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 then 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 in 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)