1994)

Section 300.284 Calculation of Penalties

- a) For the purpose of calculating penalties as provided in Section 300.282, *each day on which a violation continues to exist after the day on which notice of the violation is received by the facility shall be considered a separate violation.* The Department shall not be required to send additional notices of violation to the facility for such continuing violations. (Section 3-302 of the Act)

- b) For purposes of calculating penalties as provided in Section 300.282, *the number of residents in the facility and the number of residents on each day shall be calculated as the average number of residents in the facility during the 30 days immediately preceding the day on which the findings were made in the facility and the conditions or occurrences determined to be a violation were discovered.* The number of residents in the facility on the day on which the findings were made in the facility will be considered to be the same as the average number of residents in the facility during the preceding 30 days, unless evidence is provided by the facility substantiating that the average number of residents for that period was different. Changes in the number of residents in the facility subsequent to the day on which the findings were made shall not be considered in the calculation. (Section 3-305(5) of the Act)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.286 Determination to Assess Penalties

- a) The Director or his designee shall consider the following factors in determining whether or not to assess penalties for violations under the conditions outlined in Section 300.282.
 - 1) *The severity of harm, including death or serious physical or mental harm, which has resulted to a resident and the extent to which residents have been subject to potential serious harm.* A penalty will be assessed when the Director or his designee finds that death or serious physical or mental harm to a resident has occurred or that the facility has knowingly subjected residents to potential serious harm.

 - 2) *The gravity of the violation and the extent to which the provisions of the act or this Part were violated.* The Director or his designee will assess a monetary penalty if he finds that the violation recurred or continued, is widespread throughout the facility or evidences flagrant violation or the Act or this Part.

- 3) *The extent and seriousness of any previous violations committed by the facility and the extent of diligence exercised by the facility to correct such violations.* The Director or his designee will assess a penalty when he finds that the facility has been cited for similar violations and has failed to correct such violations as promptly as practicable or has failed to exercise diligence in taking necessary corrective action. The Director or his designee will also consider any evidence that the violations constitute a pattern of deliberate action by the facility. The extent of any change in the ownership and management of the facility will be considered in relation to the seriousness of previous violations.
 - 4) *Any possible financial benefit the facility could gain as a result of committing or continuing the violation.* Such benefits include, but are not limited to, diversion of costs associated with physical plant repairs, staff salaries, consultant fees, or direct patient care services. (Section 3-306 of the Act)
- b) If the Director or his designee determines that a penalty is to be assessed, a written notice of penalty assessment shall be sent to the facility. Each notice of penalty assessment shall include:
- 1) *The amount of the penalty* being assessed as provided in Section 300.282.
 - 2) The amount of any reduction or whether the penalty has been waived pursuant to Section 300.288.
 - 3) A description of *the violation*, including a reference to the notices of violation and plans of correction which are the basis of the assessment.
 - 4) A citation to the provision of *the act or the rule* which the facility has violated.
 - 5) A description of the right of the facility to appeal the assessment and of the *right of the facility to a hearing*.
 - 6) For violations which are continuing at the time the notice of assessment, *the amount of additional penalties per day* which will be assessed. (Section 3-307 of the Act)
- c) Penalties shall be paid by the facility to the Department within the time periods provided in Section 3-310 of the Act.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.288 Reduction or Waiver of Penalties

- a) Reductions for all types of violations subject to penalties.

- 1) The Director or his designee shall consider the factors contained in Section 300.286(a) in determining whether to reduce the amount of the penalty to be assessed from the amount calculated pursuant to Section 300.284 and in determining the amount of such reduction.
 - 2) When the Director or his designee finds that correction of a violation required capital improvements or repairs in the physical plant of the facility and the facility has a history of compliance with physical plant requirements, the penalty will be reduced by the amount of the cost of the improvements or repairs. This reduction, however, shall not reduce the penalty for a level A violation to an amount less than \$1000.
- b) Reductions and waivers for level B violations.
- 1) Penalties resulting from level B violations may be reduced or waived only under one of the following conditions:
 - A) *The facility submits a report of correction within ten days after the notice of violation is received, and the report is subsequently verified by the Department.*
 - B) *The facility submits a plan of correction within ten days after the notice of violation is received, the plan is approved by the Department, the facility submits a report of correction within 15 days after submission of the plan or correction, and the report is subsequently verified by the Department.*
 - C) *The facility submits a plan of correction within ten days after the notice of violation is received, the plan provides for correction within not more than 30 days after submission of the plan of correction, and the plan is approved by the Department.*
 - D) Correction of the violation requires substantial capital improvements or repairs in the physical plant of the facility, *the facility submits a plan or correction involving substantial capital costs, the plan of correction provides completion of the corrective action within 90 days after submission of the plan, and the plan is approved by the Department. (Section 3-308 of the Act)*
 - 2) Under these conditions, the Director or his designee shall consider the factors outlined in Section 300.286(a) in determining whether to reduce or waive the penalty and in setting the amount of any reduction.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.290 Quarterly List of Violators (Repealed)

(Source: Repealed at 24 Ill. Reg. 17330, effective November 1, 2000)

Section 300.300 Alcoholism Treatment Programs In Long-Term Care Facilities

- a) A long-term care facility that desires to provide an alcoholism treatment program must first receive written approval from the Department. Such approval will be granted only if it can be shown that such program will not interfere in any way with the residents in the other parts of the facility.
- b) Any alcoholism treatment program in a long-term care facility must meet the program standards of the rules for Alcoholism and Substance Abuse Treatment, Intervention and Research Programs (77 Ill. Adm. Code 2058), as promulgated by the Illinois Department of Alcoholism and Substance Abuse under the Illinois Alcoholism and Other Drug Dependency Act (Ill. Rev. Stat. 1987, ch. 111½, par. 6351-1 et seq.).
- c) The alcoholism treatment program must be in a completely separate distinct part of the long-term care facility, and must include all beds in that distinct part. It must be completely separated from the rest of the facility, and have separate entrances.
- d) Beds designated for alcoholism treatment cannot be used for long-term care residents, nor can beds designated for long-term care residents be used for residents undergoing treatment for alcoholism.
- e) The alcoholism treatment program staff will not be utilized in performing services in the long-term care area of the facility, nor will long-term care program staff be utilized to provide any services in the alcoholism treatment designated area.
- f) There may be joint use of laundry, food service, housekeeping and administrative services, provided written approval is obtained from the Department. Such approval will be granted only if it can be shown that such joint usage will not interfere in any way with the residents in other parts of the facility.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

300.310 Department may Survey Facilities Formerly Licensed

The Department may survey any former facility which once held a license to insure that the facility is not operating without a license. (Section 3-107 of the Act)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.315 Supported Congregate Living Arrangement Demonstration

- a) A facility or location approved to participate in the Supported Congregate Living Arrangement Demonstration authorized by Section 4.02b of the Illinois Act on the

Aging [20 ILCS 105/4.02b] and requesting a waiver of the Act and this Part shall submit to the Department *a joint waiver request* with the Department on Aging or documentation that the Department on Aging failed to *act upon* a waiver *application within 60 days* after the applicant submitted a request to the Department on Aging. (Section 4.02b of the Illinois Act on the Aging)

- b) The waiver application shall include the following:
 - 1) a specific listing of those portions of the Act and this Part for which a waiver is being requested; and
 - 2) the applicant's proposed Program Plan.
- c) The proposed *Program Plan* shall describe *the types of residents to be served and the services that will be provided in the Supported Congregate Living Arrangement Demonstration*. (Section 3-102.2 of the Act)
- d) The Department will evaluate the waiver application based on the criteria in Section 300.320 of this Part. The applicant shall be notified within 10 days after the Department's waiver determination.
- e) *The Department may revoke the waiver if the Department determines that the Supported Congregate Living Arrangement Demonstration:*
 - 1) *is not in compliance with the Program Plan* submitted in accordance with subsection (b) of this Section (Section 3-102.2 of the Act);
 - 2) is not in compliance with the Department's waiver approval conditions; or
 - 3) has been terminated from the demonstration by the Department on Aging.

(Source: Added at 22 Ill. Reg. 7218, effective April 15, 1998)

Section 300.320 Waivers

- a) *Upon application by a facility, the Director may grant or renew the waiver of the facility's compliance with a rule or standard for a period not to exceed the duration of the current license or, in the case of an application for license renewal, the duration of the renewal period.* (Section 3-303.1 of the Act)
- b) *The waiver may be conditioned upon the facility taking action prescribed by the Director as a measure equivalent to compliance.* (Section 3-303.1 of the Act)
- c) *In determining whether to grant or renew a waiver, the Director shall consider:*
 - 1) *the duration and basis for any current waiver with respect to the same rule or standard;*
 - 2) *the continued validity of extending the waiver on the same basis;*

- 3) *the effect upon the health and safety of residents;*
 - 4) *the quality of resident care (whether the waiver would reduce the overall quality of the resident care below that required by the Act or this Part);*
 - 5) *the facility's history of compliance with the Act and this Part (the existence of a consistent pattern of violation of the Act or this Part); and*
 - 6) *the facility's attempts to comply with the particular rule or standard in question. (Section 3-303.1 of the Act)*
- d) *The Department shall renew waivers relating to physical plant standards issued pursuant to this Section at the time of the indicated reviews, unless it can show why such waivers should not be extended for the following reasons:*
- 1) *the condition of the physical plant has deteriorated or its use substantially changed so that the basis upon which the waiver was issued is materially different; or*
 - 2) *the facility is renovated or substantially remodeled in such a way as to permit compliance with the applicable rules and standards without substantial increase in cost. (Section 3-303.1 of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.330 Definitions

The terms defined in this Section are terms that are used in one or more of the sets of licensing standards established by the Department to license various levels of long-term care. They are defined as follows:

Abuse – any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. (Section 1-103 of the Act)

Abuse means:

Physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means and that requires (whether or not actually given) medical attention.

Mental injury arises from the following types of conduct:

Verbal abuse refers to the use by a licensee, employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to residents or within their hearing or seeing distance, regardless of their age, ability to comprehend or disability.

Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation, or offensive physical contact by a licensee, employee or agent.

Sexual harassment or sexual coercion perpetrated by a licensee, employee or agent.

Sexual assault.

Access – the right to:

Enter any facility;

Communicate privately and without restriction with any resident who consents to the communication;

Seek consent to communicate privately and without restriction with any resident;

Inspect the clinical and other records of a resident with the express written consent of the resident;

Observe all areas of the facility except the living area of any resident who protests the observation. (Section 1-104 of the Act)

Act – as used in this Part, the Nursing Home Care Act [210 ILCS 45].

Activity Program – a specific planned program of varied group and individual activities geared to the individual resident's needs and available for a reasonable number of hours each day.

Adaptive Behavior – the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his age and cultural group.

Adaptive Equipment – a physical or mechanical device, material or equipment attached or adjacent to the resident's body that may restrict freedom of movement or normal access to one's body, the purpose of which is to permit or encourage movement, or to provide opportunities for increased functioning, or to prevent contractures or deformities. Adaptive equipment is not a physical restraint. No matter the purpose, adaptive equipment does not include any device, material or method described in Section 300.680 of this Part as a physical restraint.

Addition – any construction attached to the original building which increases the area or cubic content of the building.

Adequate – enough in either quantity or quality, as determined by a reasonable person familiar with the professional standards of the subject under review, to

meet the needs of the residents of a facility under the particular set of circumstances in existence at the time of review.

Administrative Warning – a notice to a facility issued by the Department under Section 300.277 of this Part and Section 3-303.2 of the Act, which indicates that a situation, condition, or practice in the facility violates the Act or the Department's rules, but is not a type A or type B violation.

Administrator – the person who is directly responsible for the operation and administration of the facility, irrespective of the assigned title. (See Licensed Nursing Home Administrator.)

Advocate – a person who represents the rights and interests of an individual as though they were the person's own, in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

Affiliate – means:

With respect to a partnership, each partner thereof.

With respect to a corporation, each officer, director and stockholder thereof.

With respect to a natural person: any person related in the first degree of kinship to that person; each partnership and each partner thereof of which that person or any affiliate of that person is a partner; and each corporation in which that person or any affiliate of that person is an officer, director or stockholder. (Section 1-106 of the Act)

Aide or Orderly – any person providing direct personal care, training or habilitation services to residents.

Alteration – any construction change or modification of an existing building which does not increase the area or cubic content of the building.

Ambulatory Resident – a person who is physically and mentally capable of walking without assistance, or is physically able with guidance to do so, including the ascent and descent of stairs.

Applicant – any person making application for a license. (Section 1-107 of the Act)

Appropriate – term used to indicate that a requirement is to be applied according to the needs of a particular individual or situation.

Assessment – the use of an objective system with which to evaluate the physical, social, developmental, behavioral, and psychosocial aspects of an individual.

Audiologist – a person who is licensed as an audiologist under the Speech-Language Pathology and Audiology Practice Act [225 ILCS 110].

Autism – a syndrome described as consisting of withdrawal, very inadequate social relationships, exceptional object relationships, language disturbances and monotonously repetitive motor behavior; many children with autism will also be seriously impaired in general intellectual functioning; mental illness observed in young children characterized by severe withdrawal and inappropriate response to external stimulation.

Autoclave – an apparatus for sterilizing by superheated steam under pressure.

Auxiliary Personnel – all nursing personnel in intermediate care facilities and skilled nursing facilities other than licensed personnel.

Basement – when used in this Part, means any story or floor level below the main or street floor. Where due to grade difference, there are two levels each qualifying as a street floor, a basement is any floor below the level of the two street floors. Basements shall not be counted in determining the height of a building in stories.

Behavior Modification – treatment to be used to establish or change behavior patterns.

Cerebral Palsy – a disorder dating from birth or early infancy, nonprogressive, characterized by examples of aberrations of motor function (paralysis, weakness, incoordination) and often other manifestations of organic brain damage such as sensory disorders, seizures, mental retardation, learning difficulty and behavior disorders.

Certification for Title XVIII and XIX – the issuance of a document by the Department to the Department of Health and Human Services or the Department of Healthcare and Family Services verifying compliance with applicable statutory or regulatory requirements for the purposes of participation as a provider of care and service in a specific Federal or State health program.

Charge Nurse – a registered professional nurse or a licensed practical nurse in charge of the nursing activities for a specific unit or floor during a tour of duty.

Chemical Restraint – any drug that is used for discipline or convenience and is not required to treat medical symptoms or behavior manifestations of mental illness. (Section 2-106 of the Act)

Child Care/Habilitation Aide – any person who provides nursing, personal or rehabilitative care to residents of licensed Long-Term Care Facilities for Persons Under 22 Years of Age, regardless of title, and who is not otherwise licensed, certified or registered by the Department of Financial and Professional Regulation to render such care. Child Care/Habilitation aides must function under the supervision of a licensed nurse.

Community Alternatives – service programs in the community provided as an alternative to institutionalization.

Continuing Care Contract – a contract through which a facility agrees to supplement all forms of financial support for a resident throughout the remainder of the resident's life.

Contract – a binding agreement between a resident or the resident's guardian (or, if the resident is a minor, the resident's parent) and the facility or its agent.

Convenience – the use of any restraint by the facility to control resident behavior or maintain a resident, which is not in the resident's best interest, and with less use of the facility's effort and resources than would otherwise be required by the facility. This definition is limited to the definition of chemical restraint and Section 300.680 of this Part.

Corporal Punishment – painful stimuli inflicted directly upon the body.

Cruelty and Indifference to Welfare of the Resident – failure to provide a resident with the care and supervision he requires; or, the infliction of mental or physical abuse.

Dentist – any person licensed to practice dentistry, including persons holding a Temporary Certificate of Registration, as provided in the Illinois Dental Practice Act [225 ILCS 25].

Department – as used in this Part means the Illinois Department of Public Health.

Developmental Disabilities (DD) Aide – any person who provides nursing, personal or habilitative care to residents of Intermediate Care Facilities for the Developmentally Disabled, regardless of title, and who is not otherwise licensed, certified or registered to render medical care. Other titles often used to refer to DD Aides include, but are not limited to, Program Aides, Program Technicians and Habilitation Aides. DD Aides must function under the supervision of a licensed nurse or a Qualified Mental Retardation Professional (QMRP).

Developmental Disability – means a severe, chronic disability of a person which:

is attributable to a mental or physical impairment or combination of mental and physical impairments, such as mental retardation, cerebral palsy, epilepsy, autism;

is manifested before the person attains age 22;

is likely to continue indefinitely;

results in substantial functional limitations in 3 or more of the following areas of major life activity:

self-care,
receptive and expressive language,
learning,
mobility,
self-direction,
capacity for independent living, and
economic self-sufficiency; and

reflects the person's need for combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.(Section 3-801.1 of the Act)

Dietetic Service Supervisor – a person who:

is a dietitian; or

is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or

is a graduate, prior to July 1, 1990, of a Department-approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or

has successfully completed a Dietary Manager's Association approved dietary managers course; or

is certified as a dietary manager by the Dietary Manager's Association; or

has training and experience in food service supervision and management in a military service equivalent in content to the programs in the second, third or fourth paragraph of this definition.

Dietitian – a person who is a licensed dietitian as provided in the Dietetic and Nutrition Services Practice Act [225 ILCS 30].

Direct Supervision – work performed under the guidance and direction of a supervisor who is responsible for the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not

strictly routine, who regularly reviews the work performed, and who is accountable for the results.

Director – the Director of the Department of Public Health or designee. (Section 1-110 of the Act)

Director of Nursing Service – the full-time Professional Registered Nurse who is directly responsible for the immediate supervision of the nursing services.

Discharge – the full release of any resident from a facility. (Section 1-111 of the Act)

Discipline – any action taken by the facility for the purpose of punishing or penalizing residents.

Distinct Part – an entire, physically identifiable unit consisting of all of the beds within that unit and having facilities meeting the standards applicable to the levels of service to be provided. Staff and services for a distinct part are established as set forth in the respective regulations governing the levels of services approved for the distinct part.

Emergency – a situation, physical condition or one or more practices, methods or operations which present imminent danger of death or serious physical or mental harm to residents of a facility. (Section 1-112 of the Act)

Epilepsy – a chronic symptom of cerebral dysfunction, characterized by recurrent attacks, involving changes in the state of consciousness, sudden in onset, and of brief duration. Many attacks are accompanied by a seizure in which the person falls involuntarily.

Existing Long-Term Care Facility – any facility initially licensed as a health care facility or approved for construction by the Department, or any facility initially licensed or operated by any other agency of the State of Illinois, prior to March 1, 1980. Existing long-term care facilities shall meet the design and construction standards for existing facilities for the level of long-term care for which the license (new or renewal) is to be granted.

Facility, Intermediate Care – a facility that provides basic nursing care and other restorative services under periodic medical direction. Many of these services may require skill in administration. Such facilities are for residents who have long-term illnesses or disabilities that may have reached a relatively stable plateau.

Facility, Intermediate Care for the Developmentally Disabled – when used in this Part, is a facility of three or more persons, or distinct part thereof, serving residents of which more than 50 percent are developmentally disabled.

Facility or Long-Term Care Facility – a private home, institution, building, residence, or any other place, whether operated for profit or not, or a county home for the infirm and chronically ill operated pursuant to Division 5-21 or 5-22

of the Counties Code [55 ILCS 5], or any similar institution operated by a political subdivision of the State of Illinois, which provides, through its ownership or management, personal care, sheltered care or nursing for three or more persons, not related to the applicant or owner by blood or marriage. It includes skilled nursing facilities and intermediate care facilities as those terms are defined in Title XVIII and Title XIX of the Federal Social Security Act (42 USCA 1395 et seq. and 1936 et seq.). It also includes homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs. A "facility" may consist of more than one building as long as the buildings are on the same tract, or adjacent tracts of land. However, there shall be no more than one "facility" in any one building. "Facility" does not include the following:

A home, institution, or other place operated by the federal government or agency thereof, or by the State of Illinois other than homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs;

A hospital, sanitarium, or other institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation as organized facilities therefor, which is required to be licensed under the Hospital Licensing Act [210 ILCS 85];

Any "facility for child care" as defined in the Child Care Act of 1969 [225 ILCS 10];

Any "community living facility" as defined in the Community Living Facilities Licensing Act [210 ILCS 35];

Any "community residential alternative" as defined in the Community Residential Alternatives Licensing Act [210 ILCS 140];

Any nursing home or sanatorium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination. However, such nursing home or sanatorium shall comply with all local laws and rules relating to sanitation and safety;

Any facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act [210 ILCS 135];

Any supportive residence licensed under the Supportive Residences Licensing Act [210 ILCS 65];

Any supportive living facility in good standing with the demonstration project established under Section 5-5.01a of the Illinois Public Aid Code [305 ILCS 5/5-5.01a];

Any assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act [210 ILCS 9]; or

*An Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act [210 ILCS 3].
(Section 1-113 of the Act)*

Facility, Long-Term Care, for Residents Under 22 Years of Age – when used in this Part is synonymous with a long-term care facility for residents under 22 years of age, which facility provides total habilitative health care to residents who require specialized treatment, training and continuous nursing care because of medical or developmental disabilities.

Facility, Sheltered Care – when used in this Part is synonymous with a sheltered care facility, which facility provides maintenance and personal care.

Facility, Skilled Nursing – when used in this Part is synonymous with a skilled nursing facility. A skilled nursing facility provides skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision. Such facilities are provided for patients who need the type of care and treatment required during the post-acute phase of illness or during recurrences of symptoms in long-term illness.

Financial Responsibility – having sufficient assets to provide adequate services such as: staff, heat, laundry, foods, supplies, and utilities for at least a two-month period of time.

Full-time – means on duty a minimum of 36 hours, four days per week.

Goal – an expected result or condition that involves a relatively long period of time to achieve, that is specified in behavioral terms in a statement of relatively broad scope, and that provides guidance in establishing specific, short-term objectives directed toward its attainment.

Governing Body – the policy-making authority, whether an individual or a group, that exercises general direction over the affairs of a facility and establishes policies concerning its operation and the welfare of the individuals it serves.

*Guardian – a person appointed as a guardian of the person or guardian of the estate, or both, of a resident under the Probate Act of 1975 [755 ILCS 5].
(Section 1-114 of the Act)*

Habilitation – an effort directed toward the alleviation of a disability or toward increasing a person's level of physical, mental, social or economic functioning. Habilitation may include, but is not limited to, diagnosis, evaluation, medical services, residential care, day care, special living arrangements, training,

education, sheltered employment, protective services, counseling and other services.

Health Information Management Consultant – a person who is certified as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT) by the American Health Information Management Association; or is a graduate of a school of health information management that is accredited jointly by the American Medical Association and the American Health Information Management Association.

Health Services Supervisor (Director of Nursing Service) – the full-time Registered Nurse who is directly responsible for the immediate supervision of the health services in an Intermediate Care Facility.

Home for the Aged – any facility that is operated: by a not-for-profit corporation incorporated under, or qualified as a foreign corporation under, the General Not For Profit Corporation Act of 1986 [805 ILCS 105]; or by a county pursuant to Division 5-22 of the Counties Code [55 ILCS 5]; or pursuant to a trust or endowment established for nonprofit, charitable purposes; and that provides maintenance, personal care, nursing or sheltered care to three or more residents, 90 percent of whom are 60 or more years of age.

Hospitalization – the care and treatment of a person in a hospital as an inpatient.

Identified Offender – a person who has been convicted of any felony offense listed in Section 25 of the Health Care Worker Background Check Act, is a registered sex offender, or is serving a term of parole, mandatory supervised release, or probation for a felony offense. (Section 1-114.01 of the Act)

Individual Education Program (IEP) – a written statement for each resident that provides for specific education and related services. The Individual Education Program may be incorporated into the Individual Habilitation Plan (IHP).

Individual Habilitation Plan (IHP) – a total plan of care that is developed by the interdisciplinary team for each resident, and that is developed on the basis of all assessment results.

Interdisciplinary Team – a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and designs a program to meet those needs. This team shall include at least a physician, a social worker and other professionals. In Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) at least one member of the team shall be a Qualified Mental Retardation Professional. The Interdisciplinary Team includes the resident, the resident's guardian, the resident's primary service providers, including staff most familiar with the resident; and other appropriate professionals and caregivers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the Interdisciplinary Team and participate in the process of identifying the resident's strengths and needs.

Licensed Nursing Home Administrator – a person who is charged with the general administration and supervision of a facility and licensed under the Nursing Home Administrators Licensing and Disciplinary Act [225 ILCS 70].

Licensed Practical Nurse – a person with a valid Illinois license to practice as a practical nurse.

Licensee – the person or entity licensed to operate the facility as provided under the Act. (Section 1-115 of the Act)

Life Care Contract – a contract through which a facility agrees to provide maintenance and care for a resident throughout the remainder of the resident's life.

Maintenance – food, shelter, and laundry services. (Section 1-116 of the Act)

Maladaptive Behavior – impairment in adaptive behavior as determined by a clinical psychologist or by a physician. Impaired adaptive behavior may be reflected in delayed maturation, reduced learning ability or inadequate social adjustment.

Mentally Retarded and Mental Retardation – subaverage general intellectual functioning originating during the developmental period and associated with maladaptive behavior.

Misappropriation of Property – using a resident's cash, clothing, or other possessions without authorization by the resident or the resident's authorized representative; failure to return valuables after a resident's discharge; or failure to refund money after death or discharge when there is an unused balance in the resident's personal account.

Mobile Nonambulatory – unable to walk independently or without assistance, but able to move from place to place with the use of a device such as a walker, crutches, a wheelchair, or a wheeled platform.

Mobile Resident – any resident who is able to move about either independently or with the aid of an assistive device such as a walker, crutches, a wheelchair, or a wheeled platform.

Monitor – a qualified person placed in a facility by the Department to observe operations of the facility, assist the facility by advising it on how to comply with the State regulations, and who reports periodically to the Department on the operations of the facility.

Neglect – a failure in a facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of a resident's physical or mental condition. (Section 1-117 of the Act) Neglect means the failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or

in the deterioration of a resident's physical or mental condition. This shall include any allegation where:

the alleged failure causing injury or deterioration is ongoing or repetitious;
or

a resident required medical treatment as a result of the alleged failure; or

the failure is alleged to have caused a noticeable negative impact on a resident's health, behavior or activities for more than 24 hours.

New Long-Term Care Facility – any facility initially licensed as a health care facility by the Department, or any facility initially licensed or operated by any other agency of the State of Illinois, on or after March 1, 1980. New long-term care facilities shall meet the design and construction standards for new facilities for the level of long-term care for which the license (new or renewal) is to be granted.

Normalization – the principle of helping individuals to obtain an existence as close to normal as possible, by making available to them patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

Nurse – *a registered nurse or a licensed practical nurse as defined in the Nursing and Advanced Practice Nursing Act [225 ILCS 65]. (Section 1-118 of the Act)*

Nursing Assistant – any person who provides nursing care or personal care to residents of licensed long-term care facilities, regardless of title, and who is not otherwise licensed, certified or registered by the Department of Financial and Professional Regulation to render medical care. Other titles often used to refer to nursing assistants include, but are not limited to, nurse's aide, orderly and nurse technician. Nursing assistants must function under the supervision of a licensed nurse.

Nursing Care – a complex of activities which carries out the diagnostic, therapeutic, and rehabilitative plan as prescribed by the physician; care for the resident's environment; observing symptoms and reactions and taking necessary measures to carry out nursing procedures involving understanding of cause and effect in order to safeguard life and health.

Nursing Unit – a physically identifiable designated area of a facility consisting of all the beds within the designated area, but having no more than 75 beds, none of which are more than 120 feet from the nurse's station.

Objective – an expected result or condition that involves a relatively short period of time to achieve, that is specified in behavioral terms, and that is related to the achievement of a goal.

Occupational Therapist, Registered (OTR) – a person who is registered as an occupational therapist under the Illinois Occupational Therapy Practice Act [225 ILCS 75].

Occupational Therapy Assistant – a person who is registered as a certified occupational therapy assistant under the Illinois Occupational Therapy Practice Act.

Operator – the person responsible for the control, maintenance and governance of the facility, its personnel and physical plant.

Other Resident Injury – occurs where a resident is alleged to have suffered physical or mental harm and the allegation does not fall within the definition of abuse or neglect.

Oversight – general watchfulness and appropriate reaction to meet the total needs of the residents, exclusive of nursing or personal care. Oversight shall include, but is not limited to, social, recreational and employment opportunities for residents who, by reason of mental disability, or in the opinion of a licensed physician, are in need of residential care.

Owner – the individual, partnership, corporation, association or other person who owns a facility. In the event a facility is operated by a person who leases the physical plant, which is owned by another person, "owner" means the person who operates the facility, except that if the person who owns the physical plant is an affiliate of the person who operates the facility and has significant control over the day-to-day operations of the facility, the person who owns the physical plant shall incur jointly and severally with the owner all liabilities imposed on an owner under the Act. (Section 1-119 of the Act)

Person – any individual, partnership, corporation, association, municipality, political subdivision, trust, estate or other legal entity whatsoever.

Personal Care – assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual. (Section 1-120 of the Act)

Pharmacist, Registered – a person who holds a certificate of registration as a registered pharmacist, a local registered pharmacist or a registered assistant pharmacist under the Pharmacy Practice Act of 1987 [225 ILCS 85].

Physical Restraint – any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body. (Section 2-106 of the Act)

Physical Therapist Assistant – a person who has graduated from a two year college level program approved by the American Physical Therapy Association.

Physical Therapist – a person who is registered as a physical therapist under the Illinois Physical Therapy Act [225 ILCS 90].

Physician – any person licensed to practice medicine in all its branches as provided in the Medical Practice Act of 1987 [225 ILCS 60].

Probationary License – an initial license issued for a period of 120 days during which time the Department will determine the qualifications of the applicant.

Psychiatrist – a physician who has had at least three years of formal training or primary experience in the diagnosis and treatment of mental illness.

Psychologist – a person who is licensed to practice clinical psychology under the Clinical Psychologist Licensing Act [225 ILCS 15].

Qualified Mental Retardation Professional – a person who has at least one year of experience working directly with individuals with developmental disabilities and meets at least one of the following additional qualifications:

Be a physician as defined in this Section.

Be a registered nurse as defined in this Section.

Hold at least a bachelor's degree in one of the following fields: occupational therapy, physical therapy, psychology, social work, speech or language pathology, recreation (or a recreational specialty area such as art, dance, music, or physical education), dietary services or dietetics, or a human services field (such as sociology, special education, or rehabilitation counseling).

Qualified Professional – a person who meets the educational, technical and ethical criteria of a health care profession, as evidenced by eligibility for membership in an organization established by the profession for the purpose of recognizing those persons who meet such criteria; and who is licensed, registered, or certified by the State of Illinois, if required.

Reasonable Visiting Hours – any time between the hours of 10 a.m. and 8 p.m. daily. (Section 1-121 of the Act)

Registered Nurse – a person with a valid license to practice as a registered professional nurse under the Nursing and Advanced Practice Nursing Act.

Repeat Violation – for purposes of assessing fines under Section 3-305 of the Act, a violation that has been cited during one inspection of the facility for which a subsequent inspection indicates that an accepted plan of correction was not complied with, within a period of not more than twelve months from the issuance

of the initial violation. *A repeat violation shall not be a new citation of the same rule, unless the licensee is not substantially addressing the issue routinely throughout the facility.* (Section 3-305(7) of the Act)

Reputable Moral Character – having no history of a conviction of the applicant, or if the applicant is a firm, partnership, or association, of any of its members, or of a corporation, of any of its officers, or directors, or of the person designated to manage or supervise the facility, of a felony, or of two or more misdemeanors involving moral turpitude, as shown by a certified copy of the record of the court of conviction, or in the case of the conviction of a misdemeanor by a court not of record, as shown by other evidence; or other satisfactory evidence that the moral character of the applicant, or manager, or supervisor of the facility is not reputable.

Resident – person residing in and receiving personal care from a facility. (Section 1-122 of the Act)

Resident Services Director – the full-time administrator, or an individual on the professional staff in the facility, who is directly responsible for the coordination and monitoring of the residents' overall plans of care in an intermediate care facility.

Resident's Representative – a person other than the owner, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian, or the parent of a minor resident for whom no guardian has been appointed. (Section 1-123 of the Act)

Restorative Care – a health care process designed to assist residents to attain and maintain the highest degree of function of which they are capable (physical, mental, and social).

Room – a part of the inside of a facility that is partitioned continuously from floor to ceiling with openings closed with glass or hinged doors.

Sanitization – the reduction of pathogenic organisms on a utensil surface to a safe level, which is accomplished through the use of steam, hot water, or chemicals.

Satisfactory – same as adequate.

Seclusion – the retention of a resident alone in a room with a door that the resident cannot open.

Self Preservation – the ability to follow directions and recognize impending danger or emergency situations and react by avoiding or leaving the unsafe area.

Sheltered Care – maintenance and personal care. (Section 1-124 of the Act)

Social Worker – a person who is a licensed social worker or a licensed clinical social worker under the Clinical Social Work and Social Work Practice Act [225 ILCS 20].

State Fire Marshal – the Fire Marshal of the Office of the State Fire Marshal, Division of Fire Prevention.

Sterilization – the act or process of destroying completely all forms of microbial life, including viruses.

Stockholder of a Corporation – any person who, directly or indirectly, beneficially owns, holds or has the power to vote, at least five percent of any class of securities issued by the corporation. (Section 1-125 of the Act)

Story – when used in this Part, means that portion of a building between the upper surface of any floor and the upper surface of the floor above except that the topmost story shall be the portion of a building between the upper surface of the topmost floor and the upper surface of the roof above.

Student Intern – means any person whose total term of employment in any facility during any 12-month period is equal to or less than 90 continuous days, and whose term of employment is either:

an academic credit requirement in a high school or undergraduate institution; or

immediately succeeds a full quarter, semester or trimester of academic enrollment in either a high school or undergraduate institution, provided that such person is registered for another full quarter, semester or trimester of academic enrollment in either a high school or undergraduate institution which quarter, semester or trimester will commence immediately following the term of employment. (Section 1-125.1 of the Act)

Substantial Compliance – meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved. This definition is limited to the phrase as used in Sections 300.140(a)(3) and 300.150(a)(3).

Substantial Failure – the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved. This definition is limited to the phrase as used in Section 300.165(b)(1).

Sufficient – same as adequate.

Supervision – authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his sphere of competence, with

initial direction and periodic inspection of the actual act of accomplishing the function or activity.

Therapeutic Recreation Specialist – a person who is certified by the National Council for Therapeutic Recreation Certification and who meets the minimum standards it has established for classification as a Therapeutic Recreation Specialist.

Time Out – removing an individual from a situation that results in undesirable behavior. It is a behavior modification procedure which is developed and implemented under the supervision of a qualified professional.

Title XVIII – Title XVIII of the Federal Social Security Act as now or hereafter amended. (Section 1-126 of the Act)

Title XIX – Title XIX of the Federal Social Security Act as now or hereafter amended. (Section 1-127 of the Act)

Transfer – a change in status of a resident's living arrangements from one facility to another facility. (Section 1-128 of the Act)

Type A Violation – a violation of the Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom. (Section 1-129 of the Act)

Type B Violation – a violation of the Act or of the rules promulgated thereunder which creates a condition or occurrence relating to the operation and maintenance of a facility directly threatening to the health, safety or welfare of a resident. (Section 1-130 of the Act)

Unit – an entire physically identifiable residence area having facilities meeting the standards applicable to the levels of service to be provided. Staff and services for each distinct resident area are established as set forth in the respective rules governing the approved levels of service.

Universal Progress Notes – a common record with periodic narrative documentation by all persons involved in resident care.

Valid License – a license which is unsuspended, unrevoked and unexpired.

(Source: Amended at 30 Ill. Reg. 5213, effective March 2, 2006)

Section 300.340 Incorporated and Referenced Materials

- a) The following regulations and standards are incorporated in this Part:

- 1) Private and professional association standards:
 - A) ANSI/ASME Standard No. A17.1-2000, Safety Code for Elevators and Escalators, which may be obtained from the American Society of Mechanical Engineers (ASME) International, 22 Law Drive, Box 2900, Fairfield, New Jersey 07007-2900.
 - B) American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), Handbook of Fundamentals (2001), and Handbook of Applications (1999), which may be obtained from the American Society of Heating, Refrigerating, and Air Conditioning Engineers, Inc., 1791 Tullie Circle, N.E., Atlanta, Georgia 30329.
 - C) American Society for Testing and Materials (ASTM) International Standard No. E90-02 (1996): Standard Test Method for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions and Elements, which may be obtained from ASTM International, 100 Barr Harbor Drive, P.O. Box C700, West Conshohocken, Pennsylvania 19428-2959.
 - D) International Building Code (IBC) (2000), which may be obtained from the International Code Council (ICC), 4051 W. Flossmoor Road, Country Club Hills, Illinois 60478-5795.
 - E) For existing facilities (see Subpart O), National Fire Protection Association (NFPA) Standard No. 101: Life Safety Code, Appendix B (1981) and the following additional standards, which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169:
 - i) No. 10 (1978): Standards for Portable Extinguishers
 - ii) No. 13 (1980): Standards for the Installation of Sprinkler Systems
 - iii) No. 56F (1977): Standards for Non-Flammable Medical Gas Systems
 - iv) No. 70 (1981): National Electric Code
 - v) No. 90A (1978): Installation of Air Conditioning and Ventilating Systems
 - vi) No. 96 (1980): Standard for the Installation of Equipment for the Removal of Smoke and Grease-Laden Vapors from Commercial Cooking Equipment
 - vii) No. 220 (1979): Standard Types of Building Construction

- viii) No. 253 (1978): Flooring Radiant Heat Energy Test
 - ix) No. 255 (1972): Test of Surface Burning Characteristics of Building Materials
 - x) Appendix C (1981): Fire Safety Evaluation System for Health Occupancies
- F) For new facilities (see Subpart N), the following standards of the National Fire Protection Association (NFPA), which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02169:
- i) NFPA 17A, Standard for Wet Chemical Extinguishing Systems – 2002 Edition
 - ii) NFPA 20, Standard for the Installation of Stationary Pumps for Fire Protection – 1999 Edition
 - iii) NFPA 22, Standard for Water Tanks for Private Fire Protection – 1998 Edition
 - iv) NFPA 24, Standard for the Installation of Private Fire Service Mains and Their Appurtenances – 2002 Edition
 - v) NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites – 2001 Edition
 - vi) NFPA 70B, Recommended Practice for Electrical Equipment Maintenance – 2002 Edition
 - vii) NFPA 70E, Standard for Electrical Safety Requirements for Employee Workplaces – 2000 Edition
 - viii) NFPA 80A, Recommended Practice for Protection of Buildings from Exterior Fire Exposures – 2001 Edition
 - ix) NFPA 101, Life Safety Code – 2000 Edition
 - x) NFPA 105, Recommended Practice for the Installation of Smoke-Control Door Assemblies – 1999 Edition
- G) For new and existing facilities (see Section 300.1610), NFPA 99: Standard for Health Care Facilities – 2003 Edition.
- H) The following standards, which may be obtained from Underwriters Laboratories (UL), Inc., 333 Pfingsten Rd., Northbrook, Illinois 60062:

- i) Fire Resistance Directory (2003 Edition)
 - ii) Building Material Directory (2003 Edition)
 - I) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (1994), which may be obtained from the American Psychiatric Association, 1000 Wilson Blvd., Suite 1825, Arlington, Virginia, 22209-3901.
 - 2) Federal guidelines:

The following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, which may be obtained from the National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161.

 - A) Guideline for Prevention of Catheter-Associated Urinary Tract Infections (October 1981)
 - B) Guideline for Hand Hygiene in Health-Care Settings (October 2002)
 - C) Guidelines for Prevention of Intravascular Catheter-Related Infections (2002)
 - D) Guideline for Prevention of Surgical Site Infection (1999)
 - E) Guideline for Prevention of Nosocomial Pneumonia (February 1994)
 - F) Guideline for Isolation Precautions in Hospitals (February 18, 1997)
 - G) Guidelines for Infection Control in Health Care Personnel (1998)
 - 3) Federal regulations:
 - A) 21 CFR 1306, Prescriptions (April 1, 2002)
 - B) 42 CFR 483.151-156, Requirements for States and Long-Term Care Facilities (October 1, 2002)
- b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations refer to the regulations and standards on the date specified and do not include any amendments or editions subsequent to the date specified.
- c) The following statutes and State regulations are referenced in this Part:

- 1) Federal statutes:
 - A) Civil Rights Act of 1964 (42 USC 2000e et seq.)
 - B) Social Security Act (42 USC 301 et seq., 1395 et seq. and 1396 et seq.)
 - C) Controlled Substances Act (21 USC 802)

- 2) State of Illinois statutes:
 - A) Illinois Alcoholism and Other Drug Dependency Act [20 ILCS 305]
 - B) Boiler and Pressure Vessel Safety Act [430 ILCS 75]
 - C) Child Care Act of 1969 [225 ILCS 10]
 - D) Court of Claims Act [705 ILCS 505]
 - E) Illinois Dental Practice Act [225 ILCS 25]
 - F) Election Code [10 ILCS 5]
 - G) Freedom of Information Act [5 ILCS 140]
 - H) General Not For Profit Corporation Act of 1986 [805 ILCS 105]
 - I) Hospital Licensing Act [210 ILCS 85]
 - J) Illinois Controlled Substances Act [720 ILCS 570]
 - K) Illinois Health Facilities Planning Act [20 ILCS 3906]
 - L) Illinois Municipal Code [65 ILCS 5]
 - M) Nursing and Advanced Practice Nursing Act [225 ILCS 65]
 - N) Illinois Occupational Therapy Practice Act [225 ILCS 75]
 - O) Illinois Physical Therapy Act [225 ILCS 90]
 - P) Life Care Facilities Act [210 ILCS 40]
 - Q) Local Governmental and Governmental Employees Tort Immunity Act [745 ILCS 10]
 - R) Medical Practice Act of 1987 [225 ILCS 60]

- S) Mental Health and Developmental Disabilities Code [405 ILCS 5]
- T) Nursing Home Administrators Licensing and Disciplinary Act [225 ILCS 70]
- U) Nursing Home Care Act [210 ILCS 45]
- V) Pharmacy Practice Act of 1987 [225 ILCS 85]
- W) Private Sewage Disposal Licensing Act [225 ILCS 225]
- X) Probate Act of 1975 [775 ILCS 5]
- Y) Illinois Public Aid Code [305 ILCS 5]
- Z) Safety Glazing Materials Act [430 ILCS 60]
- AA) Illinois Administrative Procedure Act [5 ILCS 100]
- BB) Clinical Psychologist Licensing Act [225 ILCS 15]
- CC) Dietetic and Nutrition Services Practice Act [225 ILCS 30]
- DD) Health Care Worker Background Check Act [225 ILCS 46]
- EE) Clinical Social Work and Social Work Practice Act [225 ILCS 20]
- FF) Living Will Act [755 ILCS 35]
- GG) Powers of Attorney for Health Care Law [755 ILCS 45/Art. IV]
- HH) Health Care Surrogate Act [755 ILCS 45]
- II) Right of Conscience Act [745 ILCS 70]
- JJ) Abused and Neglected Long-Term Care Facility Residents Reporting Act [210 ILCS 30]
- KK) Supportive Residences Licensing Act [210 ILCS 65]
- LL) Community Residential Alternatives Licensing Act [210 ILCS 40]
- MM) Community Living Facilities Licensing Act [210 ILCS 35]
- NN) Community-Integrated Living Arrangements Licensure and Certification Act [210 ILCS 135]

- OO) Counties Code [55 ILCS 5]
- PP) Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]
- QQ) Podiatric Medical Practice Act of 1987 [225 ILCS 100]
- RR) Illinois Optometric Practice Act of 1987 [225 ILCS 80]
- SS) Physician Assistant Practice Act of 1987 [225 ILCS 95]
- TT) Alzheimer's Special Care Disclosure Act [210 ILCS 4]
- UU) Illinois Act on the Aging [20 ILCS 105]
- VV) Alternative Health Care Delivery Act [210 ILCS 3]
- WW) Assisted Living and Shared Housing Act [210 ILCS 9]
- XX) Language Assistance Services Act [210 ILCS 87]

3) State of Illinois rules:

- A) Office of the State Fire Marshal, Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120)
- B) Capital Development Board, Illinois Accessibility Code (71 Ill. Adm. Code 400)
- C) Department of Public Health:
 - i) Control of Communicable Diseases Code (77 Ill. Adm. Code 690)
 - ii) Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693)
 - iii) Food Service Sanitation Code (77 Ill. Adm. Code 750)
 - iv) Illinois Plumbing Code (77 Ill. Adm. Code 890)
 - v) Private Sewage Disposal Code (77 Ill. Adm. Code 905)
 - vi) Drinking Water Systems Code (77 Ill. Adm. Code 900)
 - vii) Illinois Water Well Construction Code (77 Ill. Adm. Code 920)

- viii) Illinois Water Well Pump Installation Code (77 Ill. Adm. Code 925)
- ix) Freedom of Information Code (2 Ill. Adm. Code 1126)
- x) Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)
- xi) Sheltered Care Facilities Code (77 Ill. Adm. Code 330)
- xii) Intermediate Care for the Developmentally Disabled Facilities Code (77 Ill. Adm. Code 350)
- xiii) Long-Term Care for Under Age 22 Facilities Code (77 Ill. Adm. Code 390)
- xiv) Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395)
- xv) Control of Tuberculosis Code (77 Ill. Adm. Code 696)
- xvi) Health Care Worker Background Check Code (77 Ill. Adm. Code 955)
- xvii) Language Assistance Services Code (77 Ill. Adm. Code 940)
- D) Department of Financial and Professional Regulation:
 - i) Controlled Substances Act (68 Ill. Adm. Code 3100)
 - ii) Pharmacy Practice Act of 1987 (68 Ill. Adm. Code 1330)
- E) Department of Human Services, Alcoholism and Substance Abuse Treatment and Intervention Licenses (77 Ill. Adm. Code 2060)
- F) Department of Natural Resources, Regulation of Construction within Flood Plains (17 Ill. Adm. Code 2706)
- G) Department of Public Aid, Medical Payment (89 Ill. Adm. Code 140)

(Source: Amended at 29 Ill. Reg. 12852, effective August 2, 2005)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.510 ADMINISTRATOR**

Section 300.510 Administrator

- a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days.
- b) The administrator shall delegate in writing adequate authority to a person at least 18 years of age who is capable of acting in an emergency during his or her absence. Such administrative assignment shall not interfere with resident care and supervision. The administrator or the person designated by the administrator to be in charge of the facility in the administrator's absence, shall be deemed by the Department to be the agent of the license for the purpose of Section 3-212 of the Act, which requires Department staff to provide the licensee with a copy of their report before leaving the facility. (B)
- c) The administrator shall arrange for facility supervisory personnel to annually attend appropriate educational programs on supervision, nutrition, and other pertinent subjects.
- d) The administrator shall appoint in writing a member of the facility staff to coordinate the establishment of, and render assistance to, the residents' advisory council.
- e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. (A, B)
- f) If the facility has an assistant administrator, the Department shall be informed of the name and dates of employment and termination of this person. This will provide documentation of service to qualify for a license under the Nursing Home

Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.).

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE**

Section 300.610 Resident Care Policies

- a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. (B)
- b) All the information contained in the policies shall be available to the public, staff, residents and for review by Department personnel.
- c) These written policies shall include, at a minimum the following provisions:
 - 1) Admission, transfer, and discharge of residents including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers.
 - 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). (B)
 - 3) There shall also be a policy prohibiting blood transfusions, unless the facility is hospital connected and appropriate services are available in case of an adverse reaction to the transfusions. (B)
- d) The facility shall have a written agreement with one or more hospitals which indicates the hospital or hospitals will provide the following services. This

requirement shall be waived when the facility can document to the satisfaction of the Department that by reason of remote location or refusal of local hospitals to enter an agreement, it is unable to effect such arrangements.

- 1) Emergency admissions.
- 2) Admission to a hospital of residents from the facility who are in need of hospital care.
- 3) Needed diagnostic services.
- 4) Any other hospital based services needed by the resident.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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

- a) For the purpose of this Section only, a nursing facility is any bed licensed as a skilled nursing or intermediate care facility bed, or a location certified to participate in the Medicare program under Title XVIII of the Social Security Act or Medicaid program under Title XIX of the Social Security Act.
- 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.
- c) *Any person who seeks to become eligible for medical assistance from the Medical Assistance program under the Illinois Public Aid Code to pay for long-term care services while residing in a facility shall be screened in accordance with 89 Ill. Adm. Code 140.642(b)(4).* (Section 2-201.5(a) of the Act)
- d) *Screening shall be administered through procedures established by administrative rule by the agency responsible for screening.* (Section 2-201.5(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)*
- f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.
- g) *If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check, unless the fingerprint check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.*
- h) *A waiver issued pursuant to Section 2-201.5 of the Act shall be valid only while the resident is immobile or while the criteria supporting the waiver exist. (Section 2-201.5(b) of the Act)*
- i) *The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5 of the Act.*

- j) *If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history to the Department pursuant to the requirements of Section 2-201.6 of the Act and Section 300.625 of this Part. (Section 2-201.5(c) of the Act)*
- k) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Criminal History Analysis Report is pending.

(Source: Amended at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.620 Admission, Retention and Discharge Policies

- a) All involuntary discharges and transfers shall be in accordance with Sections 3-401 through 3-423 of the Act.
- b) An individual who needs services that are not readily available in a particular facility, or through arrangement with a qualified outside resource, shall not be admitted to or kept in that facility. The Department defines a "qualified outside source" as one recognized as meeting professional standards for services provided.
- c) Each facility shall have a policy concerning the admission of persons needing prenatal and/or maternity care, and a policy concerning the keeping of such persons who become pregnant while they are residents of the facility. If these policies permit such persons to be admitted to or kept in the facility, then the facility shall have a policy concerning the provision of adequate and appropriate prenatal and maternity care to such individuals from in-house and/or outside resources. (See Section 300.3220.)
- d) No person shall be admitted to or kept in the facility:
 - 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation;
 - 2) Who is destructive of property, if the destruction jeopardizes the safety of him/herself or others; or

- 3) Who is an identified offender, unless the requirements of Section 300.615 for new admissions and the requirements of Section 300.625 are met.
- e) No resident shall be admitted to the facility who is developmentally disabled and who needs programming for such conditions, as described in the rules governing intermediate care facilities for the developmentally disabled (77 Ill. Adm. Code 350). Such persons shall be admitted only to facilities licensed as intermediate care facilities for the developmentally disabled under 77 Ill. Adm. Code 350 or, if the person is under 18, to a long-term care facility for persons under 22 years of age that is licensed under 77 Ill. Adm. Code 390. Persons from 18 to 21 years of age in need of such care may be kept in either facility.
- f) Persons under 18 years of age may not be cared for in a facility for adults without prior written approval from the Department.
- g) A facility shall not refuse to discharge or transfer a resident when requested to do so by the resident or, if the resident is incompetent, by the resident's guardian.
- h) If a resident insists on being discharged and is discharged against medical advice, the facts involved in the situation shall be fully documented in the resident's clinical record.
- i) Persons with communicable, contagious, or infectious diseases may be admitted under the conditions and in accordance with the procedures specified in Section 300.1020.
- j) A facility shall not admit more residents than the number authorized by the license issued to it.

(Source: Amended at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.624 Criminal History Background Checks for Persons Who Were Residents on May 10, 2006

- a) *The facility shall, by July 9, 2006, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons who were residents of the facility on May 10, 2006. (Section 2-201.5(b) of the Act)*
- b) If the current resident has already had a criminal history record check requested by that facility and performed subsequent to July 12, 2005, subsection (a) shall not apply.

- c) The facility shall be responsible for taking all steps necessary to ensure the safety of all residents while the results of the name-based background check are pending.

(Source: Added at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.625 Identified Offenders

- a) *The facility shall review the results of the criminal history background checks immediately upon receipt of those checks. If the results of the background check are inconclusive, the facility shall initiate a fingerprint-based check unless the fingerprint-based check is waived by the Director of Public Health based on verification by the facility that the resident is completely immobile or that the resident meets other criteria related to the resident's health or lack of potential risk, such as the existence of a severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. (Section 2-201.5(b) of the Act) The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within 5 days after receiving inconclusive results of a name-based background check. The fingerprint-based background check shall be conducted within 25 days after receiving the inconclusive results of the name-based check.*
- b) *A waiver issued pursuant to Section 2-201.5 of the Act shall be valid only while the resident is immobile or while the criteria supporting the waiver exist.*
- c) *The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility.*
- d) *If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.*
- e) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Criminal History Analysis Report is pending.

- f) *If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history information to the Department. (Section 2-201.5(c) of the Act)*
- g) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements:
- 1) The facility shall inform the appropriate county and local law enforcement offices of the identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense who are residents of the facility. *If a resident of a licensed facility is an identified offender, any federal, State, or local law enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirements of the Sex Offender Registration Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release.*(Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care.
 - 2) The facility staff shall meet with local law enforcement officials to discuss the need for and to develop, if needed, policies and procedures to address the presence of facility residents who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense, including compliance with Section 300.695 of this Part.
 - 3) *Every licensed facility shall provide to every prospective and current resident and resident's guardian, and to every facility employee, a written notice, prescribed by the Department, advising the resident, guardian, or employee of his or her right to ask whether any residents of the facility are identified offenders. The facility shall confirm whether identified offenders are residing in the facility.*
 - A) *The notice shall also be prominently posted within every licensed facility.*
 - B) *The notice shall include a statement that information regarding registered sex offenders may be obtained from the Illinois State Police website, www.isp.state.il.us, and*

that information regarding persons serving terms of parole or mandatory supervised release may be obtained from the Illinois Department of Corrections website, www.idoc.state.il.us. (Section 2-216 of the Act)

- 4) If the identified offender is on probation, parole, or mandatory supervised release, the facility shall contact the resident's probation or parole officer, acknowledge the terms of release, update contact information with the probation or parole office, and maintain updated contact information in the resident's record. The record must also include the resident's criminal history record.
- h) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part.
- i) Facilities must annually complete all of the steps required in subsection (g) of this Section for identified offenders. This requirement does not apply to residents who have not been discharged from the facility during the previous 12 months.
- j) For current residents who are identified offenders, the facility shall review the security measures listed in the Criminal History Analysis Report provided by the Department.
- k) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.
- 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)*
- m) *If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Criminal History Analysis conducted pursuant to Section 2-201.6 of the Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act)*
- n) The facility's reliance on the Criminal History Analysis Report prepared pursuant to Section 2-201.6(d) of the Act shall not relieve or indemnify in any manner the facility's liability or responsibility with regard to the identified offender or other facility residents.

- o) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and must document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.
- p) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility must identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.
- q) The facility shall notify the appropriate local law enforcement agency, the Illinois Prisoner Review Board, or the Department of Corrections of the incident and whether it involved substance abuse, aggressive behavior, or inappropriate sexual behavior that would necessitate relocation of that resident.
- r) The facility shall develop procedures for implementing changes in resident care and facility policies when the resident no longer meets the definition of identified offender.

(Source: Amended at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.626 Discharge Planning for Identified Offenders

- a) *If, based on the security measures listed in the Criminal History Analysis Report, a facility determines that it cannot manage the identified offender resident safely within the facility, it shall commence involuntary transfer or discharge proceedings pursuant to Section 3-402 of the Act and Section 300.3300 of this Part. (Section 2-201.6(g) of the Act)*
- b) All discharges and transfers shall be in accordance with Section 300.3300 of this Part.

- c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department.
- d) A facility that admits or retains an identified offender shall have in place policies and procedures for the discharge of an identified offender for reasons related to the individual's status as an identified offender, including, but not limited to:
 - 1) The facility's inability to meet the needs of the resident, based on Section 300.625 of this Part and subsection (a) of this Section;
 - 2) The facility's inability to provide the security measures necessary to protect facility residents, staff and visitors; or
 - 3) The physical safety of the resident, other residents, the facility staff, or facility visitors.
- e) Discharge planning shall be included as part of the plan of care developed in accordance with Section 300.625(k).

(Source: Amended at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.627 Transfer of an Identified Offender

- a) *If, based on the security measures listed in the Criminal History Analysis Report, a facility determines that it cannot manage the identified offender resident safely within the facility, it shall commence involuntary transfer or discharge proceedings pursuant to Section 3-402 of the Act and Section 300.3300 of this Part. (Section 2-201.6(g) of the Act)*
- b) All discharges and transfers shall be in accordance with Section 300.3300 of this Part.
- c) When a resident who is an identified offender is transferred to another facility regulated by the Department, the Department of Healthcare and Family Services, or the Department of Human Services, the transferring facility shall notify the Department and the receiving facility that the individual is an identified offender before making the transfer.
- d) This notification must include all of the documentation required under Section 300.625 of this Part and subsection (a) of this Section, and the transferring facility must provide this information to the receiving facility to complete the discharge planning.

- e) If the following information has been provided to the transferring facility from the Department of Corrections, the transferring facility shall provide copies to the receiving facility before making the transfer:
- 1) *The mittimus and any pre-sentence investigation reports;*
 - 2) *The social evaluation prepared pursuant to Section 3-8-2 of the Unified Code of Corrections [730 ILCS 5/3-8-2];*
 - 3) *Any pre-release evaluation conducted pursuant to subsection (j) of Section 3-6-2 of the Unified Code of Corrections [730 ILCS 5/3-6-2];*
 - 4) *Reports of disciplinary infractions and dispositions;*
 - 5) *Any parole plan, including orders issued by the Illinois Prisoner Review Board and any violation reports and dispositions; and*
 - 6) *The name and contact information for the assigned parole agent and parole supervisor. (Section 3-14-1 of the Unified Code of Corrections)*
- f) The information required by this Section shall be provided upon transfer. Information compiled concerning an identified offender must not be further disseminated except to the resident; the resident's legal representative; law enforcement agencies; the resident's parole or probation officer; the Division of Long Term Care Field Operations in the Department's Office of Health Care Regulation; other facilities licensed by the Department, the Illinois Department of Healthcare and Family Services, or the Illinois Department of Human Services that are or will be providing care to the resident, or are considering whether to do so; health care and social service providers licensed by the Illinois Department of Financial and Professional Regulation who are or will be providing care to the resident, or are considering whether to do so; health care facilities and providers in other states that are licensed and/or regulated in their home state and would be authorized to receive this information if they were in Illinois.

(Source: Amended at 31 Ill. Reg. 6044, effective April 3, 2007)

Section 300.630 Contract Between Resident and Facility

- a) Contract Execution

- 1) *Before a person is admitted to a facility, or at the expiration of the period of previous contract, or when the source of payment for the resident's care changes from private to public funds or from public to private funds, a written contract shall be executed between a licensee and the following in order of priority:*
 - A) *The person, or if the person is a minor, his parent or guardian; or*
 - B) *The person's guardian, if any, or agent, if any, as defined in Section 2-3 of the Illinois Power of Attorney Act; or*
 - C) *A member of the person's immediate family. (Section 2-202(a) of the Act)*
- 2) *An adult person shall be presumed to have the capacity to contract for admission to a long-term care facility unless he has been adjudicated a "disabled person" within the meaning of Section 11a-2 of the Probate Act of 1975, or unless a petition for such an adjudication is pending in a circuit court of Illinois. (Section 2-202(a) of the Act)*
- 3) *If there is no guardian, agent or member of the person's immediate family available, able or willing to execute the contract required by Section 2-202 of the Act and a physician determines that a person is so disabled as to be unable to consent to placement in a facility, or if a person has already been found to be a "disabled person," but no order has been entered allowing residential placement of the person, that person may be admitted to a facility before the execution of a contract required by that Section; provided that a petition for guardianship or for modification of guardianship is filed within 15 days of the person's admission to a facility, and provided further that such a contract is executed within ten days of the disposition of the petition. (Section 2-202(a) of the Act)*
- 4) *No adult shall be admitted to a facility if he objects, orally or in writing, to such admission, except as otherwise provided in Chapters III and IV of the Mental Health and Developmental Disabilities Code, or Section 11a-14.1 of the Probate Act of 1975. (Section 2-202(a) of the Act)*
- 5) *If on the effective date of this Part, a person has not executed a contract as required by Section 2-202 of the Act, then such a contract shall be executed by, or on behalf of, the person, within ten days of the effective date of this Part, unless a petition has been*

filed for guardianship or modification of guardianship. If a petition for guardianship or modification of guardianship has been filed, and there is no guardian, agent or a member of the person's immediate family available, able, or willing to execute the contract at that time, then a contract shall be executed within ten days of the disposition of such petition.

- b) The contract shall be clearly and unambiguously entitled, "Contract Between Resident and (name of facility)."
- c) *Before a licensee (any facility licensed under the Act) enters a contract under Section 2-202 of the Act, it shall provide the prospective resident and his guardian, if any, with written notice of the licensee's policy regarding discharge of a resident whose private funds for payment of care are exhausted. (Section 2-202(a) of the Act)*
- d) *A resident shall not be discharged or transferred at the expiration of the term of a contract, except as provided in Sections 3-401 through 3-423 of the Act. (Section 2-202(b) of the Act)*
- e) *At the time of the resident's admission to the facility, a copy of the contract shall be given to the resident, his guardian, if any, and any other person who executed the contract. (Section 2-220(c) of the Act)*
- f) The contract shall be signed by the licensee or his agent. The title of each person signing the contract for the facility shall be clearly indicated next to each such signature. The nursing home administrator may sign as the agent of the licensee.
- g) The contract shall be signed by, or for, the resident, as described in subsection (a) of this Section. If any person other than the principal signatory is to be held individually responsible for payments due under the contract, that person shall also sign the contract on a separate signature line labelled "signature of responsible party" or "signature of guarantor."
- h) The contract shall include a definition of "responsible party" or "guarantor," which describes in full the liability incurred by any such person.
- i) *A copy of the contract for a resident who is supported by nonpublic funds other than the resident's own funds shall be made available to the person providing the funds for the resident's support. (Section 2-202(d) of the Act)*

- j) *The original or a copy of the contract shall be maintained in the facility and be made available upon request to representatives of the Department and the Department of Public Aid. (Section 2-202(e) of the Act)*
- k) *The contract shall be written in clear and unambiguous language and shall be printed in not less than 12 point type. (Section 2-202(f) of the Act)*
- l) *The contract shall specify the term of the contract. (Section 2-202(g)(1) of the Act) The term can be until a certain date or event. If a certain date is specified in the contract, an addendum can extend the term of the contract to another date certain or on a month-to-month basis.*
- m) *The contract shall specify the services to be provided under the contract and the charges for the services. (Section 2-202(g)(2) of the Act) A paragraph shall itemize the services and products to be provided by the facility and express the costs of the itemized services and products to be provided either in terms of a daily, weekly, monthly or yearly rate, or in terms of a single fee. The contract may provide that the charges for services may be changed with thirty (30) days advance written notice to the resident or the person executing the contract on behalf of the resident. The resident or the person executing the contract on behalf of the resident may either assent to the change or choose to terminate the contract at any time within 30 days of the receipt of the written notice of the change. The written notice shall become an addendum to the contract.*
- n) *The contract shall specify the services that may be provided to supplement the contract and the charges for the services. (Section 2-202(g)(3) of the Act)*
 - 1) A paragraph shall itemize all services and products offered by the facility or related institutions which are not covered by the rate or fee established in subsection (m) of this Section. If a separate rate or fee for any such supplemental service or product can be calculated with definiteness at the time the contract is executed, then such additional cost shall be specified in the contract.
 - 2) If the cost of any itemized service or product to be provided to the resident by the facility or related institutions cannot be established or predicted with definiteness at the time of the resident's admission to the facility or at the time of the execution of the contract, then no cost for that service or product need be stated in the contract. But the contract shall include a statement explaining the resident's liability for such itemized service or product and explaining that the resident will be receiving a bill for such

itemized service or product beyond and in addition to any rate or fee set forth in the contract.

- 3) The contract may provide that the charges for services and products not covered by the rate or fee established in subsection (m) may be changed with thirty (30) days advance written notice to the resident or the person executing the contract on behalf of the resident. The resident or the person executing the contract on behalf of the resident may either assent to the change or choose to terminate the contract at any time within 30 days of the receipt of the written notice of the change. The written notice shall become an addendum to the contract.
- o) *The contract shall specify the sources liable for payment due under the contract.*(Section 2-202(g)(4) of the Act)
- p) *The contract shall specify the amount of deposit paid.* (Section 2-202(g)(5) of the Act) Such amount shall be expressed in terms of a precise number of dollars and be clearly designated as a deposit. The contract shall specify when such deposit shall be paid by the resident, and the contract shall specify when such deposit shall be returned by the facility. The contract shall specify the conditions (if any) which must be satisfied by the resident before the facility shall return the deposit. Upon the satisfaction of all such conditions, the deposit shall be returned to the resident. If the deposit is nonrefundable, the contract shall provide express notice of such nonrefundability.
- q) *The contract shall specify the rights, duties and obligations of the resident, except that the specification of a resident's rights may be furnished on a separate document which complies with the requirements of Section 2-211 of the Act.* (Section 2-202(g)(6) of the Act)
- r) *The contract shall designate the name of the resident's representative, if any. The resident shall provide the facility with a copy of the written agreement between the resident and the resident's representative which authorizes the resident's representative to inspect and copy the resident's records and authorizes the resident's representative to execute the contract on behalf of the resident required by Section 2-202 of the Act.* (Section 2-202(h) of the Act)
- s) *The contract shall provide that if the resident is compelled by a change in physical or mental health to leave the facility, the contract and all obligations under it shall terminate on seven days notice. No prior notice of termination of the contract shall be required, however, in the case of a resident's death. The contract shall also provide that in all other situations, a resident may terminate the contract and all obligations under*

it with 30 days notice. All charges shall be prorated as of the date on which the contract terminates, and, if any payments have been made in advance, the excess shall be refunded to the resident. This provision shall not apply to life-care contracts through which a facility agrees to provide maintenance and care for a resident throughout the remainder of the resident's life nor to continuing-care contracts through which a facility agrees to supplement all available forms of financial support in providing maintenance and care for a resident throughout the remainder of the resident's life. (Section 2-202(i) of the Act)

- t) *All facilities which offer to provide a resident with nursing services, medical services or personal care services, in addition to maintenance services, conditioned upon the transfer of an entrance fee to the provider of such services in addition to or in lieu of the payment of regular periodic charges for the care and services involved, for a term in excess of one year or for life pursuant to a life care contract, shall meet all of the provisions of the Life Care Facilities Act (Ill. Rev. Stat. 1991, ch. 111½, par. 4160-1 et seq.) [210 ILCS 40], including the obtaining of a permit from the Department, before they may enter into such contracts. (Section 2(c) of the Life Care Facilities Act)*

- u) *In addition to all other contract specifications contained in this Section, admission contracts shall also specify:*
 - 1) *whether the facility accepts Medicaid clients;*
 - 2) *whether the facility requires a deposit of the resident or his family prior to the establishment of Medicaid eligibility;*
 - 3) *in the event that a deposit is required, a clear and concise statement of the procedure to be followed for the return of such deposit to the resident or the appropriate family member or guardian of the person;*
 - 4) *that all deposits made to a facility by a resident, or on behalf of a resident, shall be returned by the facility within 30 days of the establishment of Medicaid eligibility, unless such deposits must be drawn upon or encumbered in accordance with Medicaid eligibility requirements established by the Illinois Department of Public Aid. (Section 2-202(j) of the Act)*

- v) *It shall be a business offense for a facility to knowingly and intentionally both retain a resident's deposit and accept Medicaid payments on behalf of the resident. (Section 2-202(k) of the Act)*

(Source: Amended at 18 Ill. Reg. 15868, effective October 15, 1994)

Section 300.640 Residents' Advisory Council

- a) *Each facility shall establish a residents' advisory council consisting of at least five resident members. If there are not five residents capable of functioning on the residents' advisory council, as determined by the Interdisciplinary Team, residents' representatives shall take the place of the required number of residents. The administrator shall designate another member of the facility staff other than the administrator to coordinate the establishment of, and render assistance to, the council.* (Section 2-203 of the Act)
- b) Each facility shall develop and implement a plan for assuring a liaison with concerned individuals and groups in the local community. Ways in which this requirement can be met include, but are not limited to, the following:
 - 1) the inclusion of community members such as volunteers, family members, residents' friends, residents' advocates, or community representatives, etc. on the council;
 - 2) the establishment of a separate community advisory group with persons of the residents' choosing; or
 - 3) finding a church or civic group to "adopt" the facility.
- c) The resident members shall be elected to the council by vote of their fellow residents and the nonresident members shall be elected to the council by vote of the resident members of the council.
- d) In facilities of 50 or fewer beds, the council may consist of all of the residents of the facility, if the residents choose to operate this way.
- e) All residents' advisory councils shall elect at least a Chairperson or President and a Vice Chairperson or Vice President from among the members of the council. These persons shall preside at the meetings of the council, assisted by the facility staff person designated by the administrator to provide such assistance.
- f) Some facilities may wish to establish mini-residents' advisory councils for various smaller units within the facility. If this is done, each such unit shall be represented on an overall facility residents' advisory council with the composition described in subsection (a) of this Section.
- g) All residents' advisory council meetings shall be open to participation by all residents and by their representatives.

- h) *No employee or affiliate of any facility shall be a member of any council. Such persons may attend to discuss interests or functions of the non-members when invited by a majority of the officers of the council. (Section 2-203(a) of the Act)*
- i) *The council shall meet at least once each month with the staff coordinator who shall provide assistance to the council in preparing and disseminating a report of each meeting to all residents, the administrator, and the staff. (Section 2-203(b) of the Act)*
- j) *Records of the council meetings shall be maintained in the office of the administrator. (Section 2-203(c) of the Act)*
- k) *The residents' advisory council may communicate to the administrator the opinions and concerns of the residents. The council shall review procedures for implementing resident rights and facility responsibilities and make recommendations for changes or additions which will strengthen the facility's policies and procedures as they affect residents' rights and facility responsibilities. (Section 2-203(d) of the Act)*
- l) *The council shall be a forum for:*
 - 1) *Obtaining and disseminating information;*
 - 2) *Soliciting and adopting recommendations for facility programming and improvements;*
 - 3) *Early identification of problems;*
 - 4) *Recommending orderly resolution of problems. (Section 2-203(e) of the Act)*
- m) *The council may present complaints on behalf of a resident to the Department, or to any other person it considers appropriate. (Section 2-203(f) of the Act)*
- n) Families and friends of residents who live in the community retain the right to form family councils.
 - 1) If there is a family council in the facility, or if one is formed at the request of family members or the ombudsman, a facility shall make information about the family council available to all current and prospective residents, their families and their representatives. The information shall be provided by the family council, prospective members or the ombudsman.

- 2) If a family council is formed, facilities shall provide a place for the family council to meet.

(Source: Amended at 31 Ill. Reg. 8813, effective June 6, 2007)

Section 300.650 Personnel Policies

- a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section.
- b) Employee Records
 - 1) Employment application forms shall be completed for each employee and kept on file in the facility. Completed forms shall be available to Department personnel for review.
 - 2) Individual personnel files for each employee shall contain date of birth; home address; educational background; experience, including types and places of employment; date of employment and position employed to fill in this facility; and (if no longer employed in this facility) last date employed and reasons for leaving.
 - 3) Individual personnel files for each employee shall also contain health records, including the initial health evaluation and the results of the tuberculin skin test required under Section 300.655, and any other pertinent health records.
 - 4) Individual personnel records for each employee shall also contain records of evaluation of performance.
- c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.
- d) The facility shall check the status of all applicants with the Nurse Aide Registry prior to hiring.
- e) All personnel shall have either training or experience, or both, in the job assigned to them.
- f) Orientation and In-Service Training

- 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. This orientation program shall include information on the prevention and treatment of decubitus ulcers and the importance of nutrition in general health care.
- 2) All employees, except student interns shall attend in-service training programs pertaining to their assigned duties at least annually. These in-service training programs shall include the facility's policies, skill training and ongoing education to enable all personnel to perform their duties effectively. The in-service training sessions regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept.
 - g) Employees shall be assigned duties that are directly related to their functions, as identified in their job descriptions. Exceptions may be made in emergencies.
 - h) Personnel policies shall include a plan to provide personnel coverage for regular staff when they are absent.
 - i) Every facility shall have a current, dated weekly employee time schedule posted where employees may refer to it. This schedule shall contain the employee's name, job title, shift assignment, hours of work, and days off. The schedule shall be kept on file in the facility for one year after the week for which the schedule was used.

(Source: Amended at 26 Ill. Reg. 10523, effective July 1, 2002)

Section 300.655 Initial Health Evaluation for Employees

- a) Each employee shall have an initial health evaluation which shall be used to insure that employees are not placed in positions which would pose undue risk of infection to themselves, other employees, residents, or visitors.
- b) The initial health evaluation shall be conducted not more than 30 days prior to the employee beginning employment in the facility. The evaluation shall be completed not more than 30 days after the employee begins employment in the facility.
- c) The initial health evaluation shall include a health inventory. This inventory shall be obtained from the employee and shall include the employee's immunization status and any available history of conditions which would predispose the employee to acquiring or transmitting infectious diseases. This inventory shall include any history of exposure to, or treatment for, tuberculosis. The inventory shall also include any history of hepatitis, dermatologic conditions, or chronic draining infections or open wounds.
- d) The initial health evaluation shall include a physical examination. The examination shall include at a minimum any procedures needed in order to:
 - 1) Detect any unusual susceptibility to infection and any conditions which would increase the likelihood of the transmission of disease to residents, other employees, or visitors.
 - 2) Determine that the employee appears to be physically able to perform the job functions which the facility intends to assign to the employee.
- e) The initial health evaluation shall include a tuberculin skin test which is conducted in accordance with the requirements of Section 300.1025. The test must meet one of the following timeframes:
 - 1) The test must be completed no more than 90 days prior to the date of initial employment in the facility, or
 - 2) The test must be commenced no more than ten days after the date of initial employment in the facility.

(Source: Added at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.660 Nursing Assistants

- a) *A facility shall not employ an individual as a nurse aide unless the facility has inquired of the Department as to information in the Registry concerning the individual.* (Section 3-206.01 of the Act) The Department shall advise the inquirer if the individual is on the Registry, if the individual has findings of abuse, neglect, or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act, and if the individual has a current background check. (See Section 300.661 of this Part.)
- b) The facility shall ensure that each nursing assistant complies with one of the following conditions:
- 1) Is approved on the Department's Nurse Aide Registry. "Approved" means that the nurse aide has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver.
 - 2) Begins a Department approved Basic Nursing Assistant Training Program (see 77 Ill. Adm. Code 395) no later than 45 days after employment. The nursing assistant shall successfully complete the training program within 120 days after the date of initial employment. A nursing assistant enrolled in a program approved in accordance with 77 Ill. Adm. Code 395.150(a)(2) shall not be employed more than 120 days prior to successfully completing the program.
 - 3) Within 120 days after initial employment, submits documentation to the Department in accordance with Section 300.663 of this Part to be registered on the Nurse Aide Registry.
- c) Each person employed by the facility as a nursing assistant shall meet each of the following requirements:
- 1) *Be at least sixteen years of age, of temperate habits and good moral character, honest, reliable and trustworthy* (Section 3-206(a)(1) of the Act);
 - 2) *Be able to speak and understand the English language or a language understood by a substantial percentage of the facility's residents* (Section 3-206(a)(2) of the Act);
 - 3) *Provide evidence of prior employment or occupation, if any, and residence for two years prior to present employment as a nursing assistant* (Section 3-206(a)(3) of the Act);

- 4) *Have completed at least eight years of grade school or provide proof of equivalent knowledge* (Section 3-206(a)(4) of the Act).
- d) The facility shall certify that each nursing assistant employed by the facility meets the requirements of this Section. Such certification shall be retained by the facility as part of the employee's personnel record.
- e) During inspections of the facility, the Department may require nursing assistants to demonstrate competency in the principles, techniques, and procedures covered by the basic nursing assistant training program curriculum described in 77 Ill. Adm. Code 395, when possible problems in the care provided by aides or other evidences of inadequate training are observed. The State approved manual skills evaluation testing format and forms will be used to determine competency of a nursing assistant when appropriate. Failure to demonstrate competency of the principles, techniques and procedures shall result in the provision of in-service training to the individual by the facility. The in-service training shall address the basic nursing assistant training principles and techniques relative to the procedures in which the nursing assistants are found to be deficient during inspection (see 77 Ill. Adm. Code 395).

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

(Source: Amended at 29 Ill. Reg. 12852, effective August 2, 2005)

Section 300.662 Resident Attendants

- a) *As used in this Section, "resident attendant" means an individual who assists residents in a facility with the following activities:*
 - 1) *eating and drinking; and*
 - 2) *personal hygiene limited to washing a resident's hands and face, brushing and combing a resident's hair, oral hygiene, shaving residents with an electric razor, and applying makeup.* (Section 3-206.03(a) of the Act)
- b) *The term "resident attendant" does not include an individual who:*

- 1) *is a licensed health professional or a registered dietitian;*
 - 2) *volunteers without monetary compensation;*
 - 3) *is a nursing assistant; or*
 - 4) *performs any nursing or nursing-related services for residents of a facility.*(Section 3-206.03(b) of the Act)
- c) *A facility may employ resident attendants to assist the nurse aides with the activities authorized under subsection (a) of this Section. The resident attendants shall not count in the minimum staffing requirements under this Part. (Section 3-206.03(b) of the Act)*
- d) Each person employed by the facility as a resident attendant shall meet the following requirements:
- 1) Be at least 16 years of age; and
 - 2) Be able to speak and understand the English language or a language understood by a substantial percentage of the facility's residents.
- e) Resident attendants shall be supervised by and shall report to a nurse.
- f) The facility shall develop and implement policies and procedures concerning the duties of resident attendants in accordance with this Section, and shall document such duties in a written job description.
- 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.
- h) *A facility may not use on a full-time or other paid basis any individual as a resident attendant in the facility unless the individual:*
- 1) *has completed a Department-approved training and competency evaluation program encompassing the tasks the individual provides; and*

- 2) *is competent to provide feeding, hydration, and personal hygiene services.*(Section 3-206.03(c) of the Act) The individual shall be deemed to be competent if he/she is able to perform a hands-on return demonstration of the required skills, as determined by a nurse.
- i) The facility shall maintain documentation of completion of the training program and determination of competency for each person employed as a resident attendant.
- j) *A facility-based training and competency evaluation program shall be conducted by a nurse and/or dietician and shall include one or more of the following units:*
 - 1) *A feeding unit that is at least five hours in length and that is specific to the needs of the residents, and that includes the anatomy of digestion and swallowing; feeding techniques; developing an awareness of eating limitations; potential feeding problems and complications; resident identification; necessary equipment and materials; resident privacy; handwashing; use of disposable gloves; verbal and nonverbal communication skills; behavioral issues and management techniques; signs of choking; signs and symptoms of aspiration; and Heimlich maneuver;*
 - 2) *A hydration unit that is at least three hours in length and that includes the anatomy of digestion and swallowing; hydration technique; resident identification; necessary equipment and materials; potential hydration problems and complications; verbal and nonverbal communication skills; behavioral issues and management techniques; use of disposable gloves; signs of choking; signs and symptoms of aspiration; handwashing; and resident privacy;*
 - 3) *A personal hygiene unit that is at least five hours in length and includes oral hygiene technique, denture care; potential oral hygiene problems and complications; resident identification; verbal and nonverbal communication skills; behavioral issues and management techniques; resident privacy; handwashing; use of disposable gloves; hair combing and brushing; face and handwashing technique; necessary equipment and materials; shaving technique. (Section 3-206.03(d) of the Act)*
- k) All training shall also include a unit in safety and resident rights that is at least five hours in length and that includes resident rights; fire safety, use of a fire extinguisher, evacuation procedures; emergency and disaster preparedness; infection control; and use of the call system.

- l) Each resident attendant shall be given instruction by a nurse or dietician concerning the specific feeding, hydration, and/or personal hygiene care needs of the resident whom he or she will be assigned to assist.
- m) *Training programs shall be reviewed and approved by the Department every two years.* (Section 3-206.03(d) of the Act)
- n) Training programs shall not be implemented prior to initial Department approval.
- o) Application for initial approval of facility-based and non-facility-based training programs shall be in writing and shall include:
 - 1) An outline containing the methodology, content, and objectives for the training program. The outline shall address the curriculum requirements set forth in subsection (h) of this Section for each unit included in the program;
 - 2) A schedule for the training program;
 - 3) Resumes describing the education, experience, and qualifications of each program instructor, including a copy of any valid Illinois licenses, as applicable; and
 - 4) A copy or description of the tools that will be used to evaluate competency.
- p) The Department will evaluate the initial application and proposed program for conformance to the program requirements contained in this Section. Based on this review, the Department will:
 - 1) Grant approval of the proposed program for a period of two years;
 - 2) Grant approval of the proposed program contingent on the receipt of additional materials, or revision, needed to remedy any minor deficiencies in the application or proposed program, which would not prevent the program from being implemented, such as deficiencies in the number of hours assigned to cover different areas of content, which can be corrected by submitting a revised schedule or outline; or
 - 3) Deny approval of the proposed program based on major deficiencies in the application or proposed program that would prevent the program from being implemented, such as deficiencies in the qualifications of instructors or missing areas of content.

- q) Programs shall be resubmitted to the Department for review within 60 days prior to expiration of program approval.
- r) If the Department finds that an approved program does not comply with the requirements of this Section, the Department will notify the facility in writing of non-compliance of the program and the reason for the finding.
- s) If the Department finds that any conditions stated in the written notice of non-compliance issued under subsection (r) of this Section have not been corrected within 30 days after the date of issuance of such notice, the Department will revoke its approval of the program.
- t) Any change in program content or objectives shall be submitted to the Department at least 30 days prior to program delivery. The Department will review the proposed change based on the requirements of this Section and will either approve or disapprove the change. The Department will notify the facility in writing of the approval or disapproval.
- u) *A person seeking employment as a resident attendant is subject to the Health Care Worker Background Check Act (Section 3-206.03(f) of the Act) and Section 300.661 of this Part.*

(Source: Added at 24 Ill. Reg. 17330, effective November 1, 2000)

Section 300.663 Registry of Certified Nursing Assistants

- a) An individual will be placed on the Nurse Aide Registry when he/she has successfully completed a training program approved in accordance with the Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395) and has met background check information required in Section 300.661 of this Part, and when there are no findings of abuse, neglect, or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act.
- b) An individual will be placed on the Nurse Aide Registry if he/she has met background check information required in Section 300.661 of this Part and submits documentation supporting one of the following equivalencies:
 - 1) Documentation of current registration from another state indicating that the requirements of 42 CFR 483.151 – 483.156 (October 1, 1997, no further amendments or editions included) have been met and that there are no documented findings of abuse, neglect, or misappropriation of property.

- 2) Documentation of successful completion of a nursing arts course (e.g., Basics in Nursing, Fundamentals of Nursing, Nursing 101) with at least 40 hours of supervised clinical experience in an accredited nurse training program as evidenced by a diploma, certificate or other written verification from the school and, within 120 days after employment, successful completion of the written portion of the Department-established nursing assistant competency test.
- 3) Documentation of successful completion of a United States military training program that includes the content of the Basic Nursing Assistant Training Program (see 77 Ill. Adm. Code 395) and at least 40 hours of supervised clinical experience, as evidenced by a diploma, certification, DD-214, or other written verification, and, within 120 days after employment, successful completion of the written portion of the Department established nursing assistant competency test.
- 4) Documentation of completion of a nursing program in a foreign country, including the following, and, within 120 days after employment, successful completion of the written portion of the Department-established nursing assistant competency test:
 - A) A copy of the license, diploma, registration or other proof of completion of the program;
 - B) A copy of the Social Security card; and
 - C) Visa or proof of citizenship.
- c) An individual shall notify the Nurse Aide Registry *of any change of address within 30 days* and of any name change within 30 days and shall submit proof of any name change to the Department. (Section 3-206.01 of the Act)

(Source: Amended at 26 Ill. Reg. 4846, effective April 1, 2002)

Section 300.665 Student Interns

- a) No person who meets the definition of student intern in Section 300.330 shall be required to complete a current course of training for nursing assistants.
- b) The facility may utilize student interns to perform basic nursing assistant skills for which they have been evaluated and deemed competent by an

approved evaluator using the State approved manual skills competency evaluation testing format and forms (see 77 Ill. Adm. Code 395.300), but shall not allow interns to provide rehabilitation nursing (see Section 300.1210(b), in-bed bathing, assistance with skin care, foot care, or to administer enemas, except under the direct, immediate supervision of a licensed nurse.

- c) No facility shall have more than fifteen percent of its nursing assistant staff positions held by student interns.

(Source: Amended at 17 Ill. Reg. 19279, effective October 26, 1993)

Section 300.670 Disaster Preparedness

- a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility.
- b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following:
 - 1) Proper instruction in the use of fire extinguishers for all personnel employed on the premises;
 - 2) A diagram of the evacuation route, which shall be posted and made familiar to all personnel employed on the premises;
 - 3) A written plan for moving residents to safe locations within the facility in the event of a tornado warning or severe thunderstorm warning; and
 - 4) An established means of facility notification when the National Weather Service issues a tornado or severe thunderstorm warning that covers the area in which the facility is located. The notification mechanism shall be other than commercial radio or television. Approved notification measures include being within range of local tornado warning sirens, an operable National Oceanic and Atmospheric Administration weather radio in the facility, or arrangements with local public safety agencies (police, fire, emergency management agency) to be notified if a warning is issued.

- c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:
 - 1) Ensure that all personnel on all shifts are trained to perform assigned tasks;
 - 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and
 - 3) Evaluate the effectiveness of disaster plans and procedures.
- d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift.
- e) The facility shall provide for the evacuation of physically handicapped persons, including those who are hearing or sight impaired.
- f) If the welfare of the residents precludes an actual evacuation of an entire building, the facility shall conduct drills involving the evacuation of successive portions of the building under conditions that assure the capability of evacuating the entire building with the personnel usually available, should the need arise.
- g) A written evaluation of each drill shall be submitted to the facility administrator and shall be maintained for one year.
- h) A written plan shall be developed for temporarily relocating the residents for any disaster requiring relocation and at any time that the temperature in residents' bedrooms falls below 55°F. for 12 hours or more.
- i) Reporting of Disasters
 - 1) Upon the occurrence of any disaster requiring hospital service, police, fire department or coroner, the facility administrator or designee shall provide a preliminary report to the Department either by using the nursing home hotline or by directly contacting the appropriate Department Regional Office during business hours. This preliminary report shall include, at a minimum:
 - A) The name and location of the facility;
 - B) The type of disaster;
 - C) The number of injuries or deaths to residents;

- D) The number of beds not usable due to the occurrence;
 - E) An estimate of the extent of damages to the facility;
 - F) The type of assistance needed, if any; and
 - G) A list of other State or local agencies notified about the problem.
- 2) If the disaster will not require direct Departmental assistance, the facility shall provide a preliminary report within 24 hours after the occurrence. Additionally, the facility shall submit a full written account to the Department within seven days after the occurrence, which includes the information specified in subsection (i)(1) of this Section and a statement of actions taken by the facility after the preliminary report.
- j) Each facility shall establish and implement policies and procedures in a written plan to provide for the health, safety, welfare and comfort of all residents when the heat index/apparent temperature (see Section 300. Table D), as established by the National Oceanic and Atmospheric Administration, inside the facility exceeds 80°F.
- k) Coordination with Local Authorities
- 1) Annually, each facility shall forward copies of all disaster policies and plans required under this Section to the local health authority and local emergency management agency having jurisdiction.
 - 2) Annually, each facility shall forward copies of its emergency water supply agreements, required under Section 300.2610(b), to the local health authority and local emergency management agency having jurisdiction.
 - 3) Each facility shall provide a description of its emergency source of electrical power, including the services connected to the source, to the local health authority and local emergency management agency having jurisdiction. The facility shall inform the local health authority and local emergency management agency at any time that the emergency source of power or services connected to the source are changed.
 - 4) When requested by the local health authority and the local emergency management agency, the facility shall participate in emergency planning activities.

(Source: Amended at 34 Ill. Reg. 19182, effective November 23, 2010)

Section 300.680 Restraints

- a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.
- b) No physical restraints with locks shall be used.
- c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.
- d) The use of chemical restraints is prohibited.

(Source: Amended at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.682 Nonemergency Use of Physical Restraints

- a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:
 - 1) the assessment of the resident's capabilities and an evaluation and *trial of less restrictive* alternatives that could prove effective;
 - 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or

her *highest practicable physical, mental or psychosocial well being*;

- 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and
 - 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the *highest practicable physical, mental or psychosocial well being*. (Section 2-106(c) of the Act)
- b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact.
 - c) The informed consent may authorize the use of a physical restraint only for a specified period of time. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used.
 - d) After 50 percent of the period of physical restraint use authorized by the informed consent has expired, but not less than 5 days before it has expired, information about the actual effectiveness of the physical restraint in treating the resident's medical symptoms or as a therapeutic intervention and about any actual negative impact on the resident shall be given to the resident, resident's guardian, or other authorized representative before the facility secures an informed consent for an additional period of time. Information about the effectiveness of the physical restraint program and about any negative impact on the resident shall be provided in writing.
 - e) A physical restraint may be applied only by staff trained in the application of the particular type of restraint. (Section 2-106(d) Act)
 - f) Whenever a period of use of a physical restraint is initiated, the resident shall be advised of his or her right to have a person or organization of his or her choosing, including the Guardianship and Advocacy Commission, notified of the use of the physical restraint. A period of use is initiated when a physical restraint is applied to a resident for the first time under a

new or renewed informed consent for the use of physical restraints. *A recipient who is under guardianship may request that a person or organization of his or her choosing be notified of the physical restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the physical restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted.* (Section 2-106(e) of the Act) If the resident requests that the Guardianship and Advocacy Commission be contacted, the facility shall provide the following information in writing to the Guardianship and Advocacy Commission:

- 1) the reason the physical restraint was needed;
 - 2) the type of physical restraint that was used;
 - 3) the interventions utilized or considered prior to physical restraint and the impact of these interventions;
 - 4) the length of time the physical restraint was to be applied; and
 - 5) the name and title of the facility person who should be contacted for further information.
- g) *Whenever a physical restraint is used on a resident whose primary mode of communication is sign language, the resident shall be permitted to have his or her hands free from restraint for brief periods each hour, except when this freedom may result in physical harm to the resident or others.* (Section 2-106(f) of the Act)
- h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical, mental or psychosocial well being.
- i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate.
- j) No form of seclusion shall be permitted.

(Source: Added at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.684 Emergency Use of Physical Restraints

- a) *If a resident needs emergency care, physical restraints may be used for brief periods to permit treatment to proceed unless the facility has notice that the resident has previously made a valid refusal of the treatment in question. (Section 2-106(c) of the Act)*
- b) For this Section only, "emergency care" means the unforeseen need for immediate treatment inside or outside the facility that is necessary to:
 - 1) save the resident's life;
 - 2) prevent the resident from doing serious mental or physical harm to himself/herself; or
 - 3) prevent the resident from injuring another individual.
- c) If a resident needs emergency care and other less restrictive interventions have proved ineffective, a physical restraint may be used briefly to permit treatment to proceed. The attending physician shall be contacted immediately for orders. If the attending physician is not available, the facility's advisory physician or Medical Director shall be contacted. If a physician is not immediately available, a nurse with supervisory responsibility may approve, in writing, the use of physical restraints. A confirming order, which may be obtained by telephone, shall be obtained from the physician as soon as possible, but no later than within eight hours. The effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident shall be assessed by the facility throughout the period of time the physical restraint is used. The resident must be in view of a staff person at all times until either the resident has been examined by a physician or the physical restraint is removed. The resident's needs for toileting, ambulation, hydration, nutrition, repositioning, and skin care must be met while the physical restraint is being used.
- d) The emergency use of a physical restraint must be documented in the resident's record, including:
 - 1) the behavior incident that prompted the use of the physical restraint;
 - 2) the date and times the physical restraint was applied and released;

- 3) the name and title of the person responsible for the application and supervision of the physical restraint;
 - 4) the action by the resident's physician upon notification of the physical restraint use;
 - 5) the new or revised orders issued by the physician;
 - 6) the effectiveness of the physical restraint in treating medical symptoms or as a therapeutic intervention and any negative impact on the resident; and
 - 7) the date of the scheduled care planning conference or the reason a care planning conference is not needed, in light of the resident's emergency need for physical restraints.
- e) The facility's emergency use of physical restraints shall comply with Sections 300.682(e), (f), (g), and (j).

(Source: Added at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs

- a) *A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used:*
- 1) *in an excessive dose, including in duplicative therapy;*
 - 2) *for excessive duration;*
 - 3) *without adequate monitoring;*
 - 4) *without adequate indications for its use; or*
 - 5) *in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act)*
- b) *Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106.1(b) of the Act) Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will*

achieve the desired therapeutic outcome. Side effects of the medications shall be described.

- c) Residents shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident's comprehensive assessment, to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions in accordance with Section 300.Appendix F.
- d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs in accordance with Section 300.Appendix F.
- e) For the purposes of this Section:
 - 1) "Duplicative drug therapy" means any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. For example, any two or more drugs, whether from the same drug category or not, that have a sedative effect.
 - 2) "Psychotropic medication" *means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic or antianxiety behavior modification or behavior management purposes in the latest edition of the AMA Drug Evaluations (Drug Evaluation Subscription, American Medical Association, Vols. I-III, Summer 1993), United States Pharmacopoeia Dispensing Information Volume I (USP DI) (United States Pharmacopoeial Convention, Inc., 15th Edition, 1995), American Hospital Formulary Service Drug Information 1995 (American Society of Health Systems Pharmacists, 1995), or the Physician's Desk Reference (Medical Economics Data Production Company, 49th Edition, 1995) or the United States Food and Drug Administration approved package insert for the psychotropic medication. (Section 2-106.1(b) of the Act)*
 - 3) "Antipsychotic drug" means a neuroleptic drug that is helpful in the treatment of psychosis and has a capacity to ameliorate thought disorders.

(Source: Added at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.690 Incidents and Accidents

- a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.
- b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
- c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

(Source: Amended at 33 Ill. Reg. 9356, effective June 17, 2009)

Section 300.695 Contacting Local Law Enforcement

- a) For the purpose of this Section, the following definitions shall apply:
 - 1) "911" – an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue.
 - 2) Physical abuse – see Section 300.30.
 - 3) Sexual abuse – sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).
- b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:
 - 1) Physical abuse involving physical injury inflicted on a resident by a staff member or visitor;
 - 2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability;
 - 3) Sexual abuse of a resident by a staff member, another resident, or a visitor;

- 4) When a crime has been committed in a facility by a person other than a resident; or
 - 5) When a resident death has occurred other than by disease processes.
- c) The facility shall develop and implement a policy concerning local law enforcement notification, including:
- 1) Ensuring the safety of residents in situations requiring local law enforcement notification;
 - 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;
 - 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;
 - 4) Seeking advice concerning preservation of a potential crime scene;
 - 5) Facility investigation of the situation.
- d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).
- e) The facility shall also comply with other reporting requirements of this Part.

(Source: Added at 26 Ill. Reg. 4846, effective April 1, 2002)

Section 300.696 Infection Control

- a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.
- b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.

c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

- 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections
- 2) Guideline for Hand Hygiene in Health-Care Settings
- 3) Guidelines for Prevention of Intravascular Catheter-Related Infections
- 4) Guideline for Prevention of Surgical Site Infection
- 5) Guideline for Prevention of Nosocomial Pneumonia
- 6) Guideline for Isolation Precautions in Hospitals
- 7) Guidelines for Infection Control in Health Care Personnel

(Source: Added at 29 Ill. Reg. 12852, effective August 2, 2005)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.810 GENERAL

Section 300.810 General

- a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. (A, B)
- b) The number and categories of personnel to be provided shall be based on the following:
 - 1) Number of residents.
 - 2) Amount and kind of personal care, nursing care, supervision, and program needed to meet the particular needs of the residents at all times.
 - 3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms.
 - 4) Medical orders.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.820 Categories of Personnel

- a) The facility shall provide an administrator as set forth in Subpart B. (B)
- b) The facility shall provide a Resident Services Director who is assigned responsibility for the coordination and monitoring of the resident's overall plan of care. The director of nurses or an individual on the professional staff of the facility may fill this assignment to assure that residents' plans of care are individualized, written in terms of short and long-range goals, understandable and utilized; their needs are met through appropriate staff

interventions and community resources; and residents are involved, whenever possible, in the preparation of their plan of care. (B.)

- c) The facility shall provide activity personnel as set forth in Section 300.1410(b). (B)
- d) The facility shall provide dietary personnel as set forth in Sections 300.2010 and 300.2020. (B)
- e) The facility shall designate a staff member(s) to provide social services to residents. (B)
- f) The facility shall provide nursing personnel as set forth in Subpart F. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.830 Consultation Services

- a) The facility shall have all arrangements for each consultant's services in a written agreement setting forth the services to be provided. These agreements shall be updated annually.
- b) If the staff member designated to provide social services is not a social worker, the facility shall have an effective arrangement with a social worker to provide social service consultation. Skilled nursing facilities must provide a social worker to meet this requirement.
- c) The facility shall have a written agreement for activity program consultation if required under Section 300.1410(c).
- d) Specific restorative services (physical therapy, occupational therapy, etc.) provided by the facility shall include consultation as set forth in Section 300.1420(a).
- e) The facility shall arrange for an advisory physician or medical advisory committee as set forth in Section 300.1010.
- f) The facility shall arrange for an advisory dentist and dental hygienist if desired, as set forth in Section 300.1050.
- g) The facility shall arrange for a consultant pharmacist as set forth in Section 300.1610.
- h) Skilled Nursing Facilities shall arrange for consultation from a health information management consultant as set forth in Section 300.1860.

- i) Facilities shall arrange for a dietary consultant as set forth in Section 300.2010(b).

(Source: Amended at 26 Ill. Reg. 10523, effective July 1, 2002)

Section 300.840 Personnel Policies

The personnel policies required in Section 300.650 and other personnel policies established by the facility, shall be followed in the operation of the facility.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1010 MEDICAL CARE POLICIES**

Section 300.1010 Medical Care Policies

- a) Advisory Physician or Medical Advisory Committee
 - 1) There shall be an advisory physician, or a medical advisory committee composed of physicians, who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician, he may be the advisory physician. (B)
 - 2) Additional for Skilled Nursing Facilities. There shall be a medical advisory committee composed of two (2) or more physicians who shall be responsible for advising the administrator on the overall medical management of the residents and the staff in the facility. If the facility employs a house physician, the house physician may be one member of this committee.
- b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee. (B)
- c) Every resident shall be under the care of a physician.
- d) All residents, or their guardians, shall be permitted their choice of a physician.
- e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.)
- f) Physician treatment plans, orders and similar documentation shall have an original

written signature of the physician. A stamp signature, with or without initials, is not sufficient.

- g) Each resident admitted shall have a physical examination, within five days prior to admission or within 72 hours after admission. The examination report shall include at a minimum each of the following:
 - 1) An evaluation of the resident's condition, including height and weight, diagnoses, plan of treatment, recommendations, treatment orders, personal care needs, and permission for participation in activity programs as appropriate.
 - 2) Documentation of the presence or absence of tuberculosis infection by tuberculin skin test in accordance with Section 300.1025.
 - 3) Documentation of the presence or absence of incipient or manifest decubitus ulcers (commonly known as bed sores), with grade, size and location specified, and orders for treatment, if present. (A photograph of incipient or manifest decubitus ulcers is recommended on admission.)
 - 4) Orders from the physician regarding weighting of the resident, and the frequency of such weighing, if ordered.
- h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)
- i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. (B)

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.1020 Communicable Disease Policies

- a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the

facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility.

- c) All illnesses required to be reported under the Control of Communicable Diseases Code and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693) shall be reported immediately to the local health department and to the Department. The facility shall furnish all pertinent information relating to such occurrences. In addition, the facility shall inform the Department of all incidents of scabies and other skin infestations.

(Source: Amended at 29 Ill. Reg. 12852, effective August 2, 2005)

Section 300.1025 Tuberculin Skin Test Procedures

Tuberculin skin tests for employees and residents shall be conducted in accordance with the Control of Tuberculosis Code (77 Ill. Adm. Code 696).

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.1030 Medical Emergencies

- a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:
 - 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest).
 - 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest).
 - 3) Traumatic injuries (for example, fractures, burns, and lacerations).
 - 4) Toxicologic emergencies (for example, untoward drug reactions and overdoses).
 - 5) Other medical emergencies (for example, convulsions and shock).
(A, B)

- b) The facility shall maintain in a suitable location the equipment to be used during these emergencies. This equipment shall include at a minimum the following: a portable oxygen kit, including a face mask and/or cannula; an airway; and bag-valve mask manual ventilating device. (B)
- c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. (B)
- d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement.

(Source: Amended at 18 Ill. Reg. 15868, effective October 15, 1994)

Section 300.1035 Life-Sustaining Treatments

- a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be:
 - 1) implementation of Living Wills or Powers of Attorney for Health Care in accordance with the Living Will Act (Ill. Rev. Stat. 1991, ch. 110½, pars. 701 et seq.) [755 ILCS 35] and the Powers of Attorney for Health Care Law (Ill. Rev. Stat. 1991, ch. 110½, pars. 804-1 et seq.) [755 ILCS 45];
 - 2) *the implementation of physician orders limiting resuscitation such as those commonly referred to as "do-not-resuscitate" orders. This policy may only prescribe the format, method of documentation and duration of any physician orders limiting resuscitation. Any orders under this policy shall be honored by the facility.* (Section 2-104.2 of the Act);
 - 3) procedures for providing life-sustaining treatments available to residents at the facility;

- 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices;
 - 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible.
- b) For the purposes of this Section:
- 1) "Agent" means a person acting under a Health Care Power of Attorney in accordance with the Powers of Attorney for Health Care Law.
 - 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing the airway, as indicated.
 - 3) "Surrogate" means a surrogate decision maker acting in accordance with the Health Care Surrogate Act (Ill. Rev. Stat. 1991, ch. 110½, par. 851-1 et seq.) [755 ILCS 40].
- c) Within 30 days of admission for new residents, and within one year of the effective date of this Section for all residents who were admitted prior to the effective date of this Section, residents, agents, or surrogates shall be given written information describing the facility's policies required by this Section and shall be given the opportunity to:
- 1) execute a Living Will or Power of Attorney for Health Care in accordance with State law, if they have not already done so; and/or
 - 2) decline consent to any or all of the life-sustaining treatment available at the facility.
- d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's medical record. Any subsequent changes or modifications must also be recorded in the medical record.

- e) The facility shall honor all decisions made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section and may not discriminate in the provision of health care on the basis of such decision or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act (Ill. Rev. Stat. 1991, ch. 111½, pars. 5301 et seq.) [745 ILCS 70]
- f) The resident, agent, or surrogate may change his or her decision regarding life-sustaining treatment by notifying the treating facility of this decision change orally or in writing in accordance with State law.
- g) The physician shall confirm the resident's choice by writing appropriate orders in the patient record or will transfer care in accordance with the Living Will Act, the Powers of Attorney for Health Care Law, the Health Care Surrogate Act or the Right of Conscience Act.
- h) If no choice is made pursuant to subsection (c) of this Section, and in the absence of any physician's order to the contrary, then the facility's policy with respect to the provision of life-sustaining treatment shall control until and if such a decision is made by the resident, agent, or surrogate in accordance with the requirements of the Health Care Surrogate Act.

(Source: Added at 17 Ill. Reg. 16194, effective January 1, 1994)

Section 300.1040 Behavior Emergencies (Repealed)

(Source: Repealed at 20 Ill. Reg. 12160, effective September 10, 1996)

Section 300.1050 Dental Standards

- a) Each long-term care facility shall have a dental program which will provide for in-service education to residents and staff under direction of dental personnel including at a minimum the following: (B)
 - 1) Information regarding nutrition and diet control measures which are dental health oriented.
 - 2) Instruction in proper oral hygiene methods.
 - 3) Instruction concerning the importance of maintenance of proper oral hygiene and where appropriate including family members (as in the case of residents leaving the long-term care facility).

- b) The direct care staff shall receive in-service education annually. This will be provided by a dentist or a dental hygienist. (B)
 - 1) Direct care staff shall be educated in ultrasonic or manual denture and partial denture cleaning techniques.
 - 2) Direct care staff shall be educated in proper brushing and oral health care for residents who are unable to care for their own health.
 - 3) Direct care staff shall be educated in examining the mouth in order to recognize abnormal conditions for necessary referral.
 - 4) Direct care staff shall be educated regarding nutrition and diet control measures and the effect on dental health.
 - 5) Supplemental dental training films shall be included with any other health training films seen on a rotating basis.
- c) The long-term care facility's dental program shall provide for each resident having proper daily personal dental hygiene attention, with the nursing staff responsible for continuity of care which includes, but is not limited to, the following: (B)
 - 1) Assistance in cleaning mouth with electric or hand brush if resident is unable to do so.
 - 2) Weekly ultrasonic cleaning of dentures and partials is strongly recommended.
- d) There shall be comprehensive treatment services for all residents which include, but are not limited to, the following: (B)
 - 1) Provision for dental treatment
 - 2) Provision for emergency treatment by a qualified dentist
- e) Each facility shall have a denture and dental prosthesis marking system which takes into account the identification marking system contained in Section 49 of the Illinois Dental Practice Act (Ill. Rev. Stat. 1987, ch. 111, par. 2349). Policies and Procedures shall be written and contained in the facility's Policies and Procedure Manual. It shall include, at a minimum, provisions for: (B)

- 1) Marking individual dentures or dental prostheses, if not marked prior to admission to the facility, within ten days of admittance; and
- 2) individually marked denture cups for denture storage at night.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1060 Vaccinations

- a) *A facility shall annually administer a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213 of the Act)*
- b) *A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, refused or medically contraindicated. (Section 2-213 of the Act)*
- c) *A facility shall provide or arrange for administration of a pneumococcal vaccination to each resident who is age 65 or over, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213 of the Act)*
- d) *A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213 of the Act)*

(Source: Added at 29 Ill. Reg. 12852, effective August 2, 2005)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1210 GENERAL REQUIREMENTS FOR NURSING AND PERSONAL CARE

Section 300.1210 General Requirements for Nursing and Personal Care

- a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include at a minimum the following procedures:
 - 1) The licensed nurse in charge of the restorative/rehabilitative nursing program shall have successfully completed a course or other training program that includes at least 60 hours of classroom/lab training in restorative/rehabilitative nursing as evidenced by a transcript, certificate, diploma, or other written documentation from an accredited school or recognized accrediting agency such as a State or National organization of nurses or a State licensing authority. Such training shall address each of the measures outlined in subsections (a)(2)-(5) of this Section. This person may be the Director of Nursing, Assistant Director of Nursing or another nurse designated by the Director of Nursing to be in charge of the restorative/rehabilitative nursing program.
 - 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
 - 3) All nursing personnel shall assist and encourage residents so that a resident

who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

- 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
 - 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.
- b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
- 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.
 - 2) All treatments and procedures shall be administered as ordered by the physician.
 - 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
 - 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following:
 - A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.
 - B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.
 - C) Each resident shall have clean suitable clothing in order to be

comfortable, sanitary, free of odors, and decent in appearance. Unless otherwise indicated by his/her physician, this should be street clothes and shoes.

- D) Each resident shall have clean bed linens at least once weekly and more often if necessary.
- 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.
- 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.1220 Supervision of Nursing Services

- a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse.
 - 1) This person shall have knowledge and training in nursing service administration and restorative/rehabilitative nursing. This person shall also have some knowledge and training in the care of the type of residents the facility cares for (e.g., geriatric or psychiatric residents). This does not mean that the director of nursing must have completed a specific course or a specific number of hours of training in restorative/rehabilitative nursing unless this person is in charge of the restorative/rehabilitative nursing program. (See Section 300.1210(a).)
 - 2) This person shall be a full-time employee who is on duty a minimum of 36 hours, four days per week. At least 50 percent of this person's hours shall be regularly scheduled between 7 A.M. and 7 P.M.
 - A) A facility may, with written approval from the Department, have two registered nurses share the duties of this position if the facility is unable to obtain a full-time person. Such

an arrangement will be approved only through written documentation that the facility was unable to obtain the full-time services of a qualified individual to fill this position. Such documentation shall include, but not be limited to: an advertisement that has appeared in a newspaper of general circulation in the area for at least three weeks; the names, addresses and phone numbers of all persons who applied for the position and the reasons why they were not acceptable or would not work full time; and information about the numbers and availability of licensed nurses in the area. The Department will grant approval only when such documentation indicates that there were no qualified applicants who were willing to accept the job on a full-time basis, and the pool of nurses available in the area cannot be expected to produce, in the near future, a qualified person who is willing to work full time.

- B) In facilities with a capacity of fewer than 50 beds, this person may also provide direct patient care, and this person's time may be included in meeting the staff-to-resident ratio requirements.
- 3) In skilled nursing facilities of 100 or more occupied beds, there shall be an assistant director of nursing (ADON) who is a registered nurse. This person shall also meet the qualifications specified in subsection (a)(1) of this Section for the director of nursing service.
- 4) In intermediate care facilities of 150 or more occupied beds, a licensed nurse shall be designated as the ADON. The assistant may provide direct patient care and be included in staff-to-resident ratio calculations.
- 5) The assistant shall be a full-time employee who is on duty a minimum of 36 hours, four days per week. The assistant may be assigned to work hours any time of the day or night.
- 6) The assistant shall assist the DON in carrying out his/her responsibilities.
- 7) If other duties interfere with the proper performance of the DON's or ADON's duties, another nurse shall be assigned to perform the duties of the DON or assistant for that period of time.

- b) The DON shall supervise and oversee the nursing services of the facility, including:
- 1) Assigning and directing the activities of nursing service personnel.
 - 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.
 - 4) Recommending to the administrator the number and levels of nursing personnel to be employed, participating in their recruitment and selection and recommending termination of employment when necessary.
 - 5) Participating in planning and budgeting for nursing services, including purchasing necessary equipment and supplies.
 - 6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.
 - 7) Coordinating the care and services provided to residents in the nursing facility.
 - 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

- 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).)
- 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available.

(Source: Amended at 26 Ill. Reg. 10523, effective July 1, 2002)

Section 300.1230 Staffing

- a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident needs on each shift of the day. This determination shall be made separately for both licensed and nonlicensed nursing personnel. (A, B)
- b) In a facility whose residents participate in regularly scheduled therapeutic programs outside the facility, such as school or sheltered workshops, the minimum hours per day of nursing care are reduced proportionately. Exceptions to the shift distribution will be allowed if more than 50% of the residents are regularly scheduled to be out of the facility, but the total required hours must be provided daily. For example: an ICF resident requires 1.75 hours of care per day, but attends a workshop for six hours five days a week. The resident's required minimum hours of care is reduced by 25% in calculating staffing hours required on week days.
- c) It is the responsibility of each facility to determine the staffing needed to meet the needs of its residents.
- d) In determining the level of care a resident needs, the patient evaluation system in Medical Review/Utilization Review program may be used. The facility may use other methods of determining skilled and intermediate level residents, but must make the method of determination used available to the Department. Residents whose care is reimbursed by the State shall be at the level determined by the Medical Review/Utilization Review patient evaluation system.
- e) The designations used for shifts in the following tables are used for illustrative purposes only, and are not meant to imply that other shift designations cannot be used by the facility.
- f) The following figures apply to numbers of persons actually on duty and not to numbers of persons scheduled to be on duty.

- g) The director of nursing's time shall not be included in staffing ratios.
- h) Level of Care Determinations
 - 1) The following figures are also considered to be minimum requirements, and each facility, except those of 250 or more occupied beds, shall provide at least the amount of staffing indicated. However, it is recognized that there may be occasional differences of opinion between facility staff and Department surveyors regarding the level of care an individual resident may require. When such differences occur, the surveyor shall determine whether or not the resident is receiving appropriate care. If the resident is, the surveyor shall accept the facility's level of care determination in determining the number of nursing hours to be provided by the facility.
 - 2) Facilities of more than 250 occupied beds must meet the staff-resident ratio for the 250 residents needing the highest level of care. Additional staff shall be provided to meet resident needs as determined by the facility and verified by the Department. The Department may, based upon the Department's Patient Care Evaluation System review of resident care, require the facility to provide additional nursing hours to meet resident needs.
- i) In computing the number of persons needed in the following examples, any figure less than .25 will be dropped from the computation and any figure of .75 or higher will go to the next higher number. Figures in between .25 and .75 will require at least the amount of coverage indicated: for example, .25 will require two hours of coverage; .3 will require two hours of coverage; .5 will require four hours of coverage; .6 will require five hours of coverage; .74 will require six hours of coverage; .75 or higher will require eight hours of coverage.
- j) These additional hours may be provided by: a part-time person working those hours only on that shift each day; a full-time person working a shift that spans two regular shifts - for example from noon to 8 P.M.; or by an additional full-time person on the shift. However, these figures are minimal staffing requirements, and it is recommended that a full-time person be provided.
- k) The facility shall schedule nursing personnel in such a manner that the needs of all residents are met. At least 40% of the minimum required hours shall be on the day shift, at least 25% of the minimum required hours shall be on the evening shift, and at least 15% of the minimum required hours shall be on the night shift.

- l) **Skilled Nursing Care**
Residents needing skilled nursing care may only be cared for in facilities licensed as Skilled Nursing Facilities. Each resident needing skilled care shall be provided at least 2.5 hours of nursing-personal care each day, of which 20% must be licensed nurse time. (A, B)
- m) **Intermediate Nursing Care – General**
Residents needing intermediate care may be cared for in facilities licensed as either Skilled Nursing Facility or Intermediate Care Facility. Each resident needing intermediate care shall be provided at least 1.7 hours of nursing/personal care each day, of which at least 20% must be licensed nurse time. (A, B)
- n) **Intermediate Nursing Care – Light**
A Long-term care resident needing light intermediate care is one who needs personal care as defined in Section 1-120 of the Act; is mobile; requires some nursing services; needs a program of social services and activities directed toward independence in daily living skills; and needs daily monitoring. Each resident needing light intermediate care shall be provided with at least one hour of nursing/personal care each day, of which at least 20% must be licensed nurse time. (A, B)
- o) In order to determine the numbers of nursing personnel needed to staff any facility, the following procedures shall be used:
 - 1) The facility shall determine the number of residents needing skilled, general intermediate, and light intermediate or sheltered care.
 - 2) The number of residents in each of the three categories shall be multiplied by the overall hours of coverage needed each day for each category.
 - 3) Adding the hours of care needed for the residents in each of the three categories will give the total hours of care needed by all residents in the facility.
 - 4) Multiplying the total hours needed each day by the percentages assigned to each shift will give the total minimum hours of care that must be provided on that shift. (Remember that the percentages assigned to each shift must total 100% each day.)
 - 5) Multiplying the total minimum hours of care needed on each shift by 20% will give the minimum amount of licensed nurse time that must be provided during a 24-hour period.

- 6) The remaining 80% of the minimum required nursing hours of care can be fulfilled by either nursing assistants or licensed nursing personnel as long as it can be documented that they provide restorative/rehabilitative nursing measures, general nursing care, and personal care as defined in Section 300.1210.
- 7) The amount of time determined in subsection (5) and (6) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually seven and one half or eight hours) will give the number of persons needed to staff each shift.

p) Example of Staffing Calculations

- 1) Following is an example of this computation assuming a 100 bed Skilled Nursing Facility which has 25 skilled, 50 general intermediate and 25 light intermediate residents, assigning 45% to day shift; 35% to evening shift and 20% to the night shift.
- 2) Staffing would be computed as follows:

A) Total Minimum Hours of Care Needed

Level of Care	# of Residents		Total Hrs. Needed/Day Per Resident	=	Total Hrs. Needed/Day Per Facility
Skilled	25	[times]	2.5	=	62.5
General ICF	50	[times]	1.7	=	85.0
Light ICF	25	[times]	1.0	=	<u>25.0</u>
Total hours needed					172.5

B) Minimum Total Hours Needed Per Shift

Shift	Total Hrs. Per Day		Minimum Percent	Total Hrs. Needed
7-3	172.5	[times]	45%	77.6
3-11	172.5	[times]	35%	60.4
11-7	172.5	[times]	<u>20%</u>	<u>34.5</u>
			100%	172.5

C) Licensed Nurse Coverage

Shift	Minimum	Minimum	Minimum
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	Hrs. Per Shift		Percent	Nurse Hours Required
7-3	77.6	[times]	20%	15.5
3-11	60.4	[times]	20%	12.1
11-7	34.5	[times]	20%	6.9

D) Licensed Nurses Required

Shift	Minimum Nurse Hrs. Required		Hrs. Worked Per Shift		# of Nurses Needed
7-3	15.5	[divided by]	8	=	1.93 (2)
3-11	12.1	[divided by]	8	=	1.51 (1.5)
11-7	6.9	[divided by]	8	=	0.86 (1)

E) Nurse Aide/Orderly Coverage

Shift	Minimum Nurse Hrs. Required		Hrs. Worked Per Shift		# of Nurses Needed
7-3	77.6	[minus]	15.6	=	62.1
3-11	60.4	[minus]	12.1	=	48.3
11-7	34.5	[minus]	6.9	=	27.6

F) Nurse Aides/Orderlies Required

Shift	Minimum Aide Hrs. Required		Hrs. Worked Per Shift		# of Aides Needed
7-3	62.1	[divided by]	8	=	7.76 (8)
3-11	48.3	[divided by]	8	=	6.03 (6)
11-7	27.6	[divided by]	8	=	3.45 (3.5)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1240 Additional Requirements

In addition to the staffing requirements, in Section 300.1230, the following staffing requirements also apply to all Skilled Nursing Facilities and Intermediate Care Facilities:

- a) There shall be a licensed nurse designated as being in charge of nursing services on all shifts when neither the director of nursing or assistant director of nursing are on duty. If registered nurses and licensed practical nurses are on duty on the same shift, this person shall be a registered nurse. This person may be a charge nurse on one of the nursing units. (A, B)
- b) There shall be at least one person awake, dressed and on duty at all times in each separate nursing unit. (A, B)
- c) There shall be at least one registered nurse on duty seven days per week, 8 consecutive hours, in a skilled nursing facility. (A, B)
- d) There shall be at least one registered nurse or licensed practical nurse on duty at all times in an intermediate care facility or a skilled nursing facility. (A, B)
- e) There shall be at least one registered nurse or licensed practical nurse on duty on each floor housing residents in a skilled nursing facility. (A, B)
- f) The need for licensed nurses on each nursing unit in a skilled nursing facility and each floor or nursing unit in an intermediate care facility will be determined on an individual case basis, dependent upon the individual situation. If such additional staffing is required, the Department will inform the facility in writing of the kind and amount of additional staff time required, and the reason why it is needed.
- g) The need for an additional licensed nurse to serve as a "house supervisor" will be determined on an individual case basis. If the Department determines that there is a need for a registered nurse in a skilled nursing facility or a licensed practical nurse in an intermediate care facility on certain shifts whose sole duties will consist of supervising the nursing services of the facility, the Department shall notify the facility in writing when and why such a person is needed. This person shall not perform the duties of a charge nurse while serving as the "house supervisor".

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1410 ACTIVITY PROGRAM**

Section 300.1410 Activity Program

- a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents.
- b) Activity personnel shall be provided to meet the needs of the residents and the program. Activity staff time each week shall total not less than 45 minutes multiplied by the number of residents in the facility. This time shall be spent in providing activity programming as well as planning and directing the program. The time spent in the performance of other duties not related to the activity program shall not be counted as part of the required activity staff time.
 - 1) In a facility whose residents participate in regularly scheduled therapeutic programs outside the facility, such as school, employment or sheltered workshop, the minimum hours per week of activity staff time may be reduced. The reduction shall be calculated by multiplying the number of residents in the facility who participate in such programs by the percentage of the day that these residents spend in such programs.
 - 2) Activity personnel working under the direction of the activity director shall have a minimum of 10 hours of in-service training per calendar or employment year, directly related to recreation/activities. In-service training may be provided by qualified facility staff and/or consultants, or may be obtained from college or university courses, seminars and/or workshops, educational offerings through professional organizations, similar educational offerings or any combination thereof.
- c) Activity Director and Consultation

- 1) A trained staff person shall be designated as activity director and shall be responsible for planning and directing the activities program. This person shall be regularly scheduled to be on duty in the facility at least four days per week.
- 2) If the activity director is not a Certified Therapeutic Recreation Specialist (CTRS), Occupational Therapist Registered and Licensed (OTR/L), or a Licensed Social Worker (LSW) or Licensed Clinical Social Worker (LCSW) who has specialized course work in social group work, the facility shall have a written agreement with a person from one of those disciplines to provide consultation to the activity director and/or activity department at least monthly, to ensure that the activity programming meets the needs of the residents of the facility.
- 3) Any person designated as activity director hired after December 24, 1987, shall have a high school diploma or equivalent.
- 4) Except for individuals qualified as a CTRS, OTR/L, LSW or LCSW as listed in subsection (c)(2) of this Section, any person hired as an activity director after November 1, 2000 shall have taken a 36-hour basic orientation course or shall register to take a 36-hour basic orientation course within 90 days after employment and shall complete the course within 180 days after employment. This course shall be recognized by an accredited college or university or a nationally recognized continuing education sponsor following the guidelines of the International Association for Continuing Education and Training and shall include at least the following: resident rights; activity care planning for quality of life, human wellness and self-esteem; etiology and symptomatology of persons who are aged, developmentally disabled or mentally ill; therapeutic approaches; philosophy and design of activity programs; activity program resources; program evaluation; practitioner behavior and ethics; resident assessment and supportive documentation; standards and regulations concerning activity programs; management and administration. Individuals who have previously taken a 36-hour basic orientation course, a 42-hour basic activity course or a 90-hour basic education course shall be considered to have met this requirement.
- 5) The activity director shall have a minimum of ten hours of continuing education per year pertaining to activities programming.
- 6) Consultation shall be required only quarterly when the activity director meets or exceeds the following criteria:
 - A) High school diploma or equivalent, five years of full-time or 10,000 hours of part-time experience in activities (three years of that experience as an activity director), and completion of a basic orientation course of at least 36 hours; or

- B) A two-year associate's degree, three years of experience as an activity director, and completion of a basic orientation course of at least 36 hours; or
 - C) A four-year degree, one year of full-time experience as an activity director, and completion of a basic orientation course of at least 36 hours.
- d) Written permission, with any contraindications stated, shall be given by the resident's physician if the resident participates in the activity program. Standing orders will be acceptable with individual contraindications noted.
 - e) Activity program staff shall participate in the assessment of each resident, which shall include the following:
 - 1) Background information, including education level, cultural/social issues, and spiritual needs;
 - 2) Current functional status, including communication status, physical functioning, cognitive abilities, and behavioral issues; and
 - 3) Leisure functioning, including attitude toward leisure, awareness of leisure resources, knowledge of activity skills, and social interaction skills and activity interests, both current and past.
 - f) The activity staff shall participate in the development of an individualized plan of care addressing needs and interests of the residents, including activity/recreational goals and/or interventions.
 - g) The facility shall provide a specific, planned program of individual (including self-initiated) and group activities that are aimed at improving, maintaining, or minimizing decline in the resident's functional status, and at promoting well-being. The program shall be designed in accordance with the individual resident's needs, based on past and present lifestyle, cultural/ethnic background, interests, capabilities, and tolerance. Activities shall be daily and shall reflect the schedules, choices, and rights of the residents (e.g., morning, afternoon, evenings and weekends). The residents shall be given opportunities to contribute to planning, preparing, conducting, concluding and evaluating the activity program.
 - h) The activity program shall be multifaceted and shall reflect each individual resident's needs and be adapted to the resident's capabilities. The activity program philosophy shall encompass programs that provide stimulation or solace; promote physical, cognitive and/or emotional health; enhance, to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing, for example, activities that support self-expression and choice. Specific

types of activities may include:

- 1) Physical activity (e.g., exercise, fitness, adapted sports);
 - 2) Cognitive stimulation/intellectual/educational activity (e.g., discussion groups, reminiscence, guest speakers, films, trivia, quizzes, table games, puzzles, writing, spelling, newsletter);
 - 3) Spiritual/religious activity (e.g., religious services, spiritual study groups, visits from spiritual support groups);
 - 4) Service activity (e.g., volunteer work for the facility, other individuals and/or the community);
 - 5) Sensory stimulation (e.g., tactile, olfactory, auditory, visual and gustatory);
 - 6) Community involvement (e.g., community groups coming into the facility for intergenerational programs, special entertainment and volunteer visits; excursions outside the facility to museums, sporting events, entertainment, parks);
 - 7) Expressive and creative arts/crafts (adapted to the resident's capabilities), music, movement/dance, horticulture, pet-facilitated therapy, drama, literary programs, art, cooking;
 - 8) Family involvement (e.g., correspondence, family parties, holiday celebrations, family volunteers; and
 - 9) Social activity (e.g., parties and seasonal activities).
- i) If residents participate in regularly scheduled therapeutic programs outside the facility (e.g., school, employment, or sheltered workshop), the residents' needs for activities while they are in the facility shall be met.
 - j) Residents' participation in and response to the activity program shall be documented at least quarterly and included in the clinical record. The facility shall maintain current records of resident participation in the activity program.

(Source: Amended at 24 Ill. Reg. 17330, effective November 1, 2000)

Section 300.1420 Specialized Rehabilitation Services

If physical therapy, occupational therapy, speech therapy or any other specialized rehabilitative service is offered, it shall be provided by, or supervised by, a qualified professional in that specialty and upon the written order of the physician. (B)

- a) In addition to the provision of direct services, any such qualified professional personnel shall be used as consultants to the total restorative program and shall assist with resident evaluation, resident care planning, and in-service education.
- b) Appropriate records shall be maintained by these personnel. Direct service to individual residents shall be documented on the individual clinical record as set forth in Section 300.1810(c). A summary of program consultation and recommendations as set forth in Section 300.1810(h) shall be documented.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1430 Work Programs

- a) Work programs for individual residents in facilities shall be allowed only if they are oriented toward resident adjustment and therapeutic benefits and if they are approved in writing by the Department. Such programs should be a rarity in skilled nursing facilities.
- b) Permission for each such program shall be secured from the Department. Each program shall be presented in writing indicating such things as objectives, possible work assignment, duties, policies governing the program, agency involvement (where appropriate), and supervision.
- c) Residents involved in such programs shall meet all requirements of the Department for persons functioning in these positions.
- d) Residents shall not be used to replace employed staff. (B)
- e) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record. (See Section 300.1810(c).)
- f) All such programs shall be in full compliance with all applicable regulations of both the State and Federal Departments of Labor. Any program found by the Department not to be in compliance with State and Federal Departments of Labor regulations shall be terminated immediately.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1440 Volunteer Program

- a) If the facility has a volunteer or auxiliary program, a facility staff person shall direct the program. Community groups such as Boy and Girl Scouts, church groups and civic organizations that may occasionally present programs, activities, or entertainment in the facility shall not be considered volunteers for the purposes of this Section.
- b) Volunteers shall complete a standard orientation program, in accordance with their facility responsibilities and with the facility's policies and procedures governing the volunteer program. The orientation shall include, but not be limited to:
 - 1) Residents' rights;
 - 2) Confidentiality;
 - 3) Disaster preparedness (i.e., fire, tornado);
 - 4) Emergency response procedures;
 - 5) Safety procedures/precautions;
 - 6) Infection control; and
 - 7) Body mechanics.
- c) Volunteers shall respect all aspects of confidentiality.
- d) Volunteers shall be informed of and shall implement medical and physical precautions related to the residents with whom they work.
- e) Volunteers shall not take the place of qualified staff (e.g., activity professionals, nursing assistants, or case workers).

(Source: Added at 24 Ill. Reg. 17330, effective November 1, 2000)

Section 340.1450 Language Assistance Services

A facility shall provide language assistance services in accordance with the Language Assistance Services Act [210 ILCS 87] and the Language Assistance Services Code (77 Ill. Adm. Code 940).

(Source: Added at 29 Ill. Reg. 12852, effective August 2, 2005)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1610 MEDICATION POLICIES AND PROCEDURES**

Section 300.1610 Medication Policies and Procedures

- a) Development of Medication Policies
 - 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.
 - 2) Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly.
- b) For the purpose of this Subpart, "licensed prescriber" means a physician; a dentist; a podiatrist; an optometrist certified to use therapeutic ocular pharmaceutical agents; a physician assistant to whom prescriptive authority has been delegated by a supervising physician; or an advanced practice nurse practicing under a valid collaborative agreement.
- c) All legend medications maintained in the facility shall be on individual prescription or from the licensed prescriber's personal office supply, and shall be labeled as set forth in Section 300.1640. A licensed prescriber who dispenses medication from his or her personal office supply shall comply with Sections-33 and 54.5 of the Medical Practice Act of 1987 [225 ILCS 60/33 and 54.5]; or Section 51 of the Illinois Dental Practice Act [225 ILCS 25/51]; or the Podiatric Medical Practice Act of 1987 [225 ILCS 100]; or Section 15.1 of the Illinois Optometric Practice Act of 1987 [225 ILCS 80/15.1]; or Section 15-20 of the Nursing and Advanced Practice Nursing Act [225 ILCS 65/15-20]; or Section 7.5 of the Physician Assistant Practice Act of 1987 [225 ILCS 95/7.5].

- d) All medications administered shall be recorded as set forth in Section 300.1810. Medications shall not be recorded as having been administered prior to their actual administration to the resident.
- e) The staff pharmacist or consultant pharmacist shall participate in the planned in-service education program of the facility on topics related to pharmaceutical service.
- f) A pharmacist shall obtain a Division III license to operate an on-premises pharmacy in accordance with the Pharmacy Practice Act of 1987 [225 ILCS 85] and the rules of the Department of Professional Regulation (68 Ill. Adm. Code 1330).
- g) No facility shall maintain a stock supply of controlled drugs or legend drugs, except for those in the emergency medication kits and convenience boxes, as described in this Section.
- h) A facility may stock drugs that are regularly available without prescription. These shall be administered to a resident only upon the order of a licensed prescriber (see Section 300.1620). Administration shall be from the original containers, and shall be recorded in the resident's clinical record.
- i) A facility may keep convenience boxes containing medications to be used for initial doses.
 - 1) The contents and number of convenience boxes shall be determined by the pharmaceutical advisory committee. The contents shall be listed on the outside of each box.
 - 2) Each convenience box shall be the property of and under the control of the pharmacy that supplies the contents of the box, and it shall be kept in a locked medicine room or cabinet.
 - 3) No Schedule II controlled substances shall be kept in convenience boxes.
- j) The contents and number of emergency medication kits shall be approved by the facility's pharmaceutical advisory committee, and shall be available for immediate use at all times in locations determined by the pharmaceutical advisory committee.
 - 1) Each emergency medication kit shall be sealed after it has been checked and refilled.
 - 2) Emergency medication kits shall also contain all of the equipment needed to administer the medications.
 - 3) The contents of emergency medication kits shall be labeled on the outside of each kit. The kits shall be checked and refilled by the pharmacy after use

and as otherwise needed. The pharmaceutical advisory committee shall review the list of substances kept in emergency medication kits at least quarterly. Written documentation of this review shall be maintained.

- k) The following requirements shall be met when controlled substances are kept as part of the emergency medication kits:
- 1) If an emergency medication kit is not stored in a locked room or cabinet, or if the kit contains controlled substances that require refrigeration, then the controlled substances portion of the kit shall be stored separately in a locked cabinet or room (or locked refrigerator or a locked container within a refrigerator, as appropriate) and labeled with a list of the substances and a statement that they are part of the emergency medication kit. The label of the emergency medication kit shall list the substances and the specific location where they are stored.
 - 2) Controlled substances for emergency medication kits shall be obtained from a federal Drug Enforcement Administration registered hospital, pharmacy, or licensed prescriber.
 - 3) Only the director of nursing, registered nurse on duty, licensed practical nurse on duty, consultant pharmacist or licensed prescriber shall have access to controlled substances stored in emergency medication kits.
 - 4) No more than ten different controlled substances shall be kept as part of an emergency medication kit, and there shall be no more than three single-doses of any one controlled substance.
 - 5) Controlled substances in emergency medication kits may be administered only by persons licensed to administer medications, in compliance with 21 CFR 1306.11 and 1306.21 and the Illinois Controlled Substances Act [720 ILCS 570].
 - 6) A proof-of-use sheet shall be stored with each controlled substance. Entries shall be made on the proof-of-use sheet by the nursing staff or licensed prescriber when any controlled substance from the kit is used. The consultant pharmacist shall receive and file for two years a copy of all completed proof-of-use sheets.
 - 7) Whenever the controlled substance portion of an emergency medication kit is opened, the consultant pharmacist shall be notified within 24 hours. During any period when this kit is opened, a shift count shall be done on all controlled substances until the kit is closed or locked, or the controlled substance is replaced. Shift counts are not mandatory when the kit is sealed. Forms for shift counts shall be kept with the controlled substances portion of the emergency medication kit.

- 8) The consultant pharmacist shall check the controlled substances portions of emergency medication kits at least monthly and so document on the outside of each kit.
 - 9) Failure to comply with any provision of this Section or with any applicable provision of State or federal statutes or State regulations pertaining to controlled substances shall result in loss of the privilege of having or placing controlled substances in emergency medication kits until the facility can demonstrate that it is in compliance with such regulations. This is in addition to the usual methods of corrective action available to the Department, such as fines and other penalties.
- l) Oxygen may be administered in a facility. The oxygen supply shall be stored and handled in accordance with the National Fire Protection Association Standard No. 99: Standard for Health Care Facilities (2002, no later amendments or editions included) for nonflammable medical gas systems. The facility shall comply with directions for use of oxygen systems as established by the manufacturer and the applicable provisions of the NFPA Life Safety Code (see Section 300.340) and NFPA 99.
- 1) Facilities shall store medical grade products separately from industrial grade products. The storage area for medical grade products shall be well defined with one area for receiving full medical gas vessels and another for storing empty vessels.
 - 2) All personnel who will be handling medical gases shall be trained to recognize the various medical gas labels. Personnel shall be trained to examine all labels carefully.
 - 3) If the facility's supplier uses 360-degree wrap-around labels to designate medical oxygen, personnel shall be specifically trained to make sure each vessel they connect to the oxygen system bears such a label.
 - 4) All facility personnel responsible for changing or installing medical gas vessels shall be trained to connect medical gas vessels properly. Personnel shall understand how vessels are connected to the oxygen supply system and shall be alerted to the serious consequences of changing connections.
 - 5) If a medical gas vessel fitting does not seem to connect to the oxygen system fitting, the supplier shall be contacted immediately. The vessel shall be returned to the supplier to determine the fitting or connection problem.
 - 6) Once a medical gas vessel has been connected to the oxygen supply system, but prior to introducing the product into the system, a trained facility staff member shall ensure that the correct vessel has been connected properly.

(Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003)

Section 300.1620 Compliance with Licensed Prescriber's Orders

- a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.
- b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days.
- c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon.
- d) A medication order not specifically limiting the time or number of doses shall be automatically stopped in accordance with written policies approved by the pharmaceutical advisory committee.
- e) The resident's licensed prescriber shall be notified of medications about to be stopped so that the licensed prescriber may promptly renew such orders to avoid interruption of the resident's therapeutic regimen.
- f) The licensed prescriber shall approve the release of any medications to the resident, or person responsible for the resident's care, at the time of discharge or when the resident is going to be temporarily out of the facility at medication time. Disposition of the medications shall be noted in the resident's clinical record.

(Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003)

Section 300.1630 Administration of Medication

- a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.
 - 1) Medications shall be administered as soon as possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems.
 - 2) Each dose administered shall be properly recorded in the clinical record-by the person who administered the dose. (See Section 300.1810.)
 - 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber.
- b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available , a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.
- c) Medications prescribed for one resident shall not be administered to another resident.
- d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.
- e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same

pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

- f) Nurses' stations shall be equipped as per Sections 300.2860 or 300.3060 and shall have all necessary items readily available for the proper administration of medications.
- g) Current medication references shall be available, such as the current edition of "Drug Facts and Comparisons", "Hospital Formulary", "USP-DI (United States Pharmacopeia-Drug Information)", "Physician's Desk Reference" or other suitable references.

(Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003)

Section 300.1640 Labeling and Storage of Medications

- a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.)
 - 1) These cabinets, rooms, and carts shall be well lighted and of sufficient size to permit storage without crowding.
 - 2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely.
- b) All medications for external use shall be kept in a separate area in the medicine cabinet, medicine room, or mobile medication cart.
- c) All poisonous substances and other hazardous compounds shall be kept in a separate locked container away from medications.
- d) Biologicals or medications requiring refrigeration shall be kept in a separate, securely fastened locked box within a refrigerator or a locked refrigerator, at or near the nurses' station or in a refrigerator within a locked medication room.
- e) The key or access code to the medicine cabinet, medicine room, or mobile medication cart shall be the responsibility of, and in the possession of, the persons authorized to handle and administer medications, at all times.
- f) The label of each individual multi-dose medication container filled by a pharmacist shall clearly indicate the resident's full name; licensed prescriber's-name; prescription number, name, strength and quantity of

drug; date this container was last filled; the initials of the pharmacist filling the prescription; the name and address of the pharmacy; and any necessary special instructions. If the individual multi-dose medication container is dispensed by a licensed prescriber-from his or her own supply, the label shall clearly indicate all of the preceding information and the source of supply; it shall exclude identification of the pharmacy, pharmacist and prescription number.

- g) Each single unit or unit dose package shall bear the proprietary or nonproprietary name of the drug, strength of dose and total contents delivered, lot or control number, and expiration date, if applicable. The names of the resident and the licensed prescriber do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right resident. Appropriate accessory and cautionary statements and any necessary special instruction shall be included, as applicable. Hardware for storing and delivering the medications shall be labeled with the identity of the dispensing pharmacy. The pharmacist shall provide written verification of the date the medications were dispensed and the initials (or unique identifier) of the pharmacist who reviewed and verified the medications. The pharmacist need not store such verification at the facility but shall readily make it available to the Department upon request. The lot or control number need not appear on unit dose packages if the dispensing pharmacy has a system for identifying those doses recalled by the manufacturer/distributor or if the dispensing pharmacy will recall and destroy all dispensed doses of a recalled medication, irrespective of a manufacturer's/distributor's specifically recalled lot.
- h) Medication in containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or dispensing licensed prescriber for relabeling or disposal. Medications whose directions for use have changed since the medication was originally dispensed and labeled may be retained for use at the facility, in accordance with the licensed prescriber's current medication order. Medications in containers having no labels shall be destroyed in accordance with federal and State laws.
- i) The medications of each resident shall be kept and stored in their originally received containers. Medications shall not be transferred between containers, except that a licensed nurse, acting as the agent of the resident, may remove previously dispensed medication from original containers and place it in other containers to be sent with a resident when the resident will be out of the facility at the time of scheduled administration of medication. When medication is sent out of the facility with the resident, it shall be labeled by the nurse with the name of the

resident, name and strength of the medication, instructions for administration and any other appropriate information.

(Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003)

Section 300.1650 Control of Medications

- a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications.
- b) All Schedule II controlled substances shall be stored so that two separate locks, using two different keys, must be unlocked to obtain these substances. This may be accomplished by several methods, such as locked cabinets within locked medicine rooms; separately locked, securely fastened boxes (or drawers) within a locked medicine cabinet; locked portable medication carts that are stored in locked medicine rooms when not in use; or portable medication carts containing a separate locked area within the locked medication cart, when such cart is made immobile.
- c) All medications having an expiration date that has passed, and all medications of residents who have been discharged or who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 300.1610. Medications shall be transferred with a resident, upon the order of the resident's physician, when a resident transfers to another facility. All discontinued medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Medications for any resident who has been temporarily transferred to a hospital shall be kept in the facility. Medications may be given to a discharged resident only upon the order of the licensed prescriber.
- d) **Inventory Controls**
 - 1) For all Schedule II controlled substances, a controlled substances record shall be maintained that lists on separate sheets, for each type and strength of Schedule II controlled substance, the following information: date, time administered, name of resident, dose, licensed prescriber's name, signature of person administering dose, and number of doses remaining.
 - 2) The pharmaceutical advisory committee may also require that other medications shall be subject to such inventory records.

(Source: Amended at 27 Ill. Reg. 5862, effective April 01, 2003)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.1810 RESIDENT RECORD REQUIREMENTS**

Section 300.1810 Resident Record Requirements

- a) Each facility shall have a medical record system that retrieves information regarding individual residents.
- b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.
- c) Record entries shall meet the following requirements:
 - 1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.
 - 2) All entries into the medical record shall be authenticated by the individual who made or authored the entry. "Authentication", for purposes of this Section, means identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
 - 3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiologic or laboratory reports and other similar reports.
 - 4) Authentication shall include the initials of the signer's credentials. If the electronic signature system will not allow for the credential initials, the facility shall have a means of identifying the signer's credentials.
 - 5) Electronic Medical Records Policy. The facility shall have a written policy on electronic medical records. The policy shall address persons authorized

to make entries, confidentiality, monitoring of record entries, and preservation of information.

- A) Authorized Users. The facility shall develop a policy to assure that only authorized users make entries into medical records and that users identify the date and author of every entry in the medical records. The policy should allow written signatures, written initials supported by a signature log, or electronic signatures with assigned identifiers, as authentication by the author that the entry made is complete, accurate and final.
 - B) Confidentiality. The facility policy shall include adequate safeguards to ensure confidentiality of patient medical records, including procedures to limit access to authorized users. The authorized user must certify in writing that he or she is the only person with authorized user access to the identifier and that the identifier will not be shared or used by any other person. A surveyor or inspector in the performance of a State-required inspection may have access to electronic medical records, using the identifier and under the supervision of an authorized user from the facility. A surveyor or inspector may have access to the same electronic information normally found in written patient records. Additional summary reports, analyses, or cumulative statistics available through computerized records are the internal operational reports of the facility's Quality Assurance Committee.
 - C) Monitoring. The facility shall develop a policy to periodically monitor the use of identifiers and take corrective action as needed. The facility shall maintain a master list of authorized users past and present and maintain a computerized log of all entries. The logs shall include the date and time of access and the user ID under which access occurred.
 - D) Preservation. The facility shall develop a plan to ensure access to medical records over the entire record retention period for that particular piece of information.
- 6) A user may terminate authorization for use of electronic or computer-generated signature upon written notice to the individual responsible for medical records or other person designated by the facility's policy.
 - 7) Each report generated by a user must be separately authenticated.
- d) All physician's orders, plans of treatment, Medicare or Medicaid certification, recertification statements, and similar documents shall have the authentication of the physician. The use of a physician's rubber stamp signature, with or without initials,

is not acceptable.

- e) The record shall include medically defined conditions and prior medical history, medical status, physical and mental functional status, sensory and physical impairments, nutritional status and requirements, special treatments and procedures, mental and psychosocial status, discharge potential, rehabilitation potential, cognitive status and drug therapy.
- f) An ongoing resident record including progression toward and regression from established resident goals shall be maintained.
 - 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change.
 - 2) Recommendations and findings of direct service consultants, such as providers of social, dental, dietary or rehabilitation services shall be included in the resident's progress record when the recommendations pertain to an individual resident.
- g) A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered.
- h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output.
- i) The facility may use universal progress notes in the medical records.
- j) Each facility shall have a policy regarding the retirement and destruction of medical records. This policy shall specify the time frame for retiring a resident's medical record, and the method to be used for record destruction at the end of the record retention period. The facility's record retirement policy shall not conflict with the record retention requirements contained in Section 300.1840 of this Part.
- k) Discharge information shall be completed within 48 hours after the resident leaves the facility. The resident care staff shall record the date, time, condition of the resident, to whom released, and the resident's planned destination (home, another facility, undertaker). This information may be entered onto the admission record form.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.1820 Content of Medical Records

- a) No later than the time of admission, the facility shall enter the following information onto the identification sheet or admission sheet for each resident:
 - 1) Name, sex, date of birth and Social Security Number,
 - 2) Marital Status, and the name of spouse (if there is one),
 - 3) Whether the resident has been previously admitted to the facility,
 - 4) Date of current admission to the facility,
 - 5) State or country of birth,
 - 6) Home address,
 - 7) Religious affiliation (if any),
 - 8) Name, address and telephone number of any referral agency, state hospital, zone center or hospital from which the resident has been transferred (if applicable),
 - 9) Name and telephone number of the resident's personal physician,
 - 10) Name and telephone number of the resident's next of kin or responsible relative.
 - 11) Race and origin,
 - 12) Most recent occupation,
 - 13) Whether the resident or the resident's spouse is a veteran,
 - 14) Father's name and mother's maiden name,
 - 15) Name, address and telephone number of the resident's dentist, and
 - 16) The diagnosis applicable at the time of admission.
- b) At the time of admission, the facility shall obtain a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility (if available).

- c) In addition to the information that is specified above, each resident's medical record shall contain the following:
- 1) Medical history and physical examination form that includes conditions for which medications have been prescribed, physician findings, all known diagnoses and restoration potential. This shall describe those known conditions that the medical and resident care staff should be apprised of regarding the resident. Examples of diagnoses and conditions that are to be included are allergies, epilepsy, diabetes and asthma.
 - 2) A physician's order sheet that includes orders for all medications, treatments, therapy and rehabilitation services, diet, activities and special procedures or orders required for the safety and well-being of the resident.
 - 3) Nurse's notes that describe the nursing care provided, observations and assessment of symptoms, reactions to treatments and medications, progression toward or regression from each resident's established goals, and changes in the resident's physical or emotional condition. (B)
 - 4) An ongoing record of notations describing significant observations or developments regarding each resident's condition and response to treatments and programs.
 - A) Physicians and other consultants who provide direct care or treatment to residents shall make notations at the time of each visit with a resident.
 - B) Significant observations or developments regarding resident responses to activity programs, social services, dietary services and work programs shall be recorded as they are noted. If no significant observations or developments are noted for three months, an entry shall be made in the record of that fact.
 - C) Significant observations or developments regarding resident responses to nursing and personal care shall be recorded as they are noted. If no significant observations or developments are noted for a month, an entry shall be made in the record of that fact.
 - 5) Any laboratory and x-ray reports ordered by the resident's physician.

- 6) Documentation of visits to the resident by a physician and to the physician's office by the resident. The physician shall record, or dictate and sign, the results of such visits, such as changes in medication, observations and recommendations made by the physician during the visits, in the record.
- 7) The results of the physical examination conducted pursuant to Section 300.1010(g) of this Part.
- 8) Upon admission from a hospital or state facility, a hospital summary sheet or transfer form that includes the hospital diagnosis and treatment, and a discharge summary. This transfer information, which may be included in the transfer agreement, shall be signed by the physician who attended the resident while in the hospital.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1830 Records Pertaining to Residents' Property

- a) The facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record.
- b) When purchases are made for a resident from the resident's personal monies, receipts shall be obtained and retained that verify the date, amount, and items purchased.
- c) A separate bookkeeping system shall be maintained by the facility which accounts for all transactions affecting each resident's account. Each individual resident, or the individual resident's representative, shall have access to the record of that individual resident's account.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1840 Retention and Transfer of Resident Records

- a) Records of discharged residents shall be placed in an inactive file and retained as follows:

- 1) Records for any resident who is discharged prior to being 18 years old shall be retained at least until the resident reaches the age of 23.
 - 2) Records of residents who are over 18 years old at the time of discharge shall be retained for a minimum of five years.
- b) After the death of a resident, the resident's record shall be retained for a minimum of five years.
 - c) It is suggested that the administrator check with legal counsel regarding the advisability of retaining resident records for a longer period of time, and the procedures to be followed in the event the facility ceases operation.
 - d) When a resident is transferred to another facility, the transferring facility shall send with the resident a reason for transfer, summary of treatment and results, laboratory findings, and orders for the immediate care of the resident. This information may be presented in a transfer form or an abstract of the resident's medical record. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1850 Other Resident Record Requirements

This Section contains references to rules located in other Subparts that pertain to the content and maintenance of medical records.

- a) The resident's record shall include facts involved if the resident's discharge occurs despite medical advice to the contrary, as required by Section 300.620(f) of this Part.
- b) The resident's record shall identify the reasons for any order and use of safety devices or restraints, as required by Sections 300.680(c) and 300.1040(d), respectively, of this Part.
- c) The resident's record shall include information regarding the physician's notification and response regarding any serious accident or injury, or significant change in condition, as required by Section 300.1010(h) of this Part.
- d) The resident's record shall contain the physician's permission, with contraindications noted, for participation in the activity program, as required by Section 300.1410(d) of this Part.

- e) The records of residents participating in work programs shall document the appropriateness of the program for the resident and the resident's response to the program, as described in Section 300.1430(e) of this Part.
- f) Telephone orders shall be transcribed into the resident's medical record or a telephone order form and signed by the nurse taking the order, as described in Section 300.1620(a)(2) of this Part.
- g) Documentation of the review of medication order shall be entered in the resident's medical record as described in Section 300.1620(b) of this Part.
- h) The resident's medical record shall include notations indicating any release of medications to the resident or person responsible for the resident's care, as described in Section 300.1620(e) of this Part.
- i) Instances of inability to implement a physician's medication order shall be noted in the resident's medical record, as described in Section 300.1630(d) of this part.
- j) Medication errors and drug reactions shall be noted in the resident's medical record as described in Section 300.1630(e) of this Part.
- k) The resident's record shall include the physician's diet order and observations of the resident's response to the diet, as describe in Section 300.2040 of this Part.
- l) The resident's record shall contain any physician determinations that limit the resident's access to the resident's personal property, as described in Section 300.3210(b) of this Part.
- m) The facility shall comply with Section 300.3210(g) of this Part, which requires that any medical inadvisability regarding married residents residing in the same room be documented in the resident's record.
- n) The facility shall permit each resident, resident's parent, guardian or representative to inspect and copy the resident's medical records as provided by Section 300.3220(g) of this Part.
- o) Any resident transfer or discharge mandated by the physical safety of other residents shall be documented in the resident's medical record as required by Sections 300.3300(d) and (g) of this Part.
- p) Summaries of discussions and explanations of any planned involuntary transfers or discharges shall be included in the medical record of the resident that is to be involuntarily transferred or discharged, as described in Section 300.3300(j) of this Part.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1860 Staff Responsibility for Medical Records

- a) Each skilled nursing facility shall have a health information management consultant.
 - 1) Each skilled nursing facility that has a full-time or part-time health information management consultant shall designate that employee as the person responsible for ensuring that the facility's medical records are completed, maintained and preserved in accordance with this Subpart.
 - 2) Each skilled nursing facility that does not have a full-time or part-time health information management consultant shall designate an employee to be responsible for completing, maintaining and preserving the facility's medical records. This individual shall be trained by, and receive regular consultation from, a health information management consultant in order to meet the requirements of this Subpart.
- b) Each intermediate care facility that does not have a full-time or part-time health information management consultant shall designate an employee to be responsible for completing, maintaining and preserving the medical records in accordance with the requirements of this Subpart.

(Source: Amended at 26 Ill. Reg. 10523, effective July 1, 2002)

Section 300.1870 Retention of Facility Records

The facility shall retain the records referenced in this Section for a minimum of three years. It is suggested that the administrator check with legal counsel regarding the advisability of retaining records for a longer period of time, and the procedures to be followed in the event the facility ceases operation. The records for which this requirement applies are as follows:

- a) The annual financial statement described in Section 300.210 of this Part.
- b) The minutes of resident advisory council meetings required by Section 300.640(k) of this Part.
- c) The records of in-service training required by Section 300.650(b) (3) of this Part.

- d) Copies of reports of serious incidents or accidents involving residents required by Section 300.690 of this Part.
- e) Records of the emergency medication kit review by the pharmaceutical advisory committee required by Section 300.1610(i)(3) of this Part.
- f) The reports of findings and recommendations from consultants required in Section 300.1880(a) of this Part.
- g) Copies of the quarterly reports for all employees that are filed for Social Security and Unemployment Compensation as required by Section 300.1880(d) of this Part.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.1880 Other Facility Record Requirements

- a) The facility shall maintain a file of reports of findings and recommendations from consultants. Each report shall be dated and indicate each specific date and time the consultant was in the facility.
- b) The facility shall complete the Illinois Department of Public Health Annual Long Term Care (LTC) Facility Survey.
- c) The facility shall maintain a permanent chronological resident registry showing date of admission, name of resident and date of discharge or death.
- d) The facility shall make available to the Department upon request copies of the quarterly reports for all employees that are filed for Social Security and Unemployment Compensation.
- e) Rules located in other Sections of this Part that pertain to the content and maintenance of facility records are as follows:
 - 1) The facility shall file an annual financial statement as described in Section 300.210 of this Part.
 - 2) Records and daily time schedules shall be kept on each employee as set forth in Section 300.650(a) and (b) of this Part.
 - 3) The facility shall maintain a controlled substances record as described in Section 300.1650(d) of this Part.

- 4) Menu and food purchase records shall be maintained as set forth in Section 300.2080(d) and (f) of this Part.
- 5) The facility shall maintain a file of all reports of serious incidents or accidents involving residents as required by Section 300.690 of this Part.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.2010 DIRECTOR OF FOOD SERVICES**

Section 300.2010 Director of Food Services

- a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.
 - 1) This person shall be either a dietitian or a dietetic service supervisor.
 - 2) The person responsible for the food service may assume some cooking duties but only if these duties do not interfere with the responsibilities of management and supervision.

- b) If the person responsible for food service is not a dietitian, the person shall have frequent and regularly scheduled consultation from a dietitian. Consultation, given in the facility, shall include training, as needed, in areas such as menu planning and review, food preparation, food storage, food service, safety, food sanitation, and use of food equipment. Clinical management of therapeutic diets shall also be included in consulting, covering areas such as tube feeding; nutritional status and requirements of residents, including weight, height, hematologic and biochemical assessments; physical limitations; adaptive eating equipment; and clinical observations of nutrition, nutritional intake, resident's eating habits and preferences, and dietary restrictions.
 - 1) Intermediate care facilities: A minimum of eight hours of consulting time per month shall be provided for facilities with 50 or fewer residents. An additional four minutes of consulting time per month shall be provided per resident over 50 residents, based on the average daily census for the previous year.
 - 2) Skilled nursing facilities: A minimum of eight hours of consulting time per month shall be provided for facilities with 50 or fewer residents. An additional five minutes of consulting time per month shall be provided per

resident over 50 residents, based on the average daily census for the previous year.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.2020 Dietary Staff in Addition to Director of Food Services

There shall be sufficient number of food service personnel employed and on duty to meet the dietary needs of all persons eating meals in the facility. Their working hours shall be scheduled to meet the total dietary needs of the residents. All dietary employees' time schedules and work assignments shall be posted in the kitchen. Dietary duties and job procedures shall be available in the dietary department for employees' knowledge and use. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2030 Hygiene of Dietary Staff

Food service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2040 Diet Orders

- a) Two or more copies of a current diet manual shall be available and in use. One copy shall be located in the kitchen for use by dietary personnel. Other copies shall be located at each nurses' station for use by physicians when prescribing diets.
- b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered.
- c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is changed. Each change shall be ordered by the physician. The diet order shall include, at a minimum, the following information: name of resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to dietary, name of physician ordering the diet, and the signature of the person transmitting the order to the food service department.

- d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record.
- e) A therapeutic diet means a diet ordered by the physician as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).
- f) All therapeutic diets shall be medically prescribed and shall be planned or approved by a dietitian.
- g) The kinds and variations of prescribed therapeutic diets shall be available in the kitchen. If separate menus are not planned for each specific diet, diet information for each specific type, in a form easily understood by staff, shall be available in a convenient location in the kitchen.
- h) All oral liquid diets shall be reviewed every 48 hours. Medical soft diets, sometimes known as transitional diets, shall be reviewed every three weeks. All other therapeutic and mechanically altered diets, including commercially prepared formulas that are in liquid form and blenderized liquid diets, shall be reviewed as needed, or at least every three months.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.2050 Meal Planning

Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the following Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

- a) Milk and Milk Products Group: 16 ounces or more of Grade A whole or low fat pasteurized milk where milk is used for fluid consumption.
Calcium equivalents for eight ounces of milk:
 - 1) 1½ ounces natural cheese,
 - 2) Two ounces processed cheese,
 - 3) One cup yogurt, or one cup frozen yogurt,
 - 4) One cup cottage cheese, or
 - 5) 1½ cups ice cream or ice milk.

b) Meat Group: A total of 6 ounces (by weight) of good quality protein to provide 38 to 42 grams of protein daily. To ensure variety, food items repeated within the same day shall not be counted as meeting a required serving. The following are examples of one serving.

- 1) Three ounces (excluding bone, fat and breading) of any cooked meat such as whole or ground beef, veal, pork or lamb; poultry; organ meats such as liver, heart, kidney; prepared luncheon meats.
- 2) Three ounces (excluding skin and breading) of cooked fish or shell fish or ½ cup canned fish.
- 3) Three ounces of natural or processed cheese or ¾ cup cottage cheese.
- 4) Three eggs (minimum weight 21 ounces per dozen, considered a medium egg).

Note: If one egg is served at a meal, a protein food of good quality may be reduced from six to five ounces for the remaining meals. If two eggs are served at a meal, a minimum of two ounces of good quality protein shall be served at each of the remaining meals.

- 5) 1½ cups cooked dried peas or beans, six tablespoons of peanut butter, or one cup nuts, not more than twice a week and provided that eggs, milk or lean meat is served at the same meal.
- 6) Three ounces of soy protein containing not less than 21 grams of protein or in combination with other sources of quality protein to equal 21 grams of protein, provided that it is acceptable to the resident population.
- 7) Combinations of all above examples are acceptable, provided that the minimum standard of six ounces of a good quality protein food is served daily and provided that the combinations do not conflict with eye appeal or palatability.
- 8) The content of meat alternative products shall be listed on the menu.

c) Vegetable and Fruit Group: Five or more servings of fruits or vegetables.

- 1) A serving consists of:

- A) $\frac{1}{2}$ cup chopped raw, cooked, canned or frozen fruit or vegetables;
 - B) $\frac{3}{4}$ cup fruit or vegetable juice; or
 - C) One cup raw leafy vegetable.
- 2) The five or more servings shall consist of:
- A) Sources of vitamin C
 - i) One serving of a good source of vitamin C (containing at least 60 mg of vitamin C); or
 - ii) Two servings of a fair source of vitamin C. This may be more than one food item and shall contain a total of at least 65 mg of vitamin C.
 - B) One serving of a good source of vitamin A at least three times a week supplying at least 1000 micrograms retinol equivalent (RE) of vitamin A.
 - C) Other fruits and vegetables, including potatoes, that may be served in $\frac{1}{3}$ cup or larger portions.
- 3) To ensure variety, food items repeated within the same day shall not be counted as meeting a required serving.
- d) Bread, Cereal, Rice and Pasta Group: Six or more servings of whole grain, enriched or restored products. One serving equals:
- 1) One slice of bread,
 - 2) $\frac{1}{2}$ cup of cooked cereal, rice, pasta, noodles, or grain product,
 - 3) $\frac{3}{4}$ cup of dry, ready-to-eat cereal,
 - 4) $\frac{1}{2}$ hamburger or hotdog bun, bagel or English muffin,
 - 5) One 4-inch diameter pancake,
 - 6) One tortilla,
 - 7) Three to four plain crackers (small),
 - 8) $\frac{1}{2}$ croissant (large), doughnut or danish (medium),

- 9) $\frac{1}{16}$ cake,
 - 10) Two cookies, or
 - 11) $\frac{1}{12}$ pie (2-crust, 8").
- e) Butter or Margarine: To be used as a spread and in cooking.
- f) Other foods shall be served to round out meals, satisfy individual appetites, improve flavor, and meet the individual's nutritional and caloric needs.
- g) Meals for the day shall be planned to provide a variety of foods, variety in texture and good color balance. The following meal patterns shall be used.
- 1) Three meals a day plan:
 - A) Breakfast: Fruit or juice, cereal, meat (optional, but three to four times per week preferable), bread, butter or margarine, milk, and choice of additional beverage.
 - B) Main Meal (may be served noon or evening): Soup or juice (optional), entree (quality protein), potato or potato substitute, vegetable or salad, dessert (preferably fruit unless fruit is served as a salad or will be served at another meal), bread, butter or margarine, and choice of beverage.
 - C) Lunch or Supper: Soup or juice (optional), entree (quality protein), potato or potato substitute (optional if served at main meal), vegetable or salad, dessert, bread, butter or margarine, milk, and choice of additional beverage.
 - 2) Other meal patterns may be used if facilities are able to meet residents' needs using such plans.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.2060 Therapeutic Diets (Repealed)

(Source: Repealed at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.2070 Scheduling Meals

- a) A minimum of three meals or their equivalent shall be served daily at regular times with no more than a 14 hour span between a substantial evening meal and breakfast. The 14 hour span shall not apply to facilities using the "four or five meal-a-day" plan, provided the evening meal is substantial and includes, but is not limited to, a good quality protein, bread or bread substitute, butter or margarine, a dessert and a nourishing beverage.
- b) Bedtime snacks of nourishing quality shall be offered. Snacks of nourishing quality shall be offered between meals when there is a time span of four or more hours between the ending of one meal and the serving of the next, or as otherwise indicated in the resident's plan of care.
- c) If a resident refuses food served, reasonable and nutritionally appropriate substitutes shall be served.

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.2080 Menus and Food Records

- a) Menus, including menus for "sack" lunches and between meal or bedtime snacks, shall be planned at least one week in advance. Food sufficient to meet the nutritional needs of all the residents shall be prepared for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value and shall be recorded on the original menu, or in a notebook marked "Substitutions", that is kept in the kitchen. If a notebook is used to document substitutions, it shall include the date of the substitution; the meal at which the substitution was made; the menu as originally written; and the menu as actually served.
- b) The menu for the current week shall be dated and available in the kitchen. Upon the request of the Department, sample menus shall be submitted for evaluation.
- c) Menus shall be different for the same day of consecutive weeks and adjusted for seasonal differences.
- d) All menus as actually served shall be kept on file at the facility for not less than 30 days.
- e) Food label information for purchased prepared food listing food composition and, when available, nutrient content shall be kept on file in the facility for the current menu cycle.

- f) Supplies of staple foods for a minimum of a one week period and of perishable foods for a minimum of a two day period shall be maintained on the premises. These supplies shall be appropriate to meet the requirements of the menu.
- g) Records of all food purchased shall be kept on file for not less than 30 days.

(Source: Amended at 23 Ill. Reg. 8106, effective July 15, 1999)

Section 300.2090 Food Preparation and Service

- a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use.
- b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs. (B)
- c) All residents shall be served in a dining room or multi-purpose room except for an individual with a temporary illness, who is too ill, or for other valid reasons.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2100 Food Handling Sanitation

Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750).

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2110 Kitchen Equipment, Utensils, and Supplies

Each facility shall provide an adequate number of dishes, glassware, and silverware of a satisfactory type to serve all the residents in the facility at each meal.

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

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CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.2210 MAINTENANCE**

Section 300.2210 Maintenance

- a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.
- b) Each facility shall: (B)
 - 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. (B)
 - 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. (A, B)
 - 3) Maintain all electrical cords and appliances in a safe and functioning condition. (B)
 - 4) Maintain the interior and exterior finishes of the building as needed to keep it attractive and clean and safe (painting, washing, and other types of maintenance).
 - 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition.
 - 6) Maintain the grounds and other buildings on the grounds in a safe, sanitary and presentable condition. (B)
 - 7) Maintain the grounds free from refuse, litter, insect and rodent breeding areas.

- 8) The building and grounds shall be kept free of any possible infestations of insects and rodents by eliminating sites of breeding and harborage inside and outside the building; eliminating sites of entry into the building with screens of not less than 16 mesh screen to the inch and repair of any breaks in construction. (B)
- 9) Maintain all plumbing fixtures and piping in good repair and properly functioning. (B)
- 10) Protect the potable water supply from contamination by providing and properly installing adequate, backflow protection devices or providing adequate air gaps on all fixtures that may be subject to backflow or back siphonage.

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

Section 300.2220 Housekeeping

- a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall: (B)
 - 1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors, attics, basements, and storage areas. (B)
 - 2) Keep floors clean, as nonslip as possible, and free from tripping hazards including throw or scatter rugs.
 - 3) Control odors within the housekeeping staff's areas of responsibility by effective cleaning procedures and by the proper use of ventilation systems. Deodorants shall not be used to cover up persistent odors caused by unsanitary conditions or poor housekeeping practices.
- b) Attics, basements, stairways, and similar areas shall be kept free of accumulations of refuse, discarded furniture, old newspapers, boxes, discarded equipment, and other items. (B)
- c) Bathtubs, shower stalls, and lavatories shall not be used for laundering, janitorial, or storage purposes.
- d) All cleaning compounds, insecticides, and all other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24 1989)

Section 300.2230 Laundry Services

- a) Every facility shall have an effective means of supplying an adequate amount of clean linen for operation, either through an in-house laundry or a contract with an outside service.
 - 1) An adequate supply of clean linen shall be defined as the three sets of sheets, draw sheets, and pillow cases required to provide for the residents' needs. Additional changes of linen may be required in consideration of the time involved for laundering and transporting soiled linens.
 - 2) If an in-house laundry service is provided then the following conditions shall exist:
 - A) The laundry area shall be maintained and operated in a clean, safe and sanitary manner. No part of the laundry shall be used as a smoking or dining area.
 - B) Written operating procedures shall be developed, posted and implemented which provide for the handling, transport and storage of clean and soiled linens.
 - C) Laundry personnel must be in good health and practice good personal grooming. Employees must thoroughly wash their hands and exposed portions of their arms with soap and warm water before starting work, during work as often as necessary to keep them clean and after smoking, eating, drinking, using the toilet and handling soiled linens.
 - D) Clean linen shall be protected from contamination during handling, transport and storage.
 - E) Soiled linen shall be handled, transported and stored in a manner that protects facility residents and personnel.
 - F) If supplies and equipment not directly connected with the operation of the laundry are stored in the laundry or its accessory storage and handling areas, they shall be protected from contamination by the soiled linens and shall not contribute to contamination of the clean linens.

- b) If an outside laundry service is used it shall comply with the requirements of in-house laundries and, in addition, shall provide for protection of clean linens during transport back to the facility.
- c) If the facility provides laundry service for residents' personal clothing it must be handled, transported and stored in a manner that will not allow contamination of clean linen or allow contamination by soiled linen. The facility shall assure that the personal clothing of each resident is returned to that individual resident after laundering.

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

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SECTION 300.2410 FURNISHINGS**

Section 300.2410 Furnishings

- a) Each resident shall be provided with a separate bed suitable to meet the needs of the resident. Each bed shall be at least 36 inches wide, have a headboard, be of sturdy construction and in good repair. A double bed shall be provided for married couples, if they request this arrangement, and there are no medical contraindications.
- b) Each bed shall be provided with satisfactory type springs in good repair and a clean, firm, comfortable mattress of appropriate size for the bed.
- c) Each bedroom shall have window shades, or equivalent, in good repair.
- d) A satisfactory reading lamp, or equivalent, shall be provided for each bed.
- e) Pillows
 - 1) Each bed shall be provided with a minimum of one clean, comfortable pillow.
 - 2) There shall be additional pillows available in the home to satisfactorily serve the needs of the residents.
- f) Each bedroom shall be provided with a mirror, unless there is a mirror in a bathroom opening into this bedroom. Each lavatory shall be provided with a mirror.
- g) Each living room for residents use shall be provided with an adequate number of reading lamps, tables, and chairs or settees. These furnishings shall be well constructed and of satisfactory design for the residents.
- h) Dining room furnishings shall be provided for each resident which are well constructed, comfortable, in good repair, and of satisfactory design for the

residents. There shall be a sufficient number of tables, of a type that can be used by wheelchair residents, to accommodate all such residents in the facility.

- i) Office spaces, nurses' stations, treatment rooms, and other areas shall be satisfactorily furnished with desks, chairs, lamps, cabinets, benches, work tables, and other furnishings essential to the proper use of the area.
- j) For each bed there shall be furnished:
 - 1) A minimum of two adequately sized dresser drawers.
 - 2) A comfortable chair.
 - 3) An individual towel rack.
 - 4) A satisfactory reading light over, or at the side of, the bed.
 - 5) Adequate closet, locker, or wardrobe space for hanging clothing within the room.
 - 6) A satisfactory bedside cabinet.
- k) A sufficient number of tables that can be either rolled over the resident's bed or that can be placed next to bed shall be provided to serve every resident who cannot, or does not, eat in a dining room or area.
- l) Provide proper storage in each resident's room, either within the bedside cabinet or in a separate cabinet, for individual equipment such as an emesis basin, bedpan, urinal, washbasin. Such storage need not be provided in the resident's room if it is satisfactorily provided in a connecting bath or toilet room.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2420 Equipment and Supplies

- a) Equipment
 - 1) The facility shall have a supply of thermometers, emesis basins, ice bags, hot water bottles or equivalent, bedpans, urinals, and sets of enema equipment, sufficient to meet the needs of its residents. (B)
 - 2) If the facility has residents who need the services of a suction machine, a sufficient quantity of such machines shall be provided to meet the needs of all such residents. (B)

- b) Privacy Screens and Curtains
 - 1) There shall be at least one privacy screen available in the facility for emergency use when resident privacy is needed.
 - 2) Each multiple-bed resident room must be designed or equipped to assure full visual privacy for each resident. Full visual privacy means that residents have a means of completely withdrawing from view while occupying their beds (e.g., curtains, movable screens).
- c) There shall be a sufficient supply of clean linen and bedding in good condition to provide proper care and comfort to the residents. (B)
- d) There shall be a first-aid kit or emergency box in every facility. This shall contain bandages, sterile gauze dressing, bandage scissors, tape, sling, burn ointment, and other equipment deemed necessary by the advisory physician or the medical advisory committee.
- e) Activity program supplies shall be provided to maintain an ongoing program to meet the varied interests and needs of the residents. These shall include, but are not limited to, games, craft supplies, current magazines, books, radio, television, and record player. A piano or organ is recommended as an important adjunct to the activity program equipment.
- f) Kitchen equipment shall be provided as set forth in Section 300.2100.
- g) Cleaning equipment and supplies shall be provided as set forth in Sections 300.2210 through 300.2220.
- h) Each resident shall have a satisfactory nurse call device. (See Sections 300.2940(g) and 300.3140(e).)
- i) There shall be special equipment, implements, or utensils provided to residents as needed to assist them when eating.
- j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys.

(Source: Amended at 16 Ill. Reg. 5977, effective March 27, 1992)

Section 300.2430 Sterilization of Equipment and Supplies

- a) Every facility shall follow an acceptable plan to provide for sterile equipment and supplies, such as needles, syringes, catheters, and dressing. There shall be an autoclave available for sterilizing this type of equipment and supplies. The autoclave should be located in a central sterilization area, or clean utility area. It may be located at the nurses' station. An autoclave will not be required in a facility when other acceptable arrangements have been made, such as: (A, B)
 - 1) Use of individually wrapped sterile dressings, disposable syringes, needles, catheters, and gloves which shall be disposed of after a single use.
 - 2) Formal plan with another facility for the autoclaving of equipment and supplies.
 - 3) Other alternative methods when approved on an individual basis in writing from the Department based on a written request from the facility giving in detail the method proposed to be used and which method meets equivalent criteria for proper sterilization for these items to be sterilized.

- b) Every facility shall sanitize bed pans, urinals, wash basins, emesis basins, enema equipment, and similar patient care utensils as follows:
 - 1) Individual bed pans, urinals, wash basins, and similar equipment shall be washed and rinsed after each use, and be sanitized at least weekly. If individual equipment is not provided, the equipment shall be washed, rinsed, and sanitized after each use. (B)
 - 2) Utensils shall be pre-flushed prior to washing. Utensils shall be washed in a hot detergent solution that is maintained clean. After washing, utensils shall be rinsed free of detergents with clean water.
 - 3) Utensils shall be sanitized, either mechanically or manually, through the use of steam, hot water, or chemicals approved by the U.S. Environmental Protection Agency and formulated for the sanitization of patient care utensils. Chemical sanitizers shall be used in accordance with label instructions.
 - 4) Patient care utensils sanitization shall be completed in the soiled utility room. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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SECTION 300.2610 CODES

Section 300.2610 Codes

Water supply, sewage disposal and plumbing systems shall comply with all applicable State and local codes and ordinances. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2620 Water Supply

- a) Each facility shall be served by water from a municipal public water supply when available. (B)
- b) When a municipal public water supply is not available, the water supply shall comply with the Department's rules entitled "Drinking Water Systems" (77 Ill. Adm. Code 900). (B)
- c) If water is supplied by a well that is not part of a municipal system, the well shall be constructed and maintained in accordance with the Department's rules entitled "Illinois Water Well Construction Code" (77 Ill. Adm. Code 920) and "Water Well Pump Installation Code" (77 Ill. Adm. Code 925).
- d) Each facility shall have a written agreement with a water company, dairy, or other water purveyor to provide an emergency supply of potable water for drinking and culinary purposes.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2630 Sewage Disposal

- a) All sewage and liquid wastes shall be discharged into a public sewage system when available. (B)
- b) When a public sewage system is not available, sewage and liquid wastes shall be collected, treated, and disposed of in a private sewage disposal system. The design, construction, maintenance, and operation of the system shall comply with the Department's rules entitled "Private Sewage Disposal Code" (77 Ill. Adm. Code 905). (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2640 Plumbing

Each plumbing system shall comply with the Department's rules entitled "Illinois Plumbing Code" (77 Ill. Adm. Code 890) effective at the time of construction or approved acceptance by the Department.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

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SECTION 300.2810 APPLICABILITY OF THESE STANDARDS

Section 300.2810 Applicability of these Standards

- a) Applicability of New Construction Requirements
 - 1) These standards shall apply to all new Long-Term Care Facilities and major alterations and additions to existing Long-Term Care Facilities. (Major alterations are those that are not defined as minor alterations in subsection (f) of this Section.) Long-Term Care Facilities contemplating construction shall contact the Health Facilities Planning Board for information concerning the current requirements.
 - 2) Projects for which working drawings and specifications have received final approval by the Department prior to the promulgation of these Standards will only be required to meet those Standards that were in effect at the time that the final approval was given.
- b) When construction is contemplated, either for new buildings or additions or major alterations to existing buildings coming within the scope of these standards, design development drawings and outline specifications shall be submitted to the Department for review. Approval of design development drawings and specifications shall be obtained from the Department prior to starting final working drawings and specifications. Such approval will be based upon compliance with Section 300.2830. Comments or approval will be provided within 30 days of receipt by the Department.
- c) The final working drawings and specifications shall be submitted to the Department for review and approval prior to beginning of construction. For final approval to remain valid, contracts must be signed within one year of the date of final approval. Alternate methods of design development and construction such as fast track shall be acceptable if equivalency can be proved. Comments of approval will be provided within thirty days of receipt by the Department.

- d) Any contract modifications which affect or change the function, design, or purpose of a facility shall be submitted to the Department for approval prior to authorizing the modifications. Such approval will be based upon compliance with Section 300.2830. Comments or approval will be provided within 30 days of receipt by the Department.
- e) The Department shall be notified at least 30 days before construction has been completed. The Department will then complete a final inspection. Deficiencies noted during the final inspection must be completed before occupancy will be allowed.
- f) Minor alterations or remodeling changes which do not affect the structural integrity of the building, which do not change functional operation, which do not affect fire safety, and which do not add beds or facilities over those for which the Long-Term Care Facility is licensed need not be submitted for drawing approval. However, the Health Facilities Planning Board requirements must be met for all alterations and remodeling projects.
- g) No system of water supply, plumbing, sewage, garbage or refuse disposal shall be installed, nor any such existing system materially altered or extended until complete plans and specifications for the installation, alteration or extension have been submitted to the Department and have been reviewed and approved. Such approval will be based upon compliance with Section 300.2820.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2820 Codes and Standards

- a) Each facility shall comply with the applicable provisions of the following codes and standards. Any incorporation by reference in this Section of federal regulations or of any standards of a nationally recognized organization or association refers to the regulations and standards on the date specified and does not include any editions or amendments subsequent to the date specified.
 - 1) State of Illinois rules
 - A) Illinois Plumbing Code (77 Ill. Adm. Code 890),
Department of Public Health
 - B) Illinois Accessibility Code (71 Ill. Adm. Code 400), Capital
Development Board
 - C) Food Service Sanitation Code (77 Ill. Adm. Code 750),
Department of Public Health

- D) Boiler and Pressure Vessel Safety Code (41 Ill. Adm. Code 120), Office of the State Fire Marshal
- 2) Codes and standards
- A) National Fire Protection Association (NFPA), Standard No. 101: Life Safety Code, 2000 Edition (New Health Care Occupancies), including all appropriate references under Chapter 33, and excluding Chapter 5, Performance Based Options, and all other references to performance based options. NFPA 101A: Alternative Approaches to Life Safety shall not be allowed to establish equivalencies for new construction. In addition to the publications referenced in Chapter 33, the following documents shall be applicable for all long-term care facilities:
 - i) NFPA 17A, Standard for Wet Chemical Extinguishing Systems – 2002 Edition
 - ii) NFPA 20, Standard for the Installation of Stationary Pumps for Fire Protection – 1999 Edition
 - iii) NFPA 22, Standard for Water Tanks for Private Fire Protection – 1998 Edition
 - iv) NFPA 24, Standard for the Installation of Private Fire Service Mains and Their Appurtenances – 2002 Edition
 - v) NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites – 2001 Edition
 - vi) NFPA 70B, Recommended Practice for Electrical Equipment Maintenance – 2002 Edition
 - vii) NFPA 70E, Standard for Electrical Safety Requirements for Employee Workplaces – 2000 Edition
 - viii) NFPA 80A, Recommended Practice for Protection of Buildings from Exterior Fire Exposures – 2001 Edition

- ix) NFPA 105, Recommended Practice for the Installation of Smoke-Control Door Assemblies – 1999 Edition
 - B) Underwriters' Laboratories, Inc. (UL):
 - i) Fire Resistance Directory (2003 Edition)
 - ii) Building Material Directory (2003 Edition)
 - C) American Society for Testing and Materials (ASTM) International, Standard No. E90-02 (1996), Standard Test Method for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions and Elements
 - D) American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE):
 - i) Handbook of Fundamentals, 2001
 - ii) Handbook of Applications, 1999
 - E) International Building Code (2000)
 - F) American Society of Mechanical Engineers (ASME) International, ANSI/ASME Standard No. A17.1-2000, Safety Code for Elevators and Escalators
- b) In addition to compliance with the standards set forth in this Section, all building codes, ordinances and regulations that are enforced by city, county or other local jurisdictions in which the facility is, or will be, located shall be observed.
- c) Where no local building code exists, the recommendations of the 2000 Edition of the International Building Code shall apply.
- d) The local building code or the recommendations of the 2000 Edition of the International Building Code shall apply insofar as such recommendations are not in conflict with the standards set forth in this Part, or with the National Fire Protection Association Standard No. 101: Life Safety Code, 2000.
- e) Amendments to this Section effective November 15, 2003 supersede all other codes and standards incorporated in this Subpart N.

(Source: Expedited Correction at 28 Ill. Reg. 3528, effective November 15, 2003)

Section 300.2830 Preparation of Drawings and Specifications

- a) The preparation of drawings and specifications shall be executed by or be under the immediate supervision of an architect registered in the State of Illinois:
- b) The first submission shall be the design development drawings indicating in detail the assignment of all spaces, size or areas and rooms, and indicating in outline, the fixed and movable equipment and furniture, and the outline specifications.
- c) The plans shall be drawn at a scale sufficiently large to clearly present the proposed design.
- d) The drawings shall include:
 - 1) a plan of each floor including the basement or ground floor,
 - 2) roof plan,
 - 3) plot plan showing roads, parking areas, and sidewalks,
 - 4) elevations of all facades,
 - 5) sections through the building,
 - 6) identification of all fire and smoke compartmentation.
- e) Outline specifications shall provide a general description of the construction including finishes; acoustical material, floor covering; heating and ventilating systems; description of the electrical system including the emergency electrical system and the type of elevators.
- f) The total gross floor area and bed count shall be shown on the drawings.
- g) A brief narrative of the proposed program shall be submitted with the preliminary drawings and outline specifications.
- h) Following approval of the design development drawings and the outline specifications, working drawings and specifications shall be submitted. All working drawings shall be well prepared and clean and distinct prints shall be submitted. Drawings shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. Working drawings shall be complete and adequate for contract purposes. Drawings shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Plumbing.

- 1) The architectural drawings shall show:
 - A) Site plan showing all topography, newly established levels and grades, existing structures on the site (if any), new buildings and structures, roadways, walks, and the extent of the areas to be landscaped. All structures which are to be removed under the construction contract shall be shown.
 - B) Plan of each floor and roof.
 - C) Elevation of each facade.
 - D) Sections through building.
 - E) Elevators and dumbwaiters drawings delineating shaft details and dimensions, sizes of cab platforms and doors, travel distances including elevation height of landings, pit sizes, and machine rooms.
 - F) Kitchen, laundry, clean and soiled utility room, special care areas, and similar areas detailed at a scale to show the locations, type, size and connection of all fixed and movable equipment.
 - G) Scale details as necessary at a scale sufficiently large to properly indicate details of the work.
 - H) Schedule of finishes.
- 2) The structural drawings shall show:
 - A) Plans of foundations, floors, roofs and all intermediate levels shall show the complete design with sizes, sections, and the relative location of the various members including:
 - B) Schedule of beams, girders and columns.
 - C) Notes on design data including the name of the governing building code, values of allowable unit stresses, assumed live loads, wind loads, earthquake load, and soil bearing pressures.
 - D) Details of special connections, openings, pipe sleeves and expansion joints.

- E) Special structures shall include calculations defining load assumption, shear and moment diagrams and horizontal and vertical reactions.
- 3) Mechanical drawings with specifications shall show the complete heating, cooling and ventilation systems; plumbing, drainage, stand pipe, and sprinkler systems.
- A) Heating, Cooling and Ventilation.
 - i) Pumps, tanks, boilers and piping and boiler room accessories.
 - ii) Air conditioning systems with required equipment, water and refrigerant piping, and ducts.
 - iii) Supply and exhaust ventilating systems with connections and piping.
 - iv) Air quantities for all rooms including supply and exhaust ventilating duct openings.
 - B) Plumbing, Drainage and Stand Pipe Systems.
 - i) Size and elevation of: street sewer, house sewer, house drains, street water main and water service into the building.
 - ii) Location and size of soil, waste, and vent stacks with connections to house drains, cleanouts, fixtures and equipment.
 - iii) Size and location of hot, cold and circulating mains, branches, and risers from the service entrance, and tanks.
 - iv) Riser diagram of all plumbing stacks with vents, water risers and fixture connections.
 - v) Gas, oxygen and similar piped systems.
 - vi) Stand pipe and sprinkler systems.
 - vii) All fixtures and equipment that require water and drain connections.

- 4) Electrical drawings shall show all electrical wiring, outlets, and equipment which require electrical connections.
 - A) Electrical service entrance with switches and feeders to the public service feeders, characteristics of the light and power current, transformers and their connections.
 - B) Location of main switchboard, power panels, light panels and equipment. Feeder and conduit sizes shall be shown with schedule of feeder breakers or switches.
 - C) Light outlets, receptacles, switches, power outlets, and circuits.
 - D) Telephone layout showing service entrance, telephone switchboard, strip boxes, telephone outlets and branch conduits as approved by the telephone company. Where public telephones are used for inter-communication, provide separate room and conduits for racks and automatic switching equipment as required by the telephone company.
 - E) Nurses' call systems with outlets for beds, duty stations, corridor signal lights, annunciators and wiring diagrams.
 - F) Fire alarm system with stations, signal devices, control board and wiring diagrams.
 - G) Emergency electrical system with outlets, transfer switch, source of supply, feeders, and circuits.
 - H) All other electrically operated systems and equipment.
- 5) When the project is an addition, details and information on the existing building shall be provided as follows:
 - A) Type of activities within the existing building and distribution of existing beds.
 - B) Type of construction of existing building and number of stories in height.
 - C) Plans and details showing attachment of new construction to the existing structure.

- D) Mechanical and Electrical systems showing connections to the existing system.
 - E) The Department may require submission of drawings of all or any part of the existing structure, depending upon the extent of the modification.
- 6) Specifications shall supplement the drawings and shall: Describe, except where fully indicated and described on the drawings, the materials, workmanship, kind, sizes, capacities, finishes, and other characteristics of all materials, products, articles and devices.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2840 Site

- a) The facility shall be located on a reasonably flat or rolling, well drained site that is not subject to flooding; reasonably free from sources of excessive noise, noxious or hazardous smoke or fumes; not in deteriorated, unpleasant, or potentially hazardous area; and not near uncontrolled sources of insect and rodent breeding.
- b) The facility shall be located so that the building or buildings can comply with all applicable local zoning ordinances, building restrictions and fire safety requirements. The Department may have additional requirements if the proposed locations of the building or buildings on the site would result in a hazard to or be detrimental to the health, welfare, or safety of the residents in the facility. These additional requirements shall include, but are not limited to fences, stairs, and other types of barriers to prevent residents from injury.
- c) The facility shall be served by a potable water supply with water pressure and volume that is acceptable to the Department. (B)
- d) The distance from the fire station, the accessibility of the facility, and capability of the fire department must be approved in writing by the Office of the State Fire Marshal. (B)
- e) The facility shall have at least one municipal or private fire hydrant, located within 300 feet of every point on the perimeter of the building and satisfactory for use by the equipment of the fire department serving the building, or have an acceptable equivalent. Additional hydrants may be required if needed to properly protect the residents from fire hazards. Evaluation and written approval must be obtained from the Office of the State Fire Marshal. (B)

- f) Plans showing the proposed building location must be submitted to the Illinois Department of Transportation, Division of Water Resources to determine compliance with the State Flood Plain Regulations and Executive Order IV, 1979.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2850 Administration and Public Areas

- a) Facilities for the physically handicapped (public, staff and residents) shall be provided in administration and public areas as well as in resident areas.
- b) Lobby shall include a reception and information counter or desk, waiting space, and public telephones. See Illinois Plumbing Code for drinking fountains and toilet facilities requirements for staff and visitors.
- c) General or Individual Office shall have sufficient space to accommodate the following functions: Administrative, Business/Financial Transactions, Professional Staff (Director of Nursing, Food Service Supervisor, Activity Director, Social Service Director), and Professional Consultants (Medical Director, Pharmacist, Dietitian, Social Worker).
- d) Multipurpose room shall be provided for conferences, meetings, interviews, and educational purposes.
- e) Provide adequate space for recording, reviewing and storing resident records.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2860 Nursing Unit

- a) The number of resident beds in a nursing unit shall not exceed 75 beds.
 - 1) Not less than 60 percent of the resident beds shall be in one or two bed rooms.
 - 2) Not less than three percent of the total number of the beds in the facility shall be located in single bed rooms with a private bath, water closet and lavatory.
- b) General Requirements for Bedrooms

- 1) Resident bedrooms shall have an entrance directly off a corridor with an entrance door which swings into the room.
 - 2) Resident bedrooms shall have adequate and satisfactory artificial light and be equipped in accordance with Section 300.2940(a)2) and (e)(1).
 - 3) Residents shall have access to a toilet room without entering the general corridor area.
 - 4) The facility shall provide a closet or wardrobe of at least four square feet for each resident.
 - 5) Resident bedroom floors shall be at or above grade level.
 - 6) Each room used as a resident bedroom shall have at least one outside window, and a total window area to the outside equal to at least one-tenth the floor area of the room.
 - 7) A nurses' call system shall be provided in accordance with Section 300.2940(g). (B)
 - 8) Complete visual privacy shall be provided for each resident in multibed rooms. Design for privacy shall not restrict resident access to the entry, lavatory, nor toilet.
 - 9) No resident bedroom shall be located more than 120 feet from the nurses' station, clean utility room, and soiled utility room.
- c) Resident Bedrooms
- 1) Single resident bedrooms shall contain at least 100 square feet. Multiple resident bedrooms shall contain at least 80 square feet per bed. Minimum usable floor area shall be exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, or clearly definable entryways.
 - 2) Multiple resident bedrooms shall not have more than four beds nor more than three beds deep from an outside wall. All beds shall have a minimum clearance of three feet at the foot and sides of the bed.
- d) Special Care Room
- 1) The facility shall provide a special care room for each nursing unit.

- 2) This room shall be provided with a private toilet room containing water closet, lavatory, bathtub or shower and all other necessary facilities to meet the resident's needs. (B)
- 3) This room shall be located to allow direct visual supervision from the nurses' station.
- 4) This room shall be included in the authorized maximum bed capacity for the facility.
- 5) It is permissible for the room to be occupied by a resident, not in need of special care, provided the resident is clearly informed and understands he or she will be immediately transferred out of the room any time of day or night, whenever the room is needed to care for a resident requiring special care.

e) Nurses' Station (B)

- 1) The facility shall provide a minimum of one nursing station per unit with direct access to the corridor for each nursing unit. The location of this station shall allow visual control without the use of mirrors of each resident sleeping corridor. Separation shall be provided from the utility rooms.
- 2) One or more nursing units may be combined at a central nursing station if sufficient space is provided for all nursing functions.
- 3) A lounge with toilet room shall be provided near each station for nursing staff. Lockers for safekeeping of coats and personal effects may be provided within this space or in a convenient central location.

f) Bath and Toilet Rooms

- 1) The resident bedroom toilet room shall serve no more than two resident rooms nor more than eight beds. The toilet room shall contain a water closet and a lavatory. The lavatory may be omitted from the toilet room when the resident room contains a lavatory.
- 2) The facility shall provide one wheelchair resident toilet room for each sex residing in a nursing unit. The room shall be accessible from the corridor. This room shall contain a water closet and lavatory.
- 3) Wheelchair resident toilet rooms are not required when all resident toilet rooms can accommodate wheelchair residents.

- 4) The facility shall provide one training toilet room on each nursing floor, which is accessible from the corridor. Three-foot clearance at the front and both sides of the water closet shall be provided. This room shall contain a lavatory accessible for wheelchair use.
- 5) The facility shall provide one bathtub or shower for each ten resident beds per nursing unit which are not served by bathing or showering facilities in resident rooms.
- 6) All shower stalls for residents not needing assistance shall be at least three feet square and shall have no curb.
- 7) The facility shall provide at least one bathtub for assisted bathing per nursing unit. There shall be a clear area at least three feet wide at both sides and one end of the tub.
- 8) The facility shall provide at least one shower stall for assisted showering per nursing unit. The shower stall shall be at least four feet square with no curb.
- 9) The facility shall provide a toilet room with a water closet and lavatory, accessible to the assisted bathtub and shower without entering the general corridor. This room may be arranged to serve as the training toilet facility.
- 10) Grouped bathing and toilet facilities shall be partitioned or curtained for privacy.

g) Utility Rooms

- 1) The clean utility room shall have direct access to a corridor or access may be through the nurses' station entrance. This room shall contain work counters, single or double compartment sink with integral drainboard, storage cabinets, and an autoclave. (Autoclave may be waived in lieu of other methods if sterilization is approved by Department.)
- 2) A clean linen storage room or closet within the clean utility room shall be provided. If a closed cart system is used, storage may be in an alcove.
- 3) The soiled utility room shall have direct access to a corridor. This room shall contain work counters, storage cabinets, and a clinical rim flush sink. The room shall also contain a three compartment sink with integral drainboard if chemical sanitizing procedures are

used, or a double compartment sink with integral drainboard if a utensil sanitizer is used (See Section 300.2430).

- 4) The charging room for a linen chute shall be large enough to unload the collecting cart with the door closed.

h) Medication Facilities

- 1) A medication station shall be provided for convenient and prompt 24 hour distribution of medicine to residents. The medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A sink for handwashing and preparation of medication shall be provided in the medication preparation room.
- 2) If medicine dispensing carts are used, a specific storage space for the cart shall be provided, which may be located in the nurses' station or in an alcove or other space under the direct control of the nursing staff. A sink for handwashing and preparation of medication shall be provided in the nurses' station.

- i) A nourishment station shall be provided with a handwashing sink and equipment including refrigerator, and storage cabinets for serving nourishment between scheduled meals. Ice for residents' use shall be provided only by icemaker dispenser units.
- j) A room for examination and treatment of residents shall be provided and shall have a minimum floor area of 100 square feet, excluding space for vestibule, closets and work counters (whether fixed or movable). The minimum room dimension shall be ten feet. The room shall contain a lavatory or sink equipped for handwashing; a work counter; storage facilities; and a desk, counter, or shelf space for writing.
- k) An equipment storage room shall be provided for storage of equipment such as I.V. stands, inhalators, air mattresses, walkers, and wheelchairs.
- l) Parking space for wheelchairs shall be provided and located out of path of normal traffic.

(Source: Amended at 18 Ill. Reg. 1491, effective January 14, 1994)

Section 300.2870 Dining, Living, Activities Rooms

- a) The combined area of these rooms shall not be less than 25 square feet per resident bed.

- b) Provide a minimum of one dining room with at least ten square feet per resident bed. Provide facilities to allow individual feeding of residents on their sleeping floor if they are not able to feed themselves. Dining area provided for this function may be included in the required area.
- c) Provide a minimum of one comfortably furnished living room on each floor in multiple story buildings having a total window area of at least one-tenth the floor area.
- d) Provide activities room based on program requirements. This room may be combined with the living or dining room.
- e) Locate these rooms so that they are not an entrance vestibule from the outside.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2880 Therapy and Personal Care

- a) Physical and occupational therapy facilities shall be provided as may be required by Section 300.1420.
- b) A separate room shall be provided with appropriate equipment for hair care and grooming needs of the residents.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2890 Service Departments

- a) Dietary facilities shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750) Food service facilities shall be designed and equipped to meet the requirements of the Narrative Program. These may consist of an on-site conventional food preparing system, a convenience food service system, or an appropriate combination of the two. (B)
- b) The kitchen, consisting of food preparation, cooking and serving areas, shall be approximately ten square feet per resident bed with a minimum area of at least 200 square feet. It shall be properly located for efficient food service, and be large enough to accommodate the equipment and personnel needed to prepare and serve the number of meals required. (B)
- c) The following facilities shall be provided as required to implement the type of food service selected:
 - 1) A control station shall be provided for receiving food supplies.

- 2) Storage space shall be adequate to provide normal and emergency supply needs, approximately two and one half square feet per patient bed, for bulk and daily food storage, located in a room convenient to the kitchen.
- 3) Food Preparation Facilities Conventional food preparation systems require space and baking. Convenience food service systems such as frozen prepared meals, bulk packaged entrees, and individual packaged portions, or systems using contractual commissary service require space and equipment for thawing, portioning, heating, cooking, or baking.
- 4) Handwashing facilities shall be located in the food preparation area.
- 5) Residents' meal service facilities shall be provided as required for tray assembly and distribution.
- 6) Warewashing space shall be located in a room or an alcove separate from food preparation and serving areas. Commercial type dishwashing equipment shall be provided. Space shall also be provided for receiving, scraping, sorting, stacking and loading soiled tableware and for transferring clean tableware to the using areas. A handwashing lavatory shall be provided. (B)
- 7) Potwashing facilities shall be located conveniently for washing and sanitizing cooking utensils. (B)
- 8) Storage areas shall be provided for cans, carts, and mobile tray conveyors.
- 9) Waste storage facilities shall be located in a separate room easily accessible to the outside for direct pickup or disposal.
- 10) An office or desk space shall be provided for the dietitian or dietary service manager.
- 11) Toilets shall be accessible to the dietary staff. Handwashing facilities shall be immediately available.
- 12) A janitors' closet for the exclusive use of the food preparation areas shall be located within the dietary department. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

- 13) Self-dispensing icemaking facilities shall be provided.
 - 14) Provide adequate can, cart and mobile tray washing facilities as required.
- d) Linen Service
- 1) Provide a laundry room with commercial type equipment designed to meet the needs of the facility unless a commercial laundry service is used.
 - 2) The laundry facilities shall be designed to provide for the processing of linens from soiled linen receiving/sorting through washing, through drying, through clean linen inspection, folding and storage, maintaining a separation between soiled and clean functions.
 - 3) Provide for the storage of laundry supplies and carts.
 - 4) If washers and dryers are provided for personal use of residents, they shall be located in a room separate from the facility's laundry room.
- e) Housekeeping and Storage
- 1) Sufficient janitor's closets shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. Space for large housekeeping equipment and for back-up supplies may be centrally located.
 - 2) Provide a total area of approximately ten square feet per resident bed for the storage areas designated in this service department. This does not include closets or wardrobes in residents' rooms. Separate storage space with provisions for locking and security control shall be provided for residents' personal effects which are not kept in residents' bedroom.
 - 3) Provide storage rooms for maintenance supplies, and yard equipment.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2900 General Building Requirements

a) Elevators

- 1) Have a minimum of one elevator in all buildings of two or more stories in height. The basement shall be considered as one story if it is used by residents. (B)
- 2) If 80 to 200 beds are located above the first floor, at least one additional elevator shall be provided.
- 3) For facilities with more than 200 beds, the number of elevators shall be determined from a study of the use requirements and the estimated vertical transportation requirements.
- 4) A minimum of one car shall be of institutional type having inside dimensions that will accommodate a stretcher and attendants and shall be at least five feet by seven feet, six inches. The car door shall have a clear opening of not less than three feet, eight inches.
- 5) Elevators shall be equipped with an automatic leveling device of the two-way automatic maintaining type.
- 6) Elevator controls, alarm buttons, and telephones shall be accessible to physically handicapped in accordance with Capital Development Board rules entitled "Illinois Accessibility Code" (77 Ill. Adm. Code 400).
- 7) Elevator call buttons, controls, and door safety stops shall be of a type that will not be activated by heat or smoke. (B)
- 8) Elevators, except freight elevators, shall be equipped with a two-way special service key operated switch to permit cars to bypass all landing button calls and be dispatched directly to any floor. (B)
- 9) Fireman's emergency operations shall be furnished in accordance with American National Standards Institute Standard A17.1 Elevator Safety Code. (B)
- 10) Inspections and tests shall be made and written certification be furnished that the installation meets the requirements set forth in this section and all applicable safety regulations and codes. (B)

b) Handrails and Grab Bars

- 1) Handrails shall be provided on both sides of all corridors and ramps used by residents. (B)

- 2) Handrails shall be provided on all sides of an elevator cab not provided with a door. (B)
- 3) Handrails on stairs used by residents shall be provided on both sides of the stairs including the platforms and landings. (B)
- 4) Handrail dimensions and details shall conform to the Capital Development Board rules entitled "Illinois Accessibility Code" (71 Ill. Adm. Code 400). It is recommended that handrails be installed at a height of 32 inches measured vertically from the floor surface. (B)
- 5) Grab bars shall be provided for all resident use toilets, showers, and tubs. (B)
- 6) The ends of handrails and grab bars shall return to the wall. (B)

c) Ceiling Heights

- 1) All rooms occupied or used by residents shall have ceilings not less than eight feet.
- 2) Corridors, storage rooms, toilet rooms and other minor rooms shall have ceilings not less than seven feet, eight inches.
- 3) Suspended tracks, rails and pipes located in the path of traffic shall be no less than six feet eight inches above the floor.
- 4) Boiler room shall have ceiling clearances not less than two feet six inches above the main boiler header and connecting piping.

d) Doors and Windows

- 1) Main entrance and all exit doors shall swing outward and be provided with door closers and panic hardware. (B)
- 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)
- 3) Locks installed on resident bedroom doors shall be so arranged that they can be quickly and easily unlocked from the corridor side. All such locks shall be arranged to permit exit from the room by a simple operation without the use of a key. The door may be

lockable by the occupant if the door can be unlocked from the corridor side and keys are carried by the staff at all times. (B)

- 4) Resident toilet rooms shall open directly into a corridor or into a resident bedroom. (B)
- 5) The doors for the toilet rooms used by residents shall have a minimum door width of three feet. (B)
- 6) No toilet or bathroom door shall be provided with hardware which could allow a resident to become locked in the room. All toilet or bathroom doors and hardware shall be designed to permit emergency egress to the room. (B)
- 7) Doors and windows shall fit snugly and be weather tight, yet open and close easily.
- 8) Outside doors, other than required exits, and operable windows shall be equipped with tight-fitting, 16 mesh screens. Screen doors shall be equipped with self-closing devices.
- 9) All doors to resident's sleeping rooms shall be provided with automatic closers actuated by smoke detectors in the resident room. The doors shall normally be free swinging in the open and close directions, and be designed so they will remain in any position except when they are actuated by the detector. They shall then close gently and shall latch when closed. When so actuated they shall automatically close again if opened manually. Each door shall be equipped with a light mounted on the wall adjacent to the door. The light shall illuminate if the door has been closed as a result of the actuation of the controlling smoke detector. Each door closer will be activated only when its own detector annunciates a fire. In addition, a centrally located monitor shall contain signals which identify the resident room in which the smoke detector has signaled the alarm. The system shall be wired into the fire alarm system. (B)

e) Floors

- 1) Floors shall be smooth, free from cracks and finished so that they can be easily and properly cleaned. Floors shall be covered wall to wall with water resistant material in wet areas including but not limited to bathrooms, kitchens, utility rooms. (B)
- 2) Thresholds and expansion joints shall be flush with the floor to facilitate use of wheelchairs and carts.

- f) Mirrors shall be installed above all lavatories except handwashing lavatories in food preparation areas, or in clean and sterile supply areas or at nurses handwashing sink.
- g) Provide paper towel dispensers and waste receptacles or electric hand dryers at all lavatories.
- h) Rooms containing heat-producing equipment (such as boiler or heater rooms and laundry rooms) shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 10°F above the ambient room temperature.
- i) Sound Transmission Limitation
 - 1) Recreation rooms and exercise rooms, and similar spaces where impact noises may be generated, shall not be located directly over resident bed areas unless special provisions are made to minimize such noise.
 - 2) Sound transmission limitations shown in Table A shall apply to partitions, floors, and ceiling construction in resident areas.
- j) Hazardous Areas, Fire Extinguishers and Miscellaneous
 - 1) Interior finish flame spread ratings shall be in accordance with the National Fire Protection Association, Life Safety Code Standard 101, Standards for Flame Spread and Smoke Emission Ratings. (B)
 - 2) There shall be at least one approved fire extinguisher in all basements, furnace rooms, and kitchens, laundry rooms and beauty shops. In addition, there shall be on each floor of the building, extinguishers located so a person will not have to travel more than 50 feet from any point to reach one. They shall be inspected annually and recharged when necessary. The date of checking and recharging shall be recorded on a tag attached to the extinguisher. (B)
 - 3) Approved containers with proper covers shall be provided for daily storage of rubbish. (B)
 - 4) Housekeeping throughout the building, including basements, attics, and unoccupied rooms shall be adequately performed to minimize all fire hazards. (B)

- 5) Comply with any reasonable additional fire protection measures recommended by the Department over and above these requirements or the Office of the State Fire Marshal if conditions in and around building, including its location, indicate that such additional protection is needed. Additional fire protection measures shall include, but are not limited to the institution of a fire watch, installation of a sprinkler system, and installation of smoke detectors. (B)
- k) Have no other business not related to health care conducted in the building that constitutes a hazard or annoyance to the residents. In any case, the business shall be in a segregated portion of the building and shall have a separate entrance. (A, B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2910 Structural

- a) General Design Requirements
 - 1) The buildings and all parts thereof shall be of sufficient strength to support all dead, live, and lateral loads without exceeding the working stresses permitted for the materials of their construction in generally accepted good engineering practice. (B)
 - 2) Special provision shall be made for loads which have a greater load than the specified minimum live load, including partitions which are subject to change of location. (B)
- b) Construction shall be in accordance with the requirements of National Fire Protection Association Standard 101, Life Safety Code, and the minimum requirements contained herein. (A, B)
 - 1) Foundations shall rest on natural solid ground and shall be carried to a depth of not less than one foot below the estimated frost line or shall rest on leveled rock or load-bearing piles or caissons when solid ground is not encountered. Footings, piers, and foundation walls shall be adequately protected against deterioration from the action of ground water. It is recommended that soil test borings be taken to establish proper soil-bearing values for the soil at the building site.
 - 2) Assumed live loads shall be in accordance with the International Conference Building Officials Uniform Building Code.

- 3) The fire resistance rating of the structural members shall be as established by National Fire Protection Association Standard 220 (Standard Types of Building Construction).
- c) Provisions for Natural Disasters (B)
- 1) Earthquakes: In regions where local experience shows that earthquakes have caused loss of life or extensive property damage, buildings and structures shall be designed to withstand the force assumptions specified in the International Conference Building Officials Uniform Building Code. Seismic zones are identified on the attached map. (B)
 - 2) Tornadoes and Floods: Special provisions shall be made in the design of buildings, including structural design, in regions where local experience shows loss of life or damage to buildings resulting from hurricanes, tornadoes, or floods. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.2920 Mechanical Systems

- a) General Requirements
- 1) Mechanical systems shall be tested, balanced, and operated to demonstrate that the installation and performance of these systems conform to the requirements of these standards.
 - 2) Upon the completion of the contract, the owner shall be furnished with a complete set of manufacturer's operating and preventative maintenance instructions, parts list with numbers and descriptions for each piece of equipment and a copy of the air-balance report. A complete set of these documents shall be kept on the premises.
 - 3) The owner shall be provided with instructions in the operational use of the systems and equipment as required.
- b) Thermal and Acoustical Insulation
- 1) Insulation shall be provided for the following:
 - 2) Boilers, smoke breeching, and stacks.
 - 3) Steam supply and condensate return piping. (B)

- 4) Hot water piping above 180 degrees Fahrenheit and all hot water heaters, generators, and convertors.
- 5) Hot water piping above 125 degrees Fahrenheit which is exposed to contact by residents. (B)
- 6) Chilled water, refrigerant, other process piping and equipment operating with fluid temperatures below ambient dew point.
- 7) Water supply and drainage piping on which condensate may occur.
- 8) Air ducts and casings with outside surface temperatures below ambient dew point.
- 9) Other piping, ducts, and equipment as necessary to maintain the efficiency of the system.
- 10) Insulation may be omitted from hot water and steam condensate piping not subject to contact by residents when such insulation is not necessary for preventing excessive system heat loss or excessive heat gain.
- 11) Insulation including finishes and adhesives on exterior surfaces of ducts, pipes, and equipment shall have a flame spread rating of 25 or less and a smoke developed rating of 150 or less as determined by an independent testing laboratory in accordance with American Society Testing Materials Standard E84. (B)

Exception: Duct, pipe and equipment coverings shall not be required to meet these requirements where they are located entirely outside of a building, or do not penetrate a wall or roof or do not create an exposure hazard.

- 12) Access for filter changing shall be provided within equipment rooms.
- c) Steam and Hot Water Systems. Supply and return mains and risers for cooling, heating and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends.
 - d) Thermal Hazards. Any surface exceeding a temperature of 140 degrees Fahrenheit (such as radiators, hot water or steam pipes, baseboard heaters, or therapy equipment) that is accessible to residents shall be provided with partitions, screens, shields, or other means to protect residents from injury. Any protective device shall be designed and installed so that it

does not present a fire or safety hazard or adversely affect the safe operation of the equipment.

e) Heating, Cooling, and Ventilating Systems

- 1) A design temperature of 75 degrees Fahrenheit for both summer and winter design conditions shall be provided for all resident use areas including corridors.
- 2) All ventilation supply, return and exhaust systems shall be mechanically operated.
- 3) Outdoor air intakes shall be located as far as practical but not less than 15 feet from the exhaust outlets of ventilation systems, combustion equipment stacks, plumbing vent stacks, or from areas which may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than six feet above ground level, or if installed above the roof, three feet above roof level.
- 4) The ventilation systems shall be designed and balanced to provide the pressure relationships and ventilation rates as shown in Table B. (B)
- 5) A manometer shall be installed across each filter bed serving central air systems.
- 6) Air conditioning and ventilation systems shall be designed, installed and maintained as required by National Fire Protection Association Standard 90A. (A, B)
- 7) The hood and duct system for cooking equipment used in processes producing smoke or grease-laden vapors shall be in conformance with National Fire Protection Association Standard 96. That portion of the fire extinguishment system required for protection of the duct system may be omitted when all cooking equipment is served by a grease extractor listed by Underwriter's Laboratory or other independent testing laboratories. (A, B)
- 8) The ventilation of the medical gas storage room shall conform to the requirements of National Fire Protection Association Standard 56A "Inhalation Anesthetics" including the gravity option system. (B)
- 9) Boiler rooms and other rooms having combustion equipment shall be provided with sufficient outdoor air to maintain combustion

rates of equipment and limit temperatures to 97 degrees Fahrenheit. Effective Temperature as defined by American Society Heating Refrigeration Engineers Handbook of Fundamentals. (A, B)

- 10) Rooms containing heat producing equipment, such as boiler rooms, heater rooms, food preparation centers, laundries, and sterilizer rooms shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 10 degrees Fahrenheit above the ambient temperature. The ventilation rates shown in Table B shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

Section 300.2930 Plumbing Systems

- a) **General Requirements.** All plumbing systems shall be designed and installed in accordance with the requirements of the Illinois Plumbing Code (77 Ill. Adm. Code 890) except that the number of resident required water closets, lavatories, bathtubs, showers, and other fixtures shall be as required by this Part and the facility program. (B)
- b) **Plumbing Fixtures**
 - 1) Plumbing fixtures shall be of non-absorptive acid-resistant materials.
 - 2) The water supply spout for lavatories and sinks required for filling pitchers for nursing staff and food handlers' handwashing, shall be mounted so that its discharge point is a minimum distance of five inches above the rim of the fixture. (B)
 - 3) Handwashing lavatories used by nursing staff and food handlers shall be trimmed with valves which can be operated without the use of hands. When blade handles are used for this purpose, the blade handles shall not exceed four and one half inches in length, except the handles on clinical sinks shall not be less than six inches in length.
 - 4) Clinical rim flush sinks shall have an integral trap in which the upper portion of the trap seal provides a visible water surface.
 - 5) The potwashing sink shall be a three compartment sink with one compartment at least 14 inches deep.

- 6) Shower bases and tub bottoms shall be designed with nonslip surfaces. (B)
- c) Water Supply Systems
- 1) Water supply systems shall be designed to supply water at sufficient pressure and volume to operate all fixtures and equipment during maximum demand periods.
 - 2) Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.
 - 3) Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers.
 - 4) Hot water distribution systems shall be arranged to provide hot water of at least 100 degrees Fahrenheit at each hot water outlet at all times.
 - 5) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. (A, B)
 - 6) Each hot water system serving resident areas shall include at least one of the following equipment requirements to insure that the water temperature does not exceed 110 degrees Fahrenheit:
 - A) A thermostatically controlled mixing valve, or
 - B) An aquastat which limits the water temperature in the water heater to a maximum temperature of 110 degrees Fahrenheit and a solenoid operated shut off valve activated by a sensing element in the water line which shuts off the water and activates an alarm at the nurses station when the water temperature exceeds 110 degrees Fahrenheit. (A, B)
- d) Hot Water Heaters and Tanks
- 1) Capacity and Temperature Requirements
 - A) The hot water heating equipment shall have sufficient capacity to supply water at the temperature and quantities in the following areas:

	Resident Service	Dietary	Laundry
gallons/hour/bed	6½	4	4½
Temperature (degrees Fahrenheit)	110	140*	180

*180 degrees Fahrenheit water required at dishwasher and pot and pan sink.

- B) Water temperatures to be taken at the point of use or discharge of the hot water or inlet to processing equipment.
- 2) Water storage tanks shall be fabricated of corrosion resistant metal or lined with noncorrosive material.
- e) Drainage Systems. Insofar as possible drainage piping shall not be installed above the ceiling nor installed in an exposed location in food preparation centers, food serving facilities, food storage areas, and other critical areas. Special precautions shall be taken to protect these areas from possible leakage or condensation from necessary overhead piping systems. (B)
 - f) Nonflammable Gas Systems. Nonflammable medical gas systems if installed shall be in accordance with the requirements of National Fire Protection Association Standards 56A and 56F. (B)
 - g) Clinical Vacuum (Suction) Systems. Clinical vacuum systems if installed shall be in accordance with the requirements of the Compressed Gas Association Pamphlet P-2.1. (B)
 - h) Fire Extinguishing Systems
 - 1) A complete automatic sprinkler system shall be installed throughout all facilities regardless of construction type. (A, B)
 - 2) All sprinkler and other fire extinguishing systems shall be designed and installed in accordance with National Fire Protection Association Standard 101 and referenced codes. (A, B)
 - 3) All sprinkler systems shall be maintained in accordance with National Fire Protection Association Standard 13A. (A, B)

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

Section 300.2940 Electrical Systems

- a) General Requirements
 - 1) All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the electrical facilities required by these standards. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc. or other similarly established standards. (B)
 - 2) All electrical installations and systems shall be tested to show that the equipment is installed and operates as planned or specified and be in accordance with these standards. (A, B)
 - 3) The installation shall meet all the requirements of the latest "National Electrical Code". (A, B)
- b) Switchboards and Power Panels. Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboard shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in ambient temperature conditions.
- c) Panelboards. Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits they serve. This requirement does not apply to emergency system circuits.
- d) Lighting
 - 1) All spaces occupied by people, machinery, and equipment within buildings, approaches to and exits from buildings, and parking lots shall have lighting.
 - 2) Resident's rooms shall have general lighting. A reading light shall be provided for each resident. At least one light fixture shall be switched at the entrance to each resident room. All switches for control of lighting in resident's sleeping areas shall be of the quiet operating type.
- e) Receptacles (Convenience Outlets)

- 1) Each resident bed room shall have duplex grounding type receptacles as follows: One located each side of the head of each bed; one for television if used; and one on another wall. Receptacles are to be located between 12 to 30 inches above the finished floor. (B)
 - 2) Resident bathrooms shall have at least one duplex receptacle.
 - 3) See Article 517 of National Fire Protection Association Standard 70 for grounding requirements.
 - 4) Duplex receptacles shall be installed approximately 50 feet apart in all corridors and within 25 feet of ends of corridors.
- f) **Door Alarm System**
Each exterior door shall be equipped with a signal that will alert staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)
- g) **Nurses' Calling System**
- 1) Each resident room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. Call shall register at the nurses' station and shall activate a visible signal in the corridor at the resident's door, and in the nurse's station. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, identifying lights shall be provided at the nurse's station. (B)
 - 2) A nurses' call station shall be provided for residents' use at each resident's toilet, bath, and shower location. The cord shall be long enough to reach within six inches of the floor. (B)
- h) **Fire Alarm System**
- 1) A manually and automatically operated fire alarm system shall be installed. (A, B)
 - 2) Automatic smoke detectors shall be installed in all resident sleeping rooms and at 30 feet on center in all corridors other than sleeping area corridors. (A, B)
- i) **Emergency Electrical System**

- 1) To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. The emergency system shall consist of the life safety branch and the critical branch. (B)
- 2) The source of this emergency electrical service shall be an emergency generating set or an approved dual source of normal power. (B)
- 3) Life Safety Branch, Automatic Transfer ten Seconds.
 - A) Illumination of means of egress as necessary for corridors, passageways, stairways, landings and exit doors, and all ways of approach to and through exits. (A, B)
 - B) Exit signs and exit directional signs. (A, B)
 - C) Sufficient lighting in dining room and recreation areas to provide illumination to exit ways. (A, B)
 - D) Fire alarms activated at manual stations, by electric water flow alarm devices in connection with sprinkler systems, and by all automatic detection systems. (A, B)
 - E) Communication systems, where these are used for issuing instructions during emergency conditions. (A, B)
 - F) Task illumination, and selected receptacles at the generator set location. (B)
- 4) Critical Branch, Automatic Transfer ten Seconds
 - A) Task illumination and selected receptacles in the nurse's station including the medication preparation area. (B)
 - B) Sump pumps and other equipment required to operate for the safety of major apparatus including associated control systems and alarms. (B)
 - C) Elevator cab lighting and communication systems. (B)
 - D) Nurses' call system (B)

- 5) Critical Branch, Automatic or Manual Systems Heating equipment to provide heating for patient rooms. EXCEPTION: Where the facility is served by two or more electrical services supplied from separate generators or a utility distribution network having multiple power input sources and arranged to provide mechanical and electrical separation so that a fault between the facility and the generating sources is not likely to cause an interruption of more than one of the facility service feeders. (B)
- 6) Details
 - A) The life safety and critical branch shall be in operation within ten seconds after the interruption of normal electric power supply. (B)
 - B) Receptacles connected to emergency power shall be distinctively marked. (B)
 - C) The emergency generator shall not be solely dependent upon a public utility gas system for the fuel supply. Means shall be provided for automatically transferring from one fuel supply to another where dual fuel supplies are used. (B)
 - D) Where fuel storage facilities are provided on the site, the fuel tank shall have minimum capacity for 24 hour operation of the generator. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.3010 APPLICABILITY

Section 300.3010 Applicability

- a) These standards shall apply to all existing Long-Term Care Facilities and all minor alterations or remodeling changes to existing facilities. See Subpart N for New Construction and Major Additions and Alterations.
- b) Minor alterations or remodeling changes which do not affect the structural integrity of the building, which do not change functional operations, which do not affect fire safety, and which do not add beds or facilities over those for which the Long-Term Care Facility is licensed need not be submitted for drawing approval. However, the Health Facilities Planning Board Requirements must be met for all alteration and remodeling projects.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3020 Codes and Standards

- a) Nothing stated herein shall relieve the sponsor from compliance with building codes, ordinances and regulations which are enforced by city, county or other local jurisdictions. (B)
- b) The 1981 Edition of the National Fire Protection Association (NFPA) Standard No. 101, Life Safety Code for existing structures and all appropriate references under Appendix "B" of that Code, but no subsequently amended edition of the Code, shall apply to and become a part of these standards. (A, B) Pursuant to the Medicare/Medicaid certification requirements of 42 CFR 405.1134(a) (1983) and 42 CFR 442.321(c) (1983), but no subsequently amended editions of these Federal regulations, any skilled nursing facility that on December 4, 1980 or on November 26, 1982, or any intermediate care facility that on November 26, 1982 complied with the requirements of the 1967 or 1973 edition of the Life Safety Code, rather than the 1981 edition of the Life Safety Code,

will be accepted by the Department for licensure and certification as long as the facility continues to remain in compliance with the 1967 or 1973 edition of the Code.

- c) The following exceptions to the 1967 Life Safety Code have been established by the Department:
 - 1) Facilities shall be of the heights and construction types with sprinkler requirements identified in the Table C: (B)
 - 2) Dead-end corridors greater than 50 feet in length shall be altered so that exits are accessible in at least two directions from all points in aisles, passageways, and corridors. (B)
 - 3) Exit discharge doors and resident sleeping doors must be at least 34 inches in width. Width required is the width of the door leaf.
 - 4) All corridors shall be at least four feet wide. In Skilled Nursing Facilities, corridors shall be at least six feet wide.

- d) The following equivalencies have been established by the Department:
 - 1) Where corridor partition walls are not continuous from the floor slab to the underside of the floor or roof slab above, through any concealed spaces such as those above the suspended ceilings and through interstitial structural and mechanical spaces, the following equivalencies are permitted: (B)
 - A) A membrane ceiling which may be lath and plaster or drywall or a lay-in ceiling with all tiles clipped down and with all clips remaining in place, or with all the tiles weighing at least one pound per square foot. The ceiling may be suspended but it must be constructed continually from exterior wall to exterior wall and must be part of a one-hour rated assembly. All recessed lights, all duct outlets and all speaker outlets must be properly protected in accordance with Code. Plenums are not allowed unless each outlet is properly protected. This concept is applicable only to two-hour fire resistive and one-hour protected noncombustible construction.
 - B) A membrane ceiling of at least a one hour rating (such as two layers of 5/8" Fire Code drywall) is acceptable for noncombustible, one hour protected ordinary, ordinary, one hour protected wood frame, wood frame and heavy timber construction.

- C) Corridor walls need not run up in two-hour fire resistive and one-hour protected noncombustible construction if automatic sprinklers are installed throughout.
 - D) Smoke detectors may be used in lieu of continuous corridor wall construction all building construction types which are equipped throughout with an automatic extinguishment system required by these Standards. Automatic heat detectors, in lieu of automatic smoke detectors, may be installed in kitchens, laundry rooms, boiler/furnace rooms and attic spaces.
- 2) This equivalency is applicable only to those facilities which are in conformance with these requirements on the date of promulgation of these standards and only if the facility remains in conformance. The equivalency is applicable to facilities with nonconforming construction type. The following requirements must be met for facilities four stories or more in height of protected ordinary construction.
- A) The fire resistance rating of all structural members must meet the two-hour fire resistive classification of NFPA 220, Standard Types of Building Construction, dated May, 1961, except that floor and roof framing members and nonbearing walls may be of combustible construction.
 - B) Smoke detectors must be installed in all resident rooms, corridors, living areas, day rooms and in all hazardous and severely hazardous areas throughout the facility. However, automatic heat detectors may be installed, in lieu of automatic smoke detectors, in kitchens, laundry rooms, boiler/furnace rooms and attic spaces, (places where smoke, dust and humidity sometimes activate smoke alarms when no fire is present, resulting in false fire alarms), if the facility chooses to do so for the purpose of reducing the number of false fire alarms. A zone readout identifying areas involved in a fire must be provided.
 - C) All electrical systems shall meet the National Electrical Code in effect at the time of acceptance of the facility.
 - D) Facility shall establish and enforce written procedures to prohibit smoking in resident sleeping rooms and corridors. Smoking is permitted only in controlled areas.

- E) A complete automatic extinguishment system shall be installed throughout the facility.
 - F) All health survey deficiencies must be corrected.
 - G) The physically handicapped residents shall be housed on the lowest sleeping room floor and ambulant residents may be housed on any floor.
 - H) Complete smoke barriers including one-hour rated walls and one and three quarters inch thick solid core wood corridor doors with closers shall be installed as directed by the Department.
- e) The following rules which were effective at the date of approval by the Department of the final drawings and specifications or the final inspection of the building apply: (B)
- 1) Illinois Plumbing Code (77 Ill. Adm. Code 890), Department of Public Health
 - 2) Illinois Accessibility Code (71 Ill. Adm. Code 400) Capitol Development Board
 - 3) Fire Prevention and Safety (41 Ill. Adm. Code 100). Office of the State Fire Marshal
 - 4) Food Service Sanitation (77 Ill. Adm. Code 750). Department of Public Health
 - 5) Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120). Office of the State Fire Marshal
- f) The requirements in this Part govern in cases of differences between the requirements in this Part and the Codes and rules referenced in this Section. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3030 Preparation of Drawings and Specifications

Drawings and specifications prepared for work which is required by these Standards shall be prepared in accordance with Section 300.2830 of the Construction Standards for New Facilities.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3040 Site

- a) Each facility shall comply with all applicable zoning ordinances and be located on a reasonably flat or rolling, well-drained site that is: not subject to flooding; reasonably free from sources of excessive noise, noxious or hazardous smoke or fumes; not in a deteriorated, unpleasant, or potentially hazardous area; and not near uncontrolled sources of insect and rodent breeding.
- b) Each facility shall be located in or near a community which can provide the necessary supportive services for the facility such as physicians' services, medical facilities, public utilities, or other acceptable substitutes; and be located on a well-maintained, all-weather road.
- c) Each facility shall be served by a potable water supply with water pressure and volume that is acceptable to this Department. (B)
- d) Each facility shall have at least one municipal or private fire hydrant, located within 300 feet of the building and satisfactory for use by the equipment of the fire department serving the building, or have an acceptable equivalent. Additional hydrants may be required if needed to properly protect the residents from fire hazards. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3050 Administration and Public Areas

- a) Facilities for the physically handicapped (public, staff and residents) shall be provided in administration and public areas as well as in resident areas.
- b) Each facility shall be provided with sufficient administrative office space for clerical, financial, and managerial functions and provide satisfactory space which can be used for privacy in interviewing applicants and for discussion with relatives.
- c) Each facility shall be provided with satisfactory space or an office for the administrator.
- d) Each facility shall be served by reliable telephone service.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3060 Nursing Unit

a) General Requirements for Bedrooms

- 1) Resident bedrooms shall have an entrance directly off of a corridor with an entrance door that swings into the room. Rooms used as bedrooms and included in the licensed capacity as of December 24, 1987, which do not open directly into corridors but instead open into large living/dining/activity areas, are exempt from this subsection (a)(1). However, no additional such rooms will be permitted to be established after December 24, 1987.
- 2) Resident bedrooms shall have adequate and satisfactory artificial light and be equipped in accordance with Section 300.3140(c).
- 3) Resident toilet rooms shall open directly into a corridor or into a resident's bedroom. (B)
- 4) A closet or wardrobe at least four square feet shall be provided for each resident.
- 5) No bedroom floor shall be more than three feet below the adjacent ground level.
- 6) Each room used as a resident bedroom shall have at least one outside window, and a total window area to the outside equal to at least one-tenth the floor area of the room.
- 7) Nurses' call system shall be provided in accordance with Section 300.3140(e). (B)
- 8) Visual privacy shall be provided for each resident in multi-bedrooms. Methods for privacy shall not restrict resident access to entry, lavatory, or toilet.

b) Resident Bedroom.

- 1) Single resident bedrooms shall contain at least 100 square feet of usable floor area. Multiple resident bedrooms shall contain at least 80 square feet per bed of usable floor area. Minimum usable floor area shall be exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, or clearly definable entryways. Those bedrooms for which facilities had waivers to this subsection (b)(1) on (and continuously since) December 24, 1987, and which have at least 90 square feet for single bedrooms and 70 square feet per bed for multi-bedrooms are exempt from this subsection (b)(1). Those bedrooms for which facilities had waivers to this subsection (b)(1)

on (and continuously since) December 24, 1987, but which have less than 90 square feet for single bedrooms and 70 square feet per bed multi-bedrooms, continue to be subject to waiver procedures on an annual basis (See Section 300.320).

- 2) Maximum room capacity shall be four residents. Beds shall be at least three feet apart, and no more than three beds deep from an outside wall. There shall be a minimum of ten feet between walls or a wall and any built in furniture or storage space.

c) Special Care Room

- 1) In Intermediate Care Facilities, provide a special care room for each 150 beds. In Skilled Nursing Facilities, provide a special care room for each 50 beds or portion thereof.
- 2) Provide this room with a water closet, lavatory and all other necessary facilities to meet the resident's needs and as required to care for an ill resident.
- 3) This room shall be located to provide proper and efficient supervision of the resident by the nursing staff.
- 4) This room shall be included in the authorized maximum bed capacity for the facility.
- 5) It is permissible for the room to be occupied by a resident, not in need of special care, provided the resident is clearly informed and understands he will be immediately transferred out of the room any time of day or night, whenever the room is needed to care for a resident requiring special care.

d) Nurses' Station

- 1) Provide a minimum of one nurses' station on each floor. (In skilled nursing facilities there shall be a station for each nursing unit.) The station shall have direct access to a corridor, shall be located near the area it will serve, and shall be designed to provide visual control of the area. It shall be separated satisfactorily from the nurses' utility rooms. In Intermediate Care Facilities one nurses' station serving two floors housing residents is acceptable if there are less than 15 beds on an adjacent station. (B)
- 2) At least one nurses' station shall have a medicine sink with hot and cold running water, a work counter, a medicine cabinet, and

necessary equipment and furnishings. (In skilled nursing facilities each nurses' station shall be so equipped.)

- 3) Provide a nurses' toilet and handwashing sink convenient to the nurses' station.

e) Bath and Toilet Rooms

- 1) The maximum capacity of resident beds on each floor shall be used to determine the number of fixtures required even though some of the beds may not be occupied.
 - A) Provide a minimum of one water closet, one lavatory, and one bathtub or shower for each sex on each floor occupied by residents.
 - B) Provide a minimum of one lavatory and one water closet for each ten resident beds on each floor.
 - C) Provide a minimum of one bathtub or shower for each 15 resident beds on each floor.
 - D) Each lavatory shall be provided with a well-illuminated mirror.
- 2) All bath and toilet rooms shall be easily accessible, and conveniently located. Group bath and toilet facilities shall be partitioned or curtained for privacy.
- 3) All showers, other than those for residents needing assistance in bathing, shall have minimum dimensions of three feet by three feet.
- 4) If toilet rooms provided adjacent to residents' bedrooms are not large enough to permit use by wheelchair residents, at least one toilet room or enclosure measuring five feet by six feet shall be provided on each floor housing residents. (In Skilled Nursing Facilities there shall be one for each sex on each floor.) Provide a lavatory usable by wheelchair residents in this room.
- 5) Provide on each floor at least one bathing facility or enclosure of not less than eight feet six inches by eight feet six inches with an acceptable system for assistance in bathing persons with physical disabilities. If a shower is installed instead of a bathtub, such shower shall have a minimum dimension of four feet wide by three feet six inches deep. These showers shall have a water inlet to

which is connected a flexible hose with spray or shower head attached to the end of the hose. If desired, a conventional shower head installation may also be provided but it must be valved off from the lower water inlet.

f) Utility Rooms

1) Every facility shall have clean and soiled utility functions in separate rooms. There shall be at least one each of these rooms in the facility. (In Skilled Nursing Facilities there shall be at least one each of these rooms on each floor having resident bedrooms.)

2) Clean Utility Room

A) The clean utility room shall be large enough to contain:

- i) a work counter or table;
- ii) a sink with drainboard;
- iii) ample storage cabinets for clean and sterile supplies and equipment; and
- iv) an autoclave, if required, for sterilizing needles, syringes, catheters, dressings, and similar items.

B) The autoclave may be located in the nurses' station area. The autoclave may be waived in lieu of other methods of sterilization approved by the Department.

3) Soiled Utility Room

A) The soiled utility room shall be large enough to contain:

- i) a two compartment sink with drainboards;
- ii) ample storage cabinets;
- iii) a clinical rim flush sink for: rinsing bed pans, urinals, and linen soiled by solid materials, and similar type procedures; and
- iv) equipment and facilities for sanitizing bed pans, emesis basins, urine bottles, and other utensils, which meet accepted methods and procedures for such sanitation.

- B) Based upon approval of the program narrative, the Department will consider a waiver of this subsection for Intermediate Care Facilities.

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.3070 Living, Dining, Activities Rooms

- a) Provide at least one comfortably furnished living room and dining room for use of residents.
 - 1) The room shall be an outside room and if combined shall have an area of not less than 20 square feet per resident bed.
 - 2) The dining room shall be sufficient in area to allow proper and comfortable service for the residents.
 - 3) Be located so that the room is not an entrance vestibule from the out-of-doors.
 - 4) The furniture shall be arranged so that it is not an obstruction to traffic in or out of the facility.
- b) The activity room may be combined with the living or dining room.
- c) In multiple story buildings, living rooms must be provided on each floor unless a variance to this requirement is approved in writing by the Department. Such a variance may be granted based upon the population and condition of the residents.
- d) Additional interior rooms may be used for television, craft, or similar activities.
- e) Under no circumstances shall any of these rooms be used as a bedroom.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3080 Treatment and Personal Care

Space and appropriate equipment shall be provided to meet the resident's needs for treatment, grooming and hair care.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3090 Service Departments

a) Kitchen

- 1) Provide a kitchen area, not including food storage area, of approximately ten square feet per resident bed; this may be reduced for a facility with 40 or more beds. Any deviation from this requirement must receive approval from the Department. Such approval will only be granted if it can be shown that sufficient space can be provided to meet the needs of the residents. (B)
- 2) Provide kitchen equipment in an arrangement for convenient operation, good sanitation, healthful working conditions and control of heat, noise, and odors. (B)
- 3) Provide appropriate equipment for the preparation and serving of meals. (B)
- 4) Provide refrigeration of perishable foods. (B)
- 5) The kitchen shall be equipped with a two compartment sink for washing and sanitizing dishes, pots, pans and utensils. A commercial type dishwasher is recommended. (B)
- 6) The kitchen shall be provided with a handwashing lavatory. (B)
- 7) The walls and ceilings of all food handling rooms shall be finished with smooth, washable, light-colored surfaces.
- 8) All openings to the outside shall be effectively screened during fly seasons, and screen doors shall be equipped with self-closing devices; or a satisfactory alternative method.
- 9) The kitchen shall be located so that no resident must pass through it to reach a bathroom, resident's bedroom, the living room, dining room, or the out-of-doors. (B)
- 10) Provide approximately two and one-half square feet per patient bed for bulk and daily food storage located in a room convenient to the kitchen.

b) Laundry

- 1) Provide a laundry room equipped with adequate facilities for satisfactorily doing all laundering, unless a commercial laundry service is used.

- 2) Provide satisfactory and separate areas for soiled holding and sorting and clean linen storage. These may be in the same room if well defined and adequate separation is provided.
 - 3) The laundry facilities shall not be located in a room used by residents, or for food storage, preparation or serving. It shall be located so that soiled linens are not carried through a food handling area to reach it. (B)
- c) Storage
- 1) Provide a total area of approximately seven and one-half square feet per resident bed for the storage area required in this section.
 - 2) Provide adequate storage space for personal possessions of residents and staff, linens, supplies, and other items. This storage shall be such that it does not constitute a fire or accident hazard and will not be in the way of residents or staff.
 - 3) Provide adequate storage space in the facility, out of the way of residents and staff, to store wheelchairs, walkers, and similar equipment temporarily not being used.
 - 4) Provide closets for cleaning supplies, janitor's sinks, linen closets, storerooms for luggage, and furniture replacements.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3100 General Building Requirements

- a) Elevators
- 1) Provide a minimum of one elevator in all buildings of three or more stories in height. Additional elevators shall be provided as determined by the Department, based on the number, population, and condition of the residents. The basement, if it is used by residents, shall be considered as one story.
 - 2) If 60 to 200 beds are located above the second floor, at least one additional elevator shall be provided. If over 200 beds are located above the second floor, the number of additional elevators shall be determined by the Department.
 - 3) The administrator of the facility must be able to demonstrate to the Department the ability to transfer a patient according to physician's orders using existing elevators and elevator doors.

b) Handrails and Grab Bars

- 1) Handrails shall be provided on both sides of all corridors, stairs, and ramps. Handrails shall be one and one-half inches in diameter and one and one-half inches minimum clear of the wall. The height shall be 30 to 34 inches measured vertically from floor surface. Refer to the Rules of the Capital Development Board entitled "Illinois Accessibility Code" (77 Ill. Adm. Code 400) for other acceptable handrail dimensions and details. (B)
- 2) Grab bars shall be provided at all resident toilets, showers, tubs, and sitz bath. Refer to the rules of the Capital Development Board entitled "Illinois Accessibility Code" (71 Ill. Adm. Code 400) for grab bar dimensions and details. (B)

c) Ceiling Heights

- 1) All rooms occupied by or used by residents shall have not less than eight feet ceiling height.
- 2) Corridors, storage rooms, toilet rooms and other minor rooms shall have not be less than seven feet, eight inches ceiling height.
- 3) Suspended tracks, rails and pipes located in the path of traffic shall not be less than six feet, eight inches above the floor.

d) Doors and Windows

- 1) Main entrance and exit doors shall swing outward and be provided with door closers and panic-hardware. (B)
- 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B)
- 3) Locks installed on resident bedroom doors shall be so arranged that they can be quickly and easily unlocked from the corridor side. All such locks shall be arranged to permit exit from the room by a simple operation without the use of a key. The door may be lockable by the occupant if the door can be unlocked from the corridor side and the keys are carried by the attendants at all times. (B)

- 4) Resident toilet rooms shall open directly into a corridor or into a resident's bedroom. (B)
 - 5) The doors for the toilet rooms used by residents shall have a minimum door width of 30 inches. (B)
 - 6) No toilet or bathroom door shall be provided with hardware which could allow a resident to become locked in the room. All toilet or bathroom doors and hardware shall be designed to permit emergency egress from the room. (B)
 - 7) Thresholds or parting strips in doorways used by residents shall be flush with the floor.
 - 8) Doors and windows shall fit snugly and be weather tight, and shall open and close easily.
 - 9) Outside doors, other than required exits, and operable windows shall be equipped with tight-fitting, 16-mesh screens. Screen doors shall be equipped with self-closing devices.
- e) Floors
- 1) Floors shall be smooth, free from cracks and finished so that they can be easily and properly cleaned. (B)
 - 2) Floors in bathrooms, kitchens, and utility rooms shall be completely covered with water resistant material. (B)
- f) Walls and Ceilings
- 1) Walls and ceilings shall have sound construction, covered with plaster or sheet rock or similar material in good repair, and free from cracks or holes to permit proper cleaning.
 - 2) Be constructed and maintained so as to prevent the entrance and harborage of rats, mice, flies, and other vermin.
- g) Exit corridor walls shall be one hour fire rated construction. Adjoining open spaces shall not be greater than 600 square feet. Facilities shall provide direct visual supervision of these open spaces and equip them with an electrically supervised smoke detection system. (B)
- h) There shall be at least one approved fire extinguisher in all basements, furnace rooms, and kitchens. In addition, there shall be on each floor of the building, extinguishers located so a person will not have to travel more

than 50 feet from any point to reach one. They shall be inspected annually and recharged when necessary. The date of checking and recharging shall be recorded on a tag attached to the extinguisher. (B)

- i) Approved containers with proper covers shall be provided for daily storage of rubbish. (B)
- j) Housekeeping throughout the building, including basements, attics, and unoccupied rooms, shall be adequately performed to minimize all fire hazards. (B)
- k) Facilities shall comply with any reasonable additional fire protection measures recommended by the Department over and above these requirements or the Office of the State Fire Marshal if conditions in and around the building, including its location, indicate that such additional protection is needed. (B)
- l) The building in which a facility is located shall have no other business that is unrelated to health care and that constitutes a hazard or annoyance to the residents. The business shall be in a segregated portion of the building and shall have a separate entrance. (A, B)

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.3110 Structural

- a) Buildings and all parts thereof shall be maintained structurally to support all dead, live and lateral loads. (B)
- b) Buildings shall be maintained in good repair. Buildings that show signs of distress shall be repaired immediately. (B)

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3120 Mechanical Systems

- a) Mechanical systems shall be maintained to assure proper working order and safe operation. Instructions in the operational use of the systems and equipment must be available at the facility. (B)
- b) Thermal and Acoustical Insulation. It is recommended that insulation be provided for the following:
 - 1) Boilers, smoke breeching, and stacks.
 - 2) Steam supply and condensate return piping.

- 3) Hot water piping above 180 degrees Fahrenheit and all hot water heaters, generators, and converters.
 - 4) Hot water piping above 125 degrees Fahrenheit which is exposed to contact by residents.
 - 5) Chilled water, refrigerant, other process piping and equipment operating with fluid temperatures below ambient dew point.
 - 6) Water supply and drainage piping on which condensation may occur.
 - 7) Air ducts and casings with outside surface temperature below ambient dew point.
 - 8) Other piping, ducts, and equipment as necessary to maintain the efficiency of the system.
 - 9) Insulation may be omitted from hot water and steam condensate piping not subject to contact by residents when such insulation is not necessary for preventing excessive systems heat loss or excessive heat gain.
 - 10) Insulation on cold surfaces shall include an exterior vapor barrier.
 - 11) Insulation including finishes and adhesives on exterior surfaces of ducts, pipes, and equipment shall have a flame spread rating of 25 or less and a smoke developed rating of 150 or less as determined by an independent testing laboratory in accordance with ASTM Standard E 84. Exception: Duct, pipe and equipment coverings shall not be required to meet these requirements where they are located entirely outside of a building or do not penetrate a wall or roof or do not create an exposure hazard.
- c) Steam and Hot Water Systems. It is recommended that supply and return mains and risers for cooling, heating and process steam systems be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends.
- d) Thermal Hazards. Any surface exceeding a temperature of 140 degrees Fahrenheit (such as radiators, hot water or steam pipes, baseboard heaters, or therapy equipment) that is accessible to residents shall be provided with partitions, screens, shields, or other means to protect residents from injury. Any protective device shall be designed and installed so that it

does not present a fire or safety hazard or adversely affect the safe operation of the equipment.

e) Heating, Cooling, and Ventilating Systems

- 1) The heating system shall be capable of maintaining a temperature of 75 degrees Fahrenheit in all resident use spaces.
- 2) Auxiliary gas or electric space heaters of an approved closed type may be installed in areas requiring more heat than is produced by the central heating system. Heaters or furnaces of a type to be installed under, in, or on the floor are not permitted. (B)
- 3) All ventilation supply return and exhaust systems shall be mechanically operated.
- 4) The kitchen shall be provided with ventilation for reasonable comfort and with sufficient make-up air for the rangehood exhaust. (B)
- 5) The laundry shall be provided with ventilation for reasonable comfort with air flowing from clean areas to soiled areas with exhaust to the outdoors. (B)
- 6) It is recommended that outdoor air intakes be located as far as practical but not less than 15 feet from the exhaust outlets of ventilation systems, combustion equipment stacks, plumbing vent stacks, or from areas which may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems should be located as high as practical but not less than six feet above ground level, or if installed above the roof, three feet above roof level.
- 7) Air conditioning and ventilating systems shall be maintained to conform to the requirements of NFPA 90A. (A, B)
- 8) The hood and duct system for cooking equipment shall be in conformance with NFPA 96. That portion of the fire extinguishment system required for protection of the duct system maybe omitted when all cooking equipment is served by a grease extractor listed by Underwriter's Laboratory or other independent testing laboratory. (A, B)
- 9) Boiler rooms and other rooms housing combustion equipment shall be provided with sufficient outdoor air to maintain proper combustion rates. (A, B)

- 10) A capability shall be provided to maintain a temperature of at least 55 degrees Fahrenheit for at least 12 hours when the normal source of electrical power is interrupted. (A, B)

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

Section 300.3130 Plumbing Systems

- a) General Plumbing Requirements
 - 1) All plumbing systems shall be designed and installed in accordance with the requirements of the Illinois Plumbing Code (77 Ill. Adm. Code 890) except that the number of water closets, lavatories, bath tubs, showers and other fixtures shall be as required by these Requirements and the facility program. (B)
 - 2) New and replacement equipment, fixtures and fittings for mechanical, plumbing and electrical systems shall conform to and be installed in accordance with Subpart N of these standards.
- b) Plumbing Fixtures
 - 1) Plumbing fixtures shall be of non-absorptive acid-resistant materials and shall be kept in good repair.
 - 2) Clinical rim flush sinks shall have an integral trap in which the upper portion of the trap seal provides a visible water surface.
 - 3) When existing showers or tubs are replaced or additional showers or tubs provided, the shower bases and tub bottoms shall be designed with nonslip surfaces.
- c) Water Supply Systems
 - 1) Water supply systems shall be designed to supply potable water at sufficient pressure and volume to operate all plumbing fixtures and equipment during maximum demand periods.
 - 2) It is recommended that each water service main, branch main, riser and branch to a group of fixtures be valved. Stop valves should be provided at each fixture.
 - 3) Hot water distribution systems shall be arranged to provide hot water of at least 100 degrees Fahrenheit at each hot water outlet at all times.

- 4) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. (A, B)
 - 5) Protective measures, such as but not limited to, installation of a mixing valve, limited access to controls, and checking water temperatures daily at various points, shall be implemented to insure that the temperature of hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. (A, B)
- d) Hot Water Heaters and Tanks. Water storage tanks shall be fabricated of corrosion resistant metal or lined with noncorrosive material.
 - e) Drainage Systems. Special precautions shall be taken to protect food preparation, serving or storage areas from possible leakage or condensation from necessary overhead piping systems. (B)
 - f) Fire Extinguishment Systems. All fire extinguishment systems shall be designed and installed in accordance with NFPA 101 and NFPA 13. All fire extinguishment systems shall be maintained in accordance with NFPA 13A. (A, B)

(Source: Amended at 14 Ill. Reg. 14950, effective October 1, 1990)

Section 300.3140 Electrical Requirements

- a) The electrical installation for existing facilities shall continue to meet all the requirements of the National Electrical Code, effective at the time of approval by the Department of final drawings and specification or the inspection of the building. (A, B)
- b) Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and panelboards shall be enclosed or guarded to provide a dead-front type of assembly. Overload protective devices shall be suitable for operating properly in ambient temperature conditions.
- c) Lighting.
 - 1) All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots shall have lighting.

- 2) Resident's rooms shall have general lighting. A reading light shall be provided for each resident.
- d) Receptacles Convenience Outlets. Each resident room shall have adequate duplex type receptacles.
 - e) Nurses' Calling System.
 - 1) In resident areas, each room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. Call shall register at a central station serving the floor. In intermediate facilities only, an intercommunication system which provides only voice communication between a resident room and the nurses' station will be approved by the Department. (B)
 - 2) A nurses' call emergency station shall be provided for residents' use at each resident's toilet, bath, and shower location. The cord shall be long enough to reach within six inches of the floor. See Section 300.3140 (e)(1) for exception of intermediate facilities only. (B)
 - f) Door Alarm System. See Section 300.3100(d)(2). (B)
 - g) Fire Alarm System
 - 1) A manually-operated, electrically-supervised fire alarm system shall be installed. Pre-signal systems are not permitted. (A, B)
 - 2) There shall be an approved fire detection and alarm system throughout the facility. (A, B)
 - 3) The fire alarm signals shall automatically transmit the alarm to any available municipal fire department by direct private line or through an approved central station. (A, B)
 - 4) Fire alarms shall be activated by manual stations and all detection systems and flow alarm devices and sprinkler systems. (A, B)
 - h) Emergency Electrical Requirements (B)
 - 1) To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. (B)

- 2) The source of this emergency electrical service shall be one of the following: (B)
 - A) An emergency generating set when the normal service is supplied by only one central station transmission line.
 - B) Automatic battery operated systems or equipment that will be effective four or more hours and will be capable of supplying power for lighting for exit signs, exit corridors, stairways, nurses' stations, communication system, and all alarm systems, including the nurses' call system.
 - C) An approved dual source of normal power. Such a dual source of normal power shall consist of two or more electrical services fed from separate generator sets or a utility distribution network having multiple power input sources and arranged to provide mechanical and electrical separation so that a fault between the facility and the generating sources will not likely cause an interruption of more than one of the facility service feeders. An automatic transfer switch is required between the facility service feeders.

- 3) Provide emergency electrical service for: (B)
 - A) illumination of means of egress as necessary for corridors, passageways, stairways, landings and exit doors and all ways of approach to and through exits including outside lights,
 - B) exit signs and exit directional signs,
 - C) fire alarm systems and detection systems,
 - D) communication systems which are used for issuing instructions,
 - E) task illumination in the nurses station.
 - F) nurse call system.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

**TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.3210 GENERAL**

Section 300.3210 General

- a) *No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act) (A, B)*
- b) *A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. (Section 2-103 of the Act)*
- c) *If clothing is provided to the resident by the facility it shall be of a proper fit. (Section 2-103 of the Act)*
- d) *The facility shall provide adequate and convenient storage space for the personal property of the resident. (Section 2-103 of the Act)*
- e) *The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables. (Section 2-103 of the Act)*
- f) *The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. (Section 2-103 of the Act)*
- g) *The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints. (Section 2-103 of the Act)*
- h) *The facility administrator shall ensure that married residents residing in the same facility be allowed to reside in the same room within the facility unless there is no room available in the facility or it is deemed medically inadvisable by the*

residents' attending physician and so documented in the residents' medical records.
(Section 2-108(e) of the Act)

- i) There shall be no traffic through a resident's room to reach any other area of the building. (B)
- j) Children under 16 years of age who are related to employees or owners of a facility, and who are not themselves employees of the facility, shall be restricted to quarters reserved for family or employee use except during times when such children are part of a group visiting the facility as part of a planned program, or similar activity.
- k) *A resident may refuse to perform labor for a facility.* (Section 2-113 of the Act)
- l) *A resident shall be permitted the free exercise of religion. Upon a resident's request, and if necessary at his expense, the facility administrator shall make arrangements for a resident's attendance at religious services of the resident's choice. However, no religious beliefs or practices, or attendance at religious services, may be imposed upon any resident.* (Section 2-109 of the Act)
- m) All facilities shall comply with the "Election Code" (Ill. Rev. Stat. 1991, ch. 46, par. 1-1 et seq.) [10 ILCS 5] as it pertains to absentee voting for residents of licensed long-term care facilities.
- n) *The facility shall immediately notify the resident's next of kin, representative and physician of the resident's death or when the resident's death appears to be imminent.* (Section 2-208 of the Act)
- o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise. (B)
- p) *Where a resident, a resident's representative or a resident's next of kin believes that an emergency exists each of them, collectively or separately, may file a verified petition to the circuit court for the county in which the facility is located for an order placing the facility under the control of a receiver.* (Section 3-503 of the Act)
As used in Section 3-503 of the Act, "emergency" means a threat to the health, safety or welfare of a resident that the facility is unwilling or unable to correct.(Section 3-501 of the Act)

(Source: Amended at 17 Ill. Reg. 19279, effective October 26, 1993)

Section 300.3220 Medical and Personal Care Program

- a) *A resident shall be permitted to retain the services of his own personal physician at his own expense under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage. (B) (Section 2-104(a) of the Act)*
- b) *The Department shall not prescribe the course of medical treatment provided to an individual resident by the resident's physician in a facility. (Section 2-104(a) of the Act)*
- c) *All resident shall be permitted to obtain from their own physician or the physician attached to the facility complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand. (Section 2-104(a) of the Act)*
- d) *All resident shall be permitted to participate in the planning of their total care and medical treatment to the extent that their condition permits. (Section 2-104(a) of the Act)*
- e) *No resident shall be subjected to experimental research or treatment without first obtaining his informed, written consent. The conduct of any experimental research or treatment shall be authorized and monitored by an institutional review committee appointed by the administrator of the facility where such research and treatment is conducted. (A, B) (Section 2-104(a) of the Act)*
- f) *All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)*
- g) *Every woman resident of child-bearing age shall receive routine obstetrical and gynecological evaluations as well as necessary prenatal care. (Section 2-104(b) of the Act) In addition, women residents should be referred immediately for diagnosis whenever pregnancy is suspected.*
 - 1) "Routine obstetrical evaluations" and "necessary prenatal care" shall include, as a minimum, the following:
 - A) Early diagnosis of pregnancy;
 - B) A comprehensive health history, including menstrual history, data on the current pregnancy that allow the physician to estimate the date of delivery;

- C) Identification of factors in the current pregnancy that help to identify the patient at high risk, such as maternal age, vaginal bleeding, edema, urinary infection, exposure to radiation and chemicals, ingestion of drugs and alcohol, and use of tobacco;
- D) A comprehensive physical examination, including an evaluation of nutritional status; determination of height, weight and blood pressure; examination of the head, breasts, heart, lungs, abdomen, pelvis, rectum, and extremities.
- E) The following laboratory tests, as early in pregnancy as possible. Findings obtained from the history and physical examination may determine the need for additional laboratory evaluations.
 - i) Hemoglobin or hematocrit measurement
 - ii) Urinalysis, including microscopic examination or culture
 - iii) Blood group and Rh type determination
 - iv) Antibody screen
 - v) Rubella antibody titer measurement
 - vi) Syphilis screen
 - vii) Cervical cytology
 - viii) Viral hepatitis (HBsAg) testing
- F) A risk assessment, which, based on the findings of the history and physical examination, should indicate any risk factors that may require special management, such as cardiovascular disease, maternal age less than 15 years or more than 35 years, neurologic disorder, or congenital abnormalities.
- G) Return visits, the frequency of which will be determined by the patient's needs and risk factors. Generally a woman with an uncomplicated pregnancy should be seen every 4 weeks for the first 28 weeks of pregnancy, every 2-3 weeks until 36 weeks of gestation, and weekly thereafter.

- H) The physical examination at each visit should include determinations of blood pressure, measured fundal height, fetal heart rate, and, in later months, fetal presentation, and urinalysis for albumin and glucose. Hemoglobin or hematocrit level should be measured again early in the third trimester. Glucose screening is recommended for women who are 30 years of age or older.
 - I) Evaluation and monitoring of nutritional status and habits.
 - J) Education for health promotion and maintenance.
 - K) Counseling concerning exercise and child birth education programs.
 - L) Postpartum review and evaluation 4-8 weeks after delivery, including determination of weight and blood pressure and assessment of status of breasts, abdomen, and external and internal genitalia.
- 2) "Routine gynecological evaluations" shall include, as a minimum, the following:
- A) An initial examination, the basic components of which are:
 - i) History; any present illnesses; menstrual, reproductive, medical, surgical, emotional, social, family, and sexual history; medications; allergies; family planning; and systems review.
 - ii) Physical examination, including height, weight, nutritional status, and blood pressure; head and neck, including thyroid gland; heart; lungs; breasts; abdomen; pelvis, including external and internal genitalia; rectum; extremities, including signs of abuse; lymph nodes.
 - iii) Laboratory tests, including urine screen; hemoglobin or hematocrit determination and, if indicated, complete blood cell count; cervical cytology; rubella titer.
 - B) Annual updates:

- i) History, including the purpose of the visit; menstrual history; interval history, including systems review; emotional history:
- ii) Physical examination, including weight, nutritional status and blood pressure; thyroid gland; breasts; abdomen; pelvis, including external and internal genitalia; rectum; other areas as indicated by the interval history.
- iii) Laboratory, including urine screen; cervical cytology, unless not indicated; hemoglobin or hematocrit determinations.
- iv) Additional laboratory tests, such as screening for sexually transmitted disease, should be performed as warranted by the history, physical findings, and risk factors.

C) Cancer screening.

- i) An annual Pap test for all women who are or have been sexually active or have reached age 18.
- ii) Mammography if indicated.

3) When a resident is referred for a diagnosis of pregnancy and/or prenatal care, the facility shall send the provider a copy of the resident's medical record, including a list of prescription medications taken by the resident; use of alcohol, tobacco and illicit drugs; or exposure to radiation or chemicals during the preceding three months.

h) *Every resident shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record.* (B) (Section 2-104(c) of the Act)

i) Inspection and Copying of Records

1) *Every resident, resident's guardian, or parent (if the resident is a minor) shall be permitted to inspect and copy all of the resident's clinical and other records concerning the resident's care and maintenance kept by the facility or by the resident's physician.* (Section 2-104(d) of the Act)

- 2) *Every resident's representative shall be permitted to inspect and copy the resident's records. A "resident's representative" is a person, other than the owner or agent or employee of a facility who is not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian, or the parent of a minor resident for whom no guardian has been appointed. (Sections 1-123 and 2-202(h) of the Act) (B)*
- j) *All residents shall be permitted respect and privacy in their medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have the resident's permission to be present. (B) (Section 2-105 of the Act)*

(Source: Amended at 15 Ill. Reg. 554, effective January 1, 1991)

Section 300.3230 Restraints (Repealed)

(Source: Repealed at 22 Ill. Reg. 16609, effective September 18, 1998)

Section 300.3240 Abuse and Neglect

- a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)*
- b) *A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)*
- c) *A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)*
- d) *A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)*
- e) *Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation,*

prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

- f) *Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)*

(Source: Amended at 15 Ill. Reg. 554, effective January 1, 1991)

Section 300.3250 Communication and Visitation

- a) *Every resident shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation. (Section 2-108 of the Act)*
- b) *The facility administrator shall ensure that correspondence is conveniently received and mailed, and that telephones are reasonably accessible. (Section 2-108(a) of the Act)*
- c) *The facility administrator shall ensure that residents may have private visits at any reasonable hour unless such visits are not medically advisable for the resident as documented in the resident's clinical record by the resident's physician. (Section 2-108(a) of the Act)*
- d) *The facility shall allow daily visiting between 10:00 A.M. and 8:00 P.M. These visiting hours shall be posted in plain view of visitors.*
- e) *The facility administrator shall ensure that space for visits is available and that facility personnel knock, except in an emergency, before entering any resident's room. (Section 2-108(c) of the Act)*
- f) *Unimpeded, private and uncensored communication by mail, public telephone, and visitation may be reasonably restricted by a physician only in order to protect the resident or others from harm, harassment or intimidation provided that the reason for any such restriction is placed in the resident's clinical record by the physician and that notice of such restriction shall be given to all residents upon admission. (Section 2-108(d) of the Act)*
- g) *Notwithstanding subsection (f) of this Section, all letters addressed by a resident to the Governor, members of the General Assembly, Attorney General, judges, state's attorneys, officers of the Department, or licensed*

attorneys at law shall be forwarded at once to the persons to whom they are addressed without examination by facility personnel. Letters in reply from the officials and attorneys mentioned above shall be delivered to the recipient without examination by facility personnel. (Section 2-108(d) of the Act)

- h) *Any employee or agent of a public agency, any representative of a community legal services program or any member of a community organization shall be permitted access at reasonable hours to any individual resident of any facility, if the purpose of such agency, program or organization includes rendering assistance to residents without charge, but only if there is neither a commercial purpose nor affect to such access and if the purpose is to do any other the following:*
 - 1) *Visit, talk with and make personal, social, and legal services available to all residents;*
 - 2) *Inform residents of their rights and entitlements and their corresponding obligations, under federal and State laws, by means of educational materials and discussions in groups and with individual residents;*
 - 3) *Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance and social security benefits, as well as in all other matters in which residents are aggrieved. Assistance may include counseling and litigation; or*
 - 4) *Engage in other methods of asserting, advising and representing residents so as to extend to them full enjoyment of their rights. (Section 2-110(a) of the Act)*
- i) *No visitor shall enter the immediate living area of any resident without first identifying himself and then receiving permission from the resident to enter. The rights of other residents present in the room shall be respected. (B) (Section 2-110(b) of the Act)*
- j) *A resident may terminate at any time a visit by a person having access to the resident's living area. (Section 2-110(b) of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3260 Resident's Funds

- a) *A resident shall be permitted to manage his own financial affairs unless he or his guardian or if the resident is a minor, his parent, authorizes the administrator of the facility in writing to manage such resident's financial*

affairs under subsections (b) through (o) of this Section. (Section 2-102 of the Act)

- b) *The facility shall at the time of admission, provide in order of priority, each resident, or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any, with a written statement explaining to the resident and the resident's spouse their spousal impoverishment rights as defined at Section 5-4 of the Illinois Public Aid Code, and at Section 303 of Title III of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), and the resident's rights regarding personal funds and listing the services for which the resident will be charged. The facility shall obtain a signed acknowledgement from each resident or the resident's representative, if any, or the resident's immediate family member, if any, that such person has received the statement. (Section 2-201(1) of the Act)*
- c) *The facility may accept funds from a resident for safekeeping and managing, if it receives written authorization from, in order of priority, the resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any; such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations, and who is not connected in any way to facility personnel or the administrator in any manner whatsoever. (Section 2-101(2) of the Act)*
- d) *The facility shall maintain and allow, in order of priority, each resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any, access to a written record of all financial arrangements and transactions involving the individual resident's funds. (Section 2-201(3) of the Act)*
- e) *The facility shall provide, in order of priority, each resident, or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member, if any, with a written itemized statement at least quarterly, of all financial transactions involving the resident's funds. (Section 2-201(4) of the Act)*
- f) *The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the Departments of Public Health and Insurance that all residents' personal funds deposited with the facility are secure against loss, theft, and insolvency. (Section 2-201(5) of the Act)*
 - 1) *If a surety bond is secured, it must be issued by a company licensed to do business in Illinois, the amount of bond must be equal to or greater than all resident funds managed by the facility,*

and the obligee named in the bond must be the Illinois Department of Public Health or its assignees.

- 2) If an alternative to a surety bond is secured, the alternative must provide a protection equivalent to that afforded by a surety bond. To be acceptable, the alternative must have a person(s) or entity(ies) designated who can collect in case of loss (e.g., residents, the Department). The alternative must also provide a guarantee that lost funds will be repaid. The guarantee may be made either by an independent entity (e.g., a bank) or the facility. If the facility provides the guarantee, it must be backed by facility money at least equal to resident funds. This money must be reserved solely for the purpose of assuring the security of resident funds. Two examples of acceptable alternatives to surety bonds are letters of credit and self-insurance. Both surety bonds and alternatives must protect the full amount of residents' funds deposited with the facility.
 - 3) Any alternative to a surety bond shall be submitted to the Department for review and approval. Alternatives that meet the requirements of this Section and were in place prior to October 1, 1994, must be submitted to the Department for review and approval within 120 days after October 1, 1994.
- g) *The facility shall keep any funds received from a resident for safekeeping in an account separate from the facility's funds, and shall at no time withdraw any part or all of such funds for any purpose other than to return the funds to the resident upon the request of the resident or any other person entitled to make such request, to pay the resident his allowance, or to make any other payment authorized by the resident or any other person entitled to make such authorization. (Section 2-201(6) of the Act)*
 - h) *The facility shall deposit any funds received from a resident in excess of \$100 in an interest bearing account insured by agencies of, or corporations chartered by, the State or federal government. The account shall be in a form which clearly indicates that the facility has only a fiduciary interest in the funds and any interest from the account shall accrue to the resident. (Section 2-201(7) of the Act)*
 - i) *The facility may keep up to \$100 of a resident's money in a non-interest bearing account or petty cash fund, to be readily available for the resident's current expenditures. (Section 2-201(7) of the Act)*
 - j) *The facility shall return to the resident, or the person who executed the written authorization required in subsection (c) of this Section, upon*

written request, all or any part of the resident's funds given the facility for safekeeping, including the interest accrued from deposits. (Section 2-201(8) of the Act)

- k) *The facility shall place any monthly allowance to which a resident is entitled in that resident's personal account, or give it to the resident, unless the facility has written authorization from the resident or the resident's guardian, or if the resident is a minor, his parent, to handle it differently. (Section 2-2-1(9) of the Act)*
- l) *Unless otherwise provided by State law, the facility shall upon the death of a resident provide the executor or administrator of the resident's estate with a complete accounting of all the resident's personal property, including any funds of the resident being held by the facility. (Section 2-201(10) of the Act)*
- m) *If an adult resident is incapable of managing his funds and does not have a resident's representative, guardian, or an immediate family member the facility shall notify the Office of the State Guardian of the Guardianship and Advocacy Commission. (Section 2-201(11) of the Act)*
- n) *If the facility is sold, the seller shall provide the buyer with a written verification by a public accountant of all residents' monies and properties being transferred, and obtain a signed receipt from the new owner. (Section 2-201(12) of the Act)*
- o) *The facility shall take all steps necessary to ensure that a personal needs allowance that is placed in a resident's personal account is used exclusively by the resident or for the benefit of the resident. Where such funds are withdrawn from the resident's personal account by any person other than the resident, the facility shall require such person to whom funds constituting any part of a resident's personal needs allowance are released to execute an affidavit that such funds shall be used exclusively for the benefit of the resident. (Section 2-201(9)(b) of the Act) "Personal needs allowance," for the purposes of this subsection, refers to the monthly allowance allotted by the Illinois Department of Public Aid to public aid recipients.*

(Source: Amended at 18 Ill. Reg. 15868, effective October 15, 1994)

Section 300.3270 Residents' Advisory Council

Each resident shall have the right to participate in a residents' advisory council as indicated in Section 300.640.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3280 Contract With Facility

Each resident shall have the right to contract with the facility as indicated in Section 300.630.

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3290 Private Right of Action

- a) Each resident shall have the right to maintain a private right of action against a facility as described in subsections (b) through (i) of this Section.
- b) *The owner and licensee of a facility are liable to a resident for any intentional or negligent act or omission of their agents or employees which injures the resident. (Section 3-601 of the Act)*
- c) *The licensee shall pay three times the actual damages, or \$500, whichever is greater, and costs and attorney's fees to a facility resident whose rights as specified in Part 1 of Article II of the Act are violated. (Section 3-602 of the Act)*
- d) *A resident may maintain an action under the Act and this Part for any other type of relief, including injunctive and declaratory relief, permitted by law. (Section 3-603 of the Act)*
- e) *Any damages recoverable under subsection (b) through (i) of this Section, including minimum damages as provided by this Part, may be recovered in any action which a court may authorize to be brought as a class action pursuant to Part 8 of the Civil Practice law (Ill. Rev. Stat. 1987, ch. 110, par. 2-801 et seq.). The remedies provided in subsections (b) through (i) of this Section are in addition to and cumulative with any other legal remedies available to a resident. Exhaustion of any available administrative remedies shall not be required prior to commencement of a suit hereunder. (Section 3-604 of the Act)*
- f) *The amount of damages recovered by a resident in an action brought under subsections (b) through (i) of this Section shall be exempt for purposes of determining initial or continuing eligibility for medical assistance under "The Illinois Public Aid Code," (Ill. Rev. Stat. 1987, ch. 23, par. 1-1 et seq.) as now or hereafter amended, and shall neither be taken into consideration nor required to be applied toward the payment or partial payment of the cost of medical care or services available under "The Illinois Public Aid Code." (Section 3-605 of the Act)*

- g) *Any waiver by a resident or his legal representative of the right to commence an action under subsections (b) through (i) of this Section, whether oral or in writing, shall be null and void, and without legal force or effect. (Section 3-606 of the Act)*
- h) *Any party to an action brought under subsections (b) through (i) of this Section shall be entitled to a trial by jury and any waiver of the right to a trial by jury, whether oral or in writing, prior to the commencement of an action, shall be null and void, and without legal force or effect. (Section 3-607 of the Act)*
- i) *A licensee or its agents or employees shall not transfer, discharge, evict, harass, dismiss, or retaliate against a resident, a resident's representative, or an employee or agent who makes a report of resident abuse or neglect, brings or testifies in a private right of action, or files a complaint, because of the such action or testimony.(B) (Section 3-608 of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3300 Transfer or Discharge

- a) *A resident may be voluntarily discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged. If a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his guardian or if the resident is a minor, his parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. (Section 2-111 of the Act)*
- b) Each resident's rights regarding involuntary transfer or discharge from a facility shall be as described in subsections (c) through (y) of this Section.
- c) Reasons for Transfer or Discharge
 - 1) *A facility may involuntarily transfer or discharge a resident only for one or more of the following reasons:*
 - A) *for medical reasons.*
 - B) *for the resident's physical safety.*
 - C) *for the physical safety of other residents, the facility staff or facility visitors.*

D) *for either late payment or nonpayment for the resident's stay, except as prohibited by Title XVIII and XIX of the Federal Social Security Act. For purposes of this Section, "late payment" means non-receipt of payment after submission of a bill. If payment is not received within 45 days after submission of a bill, the facility may send a notice to the resident and responsible party requesting payment within 30 days. If payment is not received within such 30 days, the facility may thereupon institute transfer or discharge proceedings by sending a notice of transfer or discharge to the resident and responsible party by registered or certified mail. The notice shall state, in addition to the requirements of Section 3-403 of the Act and subsection (e) of this Section, that the responsible party has the right to pay the amount of the bill in full up to the date the transfer or discharge is to be made and then the resident shall have the right to remain in the facility. Such payment shall terminate the transfer or discharge proceedings. This subsection does not apply to those residents whose care is provided under the Illinois Public Aid Code. (B) (Section 3-401 of the Act)*

2) Prohibition of Discrimination

A) *A facility participating in the medical assistance program is prohibited from failing or refusing to retain as a resident any person because the resident is a recipient of or an applicant for the medical assistance program. For the purposes of this Section, a recipient or applicant shall be considered a resident in the facility during any hospital stay totaling ten days or less following a hospital admission. The day on which a resident is discharged from the facility and admitted to the hospital shall be considered the first day of the ten-day period. (Section 3-401.1(a) of the Act)*

B) *A facility which violates subsection (c)(2)(B) of this Section shall be guilty of a business offense and fined not less than \$500 nor more than \$1,000 for the first offense and not less than \$1,000 nor more than \$5,000 for each subsequent offense. (Section 3-401.1(b) of the Act)*

d) *Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days. The 21-day requirement shall not apply in any of the following instances:*

- 1) *When an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician; (Section 3-402(a) of the Act)*
 - 2) *When the transfer or discharge is mandated by the physical safety of other residents as documented in the clinical record. (Section 3-402(b) of the Act)*
- e) *The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:*
- 1) *The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)*
 - 2) *The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)*
 - 3) *A statement in not less than 12-point type, which reads:*

"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within ten days after receiving this notice. If you request a hearing, it will be held not later than ten days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below." (Section 3-403(c) of the Act)
 - 4) *A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)*
 - 5) *The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)*
- f) *A request for a hearing made under subsection (e) of this Section shall stay a transfer pending a hearing or appeal of the decision, unless a condition which would have allowed transfer or discharge in less than 21*

days as described under subsections (d)(1) and (2) of this Section develops in the interim. (Section 3-404 of the Act)

- g) *A copy of the notice required by subsection (d) of this Section shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Public Aid. (Section 3-405 of the Act)*
- h) *When the basis for an involuntary transfer or discharge is the result of an action by the Department of Public Aid with respect to a recipient of Title XIX and a hearing request is filed with the Department of Public Aid, the 21-day written notice period shall not begin until a final decision in the matter is rendered by the Department of Public Aid or a court of competent jurisdiction and notice of that final decision is received by the resident and the facility. (Section 3-406 of the Act)*
- i) *When nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to redeem up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (Section 3-407 of the Act)*
- j) *The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)*
- k) *The facility shall offer the resident counseling services before the transfer or discharge of the resident. (Section 3-409 of the Act)*
- l) *A resident subject to involuntary transfer or discharge from a facility, the resident's guardian or if the resident is a minor, his parent shall have the opportunity to file a request for a hearing with the Department within ten days following receipt of the written notice of the involuntary transfer or discharge by the facility. (Section 3-410 of the Act)*
- m) *The Department of Public Health, when the basis for involuntary transfer or discharge is other than action by the Department of Public Aid with respect to the Title XIX Medicaid recipient, shall hold a hearing at the resident's facility not later than ten days after a hearing request is filed,*

and render a decision within 14 days after the filing of the hearing request. (Section 3-411 of the Act)

- n) *The hearing before the Department provided under subsection (m) of this Section shall be conducted as prescribed under Sections 3-703 through 3-712 of the Act. In determining whether a transfer or discharge is authorized, the burden of proof in this hearing rests on the person requesting the transfer or discharge. (Section 3-412 of the Act)*
- o) *If the Department determines that a transfer or discharge is authorized under subsection (c) of this Section, the resident shall not be required to leave the facility before the 34th day following receipt of the notice required under subsection (d) of this Section, or the tenth day following receipt of the Department's decision, whichever is later, unless a condition which would have allowed transfer or discharge in less than 21 days as described under subsections (d)(1) and (2) of this Section develops in the interim. (B) (Section 3-413 of the Act)*
- p) *The Department of Public Aid shall continue Title XIX Medicaid funding during the appeal, transfer, or discharge period for those residents who are Title XIX recipients affected by subsection (c) of this Section. (Section 3-414 of the Act)*
- q) *The Department may transfer or discharge any resident from any facility required to be licensed under this Act when any of the following conditions exist:*
 - 1) *Such facility is operating without a license; (Section 3-415(a) of the Act)*
 - 2) *The Department has suspended, revoked or refused to renew the license of the facility as provided under Section 3-119 of the Act. (Section 3-415(b) of the Act)*
 - 3) *The facility has requested the aid of the Department in the transfer or discharge of the resident and the Department finds that the resident consents to transfer or discharge; (Section 3-415(c) of the Act)*
 - 4) *The facility is closing or intends to close and adequate arrangement for relocation of the resident has not been made at least 30 days prior to closure; or (Section 3-415(d) of the Act)*
 - 5) *The Department determines that an emergency exists which requires immediate transfer or discharge of the resident. (Section 3-415(e) of the Act)*

- r) *In deciding to transfer or discharge a resident from a facility under subsection (q) of this Section, the Department shall consider the likelihood of serious harm which may result if the resident remains in the facility. (Section 3-416 of the Act)*
- s) *The Department shall offer transfer or discharge and relocation assistance to residents transferred or discharged under subsections (c) through (q) of this Section including information on available alternative placements. Residents shall be involved in planning the transfer or discharge and shall choose among the available alternative placements, except that where an emergency makes prior resident involvement impossible, the Department may make a temporary placement until a final placement can be arranged. Residents may choose their final alternative placement and shall be given assistance in transferring to such place. No resident may be forced to remain in a temporary or permanent placement. Where the Department makes or participates in making the relocation decision, consideration shall be given to proximity to the resident's relatives and friends. The resident shall be allowed three visits to potential alternative placements prior to removal, except where medically contraindicated or where the need for immediate transfer or discharge requires reduction in the number of visits. (Section 3-417 of the Act)*
- t) *The Department shall prepare resident transfer or discharge plans to assure safe and orderly removals and protect residents' health, safety, welfare and rights. In nonemergencies and where possible in emergencies, the Department shall design and implement such plans in advance of transfer or discharge. (Section 3-418 of the Act)*
- u) *The Department may place relocation teams in any facility from which residents are being discharged or transferred for any reason, for the purpose of implementing transfer or discharge plans. (Section 3-419 of the Act)*
- v) *In any transfer or discharge conducted under subsections (q) through (t) of this Section the Department shall:*
 - 1) *Provide written notice to the facility prior to the transfer or discharge. The notice shall state the basis for the order of transfer or discharge and shall inform the facility of its right to an informal conference prior to transfer or discharge under this Section, and its right to a subsequent hearing under subsection (x) of this Section. If a facility desires to contest a nonemergency transfer or discharge, prior to transfer or discharge it shall, within four working days after receipt of the notice, send a written request for an informal conference to the Department. The Department shall,*

within four working days from the receipt of the request, hold an informal conference in the county in which the facility is located. Following this conference, the Department may affirm, modify or overrule its previous decision. Except in an emergency, transfer or discharge may not begin until the period for requesting a conference has passed or, if a conference is requested, until after a conference has been held; and (Section 3-420(a) of the Act)

- 2) *Provide written notice to any resident to be removed, to the resident's representative, if any, and to a member of the resident's family, where practicable, prior to the removal. The notice shall state the reason for which transfer or discharge is ordered and shall inform the resident of the resident's right to challenge the transfer or discharge under subsection (x) of this Section. The Department shall hold an informal conference with the resident or the resident's representative prior to transfer or discharge at which the resident or the representative may present any objections to the proposed transfer or discharge plan or alternative placement. (Section 3-420(b) of the Act)*

- w) *In any transfer or discharge conducted under subsection (q)(5) of this Section, the Department shall notify the facility and any resident to be removed that an emergency has been found to exist and removal has been ordered, and shall involve the residents in removal planning if possible. Following emergency removal, the Department shall provide written notice to the facility, to the resident, to the resident's representative, if any, and to a member of the resident's family, where practicable, of the basis for the finding that an emergency existed and of the right to challenge removal under subsection (x) of this Section. (Section 3-421 of the Act)*

- x) *Within ten days following transfer or discharge, the facility or any resident transferred or discharged may send a written request to the Department for a hearing under Section 3-703 of the Act to challenge the transfer or discharge. The Department shall hold the hearing within 30 days of receipt of the request. Where a challenge is by a resident, the hearing shall be held at a location convenient to the resident. If the facility prevails, it may file a claim against the State under the Court of Claims Act for payments less expenses saved as a result of the transfer or discharge. No resident transferred or discharged may be held liable for the charge for care which would have been made had the resident remained in the facility. If a resident prevails, the resident may file a claim against the State under the Court of Claims Act (Ill. Rev. Stat. 1987, ch. 37, pars. 439.1 et seq.) for any excess expenses directly caused by the order to transfer or discharge. The Department shall assist the resident in returning to the facility if assistance is requested. (Section 3-422 of the Act)*

- y) *Any owner of a facility licensed under this Act shall give 90 days notice prior to voluntarily closing a facility or closing any part of a facility, or prior to closing any part of a facility if closing such part will require the transfer or discharge of more than ten percent of the residents. Such notice shall be given to the Department, to any resident who must be transferred or discharged, to the resident's representative, and to a member of the resident's family, where practicable. Notice shall state the proposed date of closing and the reason for closing. The facility shall offer to assist the resident in securing an alternative placement and shall advise the resident on available alternatives. Where the resident is unable to choose an alternate placement and is not under guardianship, the Department shall be notified of the need for relocation assistance. The facility shall comply with all applicable laws and regulations until the date of closing, including those related to transfer or discharge of residents. The Department may place a relocation team in the facility as provided under subsection (u) of this Section. (A, B) (Section 3-423 of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3310 Complaint Procedures

- a) *A resident shall be permitted to present grievances on behalf of himself and others to the administrator, the Long-Term Care Facility Advisory Board, the residents' advisory council, State governmental agencies or other persons without threat of discharge or reprisal in any form or manner whatsoever. (Section 2-112 of the Act)*
- b) *The facility administrator shall provide all residents or their representatives with the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged. (Section 2-112 of the Act)*
- c) *A person who believes that the Act or a rule promulgated under the Act may have been violated may request an investigation. The request may be submitted to the Department in writing, by telephone, or by personal visit. An oral complaint shall be reduced to writing by the Department. (Section 3-702(a) of the Act)*
- d) *The substance of the complaint shall be provided to the licensee, owner or administrator no earlier than at the commencement of the on-site inspection of the facility which takes place pursuant to the complaint. (Section 3-702(b) of the Act)*

- e) *The Department shall not disclose the name of the complainant unless the complainant consents in writing to the disclosure or the investigation results in a judicial proceeding, or unless disclosure is essential to the investigation. The complainant shall be given the opportunity to withdraw the complaint before disclosure. Upon the request of the complainant, the Department may permit the complainant or a representative of the complainant to accompany the person making the on-site inspection of the facility. (Section 3-702(c) of the Act)*
- f) *Upon receipt of a complaint, the Department shall determine whether the Act or a rule promulgated under the Act has been or is being violated. The Department shall investigate all complaints alleging abuse or neglect within seven days after the receipt of the complaint except that complaints of abuse or neglect which indicate that a resident's life or safety is in imminent danger shall be investigated with 24 hours after receipt of the complaint. All other complaints shall be investigated within 30 days after the receipt of the complaint. All complaints shall be classified as "an invalid report," "a valid report," or "an undetermined report." For any complaint classified as "a valid report," the Department must determine within 30 working days if any rule or provision of the Act has been or is being violated. (Section 3-702(d) of the Act)*
- g) *Upon the request of a resident or complainant, the Department may permit the resident or complainant or a representative of the complainant to accompany the person making the on-site inspection of the facility pursuant to the complaint. (Section 3-702(c) of the Act)*
- h) *In all cases, the Department shall inform the complainant of its findings within ten days of its determination unless otherwise indicated by the complainant, and the complainant may direct the Department to send a copy of such findings to another person. The Department's findings may include contents or documentation provided by either the complainant or the licensee pertaining to the complaint. The Department shall also notify the facility of such findings within ten days of the determination, but the name of the complainant or residents shall not be disclosed in this notice to the facility. The notice of such findings shall include a copy of the written determination; the correction order, if any; the inspection report; the warning notice, if any; and the State licensure form on which the violation is listed. (Section 3-702(e) of the Act)*
- i) *A written determination, correction order, or warning notice concerning a complaint shall be available for public inspection, but the name of the complainant or resident shall not be disclosed without the consent of the complainant or resident. (Section 3-702(f) of the Act)*

- j) *A complainant who is dissatisfied with the determination or investigation by the Department may request a hearing under subsection (k) of this Section. The facility shall be given notice of any such hearing and may participate in the hearing as a party. If a facility requests a hearing under subsection (k) of this Section which concerns a matter covered by a complaint, the complainant shall be given written notice and may participate in the hearing as a party. A request for a hearing by either a complainant or a facility shall be submitted in writing to the Department within 30 days after the mailing of the Department's findings as described in subsection (h) of this Section. Upon receipt of the request the Department shall conduct a hearing as provided under subsection (k) of this Section. (Section 3-702(g) of the Act)*
- k) Any person aggrieved by a decision of the Department rendered in a particular case which affects the legal rights, duties or privileges created under the Act may have such decision reviewed in accordance with Sections 3-703 through 3-712 of the Act.
- l) When the Department finds that a provision of Article II of the Act regarding residents' rights has been violated with regard to a particular resident, the Department shall issue an order requiring the facility to reimburse the resident for injuries incurred, or \$100, whichever is greater.

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Section 300.3320 Confidentiality

- a) *The Department, the facility and all other public or private agencies shall respect the confidentiality of a resident's record and shall not divulge or disclose the contents of a record in a manner which identifies a resident, except upon a resident's death to a relative or guardian, or under judicial proceedings. This Section shall not be construed to limit the right of a resident or a resident's representative to inspect or copy the resident's records. (Section 2-206(a) of the Act)*
- b) *Confidential medical, social, personal, or financial information identifying a resident shall not be available for public inspection in a manner which identifies a resident. (B) (Section 2-206(b) of the Act)*

(Source: Amended at 13 Ill. Reg. 4684, effective March 24, 1989)

Section 300.3330 Facility Implementation

- a) *The facility shall establish written policies and procedures to implement the responsibilities and rights provided in Article II of the Act. The policies shall include the procedure for the investigation and resolution of*

resident complaints under the Act. The policies shall be clear and unambiguous and shall be available for inspection by any person. A summary of the policies and procedures, printed in not less than 12 point type, shall be distributed to each resident and representative. (Section 2-210 of the Act)

- b) The facility shall provide copies of these policies and procedures upon request to next of kin, sponsoring agencies, representative payees and the public.
- c) *Each resident and resident's guardian or other person acting for the resident shall be given a written explanation prepared by the Office of the State Long-term Care Ombudsman of all the rights enumerated in Part 1 of Article II of the Act and in Part 4 of Article III. For residents of facilities participating in Title 18 or 19 of the Social Security Act, the explanation shall include an explanation of residents' rights enumerated in the Act. The explanation shall be given at the time of admission to a facility or as soon thereafter as the condition of this resident permits, but in no event later than 48 hours after admission, and again at least annually thereafter. At the time of implementation of the Act each resident shall be given a written summary of all the rights enumerated in Part I of Article II of the Act. If a resident is unable to read such written explanation, it shall be read to the resident in a language the resident understands. In the case of a minor or a person having a guardian or other person acting for him, both the resident and the parent, guardian or other person acting for the resident shall be fully informed of these rights. (Section 2-211 of the Act)*
- d) The resident, resident's representative, guardian, or parent of a minor resident shall acknowledge in writing the receipt from the facility of a copy of all resident rights set forth in Article II of the Act and a copy of all facility policies implementing such rights.
- e) *The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in the Act and this Part. (Section 2-212 of the Act) (B)*

(Source: Amended at 17 Ill. Reg. 19279, effective October 26, 1993)

Section 300.3710 Day Care in Long-Term Care Facilities

- a) For a licensed long-term care facility to be approved for a day care program, it is necessary that the facility meet all licensing requirements for its level of care.
- b) In addition, the following criteria must also be met:
 - 1) Staff: Sufficient and satisfactory personnel shall be on duty to provide services that meet the total needs of the day care residents, without detracting from the services given to the residents in the facility in accordance with various staffing requirements in this Part.
 - 2) Space:
 - A) Dining – Adequate space and equipment available to accommodate the additional residents in accordance with Subpart J and L and Sections 300.2070 or 300.3070.
 - B) Activity Area – Large enough area to accommodate capacity of facility, plus additional "Day Care" residents in accordance with Sections 300.2870 or 300.3070.
 - C) Rest Area – A definite area should be designated as an area available for the Day Care resident to nap or rest. This area should be equipped with beds (roll-aways can be used) or cots and portable screens. There should also be adequate space available for personal items storage for the number of Day Care residents being cared for. Suggested areas which can be utilized for the Day Care resident could include:
 - i) Facilities having more than one communal area (such as a lounge, sunporch, and other areas) could designate one of these for rest areas;
 - ii) Non-occupied rooms (no one assigned to these rooms);
 - iii) Toilets – Adequate number to accommodate extra number of residents in accordance with Sections 300.2860 and 300.3060.
 - 3) Records:

- A) A statement by a physician who has evaluated the resident within the last 30 days stating the resident is free of communicable and infectious disease, and indicating any medication and treatments and diet needed by the resident during the period of time in the facility. Permission should also be granted in this statement for the resident to participate in activities with any contraindications or limitations.
 - B) Medication and Treatment record – Required for any medications or treatments given during resident stay in the facility. (Medications must be in original containers and properly labeled.)
 - C) "Face" sheet or admission sheet – Containing all pertinent information necessary for the "safe keeping" of the resident such as complete name; address, telephone number, social security number, medicare number, and age of resident; name, business, and home address, and telephone number of person to notify in an emergency; name of family physician; name of physician to call in an emergency.
 - D) Incident Report – in case of medication error or accident of any kind.
- 4) There must be written policies covering "Day Care" Service in the facility which explain implementation of this section.
 - 5) Permission for a Day Care Program requires identifying the services of the facility that will be used in the program. Examples: Activity area, dining area, administering of medications by nursing staff, physical therapy, speech, social services.
 - 6) The maximum number of "Day Care" residents served shall be reported with the application under Section 300.160 of this Part.
 - 7) The facility shall consider the following in developing and providing "Day Care Programs":
 - A) Use of house or advisory physician for emergencies;
 - B) Insurance coverage;
 - C) Signed agreement with family or responsible individual;

- D) Permission to be involved in activities outside of the facility (in the community);
- E) Attendance record; and
- F) Facility should be aware of method and time of pick-up and delivery of the Day Care residents.

(Source: Amended at 16 Ill. Reg. 17089, effective November 3, 1992)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.4000 APPLICABILITY OF SUBPART S

Section 300.4000 Applicability of Subpart S

- a) Beginning July 1, 2002, a licensed SNF or ICF providing services to persons with serious mental illness shall meet the requirements of this Subpart S. Applicability of this Subpart S shall not affect a facility's compliance with the remainder of this Part.

- b) For the purposes of this Subpart, "serious mental illness" is defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1400 K Street NW, Washington, DC 20005), excluding alcohol and substance abuse, Alzheimer's disease, and other forms of dementia based upon organic or physical disorders. A serious mental illness is determined by all of the following three areas:
 - 1) Diagnoses that constitute a serious mental illness are:
 - A) Schizophrenia;
 - B) Delusional disorder;
 - C) Schizo-affective disorder;
 - D) Psychotic disorder not otherwise specified;
 - E) Bipolar disorder I - mixed, manic, and depressed;
 - F) Bipolar disorder II;
 - G) Cyclothymic disorder;
 - H) Bipolar disorder not otherwise specified I;

- I) Major depression, recurrent;
- 2) In addition, the individual must be 18 years of age or older and be substantially functionally limited due to mental illness in at least two of the following areas:
- A) Self-maintenance;
 - B) Social functioning;
 - C) Community living activities;
 - D) Work-related skills;
- 3) Finally, the disability must be of an extended duration expected to be present for at least a year, which results in a substantial limitation in major life activities. These individuals will typically also have one of the following characteristics:
- A) Have experienced two or more psychiatric hospitalizations;
 - B) Receive Social Security Income (SSI) or Social Security Disability Income (SSDI) because of mental illness, or have been deemed eligible for SSI or SSDI.
- c) This Subpart applies to persons who are transferred to a facility for 120 or fewer days for a medical reason directly related to the person's diagnosis of serious mental illness, such as medication management.
- d) This Subpart does not apply to the provision of services for residents having a diagnosis in the following mental disorder categories: senile and presenile organic psychotic conditions, alcoholic psychoses, drug psychoses, transient organic psychotic conditions, other organic psychotic conditions (chronic), non-psychotic disorders due to organic brain damage, and mental retardation.
- e) This Subpart does not apply to individuals who are transferred to a facility for 120 or fewer days for a medical reason, such as from fractures or cardiac or respiratory traumas. However, during this individual's stay, the individual's mental illness needs shall be met as much as possible, taking into account the individual's medical condition.
- f) Facilities shall consider the location of a resident's room based on the resident's needs and the needs of other residents in the facility. Factors to be considered include aggressive behavior, supervision needs, noise levels, friendship patterns, common rehabilitative goals or services, sleep patterns, interests, recreational pursuits, and vulnerability.

- g) Facilities providing services to persons with serious mental illness in accordance with Subpart S shall also comply with Subparts A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and R of this Part. In case of a conflict between those Subparts and Subpart S, the more stringent requirement applies.
- h) Facilities with 20 or fewer residents with serious mental illness may request exemption from Section 300.4090(a)(1), (2) and (3); (b)(3); (c)(3) and (5); (d); and (f)(1) by submitting a declaration to the Department that meets the following requirements:
 - 1) States that no resident under age 65 with serious mental illness will be admitted to the facility;
 - 2) Is received by the Department by July 1, 2005; or within 5 days after the facility has 20 or fewer residents with serious mental illness and the facility discontinues admission of such residents; and
 - 3) Lists the names and Social Security numbers of the current residents with a diagnosis of serious mental illness.
- i) If a facility, having declared that it will not admit residents with serious mental illness under age 65, substantially fails to meet the needs of the residents with serious mental illness, as identified by the resident assessment, or fails to conduct assessments in accordance with Section 300.4010 and 300.4020, the facility is not exempt from Section 300.4090(a)(1), (2) and (3); (b)(3); (c)(3) and (5); (d); and (f)(1).
- j) A facility that has submitted a declaration to the Department in accordance with subsection (h) of this Section may resume admitting residents under age 65 with serious mental illness with the Department's written approval. Approval will be granted when the facility submits proof of compliance with Section 300.4090(a)(1), (2) and (3); (b)(3); (c)(3) and (5); (d); and (f)(1).
- k) A facility that has declared to the Department that individuals under age 65 with serious mental illness will not be admitted may request approval from the Department to admit an individual under age 65 with serious mental illness. The Department's approval will be individual specific and will be based on the individual's complex medical needs that can only be met in a skilled nursing facility. The facility must have demonstrated the ability to meet the individual's medical, nursing, social, psychological, emotional, and personal care needs. The facility cannot admit this individual until approval is provided by the Department.

(Source: Amended at 29 Ill. Reg. 876, effective December 22, 2004)

Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs.
- b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC.
- c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following:
 - 1) A psychiatric evaluation completed by a board certified or board eligible psychiatrist or, if countersigned by a board certified or board eligible psychiatrist, the evaluation may be completed by a person who is a certified psychiatric nurse, a nurse with a Bachelor of Science in Nursing (BSN) and two years of experience serving individuals with serious mental illness, or a registered nurse with five years of experience serving individuals with serious mental illness; a licensed clinical social worker; a physician; a licensed psychologist; or a licensed clinical professional counselor (LCPC) under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107]. The psychiatric evaluation shall include:
 - A) Psychiatric history with present and previous psychiatric symptoms;

- B) Comprehensive mental status examination, which includes: a statement of assets and deficits, a description of intellectual functioning, memory functioning, orientation, affect, suicidal/homicidal ideation, response to reality testing, and current attitudes and overt behaviors; and
 - C) Diagnostic formulation, problems, and diagnosis using the Diagnostic and Statistical Manual IV (DSM-IV), ensuring that information is recorded on as many of the five axes as appropriate.
- 2) Psychosocial assessment performed by the Psychiatric Rehabilitation Services Director (PRSD), a social worker, an occupational therapist, an LCPC, or the PRSC if reviewed and countersigned by the PRSD. The assessment shall cover the following points:
- A) Identifying information (including resident's name, age, race, religion, date of admission; name of individuals giving information);
 - B) Reason for admission (including specific problems and how long the problems have existed in their current state; contributing factors to exacerbation of problems; most recent psychiatric treatment and effects; goals of nursing facility as articulated by referral source);
 - C) History of mental illness, treatment, and care (including age of onset; private and public hospital inpatient episodes; community mental health care; prior nursing facility placement; specific treatments and effects);
 - D) Personal history (including current marital status; marital history including name, occupation, and age of current and previous spouses; name, age, sex and occupation of children, if any; status of significant personal relationships with individuals (past and present); work history of individual including all known past professions and/or jobs);
 - E) Residential history (including, for the last two years, the types of housing (e.g., family, public housing, apartment, room, or community agency), relationship to other occupants, the total number of known moves; factors known to have contributed to past housing loss; the highest level of residential independence attained, approximate

date and length; any patterns of persistent residential instability or homelessness);

- F) Family history (including information regarding individual's parents and siblings; any significant family illnesses, especially psychiatric illnesses; history of traumatic or significant loss including where, when and effect on individual); and
 - G) Developmental history (including early life history, place of birth, where raised and by whom and with whom; school history; and history regarding friends, hobbies, interests, social activities and interactions).
- 3) A skills assessment performed by a social worker, occupational therapist, or PRSD or PRSC with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, including but not limited to the following areas:
- A) Self-maintenance (including basic activities of daily living such as hygiene, dressing, grooming, maintenance of personal space, care of belongings, diet and nutrition, and personal safety);
 - B) Social skills (including communication, peer group involvement, friendship, family interaction, male/female relationship, and conflict avoidance and resolution);
 - C) Community living skills (including use of telephone, transportation and community navigation, avoidance of common dangers, shopping, money management, homemaking (cleaning, laundry, meal preparation), and use of community resources);
 - D) Occupational skills (including basic academic skills; job seeking and retention skills; ability to initiate and schedule activities; promptness and regular attendance; ability to accept, understand and carry out instructions; ability to complete an application; and interview skills);
 - E) Symptom management skills (including symptom monitoring and coping strategies; stress identification and management; impulse control; medication management and self-medication capability; relapse prevention); and

- F) Substance abuse management (including recovery, relapse prevention and harm reduction).
- 4) Oral screening completed by a dentist or registered nurse.
- 5) Discharge plan as required by Section 300.4060 of this Part.
- 6) Other assessments recommended by the IDT or required elsewhere in this Part, or as ordered by the resident's physician or psychiatrist to clarify diagnoses or to identify concomitant motivational, cognitive, affective, or physical deficits that could have an impact on rehabilitation efforts and outcomes, as indicated by the individual's needs.
- 7) A structured assessment of resident interests and expectations regarding psychiatric rehabilitation conducted by the PRSC or PRSD with each resident. The assessment shall include at a minimum:
 - A) Resident's identification of personal strengths, goals, needs, and resources;
 - B) Skill development and problem areas for which the resident expresses an interest in setting goals and participating in psychiatric rehabilitation programming;
 - C) Resident's beliefs and confidence regarding his/her capacity to develop increased skills and independence.
- d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to improved functioning and increased independence. The IDT's assessment of overall rehabilitation focus for the resident will also be identified as one of the following levels:
 - 1) Basic skills training and supports with opportunities for community integration;
 - 2) Intensive skills training and supports with an increasing focus on community integration; or

- 3) Advanced skills training and supports with active linkage and use of community services in preparation for expected discharge within six months.

(Source: Amended at 29 Ill. Reg. 876, effective December 22, 2004)

Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment.
- b) Complete comprehensive reassessments shall be conducted as needed but at least every 12 months in the following areas:
 - 1) Psychiatric evaluation;
 - 2) Psychosocial assessment update (including significant events, e.g., death of a significant other since the last reassessment);
 - 3) Skills assessment update, including an assessment of resident levels of functioning and reassessment of rehabilitation potential (an evaluation of the individual's strengths, potentials, environmental opportunities and ability to achieve or likelihood of achieving maximum functioning); and a narrative statement of the individual's strengths and potential as they directly relate to the individual's functional limitations with recommendations for treatment and/or services, and the potential of the individual to function more independently. A complete reassessment shall be required if changes in the resident's functional level make the current assessment inapplicable. If a complete reassessment is not required, the update must include a narrative summary of the reevaluated assessment;
 - 4) Recreation and leisure activities updates, including the resident's participation, perceived enjoyment, frequency of self-initiated involvement versus staff coaxing or refusal, and recommended interventions;
 - 5) Physical examination update, including, but not limited to:

- A) Medical history and medication history updates, including any illness and changes in medical diagnosis and medication prescription or indication of administration compliance that have occurred since the last assessment;
 - B) Oral screening update completed by a dentist or registered nurse;
 - C) Nutritional update completed by a dietician or the food service supervisor under the direction of the dietician; and
- 6) Other assessments needed, as determined by the interdisciplinary team.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim treatment plan (IITP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed:
- 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others);
 - 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation;
 - 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and

- 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with treatment planning).
- b) An ITP shall be developed within seven days after completion of the comprehensive assessment.
 - c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed.
 - d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall:
 - 1) Be developed by the IDT;
 - 2) Be based on the results obtained from the assessment process;
 - 3) Be stated in measurable terms and identify specific performance measures to assess; and
 - 4) Be developed with a projected completion or review date (month, day, year).
 - e) Services designed to implement the objectives in the resident's ITP shall specify:
 - 1) Specific approaches or steps to meet the objective;
 - 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate;
 - 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and
 - 4) Identification of the staff responsible for implementing each specific intervention.

- f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs.
- g) ITP Documentation:
 - 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented.
 - 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes.
- h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan.
- i) The resident's individual treatment plan shall be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian.
- j) If the resident refuses to attend the IDT meeting or refuses to sign the treatment plan, the PRSC shall meet with the resident to review and discuss the treatment plan as soon as possible, not to exceed 96 hours after the treatment plan review. Evidence of this meeting shall be documented in the resident's record.
- k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist.
- l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions or skills training activities, as appropriate, in the following areas:
 - 1) Self-maintenance;
 - 2) Social skills;
 - 3) Community living skills;

- 4) Occupational skills;
 - 5) Symptom management skills; and
 - 6) Substance abuse management.
- m) Activity interventions for individual residents shall be part of, but not used to replace, psychiatric rehabilitation programming and should provide for using skills in new situations. Activity programs shall comply with Section 300.1410 of this Part.
- n) Residents' attendance in therapeutic programs shall be recorded.
- o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed.
- p) The PRSC is responsible for coordinating staff in the delivery of psychiatric rehabilitation services programs, oversight of data collection, and the review of the resident's performance.
- 1) At least quarterly, and prior to the treatment plan reviews, the PRSC shall meet with the resident to review and discuss the resident's current treatment plan, progress toward achieving the objectives, and obstacles inhibiting progress. Based upon this review, the PRSC, in consultation with the appropriate IDT members, shall revise the resident's ITP as needed. The revised treatment plan shall be submitted to the appropriate IDT members for review, approval and signature.
 - 2) At least quarterly, the PRSC shall record the resident's response to treatment in the clinical record.
- q) The psychiatric rehabilitation services aides shall record the resident's response to those areas overseen by the aide.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4040 General Requirements for Facilities Subject to Subpart S

- a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S:
- 1) 24 hours of continuous supervision, support and therapeutic interventions;
 - 2) Psychotropic medication administration, monitoring, and self-administration;
 - 3) Case management services and discharge preparation and training;
 - 4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance;
 - 5) Crisis services; and
 - 6) Personal care assistance.
- b) The psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of functioning and independence.
- c) The facility's psychiatric rehabilitation program shall have the following overall goals:
- 1) Encourage the engagement of each resident in his/her recovery and rehabilitation;
 - 2) Increase acquisition, performance, and retention of skills to enhance independence and promote community integration;
 - 3) Support the progressive assumption of as much personal responsibility, self-management, and self-determination as each resident can manage;
 - 4) Broaden the use of living, coping, and occupational skills to new environments with an ultimate goal of discharge to a more independent living arrangement, as appropriate;
 - 5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors;
 - 6) Decrease the impact of cognitive deficits as an impediment to learning new skills; and

- 7) Foster the human dignity, personal worth, and quality of life of each resident.
- d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for self-management of psychotropic medications and utilization of other supportive mental health services, such as cooperation with prescribed treatment regimen, self-medication, recognition of early symptoms of relapse, and interactive effects with other drugs and alcohol.
- e) The facility shall have written policies and procedures related to smoking, including smoke-free areas, risk assessment for individuals who smoke, and the conditions and locations where smoking is permitted in the facility, if permitted at all.
- f) A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person to whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S

- a) The facility shall develop and implement a psychiatric rehabilitation program. A facility may contract with an outside entity to provide all or part of the psychiatric rehabilitation program as long as individual residents' needs are met and subsection (c)(4) is met. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following:
 - 1) Skills training programs addressing a comprehensive range of skill areas, including the major domains of self-maintenance, social functioning, community living, occupational preparedness, symptom management, and substance abuse management. Skills training programs should:
 - A) Include available published, validated modules with highly structured curricula for teaching targeted skills (e.g., trainer's manuals and videotapes that demonstrate the skills to be learned);

- B) Proceed within a training-to-mastery framework that addresses discrete sets of skill competencies, introduces targeted skills in a graded fashion, and regulates the difficulty of exercises to create a momentum of success;
 - C) Include focused instructions and modeling, frequent repetition of new material, auditory and visual representation, role playing and practice, and immediate positive feedback for attention and participation; and
 - D) Be adjusted in content, form and duration to match residents' profiles in terms of stress tolerance, learning impairments, and motivational characteristics. Environmental conditions shall be arranged to help compensate for deficits in resident concentration, attention, and memory (e.g., reduction of distracting stimuli and extensive use of supportive reminder cues), as needed.
- 2) Incentive programs, such as motivational interviewing, behavioral contracting, shaping or individual positive reinforcement, and token economy.
 - 3) Strategies for skill generalization, such as homework, in vivo training, resource management skills, problem-solving skills, and self-management skills (self-monitoring, self-evaluation and self-reinforcement).
 - 4) Aggression prevention and management, including resident screening (history of aggressive and assaultive behavior, precipitating factors, signals of escalating risk, and effective de-escalation strategies); identification and modification of environment risk factors (e.g., physical plant and resident mix); provision of skills training, behavioral, and appropriate psychopharmacological interventions based on individualized resident assessment; and policies and procedure for rapid response to behavioral emergencies.
 - 5) Substance dependence and abuse management services, including toxicological screens, psychopharmacology, alcohol and drug education, group interventions, recovery programs (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Mentally Ill Substance Abusers (MISA)), and harm reduction.
- b) The facility's psychiatric rehabilitation program shall be integrated with other services provided to residents by the facility to develop a cohesive approach to each resident's overall needs and consistent plan of care.

- c) Each facility shall have a written description of the components provided by the psychiatric rehabilitation program. Documentation shall include a description of psychiatric rehabilitation principles, the specific rehabilitation techniques and methods, and the type/level of staff utilization in providing each service to the residents.
 - 1) The facility's psychiatric rehabilitation program shall develop, apply and evaluate strategies to create opportunities for residents to practice, transfer, and utilize skills both in the facility and in the broader community.
 - 2) The facility's psychiatric rehabilitation program shall demonstrate close working alliances with community mental health and vocational service providers through such indicators as joint staff training and planning activities, mutual referrals, collaborative resident treatment planning, and effective resident transition.
 - 3) Resources utilized outside of the facility for service provision, consultation, or referrals shall be included in this documentation.
 - 4) If a facility uses consultants or contracts all or part of the psychiatric rehabilitation program to another entity:
 - A) A contract shall include a written description of the components, the name of the person responsible for each component, and the type/level and number of staff used in each component.
 - B) The facility shall have a policy that indicates coordination between facility staff and the entity or consultants, including unannounced visits by designated facility management to the site of the components of the program.
 - C) Consultants contracting directly with the facility or through another entity who are not physicians shall have participated in an Illinois Department of Public Aid-approved Psychiatric Rehabilitation Training Program.
 - D) Contracted personnel shall meet the same education and experience requirements as facility personnel under this Subpart.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4060 Discharge Plans for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- a) As part of the ITP, a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment.
- b) Within one year prior to a planned discharge, preparation shall address:
 - 1) Identification and linkage to proposed community providers;
 - 2) Self-directed initiation and compliance with mental health services while in the facility;
 - 3) Use of community mental health services;
 - 4) Assistance with locating and securing housing; and
 - 5) Assistance with identification, application and securing financial resources.
- c) At least 30 days before the individual's planned discharge, the PRSC shall notify the individual or the individual's legal representative and, when appropriate, the individual's family, both orally and in writing, of the upcoming planned discharge. A specific, individualized post-discharge plan must be developed by the IDT, and, when appropriate, with input from community support agencies, family and friends, 30 days before the planned discharge. The plan will identify:
 - 1) The alternative living site;
 - 2) Financial resources available;
 - 3) Community service needs and availability;
 - 4) Community mental health services with scheduled psychiatric appointments;
 - 5) Access to medical care and medications; and
 - 6) Case management system responsible for transition and follow-up.
- d) The discharge plan shall consider the resident's geographic preference upon discharge and the need for financial assistance.

- e) Referral and linkage to the post-discharge service provider should occur with face-to-face contact, on-site visits, and, if appropriate, assumption of partial services prior to discharge.
- f) At the time of discharge, the facility shall:
 - 1) Prepare a discharge summary of the resident's current psychiatric status; self-care skills; behavior and impulse control; social functioning; community living skills; basic educational, vocational and work-related skills; substance abuse history; and general health status. Dates of resident's pre-discharge contact with the aftercare agency shall be included, as well as specific issues that may have a negative impact on community adjustment. The discharge plan shall also include recommendations for transitional programming and the name, address, telephone number, and time and date of the resident's first post-discharge appointment with the aftercare service provider.
 - 2) Provide the post-discharge plan of care and the discharge summary to the resident's new service provider.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4070 Work Programs for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

- a) In-house facility work programs for individual residents participating in the psychiatric rehabilitation program shall be considered to increase work-related skills, further residents' socialization, foster independence, and increase a sense of well-being and adjustment.
- b) The facility shall work with State and community agencies in assisting individual program residents to avail themselves of specialized work activity programs, prevocational and work adjustment training, supportive employment, sheltered workshop programs, and other similar programs that are provided outside of the facility.
- c) Appropriate records shall be maintained for residents functioning in work programs in the facility or outside the facility. These shall show appropriateness of the program for the individual; objectives; resident duties, training and supervision; resident's response to the program; and any other pertinent observations. This information shall become a part of the resident's record.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4080 Community Based Rehabilitation Programs for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

Community-based (off-site) rehabilitation programs shall be used as an adjunct to the facility program where their use will assist in community reintegration or in the development of relationships with the agency that will be providing services to the individuals after discharge. The facility shall develop and maintain working relationships and written agreements with community agencies that provide psychiatric rehabilitation services. Appropriate records shall be maintained for residents receiving psychiatric rehabilitation services from outside agencies. These records shall show the appropriateness of the program for the individual, the ITP objectives addressed, the interventions being utilized, the resident's response to the program, the responsible community agency staff, and any other pertinent observations.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.4090 Personnel for Providing Services to Persons with Serious Mental Illness for Facilities Subject to Subpart S

- a) Psychiatric Medical Director
 - 1) The facility shall have a consultant for the psychiatric rehabilitation program who is an Illinois licensed physician and is board eligible or board certified in psychiatry from the American Board of Psychiatry and Neurology. The psychiatric medical director is responsible for advising the administrator and the Psychiatric Rehabilitation Services Director on the overall psychiatric management of the program's residents.
 - 2) There shall be communication linkages between the psychiatric medical director and the medical director.
 - 3) The psychiatric medical director, working with the administrator, shall be responsible for annually approving in writing the facility's written policies and procedures for the psychiatric rehabilitation program.
 - 4) Each resident shall be under the care of a psychiatrist. If a resident was admitted and has continuously been a resident since prior to January 1, 2002 and a psychiatrist has never served as the resident's primary physician, the resident may continue with the current physician if that physician uses psychiatric consultation, as needed, for the resident.

- 5) A psychiatrist shall be available for the psychiatric treatment and psychiatric medication management of the residents. All residents or residents' guardians shall be permitted their choice of psychiatrist.
 - 6) Each resident shall be seen by a psychiatrist at least every 90 days and as often as necessary to ensure adequate psychiatric treatment.
- b) Psychiatric Rehabilitation Services Director
- 1) A Psychiatric Rehabilitation Services Director (PRSD) shall be:
 - A) A licensed, registered, or certified psychiatrist, psychologist, social worker, occupational therapist, rehabilitation counselor, psychiatric nurse or licensed professional counselor who has a minimum of at least one year supervisory experience and at least one year of experience working directly with persons with serious mental illness and who has attended an Illinois Department of Public Aid (IDPA) training program; or
 - B) A person with a master's degree in a human services field with at least one year of supervisory experience and at least three years of experience working directly with persons with severe mental illness who has attended an IDPA training program.
 - 2) An individual who is employed at a licensed nursing home in a capacity similar to that of a Psychiatric Rehabilitation Services Director on January 1, 2002 and who has at least five years of experience in that capacity may petition the Department for approval to continue to act in that role even if the individual is not a licensed, registered, or certified psychiatrist, psychologist, social worker, rehabilitation counselor, psychiatric nurse or licensed professional counselor. The Department will consider information submitted in accordance with subsection (h) of this Section in deciding whether to grant approval. The Department may revoke approval if the individual fails to continue to meet professional standards or to complete the required training.
 - 3) Each facility shall have a PRSD for the psychiatric rehabilitation program who is assigned responsibility for:
 - A) Developing and implementing the facility's psychiatric rehabilitation program;

- B) Developing and implementing the facility's staff training and in-service programs relating to the psychiatric rehabilitation program; and
 - C) Ensuring the coordination and monitoring of the residents' participation in the psychiatric rehabilitation program ITP.
- 4) The PRSD shall ensure that each resident's ITP is developed by an Interdisciplinary Team and is individualized, states the progressive goals of treatment, includes measurable objectives, is written in behavioral terms, is understandable and acknowledged by resident and staff, and is implemented.
 - 5) The PRSD shall ensure that residents' needs are met through appropriate staff interventions and community resources and, whenever possible, that residents and their families or significant others are involved in the preparation of their plan of care.
 - 6) The PRSD shall ensure the availability of education and information for family members of residents.
- c) Psychiatric Rehabilitation Services Coordinator
- 1) A Psychiatric Rehabilitation Services Coordinator (PRSC) shall be an occupational therapist or possess a bachelor's degree in a human services field (including but not limited to: sociology, special education, rehabilitation counseling or psychology) and have a minimum of one year of supervised experience in mental health or human services.
 - 2) An individual who is employed at a licensed nursing home in a capacity similar to that of a Psychiatric Rehabilitation Services Coordinator on January 1, 2002 and who has at least five years of experience in that capacity may petition the Department for approval to continue to act in that role even if the individual does not possess a bachelor's degree in human services. The Department will consider information submitted in accordance with subsection (h) of this Section in deciding whether to grant approval. The Department may revoke approval if the individual fails to continue to meet professional standards or to complete required training.
 - 3) Each resident admitted to the facility shall have a PRSC to act as a case manager. The PRSC will be identified as the staff member to whom the resident primarily relates for the coordination of service.

- 4) The responsibilities of the PRSC are:
 - A) To provide the resident with a stable therapeutic relationship;
 - B) To orient the resident to the facility;
 - C) To review and assist the resident in understanding the treatment plan and program schedule;
 - D) To prepare and assist the resident with active participation in the treatment plan review;
 - E) To provide and/or coordinate the delivery of the psychiatric rehabilitation services programs; and
 - F) To monitor the resident in the areas of self-directed care and for overall compliance with the treatment plan.
 - 5) There shall be a PRSC for each 30 participants.
 - 6) If the PRSC is a consultant, then subsections (c)(4)(A) and (E) will also be the responsibility of facility staff.
- d) In a facility with 10 or fewer residents with serious mental illness, the PRSD may act as the PRSC.
 - e) Registry of Certified Psychiatric Rehabilitation Services Aides
 - 1) An individual will be placed on the Nurse Aide Registry as a psychiatric rehabilitation services aide when he/she has successfully completed a training program approved in accordance with the Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395) and has met background check information required in Section 300.661 of this Part, and when there are no findings of abuse, neglect, or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act.
 - 2) An individual will be placed on the Nurse Aide Registry if he/she has met background check information required in Section 300.661 of this Part and submits documentation supporting one of the following equivalencies:

- A) Documentation of current registration from another state as a psychiatric rehabilitation services aide (PRSA).
 - B) Documentation of successful completion of a PRSA training course approved by another state as evidenced by a diploma, certification or other written verification from the school. The documentation must demonstrate that the course is equivalent to, or exceeds, the requirements for PRSAs in the Long-Term Care Assistants and Aides Training Programs Code.
- f) Psychiatric Rehabilitation Services Aides
- 1) Beginning January 1, 2003, facilities shall employ PRSAs or persons who have successfully completed a psychiatric rehabilitation certificate program to provide psychiatric rehabilitation program services to residents.
 - 2) If a facility does not employ PRSAs to provide psychiatric rehabilitation program services, the following minimum training shall be provided to certified nursing assistants (CNAs) within 30 days after the CNA's first day of employment:
 - A) Understanding the impact of serious mental illness;
 - B) Understanding the role of psychiatric rehabilitation, including how to manage psychiatric disabilities and countering stigma and discrimination;
 - C) Confidentiality;
 - D) Preventative strategies for managing aggression and crisis intervention;
 - E) Goals and function of case management;
 - F) Appropriate verbal and physical interaction;
 - G) Communication skills between staff and residents; and
 - H) Basic psychiatric rehabilitation techniques and service delivery.
- g) Consultants

- 1) A facility may use consultants with advanced professional degrees who meet the same requirements as facility personnel under this Subpart to provide psychiatric rehabilitation services and to provide expertise in the development and implementation of the facility's psychiatric rehabilitation services program and individual resident assessment and care planning.
 - 2) All consultants providing services at the facility who are not physicians shall complete the Illinois Department of Public Aid-approved Psychiatric Rehabilitation Training Program.
- h) An individual petitioning the Department for approval to continue acting as a PRSD or PRSC even if that person does not meet formal education requirements shall submit the following information to the Department:
- 1) Work history;
 - 2) Education since high school;
 - 3) Employment references;
 - 4) A statement that the person is working in a capacity similar to the position for which the individual is seeking recognition; and
 - 5) Any other information that supports that the individual is capable of meeting the professional standards of the recognized position.

Within one year after approval is granted, the individual shall complete the training offered by IDPA for PRSC/PRSD, as applicable.

(Source: Amended at 29 Ill. Reg. 876, effective December 22, 2004)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.6000 APPLICABILITY OF SUBPART T

Section 300.6000 Applicability of Subpart T

- a) To be subject to this Subpart, a nursing facility shall request in writing to be subject to this Subpart and shall meet each of the following criteria:
 - 1) 90% or more of the resident population of the nursing home has a diagnosis of serious mental illness;
 - 2) No more than 15 percent of the resident population of the nursing home is 65 years of age or older;
 - 3) None of the residents have a primary diagnosis of moderate, severe, or profound mental retardation;
 - 4) None of the residents require medical or nursing care at a level higher than the intermediate nursing care light level of care as defined in Section 300.1230(n) of this Part; and
 - 5) The facility must participate in Illinois Department of Public Aid's demonstration program relating to specialized services, training, technical assistance, development and use of a standardized assessment tool, data collection, and admission restrictions.

- b) A facility shall certify annually 150 to 120 days prior to license expiration that the facility meets all of the criteria listed in subsection (a) of this Section. A facility that has remained in compliance with admission practices in 89 Ill. Adm. Code 145 (Illinois Department of Public Aid (IDPA): Mental Health Services in Nursing Facilities) and has a resident population more than 15 percent of whom are 65 years of age or older may continue to participate if IDPA provides documentation that the facility has complied with admission practices for the 12 months preceding application.

- c) A facility that has been subject to this Subpart may choose not to be subject to this Subpart by submitting a written notice to the Department within 30 days before the effective date of the facility's intent not to be subject to this Subpart.

- d) For the purposes of this Subpart, "serious mental illness" is defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), excluding alcohol and substance abuse, Alzheimer's disease, and other forms of dementia based upon organic or physical disorders. A severe mental illness is determined by all of the following three areas:
 - 1) Diagnoses that constitute a serious mental illness are:
 - A) Schizophrenia;
 - B) Delusional disorder;
 - C) Schizo-affective disorder;
 - D) Psychotic disorder not otherwise specified;
 - E) Bipolar disorder I - mixed, manic, and depressed;
 - F) Bipolar disorder II;
 - G) Cyclothymic disorder;
 - H) Bipolar disorder not otherwise specified I;
 - I) Major depression, recurrent;

 - 2) In addition, the individual must be 18 years of age or older and be substantially functionally limited due to mental illness in at least two of the following areas:
 - A) Self-maintenance;
 - B) Social functioning;
 - C) Community living activities;
 - D) Work-related skills;

 - 3) Finally, the disability must be of an extended duration expected to be present for at least a year, which results in a substantial limitation in major life activities. These individuals will typically also have one of the

following characteristics:

- A) Have experienced two or more psychiatric hospitalizations;
 - B) Receive Social Security Income (SSI) or Social Security Disability Income (SSDI) due to mental illness or could be deemed eligible for SSI or SSDI.
- e) Facilities shall consider the location of a resident's room based on the resident's needs and the needs of other residents in the facility. Factors to be considered include aggressive behavior, supervision needs, noise level, friendship patterns, common rehabilitation goals or services, sleep patterns, interests, recreational pursuits, and vulnerability.
- f) The following Sections of this Part do not apply to facilities subject to this Subpart: 300.660, 300.663, 300.682, 300.684, 300.690, 300.820, 300.830, 300.1010, 300.1220, 300.1230, 300.1240, 300.4000, 300.4010, 300.4020, 300.4030, 300.4040, 300.4050, 300.4060, 300.4070, 300.4080, and 300.4090.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6005 Quality Assessment and Improvement for Facilities Subject to Subpart T

- a) The licensee shall develop and implement a quality assessment and improvement program designed to meet at least the following goals:
 - 1) Ongoing monitoring and evaluation of the quality and accessibility of care and services provided at the facility or under contract, including, but not limited to:
 - A) Admission of residents appropriate to the capabilities of the facility;
 - B) Resident assessment;
 - C) Development and implementation of appropriate individualized psychiatric treatment plan;
 - D) Resident satisfaction;
 - E) Discharge planning;
 - F) Infection control; and

- G) Balancing resident autonomy and safety.
- 2) Identification and analysis of problems.
- 3) Identification and implementation of corrective action or changes in response to problems.
- b) The program shall operate pursuant to a written plan, which shall include, but not be limited to:
 - 1) A detailed statement of how problems will be identified;
 - 2) The methodology and criteria that will be used to formulate action plans to address problems;
 - 3) Procedures for evaluating the effectiveness of action plans and revising action plans to prevent reoccurrence of problems;
 - 4) Procedures for documenting the activities of the program; and
 - 5) Identifying the persons responsible for administering the program.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6010 Comprehensive Assessments for Residents of Facilities Subject to Subpart T

- a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs.
- b) The IDT shall identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC.

- c) A comprehensive assessment shall be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following:
- 1) A psychiatric evaluation completed by a board certified or board eligible psychiatrist or by a person who is a certified psychiatric nurse, a nurse with a Bachelor of Science in Nursing (BSN) and two years of experience serving individuals with serious mental illness or a registered nurse with five years of experience serving individuals with serious mental illness, a licensed clinical social worker, a physician, a licensed psychologist, or a licensed clinical professional counselor (LCPC) under the Professional Counselor and Clinical Professional Counselor Licensing Act [225 ILCS 107] if countersigned by a board certified or board eligible psychiatrist. The psychiatric evaluation shall include:
 - A) Psychiatric history with present and previous psychiatric symptoms;
 - B) Comprehensive mental status examination, which includes: a statement of assets and deficits, a description of intellectual functioning, memory functioning, orientation, affect, suicidal/homicidal ideation, response to reality testing, and current attitudes and overt behaviors; and
 - C) Diagnostic formulation, problems, and diagnosis using the Diagnostic and Statistical Manual IV (DSM-IV), ensuring that information is recorded on as many of the five axes as appropriate.
 - 2) Psychosocial assessment performed by the Psychiatric Rehabilitation Services Director (PRSD), a social worker, an occupational therapist, or an LCPC or the Psychiatric Rehabilitation Services Coordinator (PRSC) if reviewed and countersigned by the PRSD, a social worker, or LCPC. The assessment shall cover the following points:
 - A) Identifying information (including resident's name, age, race, religion, date of admission; name of individuals giving information);

- B) Reason for admission (including specific problems and how long the problems have existed in their current state; contributing factors to exacerbation of problems; most recent psychiatric treatment and effects; goals of nursing facility placement as articulated by referral source);
 - C) History of mental illness, treatment, and care (including age of onset; private and public hospital inpatient episodes; community mental health care; prior nursing facility placement; specific treatments and effects);
 - D) Personal history (including current marital status; marital history including name, occupation, and age of current and previous spouses; name, age, sex and occupation of children, if any; and status of significant personal relationships with individuals (past and present); work history of individual, including all known past professions and/or jobs);
 - E) Residential history (including, for the last two years, the types of housing (e.g., family, public housing, apartment, room, or community agency), relationship to other occupants, the total number of known moves; factors known to have contributed to past housing loss; the highest level of residential independence attained, approximate date and length; any patterns of persistent residential instability or homelessness);
 - F) Family history (including information regarding individual's parents and siblings; any significant family illnesses, especially psychiatric illnesses; history of traumatic or significant loss, including where, when and effect on individual); and
 - G) Developmental history (including early life history, place of birth, where raised and by whom and with whom; school history; and history regarding friends, hobbies, interests, social activities and interactions).
- 3) A skills assessment performed by a social worker, occupational therapist, or PRSC or PRSD with training in skills assessment. The skills assessment shall include an evaluation of the resident's strengths, an assessment of the resident's levels of functioning, and recommendations for treatment and services, including but not limited to the following areas:

- A) self-maintenance (including basic activities of daily living such as hygiene, dressing, grooming, maintenance of personal space, care of belongings, diet and nutrition, and personal safety);
 - B) social skills (including communication, peer group involvement, friendship, family interaction, male/female relationship, and conflict avoidance and resolution);
 - C) community living skills (including use of telephone, transportation and community navigation, avoidance of common dangers, shopping, money management, homemaking (cleaning, laundry, meal preparation), and use of community resources);
 - D) occupational skills (including basic academic skills; job seeking and retention skills; ability to initiate and schedule activities; promptness and regular attendance; ability to accept, understand and carry out instructions; ability to complete an application; and interview skills);
 - E) symptom management skills (including symptom monitoring and coping strategies; stress identification and management; impulse control; medication management and self-medication capability; relapse prevention); and
 - F) substance abuse management (including recovery, relapse prevention, and harm reduction).
- 4) Assessments and examinations required by Section 300.6047 of this Part.
 - 5) Discharge plan as required by Section 300.6060 of this Part.
 - 6) Other assessments recommended by the IDT or required elsewhere in this Subpart or as ordered by the resident's physician or psychiatrist to clarify diagnoses or to identify concomitant motivational, cognitive, affective, or physical deficits that could have an impact on rehabilitation efforts and outcomes, as indicated by the individual's needs.
 - 7) A structured assessment of resident interests and expectations regarding psychiatric rehabilitation conducted by the PRSC or PRSD with each resident. The assessment shall include at a minimum:

- A) resident's identification of personal strengths, goals, needs, and resources;
 - B) skill development and problem areas for which the resident expresses an interest in setting goals and participating in psychiatric rehabilitation programming;
 - C) resident's beliefs and confidence regarding his/her capacity to develop increased skills and independence.
- d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to improved functioning and increased independence. The IDT's assessment of overall rehabilitation focus for the resident shall also be identified as one of the following levels:
- 1) Basic skills training and supports with opportunities for community integration;
 - 2) Intensive skills training and supports with an increasing focus on community integration; or
 - 3) Advanced skills training and supports with active linkage and use of community services in preparation for expected discharge within six months.

(Source: Amended at 29 Ill. Reg. 876, effective December 22, 2004)

Section 300.6020 Reassessments for Residents of Facilities Subject to Subpart T

- a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member shall reassess the resident and update the resident's assessment, assuring the continued accuracy of the assessment.
- b) Complete comprehensive reassessments shall be conducted as needed, but at least every 12 months, in the following areas:
 - 1) Psychiatric evaluation;

- 2) Psychosocial assessment update (including significant events, e.g., death of a significant other since the last reassessment);
- 3) Skills assessment update, including an assessment of resident levels of functioning and reassessment or rehabilitation potential (an evaluation of the individual's strengths, potentials, environmental opportunities and ability/likelihood of achieving maximum functioning); and a narrative statement of the individual's strengths and potentials as they directly relate to the individual's functional limitations with recommendations for treatment and/or services, and the potential of the individual to function more independently. A complete reassessment shall be required if changes in the resident's functional level make the current assessment inapplicable. If a complete reassessment is not required, the update must include a narrative summary of the reevaluated assessment;
- 4) Recreation and leisure activities updates, including the resident's participation, perceived enjoyment, frequency of self-initiated involvement versus staff coaxing or refusal, and recommended interventions;
- 5) Physical examination update, including, but not limited to:
 - A) Medical history and medication history updates, including any illness, and changes in medical diagnosis and medication prescription or indication of administration compliance that has occurred since the last assessment;
 - B) Oral screening updates completed by a dentist or registered nurse;
 - C) Nutritional update completed by a dietician or the food service supervisor under the direction of the dietician; and
- 6) Other assessments needed, as determined by the interdisciplinary team.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6030 Individualized Treatment Plan for Residents of Facilities Subject to Subpart T

- a) On admission, information received from the admission source (e.g., resident, family, preadmission screening (PAS) agent) shall be used to develop an interim treatment plan. In developing an individual's interim

treatment plan (ITTP), the facility shall review the PAS/MH assessments and "Notice of Determination" and consider the use of this information in developing the interim treatment plan. The IITP shall focus on those behaviors and needs requiring attention prior to development of the individualized treatment plan (ITP). Each IITP shall be based on physician's orders and shall include diagnosis, allergies and other pertinent medical information. The following information shall also be considered, as appropriate, to allow for the identification and provision of appropriate services until a final plan is developed:

- 1) Known risk factors (e.g., wandering, safety issues, aggressive behavior, suicide, self-mutilation, possible victimization by others);
 - 2) Observable resident medical/psychiatric conditions that may require additional immediate assessment or consultation;
 - 3) Therapeutic involvement that might be of interest to the resident, be recommended based on referral information, aid in orientation or provide meaningful data for further professional assessment; and
 - 4) Other known factors having an impact on the resident's condition (e.g., family involvement, social interaction patterns, cooperation with treatment planning).
- b) An ITP shall be developed within 7 days after completion of the comprehensive assessment.
- c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed.
- d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall:
- 1) Be developed by the IDT;
 - 2) Be based on the results obtained from the assessment process;
 - 3) Be stated in measurable terms and identify specific performance measures to assess; and

- 4) Be developed with a projected completion or review date (month, day, year).
- e) Services designed to implement the objectives in the resident's ITP shall specify:
- 1) Specific approaches or steps to meet the objective;
 - 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (number of minutes, hours, etc.) and duration (period of time, e.g., over the next six months) and the supports necessary for the resident to participate;
 - 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and
 - 4) Identification of the staff responsible for implementing each specific intervention.
- f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs.
- g) ITP Documentation:
- 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented.
 - 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes.
- h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan.
- i) The resident's ITP must be signed by all members of the IDT participating in its development, including the resident or the resident's legal guardian.
- j) If the resident refuses to attend the IDT meeting, the PRSC shall meet with the resident to review and discuss the treatment plan as soon as

possible, not to exceed 96 hours after the treatment plan review. Evidence shall be documented that the ITP was explained to the resident or legal guardian of the resident.

- k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist.
- l) The ITP shall be based upon each resident's assessed functioning level, appropriate to age, and shall include structured group or individual psychiatric rehabilitation services interventions or skills training activities, as appropriate, in the following areas:
 - 1) Self-maintenance;
 - 2) Social skills;
 - 3) Community living skills;
 - 4) Occupational skills;
 - 5) Symptom management skills; and
 - 6) Substance abuse management.
- m) Activity interventions for individual residents shall be part of but not used to replace psychiatric rehabilitation programming and should provide for using skills in new situations. Activity programs shall comply with Section 300.1410 of this Part.
- n) Residents' attendance in therapeutic programs shall be recorded.
- o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to attend at least 50 percent of any programs included in his or her ITP over a 30-day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed.
- p) The PRSC is responsible for coordinating staff in the delivery of psychiatric rehabilitation services programs, oversight of data collection, and the review of the resident's performance.

- 1) At least quarterly, and prior to the treatment plan reviews, the PRSC shall meet with the resident to review and discuss the resident's current treatment plan, progress toward achieving the objectives, and obstacles inhibiting progress. Based upon this review, the PRSC, in consultation with the appropriate IDT members, shall revise the resident's ITP as needed. The revised treatment plan shall be submitted to the appropriate IDT members for review, approval and signature.
 - 2) At least quarterly, the PRSC shall record the resident's response to treatment in the clinical record.
- q) The psychiatric rehabilitation services aides shall record the resident's response to those areas overseen by the aide.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6040 General Requirements for Facilities Subject to Subpart T

- a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by residents of the facility:
 - 1) 24 hours of continuous supervision, support and therapeutic interventions;
 - 2) Psychotropic medication administration, monitoring, and self-administration;
 - 3) Case management services and discharge preparation and training;
 - 4) Psychiatric rehabilitation services addressing major domains of functioning and skills development: self-maintenance, social and community living, occupational preparedness, symptom management, and substance abuse avoidance;
 - 5) Crisis services; and
 - 6) Personal care assistance.
- b) The psychiatric rehabilitation services programs in the facility shall be designed to improve or maintain the resident's level of functioning and independence.
- c) The facility's psychiatric rehabilitation program shall have the following overall goals:

- 1) Encourage the engagement of each resident in his/her recovery and rehabilitation;
 - 2) Increase acquisition, performance, and retention of skills to enhance independence and promote community integration;
 - 3) Support the progressive assumption of as much personal responsibility, self-management, and self-determination as each resident can manage;
 - 4) Broaden the use of living, coping, and occupational skills to new environments with an ultimate goal of discharge to a more independent living arrangement, as appropriate;
 - 5) Decrease psychotic, self-injurious, antisocial, and aggressive behaviors;
 - 6) Decrease the impact of cognitive deficits as an impediment to learning new skills;
 - 7) Foster the human dignity, personal worth, and quality of life of each resident; and
 - 8) Support the testing and application of advanced or specialized psychiatric rehabilitation techniques that have demonstrated effectiveness in research settings and that address identified needs of individuals or groups of residents in the facility in conjunction with the demonstration project.
- d) The psychiatric rehabilitation program shall provide education and training to maximize residents' capacities for self-management of psychotropic medications and utilization of other supportive mental health services, such as cooperation with a prescribed treatment regimen, self-medication, recognition of early symptoms of relapse, and interactive effects with other drugs and alcohol.
- e) The facility shall have written policies and procedures related to smoking, including smoke-free areas, risk assessment for individuals who smoke, and the conditions and locations where smoking is permitted in the facility.
- f) A facility shall document all leaves and therapeutic transfers. Such documentation shall include date, time, condition of resident, person to whom the resident was released, planned destination, anticipated date of return, and any special instructions on medication dispensed.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6045 Serious Incidents and Accidents in Facilities Subject to Subpart T

- a) The facility shall notify the Department of any incident or accident that has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents resulting in injury requiring the services of a physician, hospital, or police, or other service provider on an emergency basis and/or requiring the services of the coroner or fire department shall be reported to the Department.
 - 1) Notification shall be made by faxing Section 300.Appendix G to (217)785-9182 within 24 hours after each serious incident or accident; or
 - 2) Notification shall be made by a phone call to the Regional Office within 24 hours after each serious incident or accident; or
 - 3) If the facility is unable to contact the Regional Office or use the fax number, notification shall be made by a phone call to the Department's toll-free complaint registry number.
- b) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days after the occurrence.
- c) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved.
- d) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6047 Medical Care Policies for Facilities Subject to Subpart T

- a) The facility shall have a written program of medical services, approved in writing by a physician, that reflects the philosophy of care provided, the policies relating to this philosophy, and the procedures for implementation of the services. The program shall emphasize the use of the resident's personal physician and arrangements, as needed, to effect prompt transfer to other facilities. The written program of medical services shall be followed in the operation of the facility.
- b) Each resident admitted shall have a physical examination within five days prior to admission or within 14 days after admission. The examination report shall include at a minimum each of the following:

- 1) An evaluation of the resident's condition, including height, weight and nutritional status; diagnoses; plan of treatment; treatment and medication orders; permission for participation in activity programs as appropriate; an assessment of sensory and physical impairments; and a medical history, including history of allergies, surgeries, medications, and other significant medical conditions;
- 2) Documentation of the presence or absence of communicable diseases, such as tuberculosis infection, in accordance with Sections 300.1020 and 300.1025 of this Part; and
- 3) Documentation of the medical needs and plans for meeting those needs, including:
 - A) an assessment of proper treatment and assistive devices to maintain vision and hearing abilities; and
 - B) an assessment for specialized rehabilitative services, such as physical therapy, speech-language pathology and occupational therapy.
- c) Each resident shall have an oral screening by a dentist or a nurse within 30 days after admission and annually thereafter.
- d) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident. The facility shall obtain and record the physician's plan of care or treatment of such accident, injury or change in condition at the time of notification.
- e) The facility shall have a written agreement with one or more hospitals or other providers, as necessary, that indicates that the hospital, hospitals, or providers will provide diagnostic, emergency and routine acute care hospital services. (This requirement shall be waived when the facility can document to the satisfaction of the Department that by reason of remote location or refusal of local hospitals to enter an agreement, it is unable to effect such an agreement.)
- f) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6049 Emergency Use of Restraints for Facilities Subject to Subpart T

- a) If a resident presents a behavioral emergency posing an immediate danger of serious injury to self or others and alternative interventions cannot ensure safety, restraint may be used for a brief period until emergency care and physical transportation to a hospital can be accomplished. The use of restraint is otherwise not permitted. In situations that are successfully resolved through manual holding lasting less than five minutes, without take-down to the ground or undue force, and without injury, transport to an emergency room/hospital is not required.
- b) Restraint use shall be limited to the least amount of physical restriction and the briefest possible duration necessary to resolve the immediate danger.
- c) The limitation on permitted restraint use applies to any physical restraint, including the physical take-down and prolonged restriction of movement by staff, as well as any mechanical restraint device. Gentle physical guidance, prompting and escort of a resident are not considered restraint.
- d) Any resident being restrained until arrival of emergency transportation to the hospital shall be continuously monitored to ensure safety, avoid injury, and minimize discomfort. The resident's position shall be monitored to ensure that breathing is unrestricted. Resident hydration or toileting needs shall be addressed unless precluded by immediate safety concerns.
- e) Nursing staff shall examine the resident as soon as possible, but within ten minutes after the start of the restraint.
- f) The resident's psychiatrist shall be contacted immediately for medical direction. If the resident's psychiatrist is unavailable, the Psychiatric Medical Director shall be contacted.
- g) The staff involved in the restraint shall be debriefed by the Director of Nursing regarding the events leading up to the restraint, take-down and/or application, and the resident's condition during the restraint. The resident shall be debriefed after return from the hospital.
- h) The emergency use of physical restraints shall be documented in the resident's record, including:
 - 1) The behavioral emergency that prompted the restraint, including preceding events, staff efforts to de-escalate the situation, and reasons for the use of restraint.
 - 2) The date and time restraint began, the methods used in restraining the resident, the duration of restraint use, the time of release, and events surrounding release.

- 3) The names and titles of the staff responsible for applying restraint and for monitoring the resident, and those of any other staff involved in the incident.
 - 4) Orders by the psychiatrist or psychiatric medical director notified of the restraint.
 - 5) The emergency transportation utilized and the hospital to which the resident was taken.
 - 6) Any injury or other negative impact to the resident.
 - 7) The date of the scheduled care planning conference and results of the care plan review in light of the use of emergency restraint.
- i) Facility staff, including security staff, shall receive a basic orientation to crisis prevention, safe take-down and restraint methods.
 - j) The facility shall maintain records of training related to the use of restraints and de-escalation practices provided to staff.
 - k) The facility's emergency use of physical restraint shall comply with Section 300.682(e), (f), (g), and (j).

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart T

- a) The facility shall develop and implement a psychiatric rehabilitation program. The program shall be designed to allow a wide array of group and individual therapeutic activities, including, but not limited to, the following:
 - 1) Skills training programs and supports addressing a comprehensive range of skill areas, including the major domains of self-maintenance, social functioning, community living, occupational preparedness, symptom management, and substance abuse management. Skills training programs should:
 - A) Include available published, validated modules with highly structured curricula for teaching targeted skills (e.g., trainer's manuals and videotapes that demonstrate the skills to be learned);

- B) Proceed within a training-to-mastery framework that addresses discrete sets of skill competencies, introduces targeted skills in a graded fashion, and regulates the difficulty of exercises to create a momentum of success;
 - C) Include focused instructions and modeling, frequent repetition of new material, auditory and visual representation, role playing and practice, and immediate positive feedback for attention and participation; and
 - D) Be adjusted in content, form and duration to match residents' profiles in terms of stress tolerance, learning impairments, and motivational characteristics. Environmental conditions shall be arranged to help compensate for deficits in resident concentration, attention, and memory (e.g., reduction of distracting stimuli and extensive use of supportive reminder cues), as needed.
- 2) Incentive programs, such as motivational interviewing, behavioral contracting, shaping or individual positive reinforcement, and token economy.
 - 3) Strategies for skill generalization, such as homework, in vivo training, resource management skills, problem-solving skills, and self-management skills (self-monitoring, self-evaluation and self-reinforcement).
 - 4) Aggression prevention and management, including resident screening (history of aggressive and assaultive behavior, precipitating factors, signals of escalating risk, and effective de-escalation strategies); identification and modification of environment risk factors (e.g., physical plant and resident mix); provision of skills training, behavioral interventions, and appropriate psychopharmacological interventions based on individualized resident assessment; and policies and procedure for rapid response to behavioral emergencies.
 - 5) Substance dependence and abuse management services, including toxicological screens, psychopharmacology, alcohol and drug education, group interventions, and recovery programs (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Mentally Ill Substance Abusers (MISA)).
- b) The facility's psychiatric rehabilitation program shall be integrated with other services provided to residents by the facility to develop a cohesive approach to each resident's overall needs and consistent plan of care.

- c) Each facility shall have a written description of the components provided by the psychiatric rehabilitation program. Documentation shall include a description of psychiatric rehabilitation principles, the specific rehabilitation techniques and methods, and the type/level of staff utilization in providing each service to the residents.
 - 1) The facility's psychiatric rehabilitation program shall include specific components aimed at residents with multiple cognitive impairments.
 - 2) The facility's psychiatric rehabilitation program shall develop, apply and evaluate strategies to create opportunities for residents to practice, transfer, and utilize skills both in the facility and in the broader community.
 - 3) Resources utilized outside the facility for service provision, consultation or referrals shall be included in this documentation.
- d) The facility's psychiatric rehabilitation program shall demonstrate close working alliances with community mental health and vocational service providers through such indicators as joint staff training and planning activities, mutual referrals, collaborative resident treatment planning, and effective resident transition.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6060 Discharge Plans for Residents of Facilities Subject to Subpart T

- a) As part of the ITP, a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment.
- b) During the year, but no later than six weeks prior to a planned discharge, preparation for discharge shall address:
 - 1) Identification and linkage to proposed community providers;
 - 2) Self-directed initiation and compliance with mental health services while in the facility;
 - 3) Use of community mental health services;
 - 4) Assistance with locating and securing housing; and

- 5) Assistance with identification, application and securing financial resources.
- c) At least 30 days before the individual's planned discharge, the PRSC must notify the individual or the individual's legal representative and, when appropriate, the individual's family, both orally and in writing, of the upcoming planned discharge. A specific, individualized post-discharge plan must be developed by the IDT, and, when appropriate, with input from community support agencies, family and friends, 30 days before the planned discharge. The plan will identify:
- 1) The alternative living site;
 - 2) Financial resources available;
 - 3) Community service needs and availability;
 - 4) Community mental health services with scheduled psychiatric appointments;
 - 5) Access to medical care and medications; and
 - 6) Case management system responsible for transition and follow-up.
- d) The discharge plan shall consider the resident's geographic preference upon discharge and the need for financial assistance.
- e) Referral and linkage to the post-discharge service provider should occur with face-to-face contact, on-site visits and, if appropriate, assumption of partial services prior to discharge.
- f) At the time of discharge, the facility shall:
- 1) Prepare a discharge summary of the resident's current psychiatric status; self-care skills; behavior and impulse control; social functioning; community living skills; basic educational, vocational and work-related skills; substance abuse history; and general health status. Dates of resident's pre-discharge contact with the aftercare agency shall be included, as well as specific issues that may have a negative impact on community adjustment. The discharge plan shall also include recommendations for transitional programming and the name, address, telephone number, and time and date of the resident's first post-discharge appointment with the aftercare service provider.

- 2) Provide the post-discharge plan of care and the discharge summary to the resident's new service provider.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6070 Work Programs for Residents of Facilities Subject to Subpart T

- a) In-house facility work programs for individual residents participating in the psychiatric rehabilitation program shall be considered to increase work-related skills, further residents' socialization, foster independence, and increase a sense of well-being and adjustment.
- b) The facility shall work with State and community agencies in assisting individual program residents to avail themselves of specialized work activity programs, prevocational and work adjustment training, supportive employment, sheltered workshop programs, and other similar programs that are provided outside of the facility.
- c) Appropriate records shall be maintained for residents functioning in work programs in the facility or outside the facility. These shall show appropriateness of the program for the individual; objectives; resident duties, training and supervision; resident's response to the program; and any other pertinent observations. This information shall become a part of the resident's record.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6080 Community-Based Rehabilitation Programs for Residents of Facilities Subject to Subpart T

Community-based (off-site) rehabilitation programs shall be used as an adjunct to the facility program where their use will assist in community reintegration or in the development of relationships with the agency that will be providing services to the individuals after discharge. The facility shall develop and maintain working relationships and written agreements with community agencies that provide psychiatric rehabilitation services. Appropriate records shall be maintained for residents receiving psychiatric rehabilitation services from outside agencies. These records shall show the appropriateness of the program for the individual, the ITP objectives addressed, the interventions being utilized, the resident's response to the program, the responsible community agency staff, and any other pertinent observations.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.6090 Personnel for Providing Services to Residents of Facilities Subject to Subpart T

a) Psychiatric Medical Director

- 1) The facility shall have a psychiatric medical director who is an Illinois licensed physician and is board eligible or board certified in psychiatry from the American Board of Psychiatry and Neurology. The psychiatric medical director is responsible for advising the administrator and the Psychiatric Rehabilitation Services Director on the overall psychiatric management of the residents.
- 2) The psychiatric medical director shall be the medical director of the entire facility or only for the psychiatric rehabilitation program. If the psychiatric medical director is only responsible for the psychiatric rehabilitation program, there shall be communication linkages between the psychiatric medical director and the medical director.
- 3) The psychiatric medical director shall be responsible for annually approving in writing the facility's written policies and procedures applicable to the psychiatric rehabilitation program.
- 4) Each resident shall be under the care of a psychiatrist. All residents or residents' guardians shall be permitted their choice of psychiatrist.
- 5) Each resident shall be seen by a psychiatrist at least every 90 days and as often as necessary to ensure adequate psychiatric treatment.

b) Psychiatric Rehabilitation Services Director

- 1) A Psychiatric Rehabilitation Services Director (PRSD) shall be a licensed, registered, or certified psychiatrist, psychologist, social worker, occupational therapist, rehabilitation counselor, psychiatric nurse or licensed professional counselor and have a minimum of at least one year of supervisory experience and at least one year of experience working directly with persons with serious mental illness.
- 2) An individual who is employed at a licensed nursing home in a capacity similar to that of a Psychiatric Rehabilitation Services Director on January 1, 2002 and who has at least five years of experience in that capacity may petition the Department for approval to continue to act in that role even if the individual is not a licensed, registered, or certified psychiatrist, psychologist, social worker, rehabilitation counselor, psychiatric nurse or licensed professional counselor. The Department will consider information

submitted in accordance with subsection (i) of this Section in deciding whether to grant approval. The Department may revoke approval if the individual fails to continue to meet professional standards or to complete the required training.

- 3) Each facility shall have a full-time PRSD for the psychiatric rehabilitation program who is assigned responsibility for:
 - A) Developing and implementing the facility's psychiatric rehabilitation program;
 - B) Developing and implementing the facility's staff training and in-service programs relating to the psychiatric rehabilitation program; and
 - C) Ensuring the coordination and monitoring of the residents' participation in the psychiatric rehabilitation program ITP.
 - 4) The PRSD shall ensure that each resident's ITP is developed by an interdisciplinary team and is individualized, states the progressive goals of treatment, includes measurable objectives, is written in behavioral terms, is understandable and acknowledged by resident and staff, and is implemented.
 - 5) The PRSD shall ensure that residents' needs are met through appropriate staff interventions and community resources and, whenever possible, that residents and their families or significant others are involved in the preparation of their plan of care.
 - 6) The PRSD shall ensure the availability of education and information for family members of residents.
- c) Psychiatric Rehabilitation Services Coordinator
- 1) A Psychiatric Rehabilitation Services Coordinator (PRSC) shall be an occupational therapist or possess a bachelor's degree in a human services field (including but not limited to: sociology, special education, rehabilitation counseling or psychology) and have a minimum of one year of supervised experience in mental health or human services.
 - 2) An individual who is employed at a licensed nursing home in a capacity similar to that of a Psychiatric Rehabilitation Services Coordinator on January 1, 2002 and who has at least five years of experience in that capacity may petition the Department for approval to continue to act in that role even if the individual does

not possess a bachelor's degree in human services. The Department will consider information submitted in accordance with subsection (i) of this Section in deciding whether to grant approval. The Department may revoke approval if the individual fails to continue to meet professional standards or to complete required training.

- 3) Each resident admitted to the facility shall have a PRSC to act as a case manager. The PRSC will be identified as the staff member to whom the resident primarily relates for the coordination of service.
 - 4) The responsibilities of the PRSC are:
 - A) To provide the resident with a stable therapeutic relationship;
 - B) To orient the resident to the facility;
 - C) To review and assist the resident in understanding the treatment plan and program schedule;
 - D) To prepare and assist the resident with active participation in the treatment plan review;
 - E) To provide the delivery of the psychiatric rehabilitation services;
 - F) To coordinate the delivery of the psychiatric rehabilitation services; and
 - G) To monitor the resident in the areas of self-directed care and for overall compliance with the treatment plan.
 - 5) There shall be a PRSC for each 20 participants.
- d) Director of Nursing
- 1) A supervisory nursing position shall be established titled Director of Nursing (DON). The DON shall be a full-time employee who is on duty at least 36 hours per week and at least four days per week. This position shall not be included in the requirement for nursing staff coverage.
 - 2) The DON shall be a registered nurse, preferably with at least one year's clinical experience in a mental health setting or a master's degree in psychiatric nursing.

- 3) The DON, in consultation with the facility's medical director, shall be responsible for the development and implementation of the facility's overall medical policies and practices, including:
 - A) The administration, monitoring, and observation of resident medications;
 - B) The medication education, compliance and self-administration program;
 - C) The monitoring and coordination of residents' physical care, medical appointments, and diagnostic consultation;
 - D) The health education of residents; and
 - E) The supervision of the facility's nursing personnel.
- e) Assistant Director of Nursing
 - 1) An Assistant Director of Nursing (ADON) position shall be established in facilities of 300 beds or more. The ADON shall be a full-time employee who is on duty at least 36 hours per week and at least four days per week.
 - 2) The ADON shall be a licensed nurse, preferably with at least one year of experience working with the chronically mentally ill.
 - 3) In consultation with the DON, the ADON shall be responsible for the direct supervision, monitoring and implementation of the facility's medical policies and residents' health services.
- f) Nursing Staff
 - 1) Adequate nursing personnel shall be provided to meet the medication, education and health needs of residents, and not fewer than one nurse per 40 residents in a 24 hour period shall be provided (i.e., a full-time equivalent ratio of one nurse to every 40 individuals being served).
 - 2) Facilities shall have at least one licensed nurse (licensed practical nurse or registered nurse) on duty at all times.
 - 3) Licensed practical nurses shall have successfully completed a pharmacology course or have at least one full year of full-time

supervised experience in administering medications in a health care setting prior to employment.

g) Psychiatric Rehabilitation Services Aide

- 1) Beginning January 1, 2003, sufficient psychiatric rehabilitation services aides (PRSAs) or persons who have successfully completed a psychiatric rehabilitation certificate program shall be on duty all hours of each day to provide services that meet the needs of the residents, and no fewer than one PRSA per 10 residents in a 24 hour period shall be provided (i.e., a full-time equivalent ratio of one PRSA for every 10 individuals being served). Prior to January 1, 2003, if the facility does not employ PRSAs, the facility may employ certified nursing assistants (CNAs) if the following minimum training is provided within 30 days after the CNA's first day of employment:
 - A) Understanding the impact of serious mental illness;
 - B) Understanding the role of psychiatric rehabilitation, including how to manage psychiatric disabilities and countering stigma and discrimination;
 - C) Confidentiality;
 - D) Preventive strategies for managing aggression and crisis intervention;
 - E) Goals and function of case management;
 - F) Appropriate verbal and physical interaction;
 - G) Communication skills between staff and resident; and
 - H) Basic psychiatric rehabilitation techniques and service delivery.
- 2) *A facility shall not employ an individual as a PRSA unless the facility has inquired of the Department as to information in the Department's Nurse Aide Registry concerning the individual.* (Section 3-206.01 of the Act) The Department shall advise the inquirer if the individual is on the Registry, if the individual has findings of abuse, neglect, or misappropriation of property in accordance with Section 3-206.01 and 3-206.02 of the Act, and if the individual has a current background check. (See Section 300.661 of this Part.)

- 3) The facility shall ensure that each PRSA complies with one of the following conditions:
 - A) Is approved on the Department's Nurse Aide Registry. "Approved" means that the PRSA has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver.
 - B) Begins an approved Psychiatric Rehabilitation Services Aide Training Program (see 77 Ill. Adm. Code 395) no later than 45 days after employment. The PRSA shall successfully complete the training program within 120 days after the date of initial employment. An aide enrolled in a program approved in accordance with 77 Ill. Adm. Code 395.150(a)(2) shall not be employed more than 120 days prior to successfully completing the program.
 - C) Within 120 days after initial employment, submits documentation to the Department in accordance with Section 300.663 of this Part to be registered on the Nurse Aide Registry.
- 4) Each person employed by the facility as a PRSA shall meet each of the following requirements:
 - A) *Be at least 16 years of age, of temperate habits and good moral character, honest, reliable, and trustworthy* (Section 3-206(a)(1) of the Act);
 - B) *Be able to speak and understand the English language or a language understood by a substantial percentage of the facility's residents*(Section 3-206(a)(2) of the Act);
 - C) *Provide evidence of prior employment or occupation, if any, and residence for two years prior to present employment as a PRSA* (Section 3-206(a)(3) of the Act);
 - D) *Have completed at least eight years of grade school or provide proof of equivalent knowledge* (Section 3-206(a)(4) of the Act).
- 5) *The facility shall certify that each PRSA employed by the facility meets the requirements of this Section. The*

certification *shall be retained by the facility as part of the employee's personnel record.* (Section 3-206(d) and (e) of the Act)

- 6) During inspections of the facility, the Department may require PRSAs to demonstrate competency in the principles, techniques, and procedures covered by the basic PRSA training program curriculum described in the Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395), when possible problems in the care provided by aides or other evidences of inadequate training are observed. The State approved manual skills evaluation testing format and forms will be used to determine competency of an aide when appropriate. Failure to demonstrate competency of the principles, techniques and procedures shall result in the provision of in-service training to the individual by the facility. The in-service training shall address the PRSA training principles and techniques relative to the procedures in which the aides are found to be deficient during inspection (see 77 Ill. Adm. Code 395).
- h) Registry of Certified Psychiatric Rehabilitation Services Aides
- 1) An individual will be placed on the Nurse Aide Registry when he/she has successfully completed a training program approved in accordance with the Long-Term Care Assistants and Aides Training Programs Code and has met background check information required in Section 300.661 of this Part, and when there are no findings of abuse, neglect, or misappropriation of property in accordance with Section 3-206.01 and 3-206.02 of the Act.
 - 2) An individual will be placed on the Nurse Aide Registry if he/she has met background check information required in Section 300.661 of this Part and submits documentation supporting one of the following equivalencies:
 - A) Documentation of current registration from another state as a PRSA.
 - B) Documentation of successful completion of a PRSA training course approved by another state as evidenced by a diploma, certification or other written verification from the school. The documentation must demonstrate that the course is equivalent to, or exceeds, the requirements for PRSAs in the Long-Term Care Assistants and Aides Training Programs Code.

- i) An individual petitioning the Department to continue acting as a PRSD or a PRSC even if that person does not meet formal education requirements shall submit the following information to the Department:
 - 1) Work history;
 - 2) Education since high school;
 - 3) Employment references;
 - 4) A statement that the person was working in a capacity similar to the position for which he/she is seeking recognition; and
 - 5) Any other information that supports that the person is capable of meeting the professional standards of the position.

Within one year after the petition is approved, the individual shall complete the training offered by IDPA for PRSC/PRSD, as applicable.

- j) Consultants
 - 1) A facility may use consultants with advanced professional degrees who meet the same requirements as facility personnel under this Subpart to provide psychiatric rehabilitation services and to provide expertise in the development and implementation of the facility's psychiatric rehabilitation services program and individual resident assessment and care planning.
 - 2) All consultants providing services at the facility who are not physicians shall complete the Illinois Department of Public Aid-approved Psychiatric Rehabilitation Training Program.

(Source: Amended at 29 Ill. Reg. 876, effective December 22, 2004)

Section 300.6095 Training and Continuing Education for Facilities Subject to Subpart T

- a) Within the first 12 months after the facility elects to comply with Subpart T, the Psychiatric Rehabilitation Services Director, Psychiatric Rehabilitation Services Coordinator and the Director of Nursing shall complete an Illinois Department of Public Aid-approved training program.
- b) Within 12 months after completing the IDPA-approved training and annually thereafter, the PRSD, PRSC, and DON shall participate in at least six continuing education units on psychiatric rehabilitation.

- c) All consultants who are not physicians providing services at the facility shall complete the IDPA-approved Psychiatric Rehabilitation Training Program.

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES
PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE
SECTION 300.7000 APPLICABILITY

Section 300.7000 Applicability

- a) This Subpart, in addition to the remainder of Part 300, as applicable, shall apply to facilities and distinct parts (units) that are subject to the Alzheimer's Special Care Disclosure Act.
- b) The facility shall comply with the Alzheimer's Special Care Disclosure Act, in accordance with Section 300.163 of this Part, for this unit.
- c) Facilities substantially in compliance with the requirements of this Subpart will receive written recognition from the Department.
- d) A location that, subsequent to the recognition, has an A violation or a repeat B violation that is related to the operation of the unit shall immediately discontinue using the recognition, including, but not limited to, removing documentation of the recognition that may have been posted and removing any mention of the recognition from written documentation provided to families or the community.
- e) A location that, subsequent to the recognition, has an A violation or repeat B violation shall notify current residents and their representatives. Within seven days after a location is issued an A or repeat violation, the licensee shall notify entities that have referred individuals to the unit within the previous 90 days, such as hospital discharge planners, Area Agency on Aging, and Alzheimer's Association.

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

Section 300.7010 Admission Criteria

- a) The unit shall have clearly defined admission, admission exclusion, and discharge criteria. This shall include a policy specifying the individuals whom the unit will admit and retain based on the stages of Alzheimer's disease, individuals' behaviors, or other definable needs. These criteria

shall reflect the unit's mission and scope of services. A copy of these criteria shall be provided to the resident, resident's family, resident's representative, and prospective residents and their family/representative prior to admission.

- b) All unit residents shall have a diagnosis of Alzheimer's disease or other types of dementia.
- 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.
- e) The health and behavior of each resident shall be considered by the facility in assigning roommates, so that no resident's physical or mental health is adversely affected by his or her roommate. If a resident's health or behavior changes after admission to the unit, or staff receive new information about a resident's health or behavior that indicates that the current room assignment would be harmful to a resident's health, rooms will be reassigned as necessary to protect the health of all residents on the unit. If there are no available rooms, and reassignment is not possible, other measures shall be taken to protect residents' physical and mental health, e.g., increased staffing or supervision.

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

Section 300.7020 Assessment and Care Planning

- 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

- 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)

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- 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)

Section 300.7040 Activities

- a) The unit's activity program shall use ability-centered care programming.
- b) Families shall have access to activity supplies and materials and shall be welcome and encouraged to participate.
- c) Units with a census of more than 40 residents shall have a full-time activity professional who meets the requirements of Section 300.1410(c). Units with a census of 40 or fewer residents shall have an activity professional on duty at least 20 hours per week. This individual shall be responsible for providing activities and training staff in an ability-centered programming approach.
- d) Activity programming shall be planned and provided throughout the day and evening, at least 7 days a week for an average of 8 hours per day.
- e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.

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

Section 300.7050 Staffing

- a) The unit shall have a full-time unit director.
 - 1) The director may have other responsibilities, within the unit, in units with fewer than 40 residents.
 - 2) The unit director may support off-unit activities related to persons with Alzheimer's disease and related dementia, such as providing training to facility staff, assessment of potential residents, counseling to potential residents and their families, and consultation/assessment/care planning for facility residents with Alzheimer's disease and related dementia who do not reside on the unit.
 - 3) The unit director shall have documented course work in dementia care and ability-centered care, and shall meet at least one of the following requirements:

- A) Have an associate's or a bachelor's degree and/or be a registered nurse and have at least one year of experience working with persons with Alzheimer's disease and other dementia; or
 - B) Have a minimum of 5 years of experience working with persons with Alzheimer's disease and other dementia, at least two years of which are management experience working with persons with Alzheimer's disease and other dementia.
- 4) The unit director shall obtain at least 12 hours of continuing education every year, especially related to serving residents with Alzheimer's disease and other dementia.
- b) The unit shall have assigned, consistent staff. There shall be enough staff to meet the scheduled and unscheduled needs of each resident, as defined in the care plan, taking into account the purpose of the setting, the severity of dementia, and the resident's physical abilities, behavior patterns, and social and medical needs.
- c) All staff who ever work on the unit (e.g., nurses, CNAs, housekeepers, social services and activities staff, and food service staff) shall receive at least four hours of dementia-specific orientation within the first 7 days of working on the unit. This orientation shall include:
- 1) Basic information about the nature, progression, and management of Alzheimer's disease and other dementia;
 - 2) Techniques for creating an environment that minimizes challenging behavior from residents with Alzheimer's disease and other dementia;
 - 3) Methods of identifying and minimizing safety risks to residents with Alzheimer's disease and other dementia; and
 - 4) Techniques for successful communication with individuals with Alzheimer's disease and other dementia.
- d) Nurses, CNAs, and social service and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall participate in a minimum of 12 additional hours of orientation within the first 45 days after employment, specifically related to the care of persons with Alzheimer's disease and other dementia. This orientation shall be defined in facility policies and procedures; shall be in a form of classroom, return

demonstration, and mentoring; and shall define to new staff the elements contained in Section 300.7050(e)(1)-(10).

- e) Nurses, CNAs, and social services and activities staff who work on the unit at least 50 percent of the time that they work at the facility shall attend at least 12 hours of continuing education every year, specifically related to serving residents with Alzheimer's disease and other dementia. (Completion of the 12 hours of orientation in accordance with subsection (d) of this Section may be counted as continuing education for the year in which this orientation is completed.) Topics shall include, but not be limited to:
 - 1) Promoting the philosophy of an ability-centered care framework;
 - 2) Promoting resident dignity, independence, individuality, privacy and choice;
 - 3) Resident rights and principles of self-determination;
 - 4) Medical and social needs of residents with Alzheimer's disease and other dementia;
 - 5) Assessing resident capabilities and developing and implementing services plans;
 - 6) Planning and facilitating activities appropriate for a resident with Alzheimer's disease and other dementia;
 - 7) Communicating with families and others interested in the resident;
 - 8) Care of elderly persons with physical, cognitive, behavioral, and social disabilities;
 - 9) Common psychotropics and their side effects; and
 - 10) Local community resources.
- f) Within 6 months after January 1, 2005, or within 6 months after hire, the facility administrator and director of nursing shall attend the orientation for staff who work on the unit at least 50 percent of the time in accordance with subsection (d).
- g) For each training requirement in this Section, staff shall be evaluated to determine if they have met or exceeded stated learning objectives. Results shall be documented.

- h) Training requirements of this Section are in addition to requirements for nurse aide training. Orientation requirements of this Section are in addition to regular staff orientation.

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

Section 300.7060 Environment

- a) The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan.
- b) The unit shall use a variety of sensory cues to differentiate rooms, spaces, and uses.
- c) The unit shall be designed and maintained to ensure an appropriate range of environmental and sensory stimulation and information; e.g., using minimally distracting security, pager and safety systems.
- d) Visual supervision of indoor and outdoor activity areas shall be provided, supported by architectural design. Staff shall be present in activity areas when residents are in these areas.
- e) Resident rooms shall not contain more than two beds. Rooms containing more than 2 beds within units established prior to January 1, 2005 may retain more than 2 beds.
- f) A secure out-of-doors space shall be provided in units established after January 1, 2005 and, whenever possible, in units established before January 1, 2005. If a secure out-of-doors space is not available, the facility shall implement a plan to provide residents with the opportunity for daily, routine outdoor activities, weather permitting.
- g) Social space appropriate to the needs of the individual with Alzheimer's disease and other dementia shall be provided. Social space is any space that is independently accessible to the resident, except for the resident's bedroom, the bathroom, or shower/bathrooms or hallways. Social space includes, but is not limited to, dining room, living room, family visitation areas, unit kitchen, and activity areas.
- h) In facilities establishing a unit after January 1, 2005, this social space shall equal at least 40 square feet per resident bed.

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

Section 300.7070 Quality Assessment and Improvement

The unit shall have a written plan that is part of the facility's overall quality assurance plan to assess residents' quality of care, quality of life, and overall well-being.

- a) The licensee shall develop and implement a quality assessment and improvement program designed to meet at least the following goals:
 - 1) Ongoing monitoring and evaluation of the quality of care and service provided at the facility, including, but not limited to:
 - A) Admission of residents who are appropriate to the capabilities of the facility;
 - B) Resident assessment;
 - C) Development and implementation of appropriate individualized, ability-centered treatment plans;
 - D) Resident satisfaction;
 - E) Infection control;
 - F) Appropriate numbers of staff; and
 - G) Staff turnover.
 - 2) Identification and analysis of problems.
 - 3) Identification and implementation of corrective action or changes in response to problems.
- b) The program shall operate pursuant to a written plan that shall include, but not be limited to:
 - 1) A detailed statement of how problems will be identified, including procedures to elicit insights from residents, residents' families, and residents' representatives;
 - 2) The methodology and criteria that will be used to formulate action plans to address problems, which shall include the insights of residents, residents' families, and residents' representatives;
 - 3) Procedures for evaluating the effectiveness of action plans and revising action plans to prevent reoccurrence of problems;

- 4) Procedures for documenting the activities of the program; and
 - 5) Identifying the persons responsible for administering the program.
- c) A copy of the plan shall be provided to residents, residents' families, or residents' representatives.

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

Section 300.7080 Variances to Enhance Residents' Quality of Life

- a) The Department will consider requests for variances from this Part where the variance will enhance the residents' quality of life. The variance shall be requested in writing and shall contain the following information:
- 1) Facility contact person;
 - 2) The specific Section of this Part from which the applicant is requesting a variance;
 - 3) The proposed alternative plan, service, or approach to meet the needs of the residents;
 - 4) The benefit to the residents if the variance is approved; and
 - 5) The facility plan to evaluate the effectiveness of the variance in meeting the residents' needs, including eliciting insights from residents, residents' families, and residents' representatives.
- b) The facility shall not implement the variance prior to receiving written approval from the Department.
- c) The Department will advise the facility in writing if the variance is approved, denied or approved with conditions or limitations within 90 days after receipt of the request. The Department's decision to approve, deny, or approve the variance with conditions or limitations shall be based on whether the proposed alternative provides an equivalent level of care and safety to the residents.
- d) Variances will not be granted for statutory requirements.

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

Section 300.APPENDIX D Forms for Day Care in Long-Term Care Facilities

SAMPLE

APPLICATION FOR DAY CARE

FORM A

NAME _____ AGE _____ BIRTH DATE _____
ADDRESS _____ PHONE _____
SOCIAL SECURITY
NUMBER _____
MEDICARE
NUMBER _____

WITH WHOM DO YOU
LIVE? _____

RELATIONSHIP? _____

PERSON TO CONTACT IN AN
EMERGENCY
ADDRESS _____
PHONE _____ BUSINESS
PHONE _____

PHYSICAL LIMITATIONS (please list)

1. _____
2. _____
3. _____
4. _____

SPECIAL PHYSICAL NEEDS (medications during day, special rest periods, etc. please list)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

MEDICAL PROBLEMS (circle)

- | | |
|----------------------------|---------------------------|
| 1. diabetic | 8. hearing |
| 2. subject to seizures | 9. eyesight |
| 3. heart disease | 10. assistance with meals |
| 4. dizziness | 11. any paralysis |
| 5. urinary control problem | 12. difficulty in walking |

- 6. bowel control problem
- 7. special diet

- 13. periodic confusion
- 14. allergies (list)
- 15. others

ARE YOU PRESENTLY UNDER A DOCTOR'S CARE?

NAME AND ADDRESS OF PHYSICIANS

SPECIAL INTEREST OR HOBBIES

DAYS ENTERED IN PROGRAMMING

	A.M.	P.M
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

DO YOU HAVE TRANSPORTATION?

(Source added at 9 Ill. Reg. 11049, effective July 1, 1985)

PHYSICIAN PERMISSION FORM

_____ has applied for admittance to the day care program at _____ . Please supply the following information and also give written

permission for _____ to participate in the activity program.

Physical Limitations _____

Degree of activity _____

Can day care resident be involved in activities outside of the facility (in the community)? _____

Has _____ been evaluated within the last 30 days and found to be free of communicable and infectious disease? _____

Medications and/or treatments and diet needed by day care resident during the period of time spent in the facility. _____

Can day care resident take own medication? _____

Allergies _____

Date: _____ Signature of Physician: _____

(Source: Added at 9 Ill. Reg. 11049, effective July 1, 1985)

Section 300.APPENDIX F Guidelines for the Use of Various Drugs

A. Long-Acting Benzodiazepine Drugs

Long-acting benzodiazepine drugs should not be used in residents unless an attempt with a shorter-acting drug (i.e., those listed under B. Benzodiazepine or Other Anxiolytic/Sedative Drugs, and under C. Drugs Used for Sleep Induction) has failed.

After an attempt with a shorter-acting benzodiazepine drug has failed, a long-acting benzodiazepine drug should be used only if:

1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out;
2. Its use results in maintenance or improvement in the resident's functional status;
3. Daily use is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful; and
4. Its use is less than, or equal to, the following listed total daily doses unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for the maintenance or improvement in the resident's functional status.

EXAMPLES OF LONG-ACTING BENZODIAZEPINES (not maximum doses)

Generic	Brand	Daily Oral Dosage
Flurazepam	(Dalmane)	15mg
Chlordiazepoxide	(Librium)	20mg
Clorazepate	(Tranxene)	15mg
Diazepam	(Valium)	5mg
Clonazepam	(Klonopin)	1.5mg
Quazepam	(Doral)	7.5mg
Halazepam	(Paxipam)	40mg

NOTES:

When diazepam is used for neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia or seizure disorders), this Guideline does not apply.

When long-acting benzodiazepine drugs are being used to withdraw residents from short-acting benzodiazepine drugs, this Guideline does not apply.

When clonazepam is used in bi-polar disorders, management of tardive dyskinesia, nocturnal myoclonus or seizure disorders, this Guideline does not apply.

The daily doses listed under Long-Acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is "clinically contraindicated."

B. Benzodiazepine or other Anxiolytic/Sedative Drugs

Use of the listed Anxiolytic/Sedative drugs for purposes other than sleep induction should only occur if:

1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out;
2. Use results in a maintenance or improvement in the resident's functional status;
3. Daily use (at any dose) is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful;
4. Use is for one of the following indications as defined by the Diagnostic and Statistical Manual of Mental Disorders; Fourth Edition (DSM-IV):

Generalized anxiety disorder;

Organic mental syndromes (now called dementia, delirium and amnesic and other "cognitive disorders" by DSM-IV) with associated agitated states which are quantitatively and objectively documented, which are persistent and not due to preventable reasons and which constitute sources of distress or dysfunction to the resident or represent a danger to the resident or others;

Panic disorder;

Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder); and

5. Use is equal to or less than the following listed total daily doses, unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for the improvement or maintenance in the resident's functional status.

EXAMPLES OF SHORT-ACTING BENZODIAZEPINES (not maximum doses)

Generic	Brand	Daily Oral Dosage
Lorazepam	(Ativan)	2mg
Oxazepam	(Serax)	30mg
Alprazolam	(Xanax)	0.75mg

EXAMPLES OF OTHER ANXIOLYTIC AND SEDATIVE DRUGS

Generic	Brand	Daily Oral Dosage
Diphenhydramine	(Benadryl)	50mg
Hydroxyzine	(Atarax, Vistaril)	50mg
Chloral Hydrate	(Many Brands)	750mg

NOTES:

This documentation is often referred to as "behavioral monitoring charts" and is necessary to assist in: (a) assessing whether the resident's behavioral symptom is in need of some form of intervention, (b) determining whether the behavioral symptom is transitory or permanent, (c) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (d) ruling out environmental causes such as excessive heat, noise, overcrowding, etc., (e) ruling out medical causes such as pain, constipation, fever, infection.

The daily doses listed under Short-Acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that a gradual dose reduction is "clinically contraindicated."

Diphenhydramine, hydroxyzine and chloral hydrate are not necessarily drugs of choice for treatment of anxiety disorders. They are only listed here in the event of their potential use.

C. Drugs Used for Sleep Induction

Drugs used for sleep induction should only be used if:

1. Evidence exists that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) have been ruled out;
2. The use of a drug to induce sleep results in the maintenance or improvement of the resident's functional status;
3. Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful;
4. The dose of the drug is equal to or less than the following listed doses unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for maintenance or improvement in the resident's functional status.

EXAMPLES OF HYPNOTIC DRUGS (not maximum doses)

Generic	Brand	Oral Dosage
Temazepam	(Restoril)	7.5mg
Triazolam	(Halcion)	0.125mg
Lorazepam	(Ativan)	1mg
Oxazepam	(Serax)	15mg
Alprazolam	(Xanax)	0.25mg
Estazolam	(ProSom)	0.5mg
Diphenhydramine	(Benadryl)	25mg
Hydroxyzine	(Atarax, Vistaril)	50mg
Chloral Hydrate	(Many Brands)	500mg
Zolipiden	(Ambien)	5mg

NOTES:

Diminished sleep in the elderly is not necessarily pathological.

The doses listed are doses for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides

evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

Diphenhydramine, hydroxyzine, and chloral hydrate are not necessarily drugs of choice for sleep disorders. They are listed here only in the event of their potential use.

For drugs in this category, a gradual dose reduction should be attempted at least three times within six months before one can conclude that a gradual dose reduction is "clinically contraindicated."

D. Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs

The initiation of the following hypnotic/sedative/anxiolytic drugs should not occur in any dose for any resident. (See Notes for exceptions.) Residents currently using these drugs or residents admitted to the facility while using these drugs should receive gradual dose reductions as part of a plan to eliminate or modify the symptoms for which they are prescribed. A gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is clinically contraindicated. Newly admitted residents using these drugs may have a period of adjustment before a gradual dose reduction is attempted.

(Caution: The rapid withdrawal of these drugs might result in severe physiological withdrawal symptoms.)

EXAMPLES OF BARBITURATES

Generic	Brand
Amobarbital	(Amytal)
Amobarbital-Secobarbital	(Tuinal)
Butobarbital	(Butisol, others)
Pentobarbital	(Nembutal)
Secobarbital	(Seconal)
Phenobarbital	(Many Brands)
Barbiturates with other drugs	(e.g., Fiorinal)

EXAMPLES OF MISCELLANEOUS
HYPNOTIC/SEDATIVE/ANXIOLYTICS

Generic	Brand
Ethchlorvynol	(Placidyl)
Glutethimide	(Doriden)
Meproamate	(Equinal, Miltown)

Methprylon
Paraldehyde

(Noludar)
(Many Brands)

NOTES:

Any sedative drug is excepted from this Guideline when used as a single dose sedative for dental or medical procedures.

Phenobarbital is excepted from this Guideline when used in the treatment of seizure disorders.

When Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs are used outside these Guidelines, they may be unnecessary drugs as a result of inadequate indications for use.

E. Antipsychotic Drugs

The following examples of antipsychotic drugs should not be used in excess of the listed doses for residents with organic mental syndromes (now called dementia, delirium, and amnesic and other "cognitive disorders" by DSM-IV) unless higher doses (as evidenced by the resident's response or the resident's clinical record) are necessary to maintain or improve the resident's functional status.

EXAMPLES OF ANTIPSYCHOTIC DRUGS FOR RESIDENTS WITH ORGANIC MENTAL SYNDROMES (not maximum dose)

Generic	Brand	Daily Oral Dosage
Chlorpromazine	(Thorazine)	75mg
Promazine	(Sparine)	150mg
Triflupromazine	(Vesprin)	20mg
Thioridazine	(Mellaril)	75mg
Mesoridazine	(Serentil)	25mg
Acetophenazine	(Tindal)	20mg
Perphenazine	(Trilafon)	8mg
Fluphenazine	(Prolixin, Permitil)	4mg
Trifluoperazine	(Stelazine)	8mg
Chlorprothixene	(Taractan)	75mg
Thiothixene	(Navane)	7mg
Haloperidol	(Haldol)	4mg
Molindone	(Moban)	10mg
Loxapine	(Loxitane)	10mg
Clozapine	(Clozaril)	50mg
Prochlorperazine	(Compazine)	10mg
Risperidone	(Resperdal)	4mg

NOTES:

The doses listed are daily doses (usually administered in divided doses) for residents with organic mental syndromes (now called dementia, delirium, and amnesic and other "cognitive disorders" by DSM-IV). The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it is necessary for the maintenance or improvement in the resident's functional status.

The "specific conditions" for use of antipsychotic drugs are listed under this Guideline G.

The dose of prochlorperazine may be exceeded for short term (seven day) treatment of nausea and vomiting. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can also be treated with higher doses for longer periods of time.

When antipsychotic drugs are used outside these Guidelines, they may be deemed unnecessary drugs as a result of excessive doses.

F. Monitoring for Antipsychotic Drug Side Effects

The facility assures that residents who are undergoing antipsychotic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on the following:

1. Tardive dyskinesia;
2. Postural (orthostatic) hypotension;
3. Cognitive/behavior impairment;
4. Akathisia; and
5. Parkinsonism.

When antipsychotic drugs are used without monitoring for these side effects, they may be unnecessary drugs because of inadequate monitoring.

G. Use of Antipsychotic Drugs

Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following "specific conditions":

1. Schizophrenia;
2. Schizo-affective disorder;

3. Delusional disorder;
4. Psychotic mood disorders (including mania and depression with psychotic features);
5. Acute psychotic episodes;
6. Brief reactive psychosis;
7. Schizophreniform disorder;
8. Atypical psychosis;
9. Tourette's disorder;
10. Huntington's disease;
11. Organic mental syndromes (now called dementia, delirium, and amnestic and other "cognitive disorders" by DSM-IV) with associated psychotic and/or agitated behaviors:

Which have been quantitatively (number of episodes) and objectively (e.g., biting, kicking, scratching) documented. This documentation is necessary to assist in: (a) assessing whether the resident's behavioral symptom is in need of some form of intervention, (b) determining whether the behavioral symptom is transitory or permanent, (c) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (d) ruling out environmental causes such as excessive heat, noise, overcrowding, (e) ruling out medical causes such as pain, constipation, fever, infection;

Which are persistent;

Which are not caused by preventable reasons; and

Which are causing the resident to:

Present a danger to her/himself or to others,

Continuously cry, scream, yell, or pace if these specific behaviors cause an impairment in functional capacity, or

Experience psychotic symptoms (hallucinations, paranoia, delusions) not exhibited as dangerous behaviors or as

crying, screaming, yelling, or pacing but which cause the resident distress or impairment in functional capacity; or

12. Short term (seven days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if one or more of the following is/are the only indication:

1. Wandering,
2. Poor self care,
3. Restlessness,
4. Impaired memory,
5. Anxiety,
6. Depression (without psychotic features),
7. Insomnia,
8. Unsociability,
9. Indifference to surroundings,
10. Fidgeting,
11. Nervousness,
12. Uncooperativeness, or
13. Agitated behaviors which do not represent danger to the resident or others.

H. Antipsychotic Drug Gradual Dose Reduction

Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual dose reduction should be under close supervision. If the gradual dose reduction is causing an adverse effect on the resident and the gradual dose reduction is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether.

"Behavioral interventions" means modification of the resident's behavior or the resident's environment, including staff approaches to care, to the largest degree possible to accommodate the resident's behavioral symptoms.

"Clinically contraindicated" means that a resident need not undergo a "gradual dose reduction" or "behavioral intervention" if the resident has a "specific condition" (as listed in these Guidelines under G, 1-11) and has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects (e.g., tardive dyskinesia). In residents with organic mental syndromes (now called dementia, delirium, and amnesic and other "cognitive disorders" by DSM-IV), "clinically contraindicated" means that a gradual dose reduction has been attempted twice in one year and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction, or a return to previous dose levels, was necessary. The resident's physician provides a justification why the continued use of the drug and the dose of the drug is clinically appropriate. This justification should include: (a) a diagnosis, but not simply a diagnostic label or code, but the description of symptoms, (b) a discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and/or agitated behaviors, and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor), (c) a description of the justification for the choice of a particular treatment, or treatments, and (d) a discussion of why the present dose is necessary to manage the symptoms of the resident. This information need not necessarily be in the physician's progress notes, but must be a part of the resident's clinical record.

I. Antidepressant Drugs

The facility is not required to use behavioral monitoring charts when antidepressant drugs are used. "Behavioral monitoring charts" include such records as quantitative evidence (number of episodes) and objective evidence (e.g., withdrawn behavior such as the resident staying in his/her room, refusal to speak, etc.) of patient behavior necessitating the use of the antidepressant drug. The following is a list of commonly used antidepressant drugs:

EXAMPLES OF ANTIDEPRESSANT DRUGS

Generic	Brand
Amitriptyline	(Elavil)
Amoxapine	(Asendin)
Desipramine	(Norpramin, Pertofrane)
Doxepin	(Sinequan)
Imipramine	(Tofranil)
Maprotiline	(Ludiomil)

Nortriptyline	(Aventyl, Panelor)
Protriptyline	(Vivactil)
Trimipramine	(Surmontil)
Fluoxetine	(Prozac)
Sertaline	(Zoloft)
Trazodone	(Desyrel)
Clomipramine	(Anafranil)
Paroxetine	(Paxil)
Bupropion	(Wellbutrin)
Isocarboxazid	(Marplan)
Phenelzine	(Nardil)
Tranlycypromine	(Parnate)
Venlafaxine	(Effexor)
Nefazadone	(Serzone)
Fluvoxamine	(Luvox)

J. Exceptions to These Guidelines

The facility shall have the opportunity to provide a rationale for the use of drugs prescribed outside these Guidelines. The facility may not justify the use of a drug prescribed outside these Guidelines solely on the basis of "the doctor ordered it." The rationale must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug.

The unnecessary drug criterion of "adequate indications for use" does not simply mean that the physician's order must include a reason for using the drug (although such order writing is encouraged). It means that the resident lacks a valid clinical reason for use of the drug as evidenced by the evaluation of some, but not necessarily all, of the following: resident assessment, plan of care, reports of significant change, progress notes, laboratory reports, professional consults, drug orders, observation and interview of the resident, and other information.

In determining whether an antipsychotic drug is without a "specific condition" or that "gradual dose reduction and behavioral interventions" have not been performed, the facility shall justify why using the drug outside these Guidelines is in the best interest of the resident.

Examples of evidence that would support a justification of why a drug is being used outside these Guidelines but in the best interests of the resident may include, but are not limited to:

1. A physician's note indicating, for example, that the dosage, duration, indication, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate; this note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using drugs outside these Guidelines;

2. A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) that confirms the physician's judgment that use of a drug outside these Guidelines is in the best interest of the resident;
3. Physician, nursing, or other health professional documentation indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;
4. Documentation confirming that previous attempts at dosage reduction have been unsuccessful;
5. Documentation (such as MDS documentation) showing resident's subjective or objective improvement, or maintenance of function while taking the medication;
6. Documentation showing that a resident's decline or deterioration is evaluated by the interdisciplinary team to determine whether a particular drug, or a particular dose, or duration of therapy, may be the cause;
7. Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, monitoring; and
8. Other evidence which may be appropriate.

(Source: Added at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.APPENDIX G Facility Report

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Facility Name _____ Phone _____

Address _____ City _____ Zip _____

Facility-wide occurrence? Yes No Resident Name _____

Age _____ M ___ F ___
Were other residents involved? Yes No (Complete this form for each resident unless occurrence is facility wide.)

<u>Type of occurrence:</u>	
1. _____ Suspected abuse/neglect	7. <u>Fire</u>
2. <u>Missing person</u>	8. <u>Bldg. emergency</u>
3. <u>Communicable disease</u>	9. <u>Loss of essential utilities</u>
4. <u>Medication error</u>	10. <u>Bomb threat</u>
5. <u>Unexplained death</u>	11. <u>Serious injury</u>
6. <u>Loss of essential staff</u>	12. <u>Sexual assault</u>
	13. _____ Other

<u>Evacuation:</u>
<u>Yes</u> ___ <u>No</u> ___
<u># of residents evacuated from</u> _____
<u>Expected return</u> _____

Status of resident:

Witness to occurrence:

<u>Police Notified?</u>		<u>Comment:</u>
<u>Doctor Notified?</u>	<u>Yes</u> <u>No</u>	_____
<u>Resident sent to hospital?</u>	<u>Yes</u> <u>No</u>	<u>Comment:</u>
<u>Resident Hospitalized?</u>	<u>Yes</u> <u>No</u>	_____
<u>Family/Guardian Notified?</u>	<u>Yes</u> <u>No</u>	<u>Date:</u>
		_____ <u>Hospital:</u> _____
		<u>Comment:</u>

Complete Description of Occurrence:

Further description attached?

Person _____	completing _____	form: _____	Title: _____
Form Faxed? <u>Yes</u> <u>No</u>	Reported by phone? <u>Yes</u> <u>No</u>		
by _____	whom? _____		by _____
whom? _____			
date: _____	time: _____	date: _____	time: _____

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.TABLE A Sound Transmission Limitations in New Skilled Nursing and Intermediate Care Facilities

	Airborne Sound Transmission Class (STC) ^a		Impact Insulation Class (IIC) ^b
	Partitions	Floors	Floors
Residents' Room to Residents' Room	40 to 44	40 to 44	44
Public space to Residents' Room ^c	45 to 49	45 to 49	49 ^d
Service areas to Residents' Room ^e	50 to 54	50 to 54	49 ^d

Notes

- ^a Sound transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM Standard E 90 and ASTM Standard E 413.
- ^b Impact insulation class (IIC) shall be determined in accordance with criteria set forth in HUD FT/TS-24, "A Guide to Airborne, Impact and Structure Borne Noise-Control in Multi-Family Dwellings."
- ^c Public space includes Lobbies, Dining Rooms, Recreation Rooms, and similar spaces.
- ^d Impact noise limitation applicable only when Corridor, Public Space, Service are, or Play or Recreation Area is over patients' room.
- ^e Service areas include Kitchens, Elevator Machine Rooms, Laundries, Garages, Maintenance Rooms, Boiler and Mechanical Equipment Rooms, and similar

spaces of high noise. Mechanical equipment located on the same floor or above Patients; Rooms, Offices, Nurses Stations, and similar occupied spaces shall be effectively isolated from the floor.

(Source: Amended at 12 Ill. Reg. 1052, effective December 24, 1987)

Section 300.TABLE A Sound Transmission Limitations in New Skilled Nursing and Intermediate Care Facilities

	Airborne Sound Transmission Class (STC) ^a		Impact Insulation Class (IIC) ^b
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(Source: Amended at 12 Ill. Reg. 1052, effective December 24, 1987)

Section 300.TABLE B Pressure Relationships and Ventilation Rates of Certain Areas for New Intermediate Care Facilities and Skilled Nursing Facilities

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes Per Hour Supplied To Room	All Air Exhausted Directly Outdoors	Recirculated within Room Units
Resident Rm	0	2	Optional	Optional
Medication Rm.	+	4	Optional	Optional
Clean Utility Rm.	+	4	Optional	Optional
Clean Linen Storage	+	2	Optional	Optional
Examination and Treatment Rm.	0	2	Optional	Optional
Physical Therapy	-	4	Optional	Optional
Occupational Therapy	-	2	Optional	Optional
Dietary Day Storage	0	2	Optional	No
Soiled Utility	-	6	Yes	No
Soiled Linen Holding Rm.	-	6	Yes	No
Soiled Linen & Trash Chute Rm.	-	6	Yes	No
Toilet Rm.	-	6	Yes	No
Shower Rm.	-	6	Yes	No
Bathroom	-	6	Yes	No
Janitors' Closet	-	6	Yes	No
Food Preparation Areas	0	6	Yes	No
Dishwashing	-	6	Yes	No
Laundry, General	0	6	Yes	No
Soiled Linen Sorting & Storage	-	6	Yes	No

+ = Positive
 - = Negative
 0 = Equal

The ventilation rates shown in the above TABLE shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

Section 300.TABLE C Construction Types and Sprinkler Requirements for Existing Skilled Nursing Facilities/Intermediate Care Facilities

Construction Type	Stories			
	1	2	3	Over 3
2-hour Fire Resistive	X	X		X
1-hour Protected Noncombustible	X	X*	X*	
Noncombustible	X*	X*	X*	
Heavy Timber	X*	X*		
1-hour Protected Ordinary	X*	X*		
1-hour Protected Wood Fram	X*	X*		
Ordinary	X*			
Frame	X*			

Key: X = Allowed types of construction
 * = Building requires automatic fire extinguishment protection

Section 300.TABLE D Heat Index Table/Apparent Temperature

		Air Temperature (degrees Fahrenheit)													
		70	75	80	85	90	95	100	105	110	115	120	125	130	135
<u>(Relative Humidity Percent)</u>	5	64	69	74	79	84	88	93	97	102	107	111	116	122	128
	10	65	70	75	80	85	90	95	100	105	110	115	120	126	132
	15	66	71	76	81	86	91	97	102	108	113	118	124	130	
	20	67	72	77	82	87	93	99	105	111	117	123	129	135	
	25	68	73	78	83	88	94	101	107	113	119	125	131	137	
	30	69	74	79	84	90	96	103	110	116	122	128	134	140	
	35	70	75	80	85	91	98	105	112	119	125	131	137	143	
	40	71	76	81	86	93	100	108	115	122	129	135	141	147	
	45	72	77	82	87	95	102	110	118	125	132	139	145	151	
	50	73	78	83	88	97	104	112	120	128	135	142	149	155	

5	6	7	8	88	96	10	12	13	15					
0	9	5	1			7	0	5	0					
5	6	7	8	89	98	11	12	14						
	9	5	1			0	6	2						
6	7	7	8	90	10	11	13	14						
0	0	6	2		0	4	2	9						
6	7	7	8	91	10	11	13							
5	0	6	3		2	9	8							
7	7	7	8	93	10	12	14							
0	0	7	5		6	4	4							
7	7	7	8	95	10	13								
5	0	7	6		9	0								
8	7	7	8	97	11	13								
0	1	8	6		3	6								
8	7	7	8	99	11									
5	1	8	7		7									
9	7	7	8	10	12									
0	1	9	8	2	2									
9	7	7	8	10										
5	1	9	9	5										

(Table is from the National Oceanic and Atmospheric Administration)

(Source: Amended at 22 Ill. Reg. 7218, effective April 15, 1998)