DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

1) Heading of the Part: Specialized Mental Health Rehabilitation Facilities Code

2) Code Citation: 77 Ill. Adm. Code 380

3)

Section Numbers:	Adopted Action:
380.100	New Section
380.110	New Section
380.120	New Section
380.130	New Section
360.140	New Section
380.150	New Section
380.160	New Section
380.170	New Section
380.180	New Section
380.190	New Section
380.200	New Section
380.210	New Section
380.220	New Section
380.300	New Section
380.310	New Section
380.320	New Section
380.330	New Section
380.400	New Section
380.410	New Section
380.420	New Section
380.430	New Section
380.440	New Section
380.500	New Section
380.510	New Section
380.515	New Section
380.520	New Section
380.530	New Section
380.540	New Section
380.550	New Section
380.560	New Section
380.570	New Section
380.580	New Section
380.600	New Section
380.610	New Section
380.620	New Section

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380.630	New Section
380.640	New Section
380.650	New Section
380.660	New Section
380.670	New Section
380.700	New Section
380.710	New Section
380.720	New Section
380.730	New Section
380.740	New Section
380.750	New Section
380.760	New Section
380.770	New Section
380.780	New Section

4) Statutory Authority: Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]

5) Effective Date of Rule:

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? Yes

8) A copy of the adopted rule, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposed Rule Published in Illinois Register: June 6, 2014 – 38 Ill. Reg. 11713

10) Has JCAR issued a Statement of Objection to this rule? No

11) Difference(s) between proposal and final version:

The following changes were made in response to comments received during the first notice or public comment period:

1. In Section 380.100, the definition for “Sentinel event” was deleted.

2. In Section 380.120, a new subsection (c) was inserted: “c) *A facility licensed under the Act and this Part may voluntarily close, and the facility may reopen in an underserved region of the State, if the facility receives a certificate of need from the Health Facilities*

and Services Review Board. At no time shall the total number of licensed beds under the Act and this Part exceed the total number of licensed beds existing on July 22, 2013 (the effective date of Public Act 98-104). (Section 1-105(c) of the Act)"

3. In Section 380.130, a new subsection (5) was inserted in subsection (k).

4. In Section 380.150(d)(10), the First Notice language was deleted and replaced with: "A consumer shall be asked to consent to the administration of a new psychotropic medication in a dosage or frequency that exceeds the maximum recommendation daily dosage as found in the Physician's Desk Reference only when the reason for exceeding the recommended daily dosage is explained to the consumer by a nurse, physician, or psychiatrist, and the reason for exceeding the recommended daily dosage is justified by the prescribing physician or psychiatrist in the clinical record. The dosage and frequency shall be reviewed and re-justified by the prescriber on a weekly basis and reviewed by a consulting pharmacist. The justification for exceeding the recommended daily dosage shall be recorded in the consumer's record, and shall be approved, in writing, by the medical director of the facility."

5. In Section 380.160(c), a new subsection (4) was inserted.

6. In Section 380.300(c), "Referrals also may come from a consumer's family, a community-based behavioral health provider, a hospital, a federally qualified health center, schools such as a college or university, or via a court order." was deleted and replaced with "*Consumers may access a triage center from a number of referral sources, including family, emergency rooms, hospitals, community behavioral health providers, federally qualified health providers, or schools, including colleges or universities.* (Section 1-102 of the Act)".

7. In Section 380.300, a new subsection (j) was inserted: "j) *A triage center may be located in a building separate from the licensed location of a facility, but shall not be more than 1,000 feet from the licensed location of the facility and must meet all of the facility standards applicable to the licensed location. If the triage center does operate in a separate building, safety personnel shall be provided, on site, 24 hours per day and the triage center shall meet all other staffing requirements without counting any staff employed in the main facility building*. (Section 1-102 of the Act)"

8. In Section 380.320(b), "be in need of recovery and rehabilitation supports units as determined by State-authorized assessment, level of service determination, and authorization criteria." was inserted after "shall" and the colon was deleted.

9. The language of Section 380.330(b)(1) was changed to, "Be in need of transitional living assistance and support as determined by State-authorized assessment, level of service determination, and authorization criteria".

10. In Section 380.520(a)(5), "*Cost and reimbursement information*" was changed to "*Consumer charges*".

11. In Section 380.550(a), the definition for "Physical abuse" was deleted.

The following changes were made in response to comments and suggestions of JCAR:

1. In Section 380.330(a), ", and no unit shall be larger than 16 beds" was inserted after "days".

2. In Section 380.330(b)(2), "an exacerbation of serious mental illness" was inserted after "for" and ". as determined by complications of any of the requirements diagnoses in subsection (b)(2)" was deleted.

3. In Section 380.330, a new subsection (c) was inserted:

4. In Section 380.330(i), "or dietetic services supervisor" was inserted after "dietitian".

5. In Section 380.330(j), in (j)(1), "25% of each full time equivalent work week" was changed to "30 minutes per week, per consumer" and "and be on the unit at least three days per week" was inserted after "unit"; in (j)(3), "four hours per day, seven days per week" was changed to "90 minutes per consumer per week" and "An MHP may substitute for a CRSS if the facility has documented efforts, at least every six months, to employ a CRSS in compliance with Section 380.130(k)" was inserted at the end of the subsection; in (j)(4), "and casework" was inserted after "health"; and subsections (5) and (6) were deleted.

6. In Section 380.330, three new subsections, (k), (l), and (m), were inserted.

In addition, various typographical, grammatical, and form changes were made in response to the comments from JCAR.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

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14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 380 implements the Specialized Mental Health Rehabilitation Act of 2013. Its six Subparts address provisional licensure, licensure, training of staff, the assessment of consumers, physical plant requirements, and the care to be provided to consumers in the four levels of service to be provided in specialized mental health rehabilitation facilities.

16) Information and questions regarding these adopted amendments shall be directed to:

Susan Meister
Division of Legal Services
Department of Public Health
535 West Jefferson, 5th Floor
Springfield, Illinois 62761

(217)782-2043
e-mail: dph.rules@illinois.gov

The full text of the adopted rule begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER c: LONG-TERM CARE FACILITIES

PART 380
SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIES CODE

SUBPART A: GENERAL PROVISIONS

SUBPART B: SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIES PROGRAMS

SUBPART C: PROGRAM PERSONNEL

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NOTICE OF ADOPTED RULE

AUTHORITY: Implementing and authorized by the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49].

SOURCE: Emergency rule adopted at 38 Ill. Reg. 11819, effective May 22, 2014, for a maximum of 150 days; emergency expired October 18, 2014; adopted at 38 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 380.100 Definitions

Act – the Specialized Mental Health Rehabilitation Act of 2013.

Activities of daily living or ADL – a consumer's abilities to bathe, dress and groom; transfer and ambulate; use the toilet; eat; and use speech, language or other functional communication systems.

Abuse – any physical or mental injury or sexual assault inflicted on a consumer other than by accidental means in a facility. (Section 1-102 of the Act)

Physical abuse means the infliction of injury or threat of injury by a consumer upon himself or herself, or by another consumer, a staff or a visitor on a consumer, that occurs other than by accidental means.

Verbal abuse means the use of demeaning, intimidating or threatening words, written or oral, or gestures, by another consumer, a staff or a visitor about, or toward, a consumer and in the presence of another person.

Accreditation – recognition by *any of the following* that a program meets their nationally-recognized standards of behavioral health care:

the Joint Commission;

the Commission on Accreditation of Rehabilitation Facilities;

the Healthcare Facilities Accreditation Program; *or*

any other national standards of care as approved by the Department. (Section 1-102 of the Act)

Active treatment – treatment that addresses an acute crisis in a consumer and that facilitates a return to a community setting. Active treatment includes, but is not limited to, therapy, family meetings, group sessions and assessment.

Agent – a representative of a facility who is an owner, licensee, executive director or employee.

Ambulatory – the ability to move from place to place independent of staff assistance. A consumer may use assistive devices, such as a cane, walker or wheelchair, and still be considered ambulatory, provided that the consumer is able to move and transfer independently on a regular basis. A consumer who needs temporary time-limited assistance, such as after surgery or a medical illness, is also still considered ambulatory.

Applicant – any person making application for a license or a provisional license under the *Act* and this Part. (Section 1-102 of the Act)

Assessment – a comprehensive clinical evaluation to determine the strengths, preferences, clinical status, including the level of functioning, and the clinical needs of a consumer. The assessment may also fulfill the requirements of federal law or State consent decrees for assessment or mental health preadmission screening and resident review prior to admission, or resident reviews during treatment. The assessment shall be conducted by a Licensed Practitioner of the Healing Arts and shall:

Determine the individualized intervention strategies that will assist the consumer in advancing in his or her recovery;

Determine what supports are needed for the individual to live in community-based settings; and

Determine the appropriate level of care for service delivery.

Authorization – a determination of the level of treatment services that best suits the clinical needs of the consumer.

Authorized representative – a person other than an owner, agent or employee of a facility designated in writing by a consumer to be his or her representative. A consumer may designate his or her guardian as an authorized representative.

Biopsychosocial approach – a model for the treatment of persons with mental illness that acknowledges the biological, psychological and social influences on a person's psyche, relying on multiple disciplines for the treatment and rehabilitation of persons with mental illness.

Certified Recovery Support Specialist or CRSS – an individual who is certified and in good standing as a Recovery Support Specialist by the Illinois Alcohol and Other Drug Abuse Professional Certification Association. A CRSS, at a minimum, shall function as a mental health professional.

Community-based behavioral health services – services provided to a consumer, e.g., by a community-based behavioral health provider, while living in his or her own home or in a group living situation of 16 or fewer beds. The services are designed to assist consumers in achieving rehabilitative, resiliency and recovery goals in the least restrictive natural settings possible. The services consist of interventions that facilitate illness self-management, identification and use of adaptive and compensatory strategies, skills-building, and the identification and use of natural supports and community resources.

Consumer – a person, 18 years of age or older, admitted to a specialized *mental health rehabilitation facility for evaluation, observation, diagnosis, treatment, stabilization, recovery, and rehabilitation. "Consumer" does not mean any of the following*:

an individual requiring a locked setting;

an individual requiring psychiatric hospitalization because of an acute psychiatric crisis;

an individual under 18 years of age;

an individual who is actively suicidal or violent toward others;

an individual who has been found unfit to stand trial;

an individual who has been found not guilty by reason of insanity based on committing a violent act, such as sexual assault, assault with a deadly weapon, arson, or murder;

an individual subject to temporary detention and examination under Section 3-607 of the Mental Health and Developmental Disabilities Code;

an individual deemed clinically appropriate for inpatient admission in a State *psychiatric hospital; and*

an individual transferred by the Department of Corrections pursuant to Section 3-8-5 of the Unified Code of Corrections. (Section 1-102 of the Act)

Consumer record – a record that organizes all information on the care, treatment, and rehabilitation services rendered to a consumer in a specialized mental health rehabilitation facility. (Section 1-102 of the Act)

Controlled drugs – those drugs covered under the federal Comprehensive Drug Abuse Prevention Control Act of 1970, as amended, or the Illinois Controlled Substances Act. (Section 1-102 of the Act)

Crisis stabilization – a secure and separate unit that provides short-term behavioral, emotional, or psychiatric crisis stabilization as an alternative to hospitalization or re-hospitalization for consumers from residential or community placement. (Section 1-102 of the Act)

Debrief – a meeting with a consumer and facility staff following a period of restraint, holding or therapeutic separation in which the impact of the intervention is assessed from a perspective of emotional impact, outcome and possible alternatives to the use of restraint.

Department – the Department of Public Health. (Section 1-102 of the Act)

DHS − the Illinois Department of Human Services

DHS-DMH − the Illinois Department of Human Services-Division of Mental Health

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 that included consultation from a dietitian; or

has successfully completed a Dietary Manager's Association approved dietary manager 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 licensed as a dietitian under the Dietitian Nutritionist Practice Act.

Director – the Director of the Department of Public Health or his or her designee.

Discharge – the full release of any consumer from a facility. (Section 1-102 of the Act)

Drug administration – the act in which a single dose of a prescribed drug or biological is given to a consumer. The complete act of administration entails removing an individual dose from a container, verifying the dose with the prescriber's orders, giving the individual dose to the consumer, and promptly recording the time and dose given. (Section 1-102 of the Act)

Drug dispensing – the act entailing the following of a prescription order for a drug or biological and proper selection, measuring, packaging, labeling, and issuance of the drug or biological to a consumer. (Section 1-102 of the Act)

DSP – the Department of State Police.

Dual diagnosis – the condition of experiencing a mental illness and a comorbid substance abuse problem.

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Emergency – a situation, physical condition, or one or more practices, methods, or operations that *present imminent danger of death or serious physical or mental harm to consumers of a facility*. (Section 1-102 of the Act)

Evidence-based practice – the conscientious use of current evidence in making decisions about the care of the individual consumer, integrating individual clinical expertise with available external clinical evidence from systematic research.

Executive director – a person who is charged with the general administration and supervision of a facility licensed under the *Act* and this Part. (Section 1-102 of the Act)

Face check – visual confirmation by a staff person to ensure the consumer's safety and well-being, to be performed at intervals as determined by the individualized treatment plan of the consumer.

Facility – a specialized mental health rehabilitation facility (SMHRF) *that provides at least one of the following services: triage center; crisis stabilization; recovery and rehabilitation supports; or transitional living units for 3 or more persons. The facility shall provide a 24-hour program that provides intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. It includes facilities that meet the following criteria*:

100% of the consumer population of the facility has a diagnosis of serious mental illness;

no more than 15% of the consumer population of the facility is 65 years of age or older;

none of the consumers are non-ambulatory;

none of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability; *and*

the facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding

the effective date of the *Act and qualifies as an institute for mental disease under the federal definition of the term*.

"Facility" does not include the following:

a home, institution, or place operated by the federal government or agency of the federal government, *or by the State of Illinois*;

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 for the treatment of mental illness that *is required to be licensed under the Hospital Licensing Act*;

a facility for child care as defined in the Child Care Act of 1969;

a community living facility as defined in the Community Living Facilities Licensing Act;

a 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, the *nursing home or sanatorium shall comply with all local laws and rules relating to sanitation and safety*;

a 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;

a supportive residence licensed under the Supportive Residences Licensing Act;

a supportive living facility in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01 of the Nursing Home Care Act;

an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act, except only for purposes of the

employment of persons in accordance with Section 3-206.01 of the Nursing Home Care Act;

an Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act;

a home, institution, or other place operated by or under the authority of the Illinois Department of Veterans' Affairs;

a facility licensed under the ID/DD Community Care Act; *or*

a facility licensed under the Nursing Home Care Act after July 22, 2013 (Section 1-102 of the Act)

Findings of root cause analysis – the conclusions of a facility's root cause analysis that summarize how the incident, accident or violation happened and reasons for the incident, accident or violation. Reportable findings do not include investigatory notes, data, staff interviews and other unrelated documentation that led to the conclusions of the root cause analysis.

Governing body – the persons responsible for the overall leadership, oversight and administration of a specialized mental health rehabilitation facility

Guardian – a person appointed as a guardian of the person or guardian of the estate, or both, of a consumer under the Probate Act of 1975. (Section 1-102 of the Act)

Identified Offender – a person who:

Has been convicted of, found guilty of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any felony offense listed in Section 25 of the Health Care Worker Background Check Act, except for the following: a felony offense described in Section 10-5 of the Nurse Practice Act; a felony offense described in Section 5, 5.1, 5.2, 7, or 9 of the Cannabis Control Act; a felony offense described in Section 401, 401.1, 404, 405, 405.1, 407, or 407.1 of the Illinois Controlled Substances Act; and a felony offense described in the Methamphetamine Control and Community Protection Act; or

Has been convicted of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any sex offense as defined in Section 10(c) of the Sex Offender Management Board Act. (Section 1-102 of the Act)

Illness Management and Recovery or IMR – an evidence-based practice aimed at assisting individuals with mental illnesses in learning to manage the symptoms of the illness to reduce interference with pursuit of personal goals.

Individualized Treatment Plan or Treatment Plan or ITP – a written compilation of the consumer's goals; the anticipated outcomes of services; the intermediate objectives to achieve the goals; the specific SMHRF services to be provided to the consumer; the amount, frequency and duration of the services; and the staff responsible for providing the services.

Institute for Mental Disease or IMD – facilities that are federally designated as institutes for mental diseases and that will be licensed as specialized mental health rehabilitation facilities under the Act and this Part, subject to the provisions in Section 1-101.5 of the Act.

Instrumental activities of daily living or IADL – activities to support daily life within the home and community that require more complex interactions than the self-care in ADLs, including, but not limited to, communication, community mobility, health management, home management, meal preparation and clean up, safety and emergency management, shopping and money management.

Interdisciplinary Team or IDT − a group of persons, representing those professions, disciplines or service areas that are relevant to identifying a consumer's strengths, preferences and needs, that designs a program to meet those needs.

Licensed Practitioner of the Healing Arts or LPHA – shall have the meaning ascribed to it in the DHS-DMH rule Medicaid Community Mental Health Services Program.

Licensed Practical Nurse − a person with a valid Illinois license to practice as a practical nurse under the Nurse Practice Act.

Licensee – the person, persons, firm, partnership, association, organization, company, corporation, or business trust to which a license has been issued. (Section 1-102 of the Act)

Linkage – A partnership between a facility and a community-based behavioral health provider that includes the community-based behavioral health provider from the time of a consumer's admission into a facility (in crisis stabilization, transitional living units, and recovery and rehabilitation supports), or as soon as possible following admission, in developing and implementing the consumer's individualized treatment plan for effective care coordination and transitioning the consumer to independent living in the community, or to the least restrictive setting of the consumer's choice. Linkage includes a face-to-face meeting between the consumer and the community-based behavioral health provider with which he or she is linked prior to discharge, except for consumers in the 23-hour triage center.

Mental Health Preadmission Screening and Resident Review or MH PASRR – a comprehensive review conducted under the auspices of DHS-DMH prior to the admission of a consumer with serious mental illness, at the end of 90 days following admission, at the end of six months, and then annually.

Mental Health Professional or MHP – shall have the meaning ascribed to it in the DHS-DMH rule the Medicaid Community Mental Health Services Program.

Misappropriation of a consumer's property – the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a consumer's belongings or money without the consent of a consumer or his or her guardian. (Section 1-102 of the Act)

Neglect – a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance that is necessary to avoid physical harm and mental anguish of a consumer. (Section 1-102 of the Act)

On site – in a facility and in a particular level of service within a facility.

Performance Improvement Project or PIP – an effort by a facility to address a specific violation or problem, either in one service area of a facility, or facility-wide. PIPs require a systematic gathering of information to clarify issues and problems to improve the delivery of care to consumers.

Person-centered care – an approach to mental health treatment that involves collaboration between the consumer, treatment providers, and other supporters of the individual, including the consumer's guardian and substitute decision maker, and is focused on the goals the consumer has identified for recovery in his or her treatment plan. Person centered care focuses on building upon the strengths and resources of the consumer to achieve recovery goals. Roles are defined for the consumer, the treatment providers, and other supporters to assist in reaching these goals.

Personal care or Activities of daily living or ADL – *assistance with meals, dressing, movement, bathing, or other personal needs, 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 or her person, whether or not a guardian has been appointed for* the *individual. "Personal care" shall not be construed to confine or otherwise constrain a facility's pursuit to develop the skills and abilities of a consumer to become self-sufficient and capable of increasing levels of independent functioning.* (Section 1-102 of the Act)

Psychiatric Medical Director – a physician who is licensed under the Medical Practice Act of 1987 and who is board eligible or board certified in psychiatry by the American Board of Psychiatry and Neurology.

Psychotropic medication – medications used for antipsychotic, antidepressant, anti-manic, anti-anxiety, or behavior modification, for behavioral management purposes as listed in the American Medical Association Drug Evaluation and the Physicians' Desk Reference.

Qualified Mental Health Professional or QMHP – shall have the meaning ascribed to it in the DHS-DMH rule Medicaid Community Mental Health Services Program.

Recovery and rehabilitation supports or RRS – *a* unit with a *program that facilitates a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units* or transition to the community *by improving living skills and community socialization.* (Section 1-102 of the Act)

Recovery – the process in which persons are able to live, work, learn and participate fully in their communities. For some persons, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

Registered Nurse − a person with a license to practice as a registered professional nurse under the Nurse Practice Act.

Rehabilitation Services Associate (RSA) – shall have the meaning ascribed to it in the DHS-DMH rule Medicaid Community Mental Health Services Program.

Restorative care – care that is designed to facilitate the consumer's recovery and re-entry into the community.

Restraint −

> *a physical restraint that is any manual method or physical or mechanical device, material, or equipment attached or adjacent to a consumer's body that the consumer cannot remove easily and restricts freedom of movement or normal access to one's body; devices used for positioning, including, but not limited to, bed rails, gait belts, and cushions, shall not be considered to be restraints for purposes of this* Part. *For the purposes of* the *Act* and this Part, *restraint shall be administered only after utilizing a coercive-free environment and culture; or*
>
> *a chemical restraint that is any drug used for discipline or convenience and not required to treat medical symptoms*. (Section 1-102 of the Act)

Root cause – a fundamental reason or reasons for an incident, accident or violation, without which the incident, accident or violation would not have occurred.

Root cause analysis – the process for determining how an incident, accident or violation occurred.

Self-administration of medication – means that *consumers shall be responsible for the control, management, and use of* their *own medication.* (Section 1-102 of the Act)

Serious mental illness – as used in this Part, any of the following diagnoses:

DSM-5 diagnosis of a psychotic disorder, excluding those caused by a general medical condition or substance use when of moderate or severe intensity and associated with moderate or severe functional impairment of a greater than 90-day duration.

DSM-5 diagnosis of bipolar or related disorder, excluding those caused by a general medical condition or substance use, when of moderate or severe intensity and associated with moderate to severe functional impairment of a greater than 90-day duration.

DSM-5 diagnosis of a depressive disorder, excluding those caused by a general medical condition or substance use, when of moderate or severe intensity and associated with severe functional impairment of a greater than 90-day duration.

DSM-5 diagnosis of borderline personality disorder associated with moderate to severe functional impairment of a greater than 90-day duration.

DSM-5 diagnosis of post-traumatic stress disorder associated with moderate to severe functional impairment of a greater than 90-day duration.

DSM-5 diagnosis of obsessive compulsive disorder associated with moderate to severe functional impairment of a greater than 90-day duration.

Substitute decision maker – a person who possesses the authority to make mental health decisions on behalf of the consumer under the Powers of Attorney for Health Care Law, under the Mental Health Treatment Preference Declaration Act, or the Probate Act of 1975.

Transitional living units – residential units within a facility that have the purpose of assisting the consumer in developing and reinforcing the necessary skills to live independently outside of the facility. The duration of stay in this *setting shall not exceed 120 days for each consumer. Nothing in this definition shall be construed to be a prerequisite for transitioning out of a facility.* (Section 1-102 of the Act)

Therapeutic separation – the removal of a consumer from the milieu to a room or area that *is designed to aid in the emotional or psychiatric stabilization of that consumer.* (Section 1-102 of the Act)

Triage center – a non-residential, 23-hour center that serves as an alternative to emergency room care, hospitalization, or re-hospitalization for consumers in need of short-term crisis stabilization. (Section 1-102 of the Act)

Unit – a crisis stabilization, recovery and rehabilitation supports, or transitional living level of service within a facility.

Wellness Recovery Action Plan (WRAP) – an evidence-based system developed by the Copeland Center for use by people dealing with mental health and other challenges who want to attain the highest possible level of wellness.

Section 380.110 Incorporated and Referenced Materials

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

1) National Fire Protection Association (NFPA) Standard No. 101: Life Safety Code, Chapter 33, Existing Board and Care Occupancies (2012) or Chapter 32, New Board and Care Occupancies (2012), and the following additional standards, which may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy MA 02169.

A) No. 10 (2010): Standard for Portable Fire Extinguishers

B) No. 13 (2010): Standard for the Installation of Sprinkler Systems

C) No. 25 (2011): Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems

D) No. 54 (2012): National Fuel Gas Code

E) No. 70 (2011): National Electrical Code

F) No. 72 (2010): National Fire Alarm and Signaling Code

G) No. 80 (2010): Standard for Fire Doors and Other Opening Protectives

H) No. 90A (2012): Standard for Installation of Air Conditioning and Ventilating Systems

I) No. 96 (2011): Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations

J) No. 99 (2012): Health Care Facilities Code

K) No. 110 (2010): Standard for Emergency and Standby Power Systems

L) No. 220 (2012): Standard on Types of Building Construction

M) No. 241 (2009): Standard for Safeguarding Construction, Alteration and Demolition

2) 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 GA 30329.

3) American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (2013) (American Psychiatric Association), which may be obtained from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington VA 22209-3901.

4) American College of Obstetricians and Gynecologists, Guidelines for Women's Healthcare, Third Edition (2007), which may be obtained from the American College of Obstetricians and Gynecologists Distribution Center, P.O. Box 933104, Atlanta GA 31193-3104 (800-762-2264).

5) Drug Burden Index to Define the Functional Burden of Medications in Older People (April, 2007), which may be obtained from the American Medical Association, AMA Plaza, 330 N. Wabash Ave., Chicago IL 60611-5885, or accessed at http://archinte.jamanetwork.com/article.aspx?articleid=412262.

6) Accreditation:

A) Standards for Behavioral Health Care (Joint Commission, 2014), One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181;

B) Behavioral Health Standards Manual (Commission on Accreditation of Rehabilitation Facilities (CARF, 2014), 4891 East Grant Road, Tucson AZ 85711; or

C) Accreditation Requirements for Behavioral Health Centers (Healthcare Facilities Accreditation Program, 2010), 142 E. Ontario Street, Chicago IL 60611.

7) Federal Guidelines:

A) Recommendations of the Advisory Committee on Immunization Practices (ACIP) (2014), which may be obtained from the Centers for Disease Control and Prevention, 1600 Clifton Rd., Atlanta GA 30333 (800-232-4636).

B) Sexually Transmitted Diseases Treatment Guidelines (2010), which may be obtained from the Centers for Disease Control and Prevention, 1600 Clifton Rd., Atlanta GA 30333 (800-232-4636).

C) "Recommended Dietary Allowances", 10th Edition (1989), adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Science, which may be obtained from the National Academy of Science, Keck Center W700, 500 Fifth St. NW, Washington DC 20001 (202-334-2352).

8) Evidence-based and evidence-informed treatment practices, including but not limited to:

A) The Illness Management and Recovery Evidence-Based Practices Kit (Substance Abuse and Mental Health Services Administration. Illness Management and Recovery: Practitioner Guides and Handouts, HHS Pub. No. SMA-09-4462, Rockville MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.).

B) Wellness Recovery Action Plan (WRAP), by Copeland, Mary Ellen, Ph.D., Peach Press (2011), P.O. Box 301, West Dummerston VT 05357.

C) Motivational Interviewing, by Miller, W. R., & Rollnick, S. Guilford Publications (2002), 72 Spring Street, New York NY 10012 (800-365-7006).

9) ADA Standards for Accessible Design (2010), which may be obtained from the U.S., Department of Justice ADA website (www.ada.gov) or by writing U.S. Department of Justice, 950 Pennsylvania Avenue, NW, Civil Rights Division, Disability Rights Section – NYA, Washington DC 20530 (800-514-0301).

10) Federal Rules:

A) 21 CFR 1306.11, Requirement of Prescription (April 1, 2013)

B) 21 CFR 1306.21, Requirement of Prescription (April 1, 2013)

C) 24 CFR 578.3, Continuum of Care (April 1, 2014)

D) 45 CFR 46, Protection of Human Subjects (October 1, 2012)

b) All incorporations by reference of federal regulations and guidelines and the standards of nationally recognized organizations refer to the regulations, guidelines and standards on the date specified and do not include any editions or amendments subsequent to the date specified.

c) The following statutes and State regulations are referenced in this Part:

1) Federal Statutes:

A) Americans With Disabilities Act (104 USC 327)

B) Health Insurance Portability and Accountability Act (110 USC 1936)

C) Comprehensive Drug Abuse Prevention Control Act of 1970 (21 USC 13)

2) State of Illinois Statutes:

A) Specialized Mental Health Act of 2013 [210 ILCS 490]

B) Mental Health and Developmental Disabilities Code [405 ILCS 5]

C) Unified Code of Corrections [730 ILCS 5]

D) Nurse Practice Act [225 ILCS 65]

E) Medical Practice Act of 1987 [225 ILCS 60]

F) Clinical Psychologist Licensing Act [225 ILCS 15]

G) Clinical Social Work and Social Work Practice Act [225 ILCS 20]

H) Illinois Occupational Therapy Practice Act [225 ILCS 75]

I) Professional Counselor and Clinical Professional Counselor Licensing and Practice Act [225 ILCS 107]

J) Marriage and Family Therapy Licensing Act [225 ILCS 55]

K) Health Care Worker Background Check Act [225 ILCS 46]

L) Nursing Home Administrators Licensing and Disciplinary Act [225 ILCS 70]

M) Illinois Controlled Substances Act [720 ILCS 570]

N) AIDS Confidentiality Act [410 ILCS 305]

O) Dietitian Nutritionist Practice Act [225 ILCS 30]

P) Smoke Detector Act [425 ILCS 65]

Q) Powers of Attorney for Health Care Law [755 ILCS 45/Art. IV]

R) Mental Health Treatment Preference Declaration Act [755 ILCS 43]

S) Whistleblower Act [740 ILCS 174]

T) Criminal Code of 2012 [720 ILCS 5]

U) Smoke Free Illinois Act [410 ILCS 82]

V) Mental Health and Development Disabilities Confidentiality Act [740 ILCS 110]

W) Probate Act of 1975 [755 ILCS 5]

X) Language Assistance Services Act [210 ILCS 87]

Y) Safety Glazing Materials Act [430 ILCS 65]

Z) Child Care Act of 1969 [225 ILCS 10]

AA) Community Living Facilities Licensing Act [210 ILCS 35]

BB) Community-Integrated Living Arrangements Licensure and Certification Act [210 ILCS 135]

CC) Supportive Residences Licensing Act [210 ILCS 65]

DD) Illinois Public Aid Code [305 ILCS 5]

EE) Assisted Living and Shared Housing Act [210 ILCS 9]

FF) Alternative Health Care Delivery Act [210 ILCS 3]

GG) Cannabis Control Act [720 ILCS 550]

HH) Methamphetamine Control and Community Protection Act [720 ILCS 646]

II) Sex Offender Management Board Act [20 ILCS 4026]

JJ) Illinois Human Rights Act [775 ILCS 5]

KK) Uniform Conviction Information Act [20 ILCS 2635]

LL) Hospital Licensing Act [210 ILCS 85]

MM) Nursing Home Care Act [210 ILCS 45]

NN) Sex Offender Registration Act [730 ILCS 150]

3) State of Illinois Administrative Rules:

A) Department of Public Health, Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100)

B) Department of Public Health, Illinois Plumbing Code (77 Ill. Adm. Code 890)

C) Department of Public Health, Control of Tuberculosis Code (77 Ill. Adm. Code 696)

D) Department of Public Health, Health Care Worker Background Check Code (77 Ill. Adm. Code 955)

E) Department of Public Health, Control of Communicable Diseases Code (77 Ill. Adm. Code 690)

F) Department of Public Health, Control of Sexually Transmissible Infections Code (77 Ill. Adm. Code 693)

G) Department of Public Health, Food Services Sanitation Code (77 Ill. Adm. Code 750)

H) Department of Public Health, Drinking Water Systems Code (77 Ill. Adm. Code 900)

I) Department of Public Health, Water Well Construction Code (77 Ill. Adm. Code 920)

J) Department of Public Health, Illinois Water Well Pump Installation Code (77 Ill. Adm. Code 925)

K) Department of Public Health, Sexual Assault Survivors Emergency Treatment Code (77 Ill. Adm. Code 545)

L) Department of Public Health, Language Assistance Services Code (77 Ill. Adm. Code 940)

M) Department of Public Health, Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)

N) Department of Public Health, Long-Term Care Assistants and Aides Training Programs Code (77 Ill. Adm. Code 395)

O) Department of Public Health, Emergency Medical Services, Trauma Center, Primary Stroke Center and Emergent Stroke Ready Hospital Code (77 Ill. Adm. Code 515)

P) Department of Human Services, Medicaid Community Mental Health Services Program (59 Ill. Adm. Code 132)

Q) Healthcare and Family Services, Mental Health Services in Nursing Facilities (89 Ill. Adm. Code 145)

R) Office of the State Fire Marshal, Fire Prevention and Safety (41 Ill. Adm. Code 100)

S) Office of the State Fire Marshal, Boiler and Pressure Vessel Safety (41 Ill. Adm. Code 120)

T) Capital Development Board, Illinois Accessibility Code (71 Ill. Adm. Code 400)

Section 380.120 Applicability and General Requirements

a) The *Act* and this Part provide *for licensure of long term care facilities that are federally designated as institutions for mental disease on* July 22, 2013 *and specialize in providing services to individuals with serious mental illness. On and*

after July 22, 2013*, these facilities shall be governed by* the *Act instead of the Nursing Home Care Act.* (Section 1-101.5(a) of the Act)

b) *All consent decrees that apply to facilities federally designated as institutions for mental disease shall continue to apply to facilities licensed under* the *Act* and this Part. (Section 1-101.5(b) of the Act)

c) *A facility licensed under* the *Act* and this Part *may voluntarily close, and the facility may reopen in an underserved region of the State, if the facility receives a certificate of need from the Health Facilities and Services Review Board. At no time shall the total number of licensed beds under* the *Act* and this Part *exceed the total number of licensed beds existing on July 22, 2013* (the effective date of Public Act 98-104) (Section 1-105(c) of the Act).

d) Subject to the Act and this Part, the facility shall develop and implement a psychiatric rehabilitation program providing individual and group therapeutic interventions, services and supports to address the goals, preferences, needs, strengths and risks of persons with a diagnosis of mental illnesses and who meet clinical criteria as specified in each level of service.

e) Triage centers, crisis stabilization units, transitional living units, and recovery and rehabilitation supports units shall be designed to improve the adaptive functioning of persons with mental illness, facilitate the recovery of those persons, and enable those persons to achieve a higher level of independence while preventing regression to a lower level of functioning.

f) As defined in the Act and this Part, the facility may develop specialized units and programs to serve different consumers in different stages of illness, including:

1) Non-residential triage centers, with a length of stay no more than 23 hours, for short-term crisis assessment and disposition;

2) Crisis stabilization units that serve consumers for no more than 21 days;

3) Recovery and rehabilitation supports units that address longer-term consumer mental health rehabilitation needs and training; and

4) Transitional living units that prepare consumers for community transition within 120 days following admission.

g) Each of these programs shall have its own separate program and staffing requirements, based on the crisis intervention and recovery treatment needs of the consumers, and as required by the Act and this Part.

h) A facility is not required to implement all of the programs in subsection (e)(1) through (4).

i) All levels of service shall incorporate evidence-based practices, biopsychosocial approaches, and programs regarding the treatment and rehabilitation of persons who have mental illnesses.

j) The mental health rehabilitation and recovery services shall be designed to assist consumers in developing skills to effectively manage their symptoms and effectively become capable of increasing levels of independent functioning in the community.

k) All services shall reflect varying individual goals, diverse needs, concerns, strengths, motivations and abilities of each consumer, which shall be documented in writing within the medical chart. The programs shall emphasize the participation of consumers in all aspects of treatment, including, but not limited to, individual treatment, services planning, program design and evaluation.

l) The facility shall have an interdisciplinary team at all levels of service. The IDT shall include a physician and a licensed clinical social worker or a licensed clinical professional counselor, as well as the consumer, the consumer's guardian, and other professionals, including the consumer's primary service providers, particularly the staff most familiar with the consumer, and other appropriate professionals and caregivers as determined by the consumer's needs. The consumer or his or her guardian may also invite other people to meet with the IDT and participate in the process of identifying the consumer's strengths and needs.

m) For all levels of service except triage centers, a facility shall provide linkage, including coordinating the consumer's care with other health care providers, including, but not limited to, primary care physicians, psychiatrists, hospitals and other medical professionals, to ensure that the mental and physical health care needs of the consumer are met. The facility shall share all relevant treatment information for a consumer with the community-based behavioral health provider or other health care provider to facilitate a consumer's recovery and rehabilitation. Linkage may occur through direct partnerships with providers, as well as through managed care entities.

n) For triage centers, linkage means connecting the consumer to a community-based behavioral health provider if the triage staff determines that community behavioral health services are needed.

o) A crisis stabilization center, recovery and rehabilitation supports center, or a transitional living unit shall not accept for treatment anyone with medical issues requiring active intervention or treatment, or who requires a higher level of medical care, e.g., issues beyond medical maintenance, including, but not limited to, persons:

1) Who require skilled nursing care, who have limited feeding capacity, or who need assistance ambulating;

2) With a swallowing problem with recurring aspiration;

3) Who require a catheter, such as a foley catheter, feeding tubes or nasogastric tubes, or central lines;

4) Who are at risk of medically significant complications due to recent major medical trauma, according to the requirements for trauma in the Emergency Medical Services, Trauma Center, Primary Stroke Center and Emergent Stroke Ready Hospital Code;

5) With acute neurological symptoms, including unstable seizure disorders;

6) Who require ongoing nebulizer treatments that are not self-administered;

7) Who require electrocardiogram monitoring/telemetry;

8) For transitional living and rehabilitation and recovery only, with a condition that potentially requires urgent surgery;

9) Who are at risk of medically significant complications due to drug withdrawal;

10) With medically significant bleeding;

11) With communicable diseases requiring isolation,except for brief contact isolation;

12) With delirium;

13) With primary dementia;

14) With moderate, severe or profound developmental disability;

15) With methadone dependency, unless he or she is in an accredited methadone program; or

16) With toxic levels of medication or who are at risk to become toxic (i.e., acetaminophen).

p) A triage center shall screen all consumers for the medical issues in subsection (n).

Section 380.130 Staff Qualifications and Training Requirements

a) *Training for all new employees specific to the various levels of care offered by a facility shall be provided to employees during their orientation period and* then *annually. Training shall be independent of the Department and overseen by* DHS-DMH *to determine the content of all facility employee training and to provide training for all trainers of facility employees.* (Section 2-103 of the Act) DHS-DMH will determine if the outlined employee training plan submitted to it by the facility meets the DHS-DMH requirements prior to the acceptance of the facility's plan of operation by the Department.

b) *Training of employees shall be consistent with nationally recognized national accreditation standards as defined in* the *Act* and this Part. *Training shall be required for all existing staff at a facility prior to the implementation of any new services authorized under* the *Act* and this Part. (Section 2-103 of the Act)

c) The facility shall have a written policy for regular staff training at all levels of service that the facility provides. Training referenced in this Section may be provided via any of the usual methods of adult education, including, but not limited to, in-service training, webinar, comport programs, on-line education, and on-the-job training.

d) The curriculum for staff training will be developed or approved by DHS-DMH and will include, but not be limited to, understanding symptoms of mental illnesses; principles of evidence-based practices and emerging best practices,

including trauma informed care, illness management and recovery, wellness recovery action plans, crisis prevention intervention training, consumer rights, and recognizing, preventing, and mandatory reporting of abuse and neglect. Training shall also include relevant health and safety matters. Training shall use didactic as well as practical and on-the-job experiences.

e) Executive Director

1) The executive director shall meet the requirements in Section 380.430.

2) The executive director shall complete at least 15 hours of training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming duties in a facility.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (e)(2) within the past five years may use this training to meet the requirements of this subsection (e). The facility shall document this training in the employee's personnel file.

4) The executive director also shall complete additional training annually as prescribed by DHS-DMH.

f) Psychiatric Medical Director

1) The psychiatric medical director shall be a board eligible or board certified psychiatrist.

2) The psychiatric medical director shall complete training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (f)(2) within the past five years may use this training to meet the requirements of this subsection (f). The facility shall document this training in the employee's personnel file.

4) The psychiatric medical director shall not have a revoked or currently suspended license, and shall not be on probation.

g) Program Director
Each program operated by the licensee shall have a program director who is a licensed practitioner of the healing arts.

h) Licensed Practitioner of the Healing Arts (LPHA)

1) The LPHA shall meet the definition of this job title in 59 Ill. Adm. Code 132.

2) The LPHA shall complete training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (h)(2) within the past five years may use this training to meet the requirements of this subsection (h). The facility shall document this training in the employee's personnel file.

4) The LPHA also shall complete additional training annually as prescribed by DHS-DMH.

i) Qualified Mental Health Professional (QMHP)

1) The QMHP shall meet the definition of this job title.

2) The QMHP shall complete training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (i)(2) within the past five years may use this training to meet the training requirements of this subsection (i). The facility shall document this training in the employee's personnel file.

4) The QMHP also shall complete additional training annually as prescribed by DHS-DMH.

j) Mental Health Professional (MHP)

1) The MHP shall meet the definition of this job title in 59 Ill. Adm. Code 132.

2) The MHP shall complete training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (j)(2) within the past five years may use this training to meet the requirements of this subsection (j). The facility shall document this training in the employee's personnel file.

4) The MHP also shall complete additional training annually as prescribed by DHS-DMH.

k) Certified Recovery Support Specialist (CRSS)

1) The CRSS shall meet the definition of this job title in Section 380.100.

2) The CRSS shall complete at least 60 hours of training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (k)(2) within the past five years may use this training to meet the requirements of this subsection (k). The facility shall document this training in the employee's personnel file.

4) The CRSS also shall complete additional training annually as prescribed by DHS-DMH.

5) A facility shall make its best efforts to hire the required CRSS staffing. If a facility is unable to meet the minimum staffing requirements of Sections 380.300(g)(4), 380.310(j)(5), 380.320(g)(3) and 380.330(i)(3), the facility may hire a person who is eligible to obtain the CRSS certification within 12 months after the date of hire. The facility shall support the individual toward obtaining the necessary training hours, work hours and completion of the exam.

A) The individual shall have a high school diploma or GED. The individual shall receive 100 hours of training and education, including 40 hours in the CRSS domains of recovery support, mentoring, advocacy and professional responsibility; 6 hours in professional ethics for a CRSS; and 54 hours in areas related to the work of the CRSS but not necessarily specific to the four domains.

B) The facility shall continue to make documented efforts to recruit and hire employees who are already certified as a CRSS.

l) Rehabilitation Services Associate (RSA)

1) The RSA shall meet the definition of this job title in 59 Ill. Adm. Code 132.

2) The RSA shall complete training as prescribed by DHS-DMH on mental illness, mental health services, psychiatric rehabilitation, State mental health administrative rules, and the mental health service system prior to assuming the duties of this position.

3) Individuals who have successfully completed training on the specific topics and training hours prescribed in subsection (l)(2) within the past five years may use this training to meet the requirements of this subsection (l). The facility shall document this training in the employee's personnel file.

4) The RSA also shall complete additional training annually as prescribed by DHS-DMH.

m) Volunteers

Volunteers who are regularly scheduled to work at least weekly with consumers at

the facility shall complete at least 12 hours of supervised training as prescribed by DHS-DMH prior to beginning their volunteer services. Volunteers shall be subject to all the hiring requirements in Subpart C. Volunteers are prohibited from working in triage centers or crisis stabilization units. In recovery and rehabilitation supports units and transitional living units, their services shall be limited to assisting consumers with ADLs, IADLs and recreational activities.

Section 380.140 Consumer Rights and Choices

a) *Consumers served by a facility under* the *Act* and this Part *shall have all the rights guaranteed pursuant to Chapter II, Article I of the Mental Health and Developmental Disabilities Code, a list of which shall be prominently posted in English and any other language representing at least 5% of the county population in which the specialized mental health rehabilitation facility is located.* (Section 3-101 of the Act)

1) *Each consumer and consumer's guardian or other person acting on behalf of the consumer shall be given a written explanation of all of his or her rights. The explanation shall be given at the time of admission to a facility or as soon thereafter as the condition of the consumer permits, but in no event later than 48 hours after admission and again at least annually thereafter,* except for triage. *If a consumer is unable to read* the *written explanation, it shall be read to the consumer in a language the consumer understands.* (Section 3-209 of the Act)

2) *The facility shall ensure that its staff is familiar with and observes the rights and responsibilities enumerated in Article 3* of the Act. (Section 3-210 of the Act)

b) *A consumer shall be permitted to manage his or her own financial affairs unless he or she or his or her guardian authorizes the executive director of the facility in writing to manage the consumer's financial affairs.* (Section 3-102 of the Act)

c) *To the extent possible, each consumer shall be responsible for his or her own moneys and personal property or possessions in his or her own immediate living quarters unless deemed inappropriate by a physician or other facility* LPHA *clinician and so documented in the consumer's record. In the event the moneys or possessions of a consumer come under the supervision of the facility, either voluntarily on the part of the consumer or so ordered by a facility physician or other* LPHA *clinician, each facility to whom a consumer's moneys or possessions*

have been entrusted shall comply with the following:

1) *No facility shall commingle consumers' moneys or possessions with those of the facility; consumers' moneys and possessions shall be maintained separately, intact, and free from any liability that the facility incurs in the use of the facility's funds*;

2) *The facility shall provide reasonably adequate space for the possessions of the consumer; the facility shall provide a means of safeguarding small items of value for its consumers in their rooms or in any other part of the facility so long as the consumers have reasonable and adequate access to* their *possessions*; *and*

3) *The facility shall make reasonable efforts to prevent loss and theft of consumers' possessions; those efforts shall be appropriate to the particular facility and particular living setting within each facility and may include staff training and monitoring, labeling possessions, and frequent possession inventories; the facility shall develop procedures for investigating complaints concerning theft of consumers' possessions and shall promptly investigate all complaints.* (Section 3-103 of the Act)

d) *Every consumer, except those in triage centers, shall be permitted unimpeded, private, and uncensored communication of his or her choice by mail, telephone, Internet, or visitation.*

1) *The executive director shall ensure that correspondence is conveniently received and reasonably accessible*.

2) *The executive director shall ensure that consumers may have private visits at any reasonable hour unless visits are restricted due to the treatment plan of the consumer*.

3) *The executive director shall ensure that space for visits is available and that facility personnel reasonably announce their intent to enter, except in an emergency, before entering any consumer's room during visits*.

4) *Consumers shall be free to leave at any time. If a consumer in a triage center expresses a desire to contact a third party for any purpose, the facility staff shall contact that third party on behalf of the consumer*. (Section 3-108 of the Act)

e) *A consumer shall be permitted the free exercise of religion. Upon a consumer's request, and if necessary, at the consumer's expense, the executive director may make arrangements for a consumer's attendance at religious services of the consumer's choice. However, no religious beliefs or practices or attendance at religious services may be imposed upon any consumer.* (Section 3-109 of the Act)

f) *Access to Consumers*

1) *Any employee or agent of a public agency, any representative of a community legal services program, or any other member of the general public shall be permitted access at reasonable hours to any individual consumer of any facility, unless the consumer is receiving care and treatment in triage centers.* This subsection (f)(1) shall not be construed to limit the Department's ability to conduct off-hour surveys or inspections.

2) *All persons entering a facility under* the Act and *this* subsection (f) *shall promptly notify appropriate facility personnel of their presence. They shall, upon request, produce identification to establish their identity. No person shall enter the immediate living area of any consumer without first identifying himself or herself and then receiving permission from the consumer to enter. The rights of other consumers present in the room shall be respected. A consumer may terminate at any time a visit by a person having access to the consumer's living area under* the Act and *this* subsection.

3) *This* subsection (f) *shall not limit the power of the Department or other public agency otherwise permitted or required by law to enter and inspect a facility.*

4) *Notwithstanding subsection* (f)(1), *the executive director of a facility may refuse access to the facility to any person if the presence of that person in the facility would be injurious to the health and safety of a consumer or would threaten the security of the property of a consumer or the facility, or if the person seeks access to the facility for commercial purposes.*

5) *Nothing in this* subsection (f) *shall be construed to conflict with, or infringe upon, any court orders or consent decrees regarding access.* (Section 3-110 of the Act)

g) *A consumer shall be permitted to present grievances on behalf of himself or herself or others to the executive director, the consumers' advisory council (see subsection (j)), State governmental agencies, or other persons without threat of discharge or reprisal in any form or manner whatsoever. The executive director shall provide all consumers or their representatives with the name, address, and telephone number of the appropriate State governmental office where complaints may be lodged*. (Section 3-112 of the Act) All facilities shall display contact information and make it accessible and visible to consumers and visitors with a minimum of interaction with staff.

h) *A consumer may refuse to perform labor for a facility*. (Section 3-113 of the Act)

i) *No consumer shall be subjected to unlawful discrimination as defined in Section 1-103 of the Illinois Human Rights Act by any owner, licensee, executive director, employee, or agent of a facility. Unlawful discrimination does not include an action by any licensee, executive director, employee, or agent of a facility that is required by* the *Act or* by this Part. (Section 3-114 of the Act)

j) Except for triage centers and crisis stabilization units, *each facility shall establish a consumers' advisory council* consisting of at least five consumers chosen by consumers. If there are not five consumers capable of functioning on the consumers' advisory council, as determined by the interdisciplinary team, consumers' substitute decision makers shall take the place of the required number of consumers. *The executive director shall designate a member of the facility staff* other than the executive director *to coordinate the establishment of, and render assistance to, the council*.

1) *No employee or affiliate of a facility shall be a member of the council*.

2) *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 consumers, the executive director, and the staff*.

3) *Records of council meetings shall be maintained in the office of the executive director,* subject to compliance with the Health Insurance Portability and Accountability Act and Mental Health and Developmental Disabilities Confidentiality Act.

4) *The consumers' advisory council may communicate to the executive*

director the opinions and concerns of the consumers. The council shall review procedures for implementing consumer rights and facility responsibilities, and make recommendations for changes or additions that will strengthen the facility's policies and procedures as they affect consumer rights and facility responsibilities.

5) *The council shall be a forum for*:

A) *Obtaining and disseminating information*;

B) *Soliciting and adopting recommendations for facility programming and improvements*; *and*

C) *Early identification and for recommending orderly resolution of problems*.

6) *The council may present complaints on behalf of a consumer to the Department or to any other person it considers appropriate*, without retaliation of any kind from the facility or any facility employee. (Section 3-203 of the Act)

k) A facility shall provide language assistance services in accordance with the Language Assistance Services Act and the Language Assistance Services Code.

l) A facility shall inform a consumer of his or her right to designate a substitute decision maker in writing and shall assist the consumer in naming a substitute decision maker, if the consumer requests it.

Section 380.150 Informed Consent

a) For the purposes of this Section and Section 380.160, the following definitions shall apply:

1) Authorized representative – a guardian with a court order granting authority to consent to psychotropic medication or the use of restraints on behalf of a consumer, or a person authorized to consent to psychotropic medication or the use of restraints on behalf of a consumer pursuant to the Power of Attorney Act or the Mental Health Treatment Preference Declaration Act.

2) Capable consumer – a consumer who is able to understand the nature of the decision to be made, the information relevant to making the decision and the possible consequences of any decision, and to make a reasoned judgment based on this information.

3) Informed consent – written consent for specific medical care, given freely, without coercion or deceit, by a capable consumer, or by a consumer's authorized representative, after the consumer, or the consumer's authorized representative, has been fully informed of, and had an opportunity to consider, the nature of the care, the likely and possible benefits and risks to the consumer of receiving the care, any other likely and possible consequences of receiving or not receiving the care, and possible alternatives to the proposed care. Written informed consent shall be obtained from a consumer or from a consumer's authorized representative when he or she is admitted. Before obtaining informed consent from a consumer, or from a consumer's authorized representative, the facility shall inform the consumer or the consumer's authorized representative that the potential consequences of an emergency situation in a SMHRF may include temporary holding, restraint, or the use of medications as ordered by the physician for safety purposes. For psychotropic medications, the informed consent shall comply with subsection (d).

b) The facility shall document in the consumer's record whether he or she is capable of giving informed consent for medical care, including for receiving psychotropic drugs. If the consumer is not capable of giving informed consent, the identity of the consumer's authorized representative shall be placed in the consumer's record.

c) No psychotropic medication may be given to any consumer without the informed consent of the consumer or, if the consumer is not capable, the informed consent of a person authorized to consent for the consumer without capacity. Informed consent shall be secured in compliance with the requirements of this Section.

d) Procedure for Securing Informed Consent for Psychotropic Medication

1) Prior to initiating any detailed discussion designed to secure informed consent, a licensed medical professional shall inform the consumer or the consumer's authorized representative that the consumer's physician has prescribed a psychotropic medication for the consumer, and that an informed decision is required from the consumer or the consumer's

authorized representative before the consumer may be given the medication.

2) The discussion designed to secure informed consent shall be private, between the consumer or the consumer's authorized representative, and the resident's physician, a registered pharmacist who is not a dispensing pharmacist for the facility where the consumer is receiving services, or a licensed nurse. The consumer shall be given the opportunity to ask questions throughout the discussion. The consumer shall be given as much time as he or she needs to grant informed consent, and shall be told that he or she is not required to make the decision during the meeting.

3) The discussion shall include information about:

A) The name of the medication;

B) The consumer's illness that the medication is intended to treat;

C) The symptoms of the illness that the medication is intended to treat, and how those symptoms are affecting the consumer;

D) How the medication is intended to affect those symptoms;

E) Other possible effects or side effects of the medication, and any reasons (e.g., age, health status, other medications) that the consumer is more or less likely to experience side effects;

F) Dosage information, including how much medication would be administered, how often, and the method of administration (e.g., orally or by injection; with, before, or after food);

G) Any tests and related procedures that are required for the safe and effective administration of the medication;

H) Any food or activities the consumer should avoid while taking the medication;

I) Any possible alternatives to taking the medication that could accomplish the same purpose; and

J) Any possible consequences to the consumer of not taking the medication.

4) The consumer or the consumer's authorized representative shall be told that his or her informed consent may be withdrawn at any time, and that, even with informed consent, the consumer may refuse to take the medication. The consumer or the consumer's authorized representative shall be told whether stopping the medication poses a risk of serious health consequences for the consumer, and whether stopping the medication and resuming it will reduce the subsequent effectiveness of the medication.

5) In addition to the oral discussion, the consumer or his or her authorized representative shall be given the information in subsection (d)(2) in writing. The information shall be in plain language, understandable to the reader. If the document is in a language not understood by the reader, the facility shall provide a translator capable of communicating with the reader and the health care professional conducting the discussion. The health care professional shall guide the consumer through the written information. The document shall include a place for the consumer or his or her authorized representative to give, or to refuse to give, informed consent, or to request more time or more information prior to making a decision. Informed consent is not secured until the consumer or authorized representative has given oral and written informed consent.

6) If a consumer has an authorized representative, the consumer may still be present at the discussion required by this Section. If a consumer has an authorized representative, that consumer shall still be given appropriate information about the medication. The information shall include, at a minimum, written information and an oral explanation of common side effects of the medication to facilitate the consumer in identifying the medication and in communicating the existence of side effects to the nursing staff. If the consumer is capable of understanding, the explanation shall also include:

A) The information in subsection (d)(3)(H);

B) Whether stopping the medication poses a risk of serious health consequences for the consumer; and

C) Whether stopping the medication and resuming it will reduce the

subsequent effectiveness of the medication.

7) The time period for informed consent for psychotropic medication shall not exceed one year.

8) Informed consent shall be given for a maximum daily dosage. Additional informed consent is not required so long as the medication administered to the consumer remains within the maximum daily dosage for which consent was given.

9) If a consumer in a triage center has a current prescription for psychotropic medication, the triage center shall take all reasonable steps to confirm that the consumer has given informed consent for the medication.

10) A consumer shall be asked to consent to the administration of a new psychotropic medication in a dosage or frequency that exceeds the maximum recommended daily dosage as found in the Physician's Desk Reference only when the reason for exceeding the recommended daily dosage is explained to the consumer by a nurse, physician, or psychiatrist, and the reason for exceeding the recommended daily dosage is justified by the prescribing physician or psychiatrist in the clinical record. The dosage and frequency shall be reviewed and rejustified by the prescriber on a weekly basis and reviewed by a consulting pharmacist. The justification for exceeding the recommended daily dosage shall be recorded in the consumer's record and shall be approved, in writing, by the medical director of the facility.

11) The facility shall obtain informed consent using forms provided by the Department pursuant to Section 2-106.1 of the Nursing Home Care Act.

Section 380.160 Restraints and Therapeutic Separation

a) The facility shall develop and implement a written plan to create coercion-free environments as defined in the Mental Health and Developmental Disabilities Code in recognition of the prevalence of trauma histories in the populations to be treated in all levels of service in the facility. The plan shall address how the facility will:

1) Use leadership to create organizational change;

2) Use data to inform practice;

3) Train the workforce in policies and practices;

4) Use restraint and therapeutic separation prevention tools;

5) Use debriefing techniques following the use of restraints or therapeutic separations; and

6) Create appropriate spaces (e.g., comfort rooms) for therapeutic separations.

b) Restraints

1) A physical restraint, or momentary physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, shall be applied only by staff trained in the safe and humane application of the particular type of restraint. Training shall be in a program administered or approved by DHS-DMH.

2) A restraint shall be used only in an emergency and when alternative interventions cannot ensure safety.

3) *Informed consent shall be required for restraints consistent with the requirements contained in Section 2-106*(c) *of the Nursing Home Care Act*. (Section 3-115 of the Act)

A) Written informed consent for the short-term emergency use of a restraint may be obtained from a consumer when he or she is admitted or after admission. Before obtaining informed consent, the facility shall inform the consumer that, in a behavioral emergency, when necessary to protect the consumer or other people from immediate physical harm, the staff may use the temporary holding, and, if informed consent has been given, may use short-term restraint until the consumer can be transported to a hospital.

B) Whenever use of a physical restraint is initiated, the consumer 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 consumer 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. The person or organization shall be notified whenever a consumer is restrained.

C) The facility shall provide the following information in writing to the person or organization named by the consumer. If the consumer requests that the Guardianship and Advocacy Commission be contacted, the facility shall also provide the following information in writing to the Guardianship and Advocacy Commission:

i) The reason the physical restraint was needed;

ii) The type of physical restraint that was used;

iii) The interventions used or considered prior to physical restraint and the impact of these interventions;

iv) The length of time the physical restraint was applied; and

v) The name and title of the facility employee to be contacted for further information.

D) Whenever a physical restraint is used on a consumer whose primary mode of communication is sign language, the consumer 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 consumer or others.

4) The use of a restraint is not permitted unless a consumer presents a behavioral emergency. In these circumstances, restraints may be used for a brief period until emergency care and physical transportation to a hospital can be accomplished. In situations that are successfully resolved through manual holding lasting less than five minutes, without physical hold to the ground or undue force, and without injury, transport to an emergency

room or hospital is not required.

A) The use of restraints in a behavioral emergency shall comply with the provisions of Sections 380.150(a) and 380.610(d).

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 allowable restraint use applies to any physical restraint, including physical hold and prolonged restriction of movement by staff, as well as the use of any mechanical restraint device. Gentle physical guidance, prompting, and escorting a consumer are not considered restraints. Momentary periods of physical restriction by direct person-to-person contact, without the aid of material or mechanical devices, accomplished with limited force, and that are designed to prevent a consumer from completing an act that would result in potential physical harm to himself or herself or another shall not constitute restraint, but shall be documented in the consumer's clinical record, and may be used only by a person trained pursuant to subsection (b)(1).

D) Any consumer being restrained shall be continuously monitored by a staff member, who shall be present throughout the period of restraint use to ensure safety, to avoid injury, and to minimize discomfort. The consumer's position shall be monitored to ensure that breathing is unrestricted. Consumer hydration or toileting needs shall be addressed unless precluded by immediate safety concerns.

E) Nursing staff shall examine the consumer as soon as possible, but no later than 10 minutes, after the start of the restraint use.

F) The consumer's psychiatrist shall be contacted immediately for medical direction. If the consumer's psychiatrist is unavailable, the psychiatric medical director shall be contacted.

G) The QMHP, pursuant to the facility's written policy, shall debrief the staff involved in the restraint use regarding the events leading up to the restraint, physical hold, or application, and the

consumer's condition during the duration of the restraint use. A consumer who was transported to a hospital shall be debriefed upon return to the facility.

H) The use of physical restraints shall be documented in the consumer's record, including:

i) The behavior emergency that prompted the use of restraints, including preceding events, staff efforts to de-escalate the situation, and reasons for the use of restraint;

ii) The date and time that restraints were applied to the consumer, the methods used in restraining the consumer, the duration of restraint use, the time of release, and events surrounding release;

iii) The names and titles of the staff responsible for applying the restraint and for monitoring the consumer, and the names and titles of any other staff involved in the incident;

iv) Orders by the psychiatrist or psychiatric medical director who was notified of the restraint;

v) The emergency transportation that was used and the hospital to which the consumer was taken;

vi) Any injury or other negative impact sustained by the consumer; and

vii) The date of the scheduled care planning conference and the results of the care plan review in light of the use of emergency restraints.

I) Facility staff, including safety personnel, shall receive a basic orientation in crisis prevention and in safe physical hold and restraint methods. No facility staff may use any physical hold or other restraint method unless trained pursuant to subsection (b)(1).

J) The facility shall maintain written records of training related to the use of restraints and to de-escalation practices provided to staff.

c) Therapeutic Separation

1) The facility shall develop policies and procedures for the use of therapeutic separation as a strategy for creating a coercion-free environment.

2) The facility shall designate specific space (e.g., a comfort room) for therapeutic separation that is designed in a way that calms the senses and provides a temporary sanctuary from stress. The comfort room shall be:

A) Used as a tool to teach individuals calming techniques to decrease agitation and aggressive behavior;

B) Used to prevent the use of emergency restraints;

C) Used at the consumer's will, and shall remain unlocked;

D) Located in an area that is easily accessible to those who will be using it and close to a staffed area for adequate line of sight and supervision;

E) Used before the onset of aggressive/uncontrolled behavior, and after as necessary; and

F) Developed and furnished with input from staff and consumers.

3) Therapeutic separation shall not be forced upon consumers and shall not be used as punishment.

4) Supervised therapeutic separation may be used for de-escalation of a potentially harmful situation, provided that:

A) The supervised separation lasts for no more than 30 minutes without the facility contacting the psychiatric medical director in accordance with Section 380.610(d);

B) The consumer is attended by an MHP or CRSS at all times in therapeutic separation until the consumer can reasonably discuss the situation or event;

C) An MHP or licensed nurse personally reviews the therapeutic separation situation at least every 15 minutes while a consumer is in therapeutic separation; and

D) The situation is entered into the consumer's record for review by the Interdisciplinary Team.

d) The use of chemical restraints is prohibited.

Section 380.170 Consumer Background Checks

a) Except for triage centers, *a facility shall, within 24 hours after admission, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons age 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to subsection (d) Section 6.09(d) of the Hospital Licensing Act. Background checks conducted pursuant to this Section shall be based on the consumer's name, date of birth, and other identifiers as required by the Department of State Police*. (Section 2-104(a) of the Act)

b) 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.

c) *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 consumer meets criteria related to the consumer's health or lack of potential risk* (Section 2-104(a) of the Act). The facility shall arrange for a fingerprint-based background check or request a waiver from the Department within five 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.

d) *A waiver issued pursuant to Section* 2-104(a) of the Act *shall be valid only while the consumer is immobile or while the criteria supporting the waiver exist.* (Section 2-104(a) of the Act)

e) *The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility* or off-site premises if accompanied by staff. *If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the consumer's dignity and that minimizes any emotional or physical hardship to the consumer.* (Section 2-104(a) of the Act)

f) If a facility does not 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 2-104(a) of the Act.

g) 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 Identified Offender Report and Recommendation prepared pursuant to Section 2-105(d) of the Act is pending.

Section 380.180 Identified Offenders

a) The facility shall review the results of the criminal history background checks immediately upon receipt of the checks.

b) The facility shall be responsible for taking all steps necessary to ensure the safety of consumers while the results of a name-based background check or a fingerprint-based check are pending.

c) *If the results of a consumer's criminal history background check reveal that the consumer is an identified offender as defined in* Section 1-102 of the *Act, the facility shall do the following*:

1) *Immediately notify the Department of State Police, in the form and manner required by* DSP*, in collaboration with the Department of Public Health, that the consumer is an identified offender.*

2) *Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender consumer. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by* DSP. *The inquiry shall be*

processed through the files of DSP *and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to* DSP *pursuant to an inquiry under this subsection* (c)(2) and Section 2-104(b) of the Act*, any criminal history record information contained in its files.* (Section 2-104(b) of the Act)

d) The facility shall comply with all applicable provisions contained in the Uniform Conviction Information Act.

e) All name-based and fingerprint-based criminal history record inquiries shall be submitted to DSP electronically in the form and manner prescribed by DSP. DSP may charge the facility a fee for processing name-based and fingerprint-based criminal history record inquiries. The fee shall be deposited into the State Police Services Fund. The fee shall not exceed the actual cost of processing the inquiry.

f) If identified offenders are consumers 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 consumers of the facility. If a consumer 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 consumer to verify compliance with the requirements of the Sex Offender Registration Act, to verify compliance with the requirements of the Act and this Part, or to verify compliance with applicable terms of probation, parole or mandatory supervised release. 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 consumers 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 380.550.

3) Every licensed facility shall provide to every prospective and current consumer and consumer's guardian, and to every facility employee, a

written notice, prescribed by the Department, advising the consumer, guardian or employee of his or her right to ask whether any consumers 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 DSP 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.

4) If the identified offender is on probation, parole or mandatory supervised release, the facility shall contact the consumer'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 consumer's record. The record must also include the consumer's criminal history record.

g) Facilities shall maintain written documentation of compliance with Section 380.170.

h) Recovery and rehabilitation supports units and transitional living units shall annually complete all of the steps required in subsection (f) for identified offenders. This requirement does not apply to consumers who have not been discharged from the facility during the previous 12 months.

i) For current consumers who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by DSP.

j) 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 psychiatric medical director and law enforcement, shall specifically address the consumer's needs in an individualized treatment plan.

k) *The facility shall incorporate the Identified Offender Report and Recommendation*

into the identified offender's care plan (treatment plan) *created pursuant to 42 CFR 483.20*. (Section 2-105(f) of the Act)

l) *If the identified offender is a convicted* (see 730 ILCS 150/2) *or registered* (see 730 ILCS 150/3) *sex offender or if the Identified Offender Report and Recommendation* prepared pursuant to Section 2-105(d) 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*. (Section 2-105(d) of the Act)

m) The facility's reliance on the Identified Offender Report and Recommendation shall not relieve or indemnify in any manner the facility's liability or responsibility with regard to the identified offender or other facility consumers.

n) The facility remains responsible for continuously evaluating the identified offender and for making any changes in the treatment plan that are necessary to ensure the safety of consumers.

o) 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 380.530. The facility shall review its treatment plan and placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall 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 consumers from misconduct by the identified offender, or *if, based on the Identified Offender Report and Recommendation, a facility determines that it cannot manage the identified offender consumer safely within the facility, it shall commence involuntary transfer or discharge proceedings pursuant to Section 3-402* of the Nursing Home Care Act. (Section 2-105(g) of the Act)

p) The facility shall notify any 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 consumer.

q) The facility shall develop written procedures for implementing changes in consumer care and facility policies when the consumer no longer meets the

definition of identified offender as defined in the Act and this Part.

Section 380.190 Consumer Records

a) *The Department shall respect the confidentiality of a consumer's record and shall not divulge or disclose the contents of a record in a manner that identifies a consumer, except upon a consumer's death to a relative or guardian or under judicial proceedings. This Section shall not be construed to limit the right of a consumer to inspect or copy the consumer's own records*, and the consumer may inspect and copy his or her own records.

b) *Confidential medical, social, personal, or financial information identifying a consumer shall not be available for public inspection in a manner that identifies a consumer*, or in a manner that violates the Mental Health and Developmental Disabilities Confidentiality Act or the federal Health Insurance Portability and Accountably Act. (Section 3-206 of the Act)

Section 380.200 Assessment, Level of Service Determination, and Authorization

a) Authorizations for levels of service shall facilitate treatment in the least restrictive settings. Authorization is not required for admission to triage centers. Authorization is required for admission to crisis stabilization, transitional living, and recovery and rehabilitation supports. Authorization shall be limited in time based on the clinical status and needs of the consumer and the maximum length of stay at each level of service. A facility may request re-authorization if the initial authorization has expired and the consumer still requires treatment at a specific level of service. Initial authorizations shall be conducted by venders who are contracted with the State. Re-authorizations may be conducted by the same vendor or by a managed care entity.

b) Admission

1) Except for triage, each consumer shall receive an assessment prior to admission to a facility. The assessment shall be used to determine the appropriate level of service for service delivery and is required for authorization of services.

2) *After the provisional license period, no individual with mental illness whose service plan provides for placement in community-based settings shall be housed or offered placement in a facility at public expense unless,*

after being fully informed, he or she declines the opportunity to receive services in a community-based setting. (Section 4-107 of the Act)

3) To ensure that consumers are fully informed of their options regarding community-based services, the facility shall document, in writing, that community-based providers were granted access to each consumer. Information to be shared with consumers whose service plans provide for placement in a community-based setting shall include those items included in subsections (f) through (h) and:

A) An introduction to community based settings, permanent supportive housing and community-based services available to assist consumers in these settings and the financial support consumers may receive in these settings; and

B) A description of the benefits of placement in a community-based setting.

4) The facility shall not admit any consumer or be compensated for services prior to the completion of the assessment and the authorization by the State-designated assessment and authorization entity. Authorizations are not required for admission to a triage unit. Authorization is required prior to admission to:

A) Crisis stabilization units;

B) Transitional living units; and

C) Recovery and rehabilitation supports units.

5) Authorization shall be valid for a limited amount of time, determined by:

1) The clinical status and needs of the consumer; and

2) The length-of-stay limitations at each level of service.

c) Continued Stay or Transfer between Units

1) Additional authorizations may be requested by the interdisciplinary team if the initial authorization has expired and the consumer continues to

require treatment at a specific level of service. Authorization shall be performed by entities authorized by the Department of Healthcare and Family Services. Authorizing entities may be, but are not required to be, managed care entities assigned as the consumer's primary provider.

2) Any transfer to a new level of service requires the authorization by the State-designated assessment and authorization entity. The facility shall not admit any consumer or be compensated for services in a new level of service prior to authorization by the State-designated assessment and authorization entity.

d) Assessment Content for Assessments Conducted by the Facility
All initial assessments and annual re-assessments conducted by the facility shall be person centered and focus on the services and supports required for the consumer to live in permanent supportive housing or another appropriate community-based setting. All assessments shall include, but are not limited to, the consumer's:

1) Social history and demographic background information;

2) Psychiatric history and history of psychiatric hospitalizations;

3) Substance use history, including a substance abuse assessment;

4) Cognitive impairment screen;

5) Co-morbid medical conditions, treatment and management;

6) Medication history and compliance;

7) Strengths and preferences;

8) Risk indicators or potential;

9) Criminal history;

10) ADL and IADL self-management skills;

11) Medical condition, including any medical condition that may have an impact on the person's appropriateness for placement in a community-

based setting;

12) History of physical abuse or trauma, including childhood sexual or physical abuse, intimate partner violence, sexual assault, or other forms of interpersonal violence;

13) Goals and objectives that the consumer will need to achieve to be discharged to community living; and

14) Preference to be placed in a gender-specific unit or bed. The facility shall provide this placement if it is available.

e) The assessment shall include a consultation with the treating psychiatrist or other professional staff and other persons of the consumer's choosing.

f) The assessments shall be completed by an LPHA and reviewed and signed by the treating psychiatrist within 14 days after admission. The psychiatrist shall complete an independent mental status exam and confirm or revise the initial diagnosis.

g) Re-assessment by the Department of Healthcare and Family Services

1) The Department of Healthcare and Family Services or its designee may conduct re-assessments to comply with the requirements of the Williams Consent Decree. The re-assessments may be conducted:

A) Annually; or

B) No more than once every three months, upon request by the consumer who declined to move to a community-based setting.

2) Annual re-assessments shall document the reasons for the consumer's opposition to transferring to a community-based setting.

h) Re-assessment by the Facility

1) The facility shall also conduct re-assessments:

A) To develop or update a treatment plan; and

B) When there is a change in the consumer's clinical functioning.

2) A recovery and rehabilitation supports unit shall conduct re-assessments within 120 days following admission of a consumer.

Section 380.210 Individualized Treatment Plan

a) Each individualized treatment plan that is implemented by a facility shall be developed with the following principles:

1) The consumer shall be an active participant in the development and evaluation of the treatment plan and progress.

2) All diagnoses and treatment recommendations and options shall be shared and explained to the consumer, within clinical limits.

3) The facility shall seek and honor the consumer's preferences as the treatment plan is developed.

4) The individualized treatment plan shall focus on developing self-reliance, personal decision making, and resiliency.

5) The consumer's strengths shall be identified, and all treatment strategies shall build upon and use these strengths to support the consumer's recovery.

6) The consumer's needs shall be identified for home, community and work environments.

7) The consumer's expressed values and culture shall be considered in the development of the plan.

b) For triage, the treatment plan shall be initiated on admission and shall be updated prior to discharge. For crisis stabilization, the treatment plan shall be updated at least once every seven days. For transitional living, the treatment plan shall be updated at least once every 30 days. For recovery and rehabilitation supports, the treatment plan shall be updated at least quarterly. For crisis stabilization, transitional living, and recovery and rehabilitation supports, the treatment plan shall be updated whenever there has been a change in the consumer's clinical function that has prompted a re-assessment. When updated, the treatment plan

shall reflect:

1) Any new interventions that are required to promote stabilization and recovery; and

2) Any changes in the consumer's needs and preferences, including his or her desire to move to a community-based setting.

c) For recovery and rehabilitation supports units only, if a consumer declines to move to a community-based setting, the new individualized treatment plan shall incorporate appropriate services to assist in the acquisition of activities of daily living and illness self-management.

d) The treatment plan shall be reviewed by the treating psychiatrist, the medical doctor, and the IDT, and signed by a physician.

Section 380.220 Transfer or Discharge

a) *Consumers shall be free to leave at any time. If a consumer in a triage center expresses a desire to contact a third party for any purpose, the facility staff shall contact that third party on behalf of the consumer*. (Section 3-108 of the Act)

b) *A consumer may be discharged from a facility after he or she gives the executive director, a physician, or a nurse of the facility written notice of the desire to be discharged. If a guardian has been appointed for a consumer, the consumer shall be discharged upon written consent of his or her guardian. In the event of a requested consumer discharge, the facility is relieved from any responsibility for the consumer's care, safety, and well-being upon the consumer's discharge*. (Section 3-111 of the Act) This requirement shall not be construed to limit the consumer's right to leave the facility at any time.

c) The process for the involuntary transfer or discharge of a consumer from a facility shall be conducted in accordance with Sections 3-401 through 3-423 of the Nursing Home Care Act.

d) The facility shall contact the community-based behavioral health provider following the consumer's discharge from the facility to ensure that the consumer is receiving follow-up care.

SUBPART B: SPECIALIZED MENTAL HEALTH

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

REHABILITATION FACILITIES PROGRAMS

Section 380.300 Triage Centers

a) Triage centers shall provide an immediate assessment of consumers who present in psychiatric distress, as an alternative to emergency room treatment or hospitalization, and shall connect the consumer with community-based services and treatment when considered necessary. Triage center staff shall determine the continued treatment needs of the consumer and refer him or her to the appropriate treatment services, if needed. A stay at a triage center shall not exceed 23 hours.

b) Consumers accepted at a triage center shall:

1) Have acute symptoms of psychiatric crisis, requiring a structured assessment within a safe, therapeutic environment; and

2) Be expected to benefit from the treatment provided in a triage center.

c) Consumers may self-refer to a triage center. *Consumers may access a triage center from a number of referral sources, including family, emergency rooms, hospitals, community behavioral health providers, federally qualified health providers, or schools, including colleges or universities.* (Section 1-102 of the Act)

d) Triage centers shall not accept for admission:

1) Consumers who are directly referred by police;

2) Anyone younger than 18 years of age;

3) Anyone who is severely intoxicated, or who is at risk of severe withdrawal symptoms from alcohol or other substances as indicated by a DHS-DMH screening instrument;

4) Anyone who has one of the medical conditions in Section 380.120(n), requiring active intervention or treatment and a higher level of medical care beyond the capabilities of the triage center;

5) Anyone who presents an imminent risk of harm to himself or herself or to others meeting the criteria of involuntary commitment in Section 1-119 of

the Mental Health and Developmental Disabilities Code;

6) Anyone who is unable to care for himself or herself meeting the criteria of involuntary commitment in Section 1-119 of the Mental Health and Developmental Disabilities Code;

7) Consumers who are non-ambulatory; or

8) Anyone who falls under any other restrictions in the Act and this Part, including exclusions from the definition of "consumer" in Section 380.100.

e) A triage center shall call 911 for consumers who need immediate medical attention and assess the need for basic life support, and administer the basic life support as clinically indicated.

f) Service Requirements
A consumer who presents at a triage center shall be immediately assessed by an LPHA, or shall be assessed as quickly as is practicable if the triage center is experiencing high consumer traffic. Additional service requirements include:

1) Initial service planning;

2) Case management to provide linkage regarding a consumer's next level of services;

3) Brief therapy interventions, as needed;

4) Assistance with ADLs, as needed;

5) Safety monitoring;

6) Medication services;

7) Determining whether a consumer may require additional services due to a dual diagnosis;

8) The provision of basic medical assessments, including, but not limited to, vital signs and blood sugar levels; and

9) Engagement of family and natural supports, as practical.

g) Staffing Requirements
The triage center shall maintain the following staffing levels on site in the triage center at all times.

1) At least one LPHA shall be on site at all times to provide clinical supervision and assessment services.

2) A psychiatrist, or a psychiatric advanced practice nurse (APN), shall be immediately available by phone 24 hours per day, and shall be able to respond on site within 90 minutes after being contacted by phone, when facility staff considers this necessary.

3) At least one registered nurse shall be on site at all times to provide health care services.

4) At least one CRSS shall be on site daily to provide recovery support services. Whenever possible, each consumer shall have at least one individual face-to-face discussion with a CRSS prior to discharge from the triage center.

5) At least one MHP per every eight or fewer consumers shall be on site and available to provide mental health services to individuals 24 hours per day.

6) Safety personnel shall be available 24 hours per day, and shall be able to respond within five minutes after being contacted by phone.

h) To ensure rapid and priority access for referrals, a triage center shall maintain collaborative agreements with psychiatric centers, detox centers, longer-term residential substance abuse treatment centers, homeless shelters, hospitals, ambulance departments, and outpatient mental health centers.

i) Discharge Planning

1) Discharge planning shall be conducted in conjunction with a community-based behavioral health provider, a community mental health center, or other service provider selected by the consumer.

2) In conjunction with the consumer and any individual acting on behalf of

the consumer at the consumer's request, a minimum of a QMHP shall develop, or supervise the development of, the discharge plan.

3) Depending on the final assessment of the consumer, he or she may be discharged to home or another living arrangement or, subject to authorization, a community-based behavioral health provider residential program, a crisis stabilization unit, a recovery and rehabilitation supports unit, a transitional living unit, or other appropriate clinical treatment site.

j) *A triage center may be located in a building separate from the licensed location of a facility, but shall not be more than 1,000 feet from the licensed location of the facility and must meet all of the facility standards applicable to the licensed location. If the triage center does operate in a separate building, safety personnel shall be provided, on site, 24 hours per day and the triage center shall meet all other staffing requirements without counting any staff employed in the main facility building.* (Section 1-102 of the Act)

Section 380.310 Crisis Stabilization Units

a) Crisis stabilization units shall provide safety, structure and the support necessary, including peer support, to help a consumer to stabilize a psychiatric episode. The maximum length of stay at a crisis stabilization unit shall not exceed 21 days.

b) Consumers admitted to a crisis stabilization unit shall:

1) Be diagnosed as having a serious mental illness;

2) Be experiencing an acute exacerbation of psychiatric symptoms;

3) Have a need for assessment and treatment within a structured, supervised therapeutic environment; and

4) Be expected to benefit from the treatment provided.

c) A consumer shall not be admitted to a crisis stabilization unit without approved authorization by the State-designated assessment and authorization entity.

d) Visiting family members who are younger than age 18 shall be accompanied by an adult.

e) Crisis stabilization units shall not accept for admission:

1) Anyone younger than 18 years of age;

2) Anyone who is intoxicated, as manifested by unstable vital signs or neurologic impairment, including but not limited to stupor, disorientation, or difficulty with swallowing or breathing that requires medical monitoring to assure medical safety, or who is at risk of severe withdrawal symptoms from alcohol or other substances;

3) Anyone who has one of the medical conditions in Section 380.120(n) requiring active intervention or treatment and a higher level of medical care beyond the capabilities of the crisis stabilization unit;

4) Anyone who is an imminent risk of harm to himself or herself or others, or who is unable to care for himself or herself, and who is eligible for involuntary commitment under the Mental Health and Developmental Disabilities Code;

5) Consumers who are non-ambulatory; or

6) Anyone who falls under any other restrictions in the Act and this Part, including exclusions from the definition of "consumer" in Section 380.100.

f) Service Requirements
The crisis stabilization unit shall ensure that all consumers who are admitted undergo an immediate assessment that, in consultation with the consumer, identifies and prioritizes the immediate and longer term services that the consumer needs. Additional service requirements include:

1) Treatment planning in accordance with Section 380.620(a);

2) Ongoing assessment to determine the consumer's progress and readiness for discharge;

3) Case management, including discharge planning, linkage to the community-based behavioral health provider that has been identified as responsible for the outpatient care for that consumer, referral and follow-up;

4) Therapeutic interventions that use evidence-based practices;

5) Meal services, in accordance with Section 380.650;

6) Assistance with activities of daily living, as needed;

7) Support and monitoring for safety, to include face checks as needed;

8) Skill building to facilitate illness self-management through the identification, development and use of individual strengths and natural supports;

9) Psychiatric evaluations;

10) Medication services; and

11) The capability of providing dual diagnoses services for a consumer, if needed.

g) The crisis stabilization unit shall provide 32 hours per week of group or individual active treatment, as prescribed by each consumer's treatment plan. The active treatment shall be documented in the consumer's record.

h) Discharge Planning

1) In conjunction with the consumer and any individual acting on behalf of the consumer at the consumer's request, a minimum of a QMHP shall develop, or supervise the development of, the discharge plan.

2) Discharge planning shall be conducted in conjunction with a community mental health center or other service provider selected by the consumer.

3) All discharge planning shall commence on admission to the crisis stabilization unit. If a consumer is homeless, the discharge planning shall include the immediate identification of living arrangements.

4) The crisis stabilization unit shall facilitate connection to the community-based behavioral health provider or community-based provider prior to discharge to foster the development of, or maintain the treatment

relationship with, the community-based behavioral health provider or community-based provider.

5) The discharge plan shall be reviewed with the consumer and with any individual acting on behalf of the consumer at the consumer's request, and it shall be revised as progress indicates. At a minimum, the review shall occur once every seven days until discharge.

6) A consumer's supervision levels and his or her needed level of service shall be part of the assessment in determining the discharge plan.

i) The assessment of a consumer's need for face checks pursuant to subsection (f)(7) shall be ongoing and adjusted as needed.

j) Staffing Requirements
In no case shall the staffing ratio in a *crisis stabilization* unit *be less than 3.6 hours of direct care for* each consumer. (Section 2-102(1) of the Act) For the purposes of this Section, "on site" means being in the crisis stabilization unit within a facility. The unit determines the work hours of the employee. For the purpose of computing staff-to-resident ratios, direct care staff shall include the following:

1) An LPHA, to provide clinical supervision of the program. The LPHA shall spend at least 50% of each full-time equivalent (FTE) work week on site at the crisis stabilization unit;

2) At least one QMHP per every 16 or fewer consumers, to provide assessment, individual and group therapy, and other mental health services as needed;

3) A psychiatrist or advance practice nurse who shall be immediately available by phone 24 hours per day and who shall be able to respond on site within 90 minutes after being contacted by phone when facility staff considers this necessary;

4) At least one registered nurse to provide at least 15 minutes of nursing care per day for each consumer;

5) At least one CRSS, on duty and available for services four hours per day, seven days per week. Each consumer shall have at least one individual,

face-to-face-discussion with a CRSS prior to discharge or transfer to another level of service, as well as the opportunity for participation in group and individual meetings to develop a consumer's Wellness Recovery Action Plan;

6) MHPs, to provide mental health services to consumers 24 hours per day. The ratio of individuals served to MHPs shall not exceed 16 to one;

7) RSAs, to provide support and assistance to consumers 24 hours per day. The ratio of individuals served to RSAs shall not exceed 16 to one.

k) The staff of a crisis stabilization unit also shall include a dietetic service supervisor and safety personnel, but these shall not be considered part of the facility's direct care staff.

l) Safety personnel shall be available 24 hours per day, and shall be able to respond within five minutes after being contacted by phone. While crisis stabilization units shall be secure, they are not required to be locked.

m) The direct care staff shall meet weekly for cross-training to support professional skill development.

n) A crisis stabilization unit shall maintain collaborative agreements with:

1) Community-based behavioral health providers to facilitate discharge planning; and

2) A local psychiatric unit to assure rapid priority access when a consumer needs to be admitted to the psychiatric unit.

o) Consumer preferences shall be considered whenever possible.

Section 380.320 Recovery and Rehabilitation Supports Centers

a) Recovery and rehabilitation supports centers shall facilitate *a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units* or transition to the community *by improving living skills and community socialization. The duration of stay in* this *setting shall be* based on the clinical needs of the consumer, as determined by the consumer's interdisciplinary team. (Section 1-102 of the Act)

b) Consumers admitted to an RRS center shall be in need of RRS care as determined by State-authorized assessment, level of service determination, and authorization criteria.

c) A consumer shall not be admitted to an RRS center without authorization and without undergoing the authorization and background check requirements of Sections 380.170 and 380.180.

d) RRS centers shall not accept for admission:

1) Anyone younger than 18 years of age;

2) Anyone with a primary diagnosis of substance use disorder;

3) Anyone who has one of the medical conditions in Section 380.120(n), requiring active intervention or treatment and a higher level of medical care beyond the capabilities of the RRS center;

4) Anyone diagnosed with a traumatic brain injury or diagnosed with dementia;

5) Consumers who are non-ambulatory;

6) Anyone who presents an imminent risk of harm to himself or to herself, or to others and is eligible for involuntary commitment under the Mental Health and Developmental Disabilities Code; or

7) Anyone who falls under any other restrictions in the Act and this Part, including exclusions from the definition of "consumer" in Section 380.100.

e) The determination that a consumer meets the requirements of subsections (d)(2) through (d)(6) shall be made by the center's LPHA. The determination shall be in writing, shall be kept on file at the center for no less than three years, and shall be made available to the Department or to DHS-DMH upon request.

f) Service Requirements
The recovery and rehabilitation supports center shall ensure that:

1) Treatment planning is conducted in accordance with Section 380.210;

2) The continued stay of all consumers is subject to demonstrated medical necessity as substantiated by regular authorization reviews pursuant to the assessment timetables in Section 380.210(b);

3) The facility is capable of performing dual diagnosis services for consumers, including the engagement of services appropriate for the pre-contemplative state of recovery;

4) The facility provides consumers with assistance in identifying and developing natural supports in the community;

5) Consumers receive an initial assessment of their mental health treatment and training needs as required in Section 380.200(d). The initial assessment shall occur within the first two weeks after admission and shall be updated no less than quarterly;

6) Consumers receive adequate case management, including discharge planning and linkage, referral and follow-up to all necessary supports needed to live safely in the community;

7) Consumers receive appropriate therapeutic interventions, including evidence-based practices of IMR, WRAP, motivational interviewing, cognitive training, and wellness and resilience support development.

8) Consumers are provided training in ADLs and IADLs, as clinically appropriate;

9) Consumers receive regular psychiatric and medical evaluations as indicated by changing conditions in their treatment plans, or as a part of other authorization processes;

10) Consumers receive 15 hours of treatment programming per week, and that the care is documented in the consumer's medical record and is part of the consumer's treatment plan; and

11) Consumers receive adequate medication services, pursuant to Section 380.630.

g) Staffing Requirements
In no case shall the staffing ratios in a *recovery and rehabilitation supports* center *be less than a staffing ratio of 1.8 hours of direct care for* each consumer. (Section 2-102(2) of the Act) For the purposes of this Section, "on site" means being present in the RRS unit within a facility. For the purpose of computing staff-to-resident ratios, direct care staff shall include the following:

1) An LPHA, to provide clinical supervision of the program. The LPHA shall spend at least 25% of each work week on site at the RRS center;

2) For each consumer, a minimum of 15 minutes of nursing care per day by a registered nurse or licensed practical nurse;

3) At least one CRSS, on site eight hours per day, five days per week, to provide recovery support services. Each consumer shall have at least one individual face-to-face discussion with a CRSS within the first week after admission to the RRS center, at least one additional individual, face-to-face discussion prior to discharge or transfer, and the opportunity for participation in group and individual meetings to develop a wellness recovery action plan;

4) MHPs, on site and available to provide mental health services to consumers 24 hours per day, seven days per week. The ratio of consumers to MHPs shall not exceed 32 to one;

5) RSAs, on site and available to provide support and assistance to consumers, as needed, 24 hours per day. The ratio of consumers to RSAs shall not exceed 16 to one;

6) An LPHA, QMHP or MHP to provide clinical services, e.g., treatment planning and therapy, for 60 minutes per consumer per week; and

7) An LPHA, QMHP, MHP, RSA or occupational therapy assistant, to provide group recreational and rehabilitative services for 60 minutes per consumer per week.

h) The RRS center shall ensure that a psychiatrist makes monthly visits to each consumer. In addition, the psychiatrist shall be on call each day and shall be available to respond on site within 24 hours after being contacted by the center when considered necessary by staff.

i) The staff of an RRS center also shall include a dietetic service supervisor, who shall not be considered part of the facility's direct care staff.

j) An RSS center shall maintain collaborative agreements with community mental health agencies to facilitate discharge planning.

k) Discharge Planning

1) In conjunction with the consumer or any individual acting on behalf of the consumer at the consumer's request, a minimum of a QMHP shall develop, or supervise the development of, the discharge plan.

2) Discharge planning shall be conducted in conjunction with a community mental health center or other service provider selected by the consumer, and shall commence as early in the admission as practicable.

3) The RSS unit shall facilitate connection to the community-based behavioral health provider or community-based provider in order to begin discharge planning. Discharge planning shall be part of, and based on, the initial assessment that is conducted when the consumer is admitted to the RSS unit.

4) The discharge plan shall be reviewed at least quarterly with the consumer and any individual acting on behalf of the consumer at the consumer's request, and revised as progress indicates.

Section 380.330 Transitional Living Units

a) Transitional living units shall provide assistance and support to consumers with mental illnesses who have not yet acquired, or who have lost previously acquired, skills needed for independent living and are in need of and can benefit from services in a structured, supervised setting in which the consumer can acquire and practice these skills. The maximum length of stay at a transitional living unit shall be 120 days, and no unit shall be larger than 16 beds.

b) Consumers admitted to a transitional living unit shall:

1) Be in need of transitional living assistance and support as determined by State-authorized assessment, level of service determination, and

authorization criteria;

2) Within the past two years, have received a minimum of 60 days of psychiatric hospital care or a minimum of 90 days of institutional care for an exacerbation of serious mental illness;

3) As a result of mental illness, lack critical ADLs or IADLs necessary for living in a less restrictive environment, and require an ongoing structured, supervised therapeutic environment to develop these skills; and

4) Demonstrate an ability to generalize skills and to receive supports from a community provider for transition to a community setting.

c) A consumer who meets the requirements of subsection (b), except for subsection (b)(2), and who receives authorization pursuant to Section 380.200, may be referred to a transitional living unit by a community mental health agency or managed care entity under an ongoing agreement under the following conditions:

1) The referral includes a documented, specific list of skill sets that the consumer needs to acquire;

2) The consumer's documented attempts to develop ADLs and IADLs in the community have been unsuccessful;

3) The consumer has a documented history of chronic homelessness as defined in 24 CFR 578.3 and has been diagnosed with serious mental illness; and

4) The consumer chooses to receive treatment in a transitional living unit, and the consumer's choice has been documented.

d) If a consumer is admitted as a result of a direct transfer from the RSS unit in the facility, and has had a background check within the previous 365 days, a background check under Section 380.180 is not required prior to admission to a transitional living unit.

e) A transitional living unit shall cooperate with a consumer's family, or other persons identified by the consumer, with whom the consumer will live after discharge.

f) A transitional living unit may admit consumers who were hospitalized, if those consumers meet the requirements of subsections (b)(1) through (b)(4) or subsection (c).

g) Transitional living units shall not accept for admission:

1) Anyone younger than 18 years of age;

2) Anyone with a demonstrated sufficient ability to perform ADLs and IADLs well enough to function in a less restrictive environment;

3) Anyone with a primary diagnosis of substance use disorder;

4) Anyone who has one of the medical conditions in Section 380.120(n), requiring active intervention or treatment and a higher level of medical care beyond the capabilities of the transitional living unit;

5) Anyone who is unable to participate in rehabilitation or engage in treatment and services in the transitional living unit;

6) Anyone diagnosed with a traumatic brain injury or diagnosed with dementia;

7) Anyone who presents an imminent risk of harm to himself or to herself, or to others and who is eligible for involuntary commitment under the Mental Health and Developmental Disabilities Code;

8) Anyone who is non-ambulatory; or

9) Anyone who falls under any other restrictions in the Act and this Part, including exclusions from the definition of "consumer" in Section 380.100.

h) Visiting family members who are younger than age 18 shall be accompanied by an adult.

i) Service Requirements
The transitional living unit shall ensure that:

1) An occupational therapist completes a face-to-face assessment within the

first week after each consumer's admission. All recommendations, including the services to be offered to the consumer, shall be discussed with the consumer;

2) Each consumer receives 90 minutes of individual occupational therapy or rehabilitation per week, provided by an occupational therapy assistant or a trained RSA and an MHP, and each consumer receives 18 hours of treatment programming per week. The RSA and the MHP shall be trained in evidence-based skills training. The occupational therapy, rehabilitation, and treatment programming shall be documented in the consumer's record and shall be part of each consumer's individualized treatment plan;

3) Treatment planning is conducted in accordance with Section 380.620(a);

4) Consumers receive an ongoing assessment, pursuant to the requirements in Section 380.210(b), of their mental health treatment and training needs related to the ADLs and IADLs. These assessments shall include:

   A) Risk assessment and appropriate risk mitigation alternative strategies;

   B) Assessing the consumer's ability to manage money; and

   C) A cognitive screen related to skill development;

5) Consumers receive adequate case management, including discharge planning, linkage, referral and follow up;

6) Consumers receive appropriate therapeutic interventions, including evidence-based practices of IMR, WRAP, motivational interviewing, cognitive training, and wellness and resilience support development;

7) Consumers undergo intensive training in ADLs and IADLs, including the use of a dietitian or dietetic services supervisor in meal planning and training for individuals with medical diet needs;

8) Consumers receive adequate skill building to facilitate illness self-management through the identification, development and use of individual strengths and natural supports;

9) Consumers receive regular psychiatric evaluations as indicated by changing conditions in the treatment plans, or as part of other authorization processes;

10) Consumers receive adequate medication services, pursuant to the requirements in Section 380.630; and

11) The transitional living unit is capable of performing dual diagnosis services for a consumer, if needed.

j) Staffing requirements
In no case shall the staffing ratios in a *transitional living* unit *be less than a staffing ratio of 1.6 hours of direct care for* each consumer [210 ILCS 49/2-102(3)]. For the purposes of this Section, "on site" means being present in the transitional living unit within a facility. For the purpose of computing staff-to-resident ratios, direct care staff shall include the following:

1) An LPHA, who shall provide clinical supervision of the program. The LPHA shall spend at least 30 minutes per week per consumer on site at the transitional living unit and be on the unit at least three days per week;

2) For every consumer, at least 15 minutes of nursing care per day by a registered or licensed practical nurse;

3) At least one CRSS on duty and available for services 90 minutes per consumer per week. Each consumer shall have at least one individual face-to-face discussion with a CRSS within the first week after admission to the transitional living unit, and at least one additional individual, face-to-face discussion prior to discharge or transfer, as well as the opportunity for participation in group and individual meetings to develop his or her wellness recovery action plan. An MHP may substitute for a CRSS if the facility has documented, unsuccessful efforts, at least every six months, to employ a CRSS in compliance with Section 380.130(k);

4) MHPs, who shall be on site and available 24 hours per day, seven days per week to provide mental health and casework services to consumers. The ratio of consumers to MHPs shall not exceed 16 to one.

k) Facility staff shall make documented, scheduled rounds every two hours to the transitional living unit whenever only one staff member is on duty. If the

transitional living unit has admitted a consumer who was not already residing in the facility, the rounds when only one staff member is present shall be every hour of the first week of the consumer's admission.

l) RSAs and other staff shall be present as needed to fulfill the service requirements of subsection (i) and any other service requirements of this Part.

m) The transitional living unit shall develop a written emergency response plan that requires, at a minimum that safety personnel be available 24 hours per day and able to respond within five minutes after being contacted by phone. Overnight staff in the transitional living unit shall be trained in the implementation of the emergency response plan.

n) The transitional living unit shall arrange for a psychiatrist to make routine visits. In addition, a psychiatrist shall be on call to the transitional living unit daily and respond on site within 24 hours when deemed necessary by staff.

o) Each transitional living unit shall have a dietitian available who conducts at least one assessment of each consumer within the first week after admission. The dietetic service supervisor shall function as a part of the treatment team, participating in the development of treatment recommendations, advising staff of any dietary concerns, and providing training to direct care staff regarding the development of meal planning, budgeting and cooking skills.

p) The treatment team shall conduct weekly meetings to facilitate cross training to support skill development.

q) A transitional living unit shall maintain collaborative agreements with community mental health agencies, local psychiatric units, and substance abuse providers to facilitate discharge planning.

r) Discharge Planning

1) In conjunction with the consumer and any individual acting on behalf of the consumer at the consumer's request, a minimum of a QMHP shall develop, or supervise the development of, the discharge plan.

2) Discharge planning shall be conducted in conjunction with a community mental health center or other service provider selected by the consumer and shall commence on admission to the transitional living unit.

3) The transitional living unit shall facilitate connection to the community-based behavioral health provider or community-based provider to begin discharge planning within the first month after admission to the transitional living unit to foster the development of, or maintain the treatment relationship with, the community-based behavioral health provider or community-based provider.

4) The discharge plan shall be reviewed with the consumer and any individual acting on behalf of the consumer at the consumer's request and revised as progress indicates. This review shall be conducted a minimum of once every 30 days until discharge.

SUBPART C: PROGRAM PERSONNEL

Section 380.400 Employee Personnel Policies and Records

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 the Department for review.

2) Individual personnel files for each employee, intern, unpaid staff and volunteer regularly scheduled at least weekly to work directly with consumers 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.

3) Individual personnel files for each employee, intern, unpaid staff and volunteer regularly scheduled at least weekly to work directly with consumers shall contain health records, including the initial health evaluation and the results of the tuberculin skin test, and any other pertinent health records.

4) Individual personnel records for each employee, intern, unpaid staff and volunteer regularly scheduled at least weekly to work directly with consumers shall contain records of the employee's performance evaluations.

c) Prior to employing any individual in a position that requires a State license or certification, the facility shall contact the Illinois Department of Financial and Professional Regulation or certifying entity to verify that the individual's license is active. A copy of the verification shall be placed in the individual's personnel file.

d) For all non-licensed employees, interns, unpaid staff and volunteers regularly scheduled at least weekly to work directly with consumers, the facility shall comply with Section 380.420.

e) All personnel shall have either training or experience, or both, in the job assigned to them. Written documentation of this training shall be placed in each employee's personnel file and shall be made available to the Department upon request.

f) The facility shall have a comprehensive set of written personnel policies and procedures that include, but are not limited to:

1) Job descriptions and qualifications and documentation of current licensure and certification for all staff, including those on contract with the facility or with an entity subcontracting with the facility. The facility shall also maintain job descriptions for volunteers, interns and other unpaid personnel;

2) Documentation that staff and interns who provide or supervise services pursuant to this Part meet the staff qualifications defined in this Part and that their individual performance is evaluated at least once every 12 months;

3) Documentation that volunteers regularly scheduled at least weekly to work directly with consumers and other unpaid personnel who provide services pursuant to this Part meet the requirements in Section 380.130(m) and that their individual performance is evaluated at least once every 12 months; and

4) Documentation that the facility has written personnel policies concerning

hiring, evaluating, disciplining and terminating employees, interns, unpaid staff and volunteers regularly scheduled at least weekly to work directly with consumers.

g) The facility shall provide to the Department, upon request, written documentation indicating that staff have engaged in professional development and continuing education as prescribed by DHS-DMH. Acceptable documentation shall demonstrate post-training competency, including copies of post tests or certificates of completion. Annual in-service training programs approved by DHS-DMH shall include the facility's policies, skill training and ongoing education to enable all personnel to perform their duties effectively. The facility shall keep written records of program content for each session and of personnel attending each session, and the records shall be available to the Department upon request.

h) Facilities shall not allow any person to work in any capacity until the facility has inquired of the Department's Health Care Worker Registry concerning the person. If the Registry has information substantiating a finding of abuse or neglect against the person, the facility shall not employ him or her in any capacity.

i) Facilities shall not allow volunteers regularly scheduled at least weekly to work directly with consumers until the facility has inquired of the Department's Health Care Worker Registry concerning the person. If the Registry has information substantiating a finding of abuse or neglect against the person, the facility shall not allow him or her to volunteer in any capacity.

j) Each facility shall develop, implement and maintain a plan for clinical supervision of QMHPs, MHPs and RSAs who perform services under the Act and this Part. Group supervision is acceptable, and the size of the group shall be conducive to the provision of clinical supervision. Supervision shall be documented in writing. Supervision of staff as noted in this subsection shall be for a minimum of one hour per week through face-to-face, teleconference or videoconference contact.

1) QMHPs shall be supervised by an LPHA.

2) MHPs and RSAs shall be supervised by, at a minimum, a QMHP.

3) LPHAs are not required to have clinical supervision under this Section.

Section 380.410 Initial Health Evaluation for Employees, Interns and Volunteers

a) Each employee, intern, unpaid staff and volunteer regularly scheduled at least weekly to work directly with consumers shall have an initial health evaluation, which shall be used to ensure that employees are not placed in positions that pose undue risk of infection to themselves, other employees, consumers or visitors.

b) The initial health evaluation shall be conducted within 90 days prior to employment through 30 days after employment.

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 that 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, chronically draining infections or open wounds.

d) The initial health evaluation shall include a physical examination and shall include a statement about the presence of any communicable disease that could pose a risk to the person, other employees, consumers or visitors. The evaluation shall also determine whether the employee is physically able to perform the job functions that the facility intends to assign to the employee, intern, unpaid staff and volunteer regularly scheduled at least weekly to work directly with consumers.

e) The initial health evaluation shall include a tuberculin skin test that is conducted in accordance with the Control of Tuberculosis Code. The facility shall have a written policy on its tuberculin skin tests.

Section 380.420 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

Section 380.430 Executive Director

a) Each facility shall employ an executive director to be responsible for the *general administration and supervision of* the *facility* (Section 1-102 of the Act), who is:

1) An LPHA or QMHP with a minimum of at least two years of supervisory

or management experience and at least one year of relevant experience, e.g., working directly with persons with serious mental illness; or

2) An administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act, with a minimum of at least two years of supervisory or management experience and at least one year of experience working directly with persons with serious mental illness.

A) At the end of the three-year provisional license period, nursing home administrators who were acting as executive directors of a specialized mental health rehabilitation facility as of July 22, 2013, and who had a minimum of at least two years of supervisory or management experience and at least one year of experience working directly with persons with serious mental illness may serve as executive director of a facility licensed under the Act.

B) After the provisional licensing period has ended, all newly hired executive directors of specialized mental health rehabilitation facilities shall meet the requirements listed in subsection (a)(1).

b) The licensee shall report any change in the executive director to the Department within five days following the change.

c) The executive director shall delegate, in writing, authority to a qualified subordinate to act during the executive director's absence. This administrative assignment shall not interfere with consumer care and supervision. The Department will consider the executive director, or the person designated by the executive director to be in charge of the facility in the executive director's absence, to be the agent of the licensee for the purpose of the Act and this Part. At the conclusion of any visit by Department surveyors, the surveyors will provide the licensee with a copy of the report before leaving the facility.

d) The executive director shall arrange for facility supervisory personnel to annually attend appropriate educational programs.

e) The executive director shall appoint, in writing, a member of the facility staff to coordinate the establishment of, and render assistance to, the consumers' advisory council.

f) The licensee and the executive director shall be familiar with the Act and this Part

and shall be responsible for ensuring that the applicable requirements are met in the facility, and that employees are familiar with the requirements of the Act and this Part relevant to their job duties.

Section 380.440 Psychiatric Medical Director

a) The facility shall have a psychiatric medical director who is licensed under the Medical Practice Act of 1987 and who 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 executive director and the program LPHA on the overall psychiatric management of the consumers.

b) The psychiatric medical director shall be the medical director of the facility. For all non-mental illness related medical issues, the medical director shall comply with Section 380.600(b)(3).

c) The psychiatric medical director shall annually approve, in writing, the facility's written policies and procedures applicable to the psychiatric programming.

d) The psychiatric medical director shall be present at the facility for at least one hour every week to meet with and observe consumers and staff and their interactions and to make suggestions for changes in staff behavior and training, including changes in the facility policies and procedures. The facility shall keep records demonstrating that this requirement has been met.

SUBPART D: ADMINISTRATION

Section 380.500 Required Policies and Procedures

a) The licensee shall be responsible for compliance with licensing requirements and for the organization, management, operation and control of the facility. The delegation of any authority by the licensee shall not diminish the responsibilities of the licensee.

b) *A facility shall establish written policies and procedures to implement the responsibilities and rights provided under* the Act and this Part. *The policies shall include the procedure for the investigation and resolution of consumer complaints. The policies and procedures 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 font, shall be distributed to each*

consumer and representative. (Section 3-208 of the Act) Written policies and procedures also shall be established and implemented for each of the following:

1) The administration and management of the facility;

2) Personnel policies and procedures, which shall include:

   A) Job descriptions detailing qualifications and essential duties of each classification of employee, available to all personnel;

   B) Employee orientation to the facility, job, consumer population, policies, procedures and staff;

   C) Employee benefits;

   D) Employee health and grooming; and

   E) Verification of licensure, credentials, certification, education, training and references;

3) Policies and procedures for consumer admission, transfer, day passes and weekend passes, discharge and other care transitions; charge for services included in the basic rate; charges for other services and causes for termination of services. The facility shall comply with the rules of the State-designated assessment and authorization entity;

4) Policies and procedures governing consumer records, including, but not limited to:

   A) Access to, duplication of, and dissemination of information from consumer records, with a specific policy and procedure for sharing information with behavioral health providers and consumers pursuant to applicable federal and State laws; and

   B) Ensuring confidentiality of consumer information, pursuant to applicable federal and State laws and this Part;

5) Policies and procedures for reporting incidents and accidents, the abuse and neglect of consumers, and the theft of consumers' property and other data as required in Section 380.530;

6) A written organizational chart showing each program, the person in charge of each program, the lines of authority, including responsibility and communication, and the staff assignments, including information on the governing structure;

7) Policies concerning the use of restraints only with informed consent, and other restraint and therapeutic separation policies and procedures pursuant to the Act and to Section 380.160;

8) Policies concerning the administration of psychotropic medication only with informed consent, and other informed consent to medical and psychiatric treatment policies and procedures pursuant to the requirements in Section 380.150 of this Part and Section 3-106(b) of the Act;

9) Policies and procedures to ensure that experimental research and treatment on consumers is conducted only in accordance with the oversight of an Institutional Review Board, pursuant to the requirements in Section 380.580;

10) Dietary services, policies and procedures; and

11) Environmental services policies and procedures, including provision for the housekeeping and maintenance of a safe, clean environment for consumers, employees and the public.

c) Each facility shall employ or otherwise provide an executive director, delegated by the licensee to be responsible for the administration and management of the facility. The executive director shall be responsible for the administration and management of only one facility. If these responsibilities are delegated to the executive director, liability shall remain with the licensee or the facility's governing body.

Section 380.510 Quality Assessment and Performance Improvement

a) The licensee shall ensure that the facility's executive director and the governing body develop, implement and maintain a data-driven quality assessment and performance improvement (QAPI) program. The program shall emphasize quality structures, processes and activities, with a goal of improved behavioral health outcomes that enable consumers to transition to the most integrated

community-based settings possible. The written program shall be updated annually and shall require the following:

1) An ongoing program for quality improvement and consumer safety as a priority for facility management that is communicated throughout the facility;

2) A quality improvement committee that shall regularly review and evaluate all QAPI activities and progress;

3) At all levels of service in a facility, the priorities for improved quality of care and consumer safety are identified and addressed, and all improvement actions are evaluated for efficacy;

4) Written benchmarks, targets and standards of care for safety and quality of care that, for each indicator, shall be well established and communicated throughout the facility. Outcomes shall be regularly reviewed to measure them against the benchmarks and targets;

5) The allocation of adequate resources for measuring, assessing, improving and sustaining the facility's performance in complying with the Act and this Part;

6) A method for investigating, monitoring and tracking incidents and accidents, with a written action plan to prevent reoccurrences;

7) That the facility share the results of the QAPI activities with the consumer's advisory council. Results of data collections and performance improvement projects (PIPs) shall be shared with the consumers' advisory council, and input and recommendations from the consumers' advisory council shall be shared with the governing body;

8) A method for conducting annual PIPs, with the report of the PIP and recommendations for process improvements shared with the executive director and the governing body; and

9) A data collection and reporting process that assures the submission, at least quarterly, of all reports or other required data within prescribed time frames.

b) Quality improvement indicators for triage, crisis stabilization, transitional living and rehabilitation and recovery services shall include, at a minimum:

1) Verification that prior-authorizations and re-authorizations were secured as applicable for appropriate care and service delivery;

2) Verification that assessments and treatment plans have been conducted to meet consumer needs;

3) Verification that evidence-based practices and person-centered treatment plans are being performed to meet consumer needs as applicable;

4) Verification that appropriate licensed and certified IDT professionals are performing duties as required;

5) Verification that planning and community linkage has occurred to facilitate consumer-community integration;

6) Verification that care coordination and case management systems are in place to achieve quality treatment outcomes and community integration;

7) Verification that facility policy and procedures are established, documented, implemented and evaluated;

8) Verification that consumer records contain all relevant information, including, but not limited to, demographic information, historical information, medical information, nutrition and dietary information, social information, psycho-social information, treatment plans, therapy information, assessments, discharge plans, and community support services; and

9) Verification of training to the administration, to the supervisory staff, and to the direct care staff.

c) The quality improvement committee shall:

1) Review all performance indicators, data from consumer quality of life surveys, staff surveys, findings from root cause analyses, performance improvement projects, and other relevant sources of data. The quality improvement committee shall make recommendations to the facility

leadership and governing body based on the facility's performance of the indicators in subsection (b). The quality improvement committee shall be composed of members of the facility management team. Procedures for the operation of the quality improvement committee shall be included in the written QAPI program plan; and

2) Conduct a root cause analysis when an in-depth understanding is needed of an incident or accident, or a violation, in the facility, including its causes and implications. The quality improvement committee shall develop policies and procedures for the use of root cause analyses to examine issues across systems in the facility to prevent future serious incidents and accidents and violations, and to promote sustained improvement. The findings of root cause analyses shall be available to the Department, DHS-DMH and the Department of Healthcare and Family Services upon request.

Section 380.515 Reportable Performance Indicators

a) The following information shall be made available to the Department upon entry to the facility by a Department survey team:

1) Census information;

2) Key personnel of the facility and the facility's governing body;

3) A roster of the facility's residents with room numbers;

4) Program discharge summaries;

5) Accrediting benchmark achievements;

6) Accrediting performance improvement reports and compliance.

7) The facility's staffing plan;

8) Staff turnover rate;

9) The facility's floor design;

10) The facility's admissions and discharges;

11) Incident reports prepared pursuant to Section 380.530;

12) The facility's performance improvement project or projects;

13) Written records on the facility's use of restraints;

14) Pharmacy reports of adverse outcomes;

15) Medication error reports;

16) The facility's written policies and procedures; and

17) The facility's identified offender list.

b) The facility shall provide to the Department upon request all data elements that a facility is required to submit to any State agency, managed care organization, accrediting body, or any other third party.

c) The facility shall submit the following information concerning each level of service to the Department, DHS-DMH and the Department of Healthcare and Family Services (HFS) at least monthly. This information shall include, but not be limited to:

1) Admissions, including referral sources and consumer living arrangements prior to admission;

2) Transfers to other facilities, to facilities licensed under the Nursing Home Care Act, to private hospitals for both medical and psychiatric treatment, and between levels of service;

3) Discharges, including the frequency of discharges to community-based behavioral health providers, other community-based providers, private hospitals for both medical and psychiatric treatment, State hospitals, detox centers, and involuntary discharges;

4) All emergency department visits for both medical and psychiatric treatment;

5) Re-admissions to a facility within 30 days after discharge;

6) Suicides and suicide attempts;

7) Deaths of consumers, including deaths of consumers during hospital visits;

8) Incidents of abuse, neglect and maltreatment, including sexual assault; and

9) The number of times restraints were used.

d) The facility shall submit the results of consumer perception of care or quality of life surveys to the Department, DHS-DMH and HFS at least biannually.

Section 380.520 Information to Be Made Available to the Public

a) The following information shall be conspicuously posted in a prominent location accessible to the public:

1) A listing of all services and programs provided directly by the facility and those provided through written contracts;

2) *Staffing and personnel levels* for each level of licensed service;

3) The location of the most recent *licensure and inspection information* for the facility, and the related plan of correction, if applicable, and that this information is available for public review;

4) *National accreditation information*;

5) *Consumer charges*;

6) *Consumer complaint information*;

7) State specialized mental health rehabilitation facility benchmark performance percentages for all certified programs provided by the facility;

8) That the facility's written admission and discharge policies are available upon request; and

9) A notice of how to file a complaint with the Department's complaint

hotline.

b) Procedures *for the public disclosure of information shall be in accordance with provisions for inspection and copying of public records in the Freedom of Information Act.* (Section 3-205 of the Act)

Section 380.530 Incidents, Accidents and Emergency Care

a) The facility shall have written policies and procedures for investigating, reporting, tracking and analyzing incidents, accidents and emergency care situations through the facility's management structure, up to and including the licensee and governing body representatives. The facility shall ensure that employees demonstrate their knowledge of and follow, these policies and procedures. A descriptive summary of each incident and accident affecting a consumer shall also be recorded in the progress notes for that consumer. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a consumer and requires medical treatment. Serious incidents, accidents and emergency care situations shall include, but are not limited to, the following:

1) Sexual assault;

2) Abuse, neglect or other maltreatment;

3) All deaths, including deaths of consumers who have been transferred to a hospital;

4) Medication errors that result in a consumer's unstable vital signs or referral to an emergency room;

5) Physical injury;

6) Assault;

7) Battery;

8) Missing persons after 24 hours;

9) Theft;

10) Criminal conduct, including arrests and other interaction with police;

11) All hospitalizations, both medical and psychiatric;

12) All emergency department admissions, both medical and psychiatric; and

13) Fires.

b) The facility shall notify the Department of any serious incident or accident requiring emergency care situations and every consumer death.

c) Any facility employee or agent who becomes aware of a serious incident or accident, emergency care situation involving a consumer, or becomes aware of a consumer death, shall report it immediately to the executive director. An executive director who becomes aware of the incident, accident or emergency care situation involving a consumer, or becomes aware of a consumer death, shall immediately report the matter by telephone and in writing to the consumer's guardian, the consumer's substitute decision maker, if any, any other individual designated in writing by the consumer, and the Department. The executive director shall report consumer allegations of abuse or neglect to the Department within 24 hours after the allegation is made.

d) The facility shall, by fax or phone, notify the Department central office within 24 hours after each serious incident, accident or emergency care situation. If a reportable incident, accident or emergency care situation results in the death of a consumer, the facility shall, after contacting local law enforcement pursuant to Section 380.550, notify the Department central office by phone only. For the purposes of this Section, "notify the Department central office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the regional office by phone has been met. If the facility is unable to reach a representative during non-business hours, the facility shall notify the Department's toll free complaint registry hotline.

e) As soon as possible, but no later than 24 hours after the occurrence, the facility shall report any incident that is subject to the Criminal Code of 2012 to local law enforcement agencies.

f) The facility shall send a written narrative summary of each serious incident, accident or emergency care situation to the Department within seven days after the occurrence.

g) The facility shall maintain a log of incidents, accidents, or emergency care situations that are not considered to be serious because the consumer has not incurred physical or mental harm or injury requiring medical treatment, including all physical altercations involving a consumer and all threats of physical violence directed at a consumer or made by a consumer. The log shall be reviewed weekly by the facility's internal clinical quality assurance staff and shall be available to the Department upon request. The log shall include, at a minimum:

1) The name of the perpetrator;

2) The name of the victim, if any;

3) Any injury sustained by the victim;

4) A brief summary of the incident;

5) The number of prior incidents involving the perpetrator;

6) The number of prior incidents involving the victim;

7) Whether a physician (and whose physician) was called and any orders entered as a result; and

8) What the staff did to prevent recurrence of the incident.

h) The provisions under the Whistleblower Act shall apply to employees of facilities licensed under the Act.

Section 380.540 Abuse, Neglect and Theft

a) *A licensee, executive director, employee, or agent of a facility shall not abuse or neglect a consumer. It is the duty of any facility employee or agent who becomes aware of abuse or neglect* of a consumer *to report it* immediately to the executive director and to the Department, but no later than *within 24 hours* after becoming aware of it. *Facilities shall comply with Section 3-610 and 3-810 of the Nursing Home Care Act.* With respect to theft or misappropriation of a consumer's property, and to whistleblower protection, *the provisions under Section 3-610 and 3-810 of the Nursing Home Care Act shall apply to employees of facilities licensed under* the *Act.* (Section 3-107 of the Act)

b) An executive director who becomes aware of the abuse or neglect of a consumer or theft of a consumer's property shall immediately report the matter by telephone and in writing to the consumer's guardian, the consumer's substitute decision maker, if any, or any other individual designated in writing by the consumer, and to the Department, but no later than within 24 hours after becoming aware of the abuse, neglect or theft.

c) Consumers shall not be subjected to verbal or physical abuse of any kind. Corporal punishment of consumers is prohibited. The facility shall not permit consumers to discipline other consumers. The facility shall comply with this Section and with Section 380.550 in every instance of assault or battery by a consumer of another consumer or of an employee.

d) A facility employee or agent who becomes aware of another facility employee's or agent's theft or misappropriation of a consumer's property shall immediately report the matter to the executive director. An executive director who becomes aware of a facility employee's or agent's theft or misappropriation of a consumer's property shall immediately report the matter by telephone and in writing to the consumer's representative, the Department, and the local law enforcement agency.

e) Consumer allegations of abuse shall be reported to the Department within 24 hours after the allegation is made, and the facility shall comply with the reporting requirements of Section 380.550. A full investigation report shall be filed with the Department within seven days after the incident occurred.

f) Employee as Perpetrator of Abuse. When an investigation of a report of suspected abuse of a consumer indicates that an employee of the facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with any consumer in the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

g) Consumer as Perpetrator of Abuse. When an investigation of a report of suspected abuse of a consumer indicates that another consumer residing in the facility is the perpetrator of the abuse, the perpetrator's condition shall be immediately evaluated to determine the most suitable therapy and placement for that person, considering the safety of that person as well as the safety of other consumers and of employees of and visitors to the facility.

g) The provisions of the Whistleblower Act shall apply to employees of facilities licensed under the Act.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

Section 380.550 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) 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 consumer by a staff member or visitor;

2) Physical abuse involving serious physical injury inflicted on a consumer by another consumer;

3) Sexual abuse of a consumer by a staff member, another consumer, or a visitor;

4) Misappropriation or financial exploitation of a consumer's property; or

5) When a crime has been committed in a facility by a person other than a consumer.

c) When a consumer death other than by natural causes has occurred, the facility shall call the coroner or medical examiner.

d) The facility shall develop and implement a written policy concerning local law enforcement notification, including:

1) Ensuring the safety of consumers in situations requiring local law enforcement notification;

2) Contacting local law enforcement in situations involving physical abuse of

a consumer by another consumer or staff;

3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure;

4) Preservation of a potential crime scene; and

5) Facility investigation of the situation.

e) Facility staff shall be trained in implementing the policy developed pursuant to subsection (d). The training shall be documented.

f) The facility shall also comply with other reporting requirements of this Part.

Section 380.560 Care and Treatment of Sexual Assault Survivors

a) For the purposes of this Section, the following definitions shall apply:

1) Sexual assault − an act of nonconsensual sexual conduct or sexual penetration, as defined in Section 11-01 of the Criminal Code of 2012, including, without limitation, acts prohibited under Sections 11-1.20 through 11-1.60 of the Criminal Code of 2012.

2) Ambulance Provider − an individual or entity that owns and operates a business or service using ambulances or emergency medical services vehicles to transport emergency patients.

b) The facility shall adhere to the following protocol for the care and treatment of consumers who are suspected of having been sexually assaulted in the facility or elsewhere:

1) Notify local law enforcement pursuant to the requirements of Section 380.550;

2) Call an ambulance provider if medical care is needed. The facility shall always request transport to a hospital if sexual penetration occurred or is suspected to have occurred and shall document whether a consumer refuses treatment;

3) Move the survivor, as quickly as reasonably possible, to a closed

environment to ensure privacy while waiting for emergency or law enforcement personnel to arrive. The facility shall ensure the welfare and privacy of the survivor, including the use of incident code to avoid embarrassment; and

4) Offer to call a friend or family member and a sexual assault crisis advocate, when available, to accompany the survivor.

c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault, and to not launder or dispose of the consumer's clothing or bed linens until local law enforcement can determine whether those items have evidentiary value.

d) The facility shall notify the Department and draft a descriptive summary of the alleged sexual assault pursuant to the requirements of Section 380.530.

e) As much as is reasonably possible, the facility shall ensure that the sexual assault survivor receives all appropriate follow-up care pursuant to the Department's rules titled Sexual Assault Survivors Emergency Treatment Code.

Section 380.570 Fire Safety and 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 consumers, personnel and others present in the facility.

b) Each facility shall have policies covering disaster preparedness for staff, consumers, and others to follow. The policy shall include, but not be limited to, the following:

1) Proper instruction in, and training on, 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 consumers 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, maintaining 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) The facility shall develop, implement, maintain and annually review a disaster preparedness plan requiring that:

1) Records and reports of fire and disaster training are maintained;

2) A record of actions taken to correct noted deficiencies in fire and disaster drills or inspections is maintained;

3) Employees know and practice how to react to fire, severe weather, disasters, missing persons, psychiatric and medical emergencies, and deaths;

4) Consumers receiving supports on site know how to react to fire or severe weather or are receiving training;

5) Employees and consumers are trained in the location of firefighting equipment, first aid kits, evacuation routes and procedures;

6) A land-line telephone is available with the listing of telephone numbers of the nearest poison control center, the police, the fire department and emergency medical personnel; and

7) The facility has a written plan for alternative arrangements if the facility becomes uninhabitable.

d) The facility shall implement procedures for evacuation ensuring that:

1) Evacuation drills are conducted at a frequency determined by the facility to be appropriate based on the needs and abilities of the consumers receiving

supports at the site, but no less than annually on each shift if 24-hour supports are provided.

2) Special provision shall be made for those consumers who cannot evacuate the building without assistance.

3) All employees are trained to carry out their assigned evacuation tasks, and the training shall be documented.

4) Inefficiency or problems identified during an evacuation drill shall result in specific corrective action.

5) Evacuation drills shall include actual evacuation of consumers to safe areas.

6) A written evaluation of each drill shall be submitted to the executive director and shall be maintained for one year.

e) At least one approved fire extinguisher shall be available in each level of service within a facility, inspected annually and recharged when necessary. If the facility has multiple floors, one fire extinguisher shall be available on each floor.

f) At least one first aid kit shall be available and inspected and re-supplied regularly.

g) Disaster Reporting

1) Upon the occurrence of any disaster requiring hospital service, police, fire department or coroner, the executive director or designee shall provide a preliminary report to the Department either by using the Department hotline or by directly contacting the appropriate Department central 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 consumers;

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 Department assistance, the facility shall provide a preliminary report within 24 hours after the occurrence. The facility shall also submit a full written account to the Department within seven days after the occurrence, which includes the information specified in subsection (h)(1) and a statement of actions taken by the facility after the preliminary report.

h) Each facility shall establish and implement written policies and procedures to provide for the health, safety, welfare and comfort of all consumers when extreme temperatures are present within the facility for a prolonged period of time, including a written temporary transfer plan.

i) Coordination with Local Authorities

1) Each facility shall annually 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) Each facility shall annually forward copies of its emergency water supply agreements, required under Section 380.670(e)(1)(C), 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.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

Section 380.580 Research

a) *No consumer shall be subjected to research or treatment without first obtaining his or her informed, written consent. The conduct of any experimental research or treatment shall be authorized and monitored by an institutional review board appointed by the executive director. No person who has received compensation in the prior 3 years from an entity that manufactures, distributes or sells pharmaceuticals, biologics, or medical devices may serve on the institutional review board.*

1) *The membership of the institutional review board shall* include, at a minimum:

A) Director of the Department of Public Health or designee;

B) Director of DHS-DMH or designee;

C) An academic faculty member of a college or university who is in a mental health field;

D) The DHS-DMH bureau chief of Evaluation and Services Research or designee;

E) Two additional persons with a background in ethics, policy development and research who may be from outside DHS-DMH or the Department; and

F) A representative from the Department's or DHS-DMH's legal services staff as a non-voting member.

2) *The operating procedures for the institutional review board shall be* jointly developed by the Department and by DHS-DMH and shall be made available to the public upon request. The operating procedures shall address:

A) The appointment protocol and tenure of the membership;

B) Conflict-of-interest policies;

C) The meeting schedule;

D) The application process, including university-initiated applications;

E) Informed consent requirements, which shall reference 45 CFR 46 (Protection of Human Subjects), Subparts B, C and D, and the Mental Health and Developmental Disabilities Confidentiality Act;

F) Requirements for progress reports; and

G) The review process and expedited review process.

3) *The review criteria for the institutional review board shall be* developed jointly by the Department and by DHS-DMH and shall include:

A) Voting procedures;

B) A categorization of risks inherent in the conduct of the research; and

C) A description of the categorical ratings that result from the review.

b) *No facility shall permit research or treatment to be conducted on a consumer, or give access to any person or person's records for a retrospective study without the prior written approval of the institutional review board. No executive director, or person licensed by the State to provide medical care or treatment to any person, may assist or participate in any experimental research on or treatment of a consumer, including a retrospective study that does not have the prior written approval of the board.* This *conduct shall be grounds for professional discipline by the Department of Financial and Professional Regulation.*

c) Following a formal review, *the institutional review board may exempt from ongoing review research or treatment initiated on a consumer before the individual's admission to a facility and for which the board determines there is adequate ongoing oversight by another institutional review board. Nothing in this Section* or the Act *shall prevent a facility, any facility employee, or any other person from assisting or participating in any experimental research on or treatment of a consumer, if the research or treatment began before the person's admission to a facility, until the board has reviewed the research or treatment and decided to grant or deny approval or to exempt the research or treatment from ongoing review.* (Section 3-116 of the Act)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

SUBPART E: SUPPORT SERVICES AND ENVIRONMENT

Section 380.600 Required Support Services

a) For the purpose of this Section, "physician orders" includes instructions from medical doctors (MD), doctors of osteopathy (OD), dentists, podiatrists, advanced practice nurses (APN) in collaboration with an MD, and physician assistants (PA) under the supervision of a physician for that physician's patients.

b) *Facilities shall provide, at a minimum, the following services: physician, nursing, pharmaceutical, rehabilitative, and dietary services. To provide these services, the facility shall adhere to the following*:

1) *Each consumer shall be encouraged and assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep consumers active and out of bed for reasonable periods of time, except where contraindicated by physician orders.*

2) *Every consumer shall participate in a person-centered planning process regarding his or her total care and treatment,* to the extent that his or her condition permits.

3) *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* the *orders have been issued to ensure facility compliance with* the *orders. Every woman consumer of child bearing age shall receive routine obstetrical and gynecological evaluations, as well as necessary prenatal care,* except in triage centers.

A) The frequency and administration of obstetrical, gynecological and pre-natal care shall be according to the guidelines set forth in the Guidelines for Women's Health Care, published by the American College of Obstetricians and Gynecologists. The date of the consumer's last obstetrical, gynecological or prenatal appointments shall be identified as part of the treatment assessment, and pregnancy screening may be required before medications are prescribed and administered.

B) If obstetrical and gynecological evaluations are performed in a facility, the facility shall ensure that the examination room is adequately equipped for these examinations.

C) If obstetrical and gynecological evaluations are not performed in a facility, the facility shall arrange with a local OB/GYN practice or clinic to have the evaluations performed at that location.

c) *Each consumer shall be provided with good nutrition and with necessary fluids for hydration* in accordance with the Food and Nutrition Board of the National Research Council of the National Academy of Science's standard.

d) *Each consumer shall be provided visual privacy during treatment and personal care.*

e) *Every consumer or consumer's guardian shall be permitted to inspect and copy all* of *his or her clinical and other records concerning his or her care kept by the facility or by his or her physician. The facility may charge a reasonable fee for duplication of a record.* (Section 3-104 of the Act)

f) A facility with a pharmacy on premises shall comply with the Controlled Substances Act. Facilities without pharmacies shall ensure that pharmacies they make arrangements, or contract, with comply with the Controlled Substances Act.

Section 380.610 Physician Medical Services

a) The licensee shall ensure sufficient physician services to meet the needs of all consumers being served by the facility. Physician services shall be provided by medical doctors who are under contract with the facility or have been chosen by the consumer or by the consumer's substitute decision maker to direct the consumer's medical care.

b) Physician services shall include, but are not limited to:

1) The initial health evaluation, including a written report of a physical examination, and history, obtained within 72 hours after admission, unless a health evaluation has been completed within 30 days prior to admission and is in the consumer's record;

2) An evaluation of the consumer and, upon change of physicians, a review

of the order for care and treatment;

3) Written and signed orders for diet, diagnostic tests, consultation and medical treatment of the consumer; and

4) Health care progress notes and other appropriate entries in the consumer record.

c) Orders for therapeutic separation shall comply with the requirements of Section 380.160.

d) Orders for emergency treatment for the safety of the consumer without informed consent shall meet the requirements of Section 380.150 and the Mental Health and Developmental Disabilities Code.

e) Non-physician practitioners may render those medical services that they are legally authorized to perform.

f) The executive director shall verify a physician's credentials by contacting a hospital through which the doctor has practicing rights and by checking applicable databases, including, but not limited to, the Illinois Department of Financial and Professional Regulation License Lookup and the National Practitioner Data Bank.

Section 380.620 Health/Nursing Services

a) The licensee shall ensure sufficient nursing services to meet the needs of all consumers being served by the facility. Licensed nursing staff shall perform nursing services within the scope of their licenses, and the nursing services shall be consistent with the care requirements for each respective level of service, including time frames, as described in Subpart B. Services shall include, but not be limited to, the following:

1) Nursing participation in the formulation of an interdisciplinary treatment plan, which shall include identification of nursing care needs based upon an initial written nursing evaluation of the consumer's needs with input, as necessary, from health professionals involved in the care of the consumer. The initial nursing care needs, including the physical evaluation required in Section 380.610(b)(1), shall commence at the time of admission of the consumer and be completed within seven days after admission;

2) The implementation of each consumer's treatment plan according to the methods indicated, with ongoing monitoring and documentation of the effectiveness of the plan, and participation in consumer treatment plan conferences for review and modification of each consumer's treatment plans;

3) Ensuring that the dietary department receives dietary orders that are prescribed by physicians or dieticians;

4) Obtaining and documenting physician orders for medical care, appointments and laboratory workups and tests, administration of medications, including pro re nata (PRN) and immediately authorized or emergency (STAT) medications;

5) Implementation and evaluation of quality improvement policies and procedures;

6) The writing, review and signoff of progress notes and notes regarding any change in a consumer's condition; and

7) Notifying the physician promptly of:

   A) The admission of a consumer;

   B) Any sudden, marked or adverse change in signs, symptoms or behavior exhibited by a consumer;

   C) An unusual incident involving a consumer, as specified in Section 380.530;

   D) Any adverse response or reaction by a consumer to a medication or treatment;

   E) Any error in the administration of a medication or treatment to a consumer that is life threatening or that presents a risk to a consumer; and

   F) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed.

b) All attempts to notify physicians shall be noted in the consumer's record, including the time and method of communication and the name of the person acknowledging contact, if any. If the physician is not readily available, emergency medical care shall be arranged immediately.

c) *If a facility orders transportation of a consumer of the facility by ambulance, then the facility must maintain a written record that shows the name of the person who placed the order for that transportation and the medical reason for that transportation.* (Section 3-212 of the Act)

d) Under the supervision of licensed nursing staff, an RSA shall monitor the following:

1) Assisting consumers with dressing, grooming, bathing and personal hygiene related activities, as needed; and

2) Measuring and recording a consumer's height, weight and vital signs, including temperature, blood pressure and pulse, on admission. At a minimum, vital signs and weight shall be taken weekly for four weeks and then monthly. Weights and vital signs shall be charted in a format that allows for trending and patterning over time. Any clinically significant worsening shall be reported to the physician to assess the need for increased monitoring.

Section 380.630 Pharmaceutical Services and Medication Administration

a) All consumers shall be assessed for drug allergies, and drug histories shall be documented and reported to the pharmacy and physician. Pharmacies shall immediately notify the physician and the facility of any potential drug interactions prior to dispensing the medication.

b) *Pharmaceutical Treatment*

1) *A consumer shall not be given unnecessary drugs. An unnecessary drug is any drug used in an excessive dose, including in duplicative therapy; for excessive duration; without adequate monitoring; without adequate indication for its use; or in the presence of adverse consequences that indicate the drug should be reduced or discontinued.*

2) *No drug shall be administered except upon the order of a person lawfully authorized to prescribe for and treat mental illness.*

3) *All drug orders shall be written, dated, and signed by the person authorized to give* the *order. The name, quantity, or specific duration of therapy, dosage, and time or frequency of administration of the drug and the route of administration if other than oral shall be specific.*

4) *Verbal orders for drugs and treatment shall be received only by those authorized under Illinois law to do so from their supervising physician. Orders shall be recorded immediately in the consumer's record by the person receiving the order and shall include the date and time of the order.* (Section 3-106 of the Act)

5) A facility with a pharmacy on the premises shall comply with the Controlled Substances Act. Facilities without pharmacies shall ensure that pharmacies with which they make arrangements, or contract, comply with the Controlled Substances Act.

c) 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 comply with all federal and State laws and administrative rules relating to the procurement, storage, dispensing, administration and disposal of medications.

2) The medication policies and procedures shall be developed with the advice of a licensed pharmacist, the medical director and the director of health services.

3) The facility shall ensure that pharmaceutical services are arranged and their administration is supervised in accordance with the Medical Practice Act of 1987 and the Nurse Practice Act. The facility shall ensure that:

A) A physician is responsible for the medical services provided to individuals and the management of consumers' medications;

B) A licensed prescriber prescribes and monitors all prescription

medications;

C) A psychiatrist performs an examination of the consumer prior to the initiation of psychotropic medications;

D) Screening for and documentation of abnormal involuntary movements, including tardive dyskinesia in individuals receiving prescribed psychotropic medications, is completed at least every six months by employees trained in performing this type of assessment;

E) A psychiatrist reviews all medications prescribed and shall be available for consultation on the prescribed medications. Psychiatrist documentation within the individual's record shall include, but is not limited to, the rationale for continuing current medications and/or initiating new medications, and medication side effects. When clinically indicated, a psychiatrist and facility shall arrange for consultation with the appropriate medical specialist.

i) A psychiatrist, a psychiatric nurse practitioner, or an advanced practice nurse review medications and perform case management on consumers as needed in triage centers.

ii) A psychiatrist review medications and see individuals three times weekly in crisis stabilization units. In addition, a psychiatrist shall be immediately available by phone 24 hours per day and respond on site within 24 hours.

iii) A psychiatrist review medications and see individuals at least monthly in transitional living units and in RRS units;

F) In recovery and rehabilitation supports and transitional living, a psychiatrist or registered professional nurse evaluates the ability of each consumer to self-administer medications within the first three months after admission, and then at least annually, after a consumer completes a self-medication training program, prior to the consumer moving to community-based services or prior to transition to community living;

G) A clinical pharmacist reviews each consumer's chart to evaluate for

unnecessary medications in accordance with the Drug Burden Index, and for potential adverse drug events based upon the total pharmacotherapy regimen and pre-existing medical conditions;

H) A psychiatrist provides the written order for a consumer to self-administer medications or participate in a self-administration of medication training program based on the results of the consumer's evaluation. The order shall become part of the individual's record;

I) Consumers in transitional living units and recovery and rehabilitation supports units who are able to independently self-administer medications have access to their medications.

i) The facility has a written policy on determining the level of independence, and documentation of the level of independence will be placed in the consumer's treatment plan.

ii) Level I independence means that the consumer shall have a secured medicine storage cabinet in his or her bedroom for which he or she has the key or the combination to the lock.

iii) Level II independence means that the consumer shall be responsible for independently requesting his or her medication from a central medication area, which shall be staffed by a licensed medical professional, at the appropriate times;

J) When facilities supervise the self-administration of medication training programs, or administer the medications, medications are secured from unauthorized access, and only a psychiatrist, pharmacist, or registered or licensed practical nurse shall supervise the self-administration of a medication training program or administer medications and have access to medications. A psychiatrist, pharmacist or licensed nurse shall be available at all times for consultation and supervision of the self-administration of medications training program;

K) A physician or pharmacist is available to consult with the QMHP or MHP in reference to staff's behavioral or other observations

relating to the individual's level, dosage and types of side effects from any prescribed medications;

L) A physician or pharmacist makes available to consumers information on expected consequences and the potential benefits and possible side effects of any prescribed medication. If requested, this information will also be made available to employees and families; and

M) All Schedule II controlled substances are stored so that two separate locks, using two different keys, shall be unlocked to obtain these substances.

d) Emergency Medication Kits

1) A facility shall not maintain a stock supply of controlled drugs, except for those in the emergency medication kits, as described in this subsection (d).

2) A facility may stock drugs that are regularly available without prescription. These shall be administered to a consumer only upon the order of a licensed prescriber. Administration shall be from the original containers and shall be recorded in the consumer's clinical record.

3) A facility may keep emergency medication kits containing medications to be used for initial doses.

4) Each emergency medication kit 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. Schedule II controlled substances shall not be kept in emergency medication kits.

5) The contents and number of emergency medication kits shall be approved by the facility's pharmacist, medical director and director of health services, and shall be available for immediate use at all times in locations determined by them.

A) Each emergency medication kit shall be sealed after it has been checked and refilled.

B) Emergency medication kits shall also contain all of the equipment

needed to administer the medications.

C) The contents of emergency medication kits shall be labeled on the outside of each kit. The label shall include expiration dates of any medications contained in the 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. The facility shall maintain written documentation of this review.

D) The contents and number of emergency medication kits shall be determined by the pharmacist, medical director and the director of health services. The contents should include, at a minimum, but not be limited to, behavioral medications and medications to specifically address anaphylactic and dystonic reactions. The contents shall be listed on the outside of each box.

6) The facility shall comply with the following requirements when controlled substances are kept as part of the emergency medication kits:

A) If an emergency medication kit is not stored in a locked room or cabinet, or if the kit contains controlled substances that require refrigeration, the controlled substances portion of the kit shall be stored separately in a locked cabinet or room (or locked refrigerator or 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.

B) Controlled substances for emergency medication kits shall be obtained from a federal Drug Enforcement Administration registered hospital, pharmacy or licensed prescriber.

C) Only the director of health services, a registered nurse on duty, a licensed practical nurse on duty, a consultant pharmacist, or a licensed prescriber shall have access to controlled substances stored in emergency medication kits.

D) No more than 10 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.

E) Controlled substances in emergency medication kits shall 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.

F) A proof-of-use sheet shall be stored with each controlled substance. The nursing staff or licensed prescriber shall enter the date and time that a drug was administered to a consumer, the dose, the name of the consumer, and the name of the prescriber on the proof-of-use sheet when any controlled substance from the kit is used. The completed proof-of-use sheets shall be filed with the consultant pharmacist and shall be retained for two years.

G) The consultant pharmacist shall be notified within 24 hours after the controlled substance portion of an emergency medication kit is opened. During any period when the kit is opened, a shift count shall be done on all controlled substances until the kit is re-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.

H) The consultant pharmacist shall check the controlled substances portions of emergency medication kits at least monthly and document the check on the outside of each kit.

Section 380.640 Infection Control and Vaccinations

a) The facility shall adopt, observe and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as needed.

b) All cases of reportable communicable diseases shall be reported to the Department and to the local health department in accordance with the Control of Communicable Diseases Code and the Control of Sexually Transmissible Infections Code.

c) All employees and consumers shall be screened for tuberculosis in accordance with the Control of Tuberculosis Code.

d) When consumers having a communicable disease, or presenting signs and symptoms that suggest that diagnosis, are admitted, precautionary measures shall be taken to avoid cross-infection to personnel, other consumers or the public.

e) Consumers presenting with a communicable disease shall be treated in accordance with the Control of Communicable Diseases Code and Control of Sexually Transmissible Infections Code. When isolation is required, the facility shall implement precautions (i.e., contact isolation) or provide temporary transfer to a licensed entity that is capable of providing enhanced isolation techniques.

f) The facility shall be responsible for developing, implementing, monitoring and enforcing a hand hygiene program. For the purposes of this Section, "hand hygiene" is a general term that applies to hand washing with plain soap and water; antiseptic hand wash using soap containing antiseptic agents and water; and antiseptic hand rub using a waterless antiseptic product, most often alcohol based, rubbed on the surface of the hands.

g) *A facility shall annually administer and arrange for administration of a vaccination against influenza to each consumer* in a recovery and rehabilitation supports unit who has been admitted for a least a year, *in accordance with the* Prevention and Control of Influenza with Vaccines: *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 consumer refuses the vaccine.* (Section 3-211(a) of the Act)

h) *All persons seeking admission to a facility shall be verbally screened for risk factors associated with hepatitis B, hepatitis C, and the Human Immunodeficiency Virus (HIV) according to the guidelines established by the U.S. Centers for Disease Control and Prevention*, the Sexually Transmitted Diseases Treatment Guidelines. *Persons who are identified as being at high risk for hepatitis B, hepatitis C, or HIV shall be offered an opportunity to undergo laboratory testing in order to determine infection status if they will be admitted to the facility for at least 7 days and are not known to be infected with any of the listed viruses. All HIV testing shall be conducted in compliance with the AIDS Confidentiality Act. All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any* level of service except triage.

A facility shall document in the consumer's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the consumer was immunized against hepatitis B. (Section 3-211(b) of the Act)

Section 380.650 Dietetic Services

a) The facility shall arrange for each consumer to have available at least three meals per day. Meals shall be brought in and served separately in the triage center and crisis stabilization unit. Not more than 14 hours shall elapse between the last and first meal.

b) Consumer food preferences, including religious practices, shall be adhered to as much as possible and shall be from appropriate food groups.

c) Between-meal options shall be provided as requested or required by a diet order.

d) The dietetic services programs shall be creatively focused on encouraging or maintaining as much consumer responsibility, participation and independence as possible in choice, preparation, purchasing and cleanup with regard to food service. This may involve formal training programs, collaborative food preparation and cleanup, family-style meal preparation with involvement of consumers, or cafeteria or buffet-style service. Consumers with a communicable disease shall be evaluated by a registered nurse or physician prior to being allowed to assist in food preparation.

e) With the exception of the triage centers and crisis stabilization units, the consumer's discharge and transition plan shall address his or her menu planning and food preparation level of knowledge and responsibility.

f) Within the context of consumer food preparation training and choice, the total daily diet for consumers shall be of the quality and in the quantity to meet the nutritional needs of the consumers and be guided by the Food and Nutrition Board of the National Research Council of the National Academy of Science's standard, Recommended Dietary Allowances, adjusted to the age, activity and environment of the group involved. All food shall be of good quality and be selected, stored, prepared and served in a safe and healthful manner.

g) In planning menus for the facility population, which includes consumers at risk for certain chronic health conditions (e.g., diabetes and hypertension), the food

and beverage options provided in prepared meals, snacks and vending machines shall include healthy choices to address these risks and conditions. The facility shall obtain consumer feedback on the desirability of the available healthy options at least twice per year and incorporate the results in planning menu and vending options.

h) A dietetic service supervisor shall manage and operate the food service in each facility. If the dietetic service supervisor is not a dietitian, the dietetic service supervisor shall have frequent and regularly scheduled consultation from a dietitian.

i) Sufficient staff shall be employed, oriented and trained, and their working hours scheduled, to provide for the nutritional needs of the consumers and to maintain the dietetic service areas. The facility shall consider having facility consumers receive food service training and employment in the facility dietary services.

j) Under supervision, only consumers who have been screened for communicable diseases pursuant to subsection (d) may assist in cooking and kitchen activities as part of their skills training program.

k) Dietetic service personnel, including consumers regularly participating in food service, shall be trained in basic food sanitation techniques, shall wear clean clothing, a cap or a hair net, and gloves, and shall be excluded from duty when affected by skin infection or communicable diseases.

Section 380.660 Dental Services

a) The facility shall have a dental program for stays over 21 days, which will provide for in-service education to consumers in collaboration with dental personnel, including, at a minimum, the following:

1) Information regarding nutrition and diet control measures that are dental health oriented;

2) Instruction on proper oral hygiene methods;

3) Instruction concerning the importance of maintaining oral hygiene; and

4) Providing dental supplies, including floss, toothpaste, and brushes.

b) The facility shall arrange, from an outside resource, the following dental services to meet the needs of each consumer:

1) Routine dental services, to the extent covered under the State plan or other resources;

2) Emergency dental services;

3) Assisting the consumer in making appointments and arranging transportation to and from the dentist's office; and

4) Prompt referral to a dentist of a consumer with loose or damaged dentures, to the extent covered under the State plan of other resources.

Section 380.670 Physical Plant and Environmental Requirements

a) Consumer living areas shall be planned and arranged with an awareness of the prevalence of trauma in people with mental health and substance abuse issues. Evidence-based practices of trauma-informed care shall be adhered to in residential settings.

b) Private meeting space shall be available in each facility for consumers to meet with outside service providers, assessors, family or other persons for other professional purposes in accordance with the consumer's treatment plan.

c) Physical Plant Requirements. The facility shall comply with locally adopted building codes as enforced by local authorities and Chapter 33 of NFPA 101 (see Section 380.110 (a)(1)) and any local fire codes that are more stringent than the NFPA as enforced by local authorities or the Office of the State Fire Marshal. New construction shall comply with Chapter 32 of NFPA 101 (see Section 380.110(a)(1)). The facility shall make available to the Department, upon request, the report of an inspection that has been made by the local authorities or the Office of the State Fire Marshal. The facility shall comply with the following additional NFPA standards:

1) No. 10: Standard for Portable Fire Extinguishers

2) No. 13: Standard for the Installation of Sprinkler Systems

3) No. 25: Standard for the Inspection, Testing and Maintenance of Water-

Based Fire Protection Systems

4) No. 54: National Fuel Gas Code

5) No. 70: National Electrical Code

6) No. 72: National Fire Alarm and Signaling Code

7) No. 80: Standard for Fire Doors and Other Opening Protectives

8) No. 90A: Standard for Installation of Air Conditioning and Ventilating Systems

9) No. 96: Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations

10) No. 99: Health Care Facilities Code

11) No. 110: Standard for Emergency and Standby Power Systems

12) No. 220: Standard on Types of Building Construction

13) No. 241: Standard for Safeguarding Construction, Alteration and Demolition

d) Living arrangements shall meet the following additional requirements:

1) A triage center shall provide a secure room within the facility, near the facility entrance, for the assessment of incoming consumers. The triage center shall provide the following:

A) A staff member, available as needed at the entrance of the triage center;

B) A centrally located nurse duty area that gives staff a direct line of site to the consumer, permitting constant observation;

C) A window to the outside that is secured from opening and contains glazing so that, when broken, it will not produce shards of glass that can inflict injury to the consumer or to staff;

D) Features such as electrical outlets, sprinkler heads, doorknobs, light switches, etc., which shall be of a type that prevent a consumer from injuring himself or herself, accidentally or deliberately;

E) Adequate space and furnishings to permit staff to assess and diagnose consumers who present for triage;

F) Separate restroom facilities for men and women, complete with baths or showers and hygiene supplies, including soap, shampoo and deodorant for consumers;

G) A maximum of eight individual areas for interviews and assessment. The physical arrangement of the rooms shall preserve the safety and privacy of each consumer served;

H) Laundry services for consumer use, including laundry detergent;

I) Clean replacement clothing for both male and female consumers, if needed by the consumer;

J) Kitchen equipment to provide hot meals and snacks for consumers; and

K) A toilet room that is accessible from within the triage center. The toilet room shall be equipped with a water closet and lavatory. The door to the toilet room shall be lockable from the outside only.

2) A crisis stabilization unit shall be a separate unit within the facility, if the facility provides more than one level of service. In addition, a crisis stabilization unit shall provide the following:

A) Meeting and therapy rooms that comply with the level of service. The rooms shall be of adequate size and number to accommodate the maximum consumer population of the unit and shall be furnished for the purpose intended;

B) A maximum of 16 beds;

C) Visual monitoring of consumers for safety reasons, when indicated in the consumer's treatment plan;

D) As much privacy for each consumer as is clinically appropriate.

E) Hallways and common areas that are visible from the nurse duty area. If electronic monitoring devices are used, the video recording must be kept for seven days; and

F) Features including, but not limited to, electrical outlets, sprinkler heads, doorknobs, and light switches that prevent a consumer from injuring himself or herself accidentally or deliberately.

3) RRS units shall provide the following:

A) Meeting and therapy rooms in accordance with the level of service. The rooms shall be of adequate size and number to accommodate the maximum consumer population, and shall be furnished for the purpose intended;

B) Bedroom doors that are visible from the nurse duty area;

C) Adequate common space for programming; and

D) Sufficient private space for consumers to meet with assessors, transition staff, and visitors.

4) RSS unit maybe designated as all-male or all-female, for consumers who prefer segregated living arrangements, or for treatment purposes.

5) Transitional Living Units shall provide the following:

A) Meeting and therapy rooms according to the level of service. The rooms shall be of adequate size and number to accommodate the maximum consumer population and shall be furnished for the purpose intended;

B) Bedroom doors that are visible from the nurse duty area; and

C) A distinct unit within a facility.

6) Nurse Duty Area

A) The nurse duty area shall be either a centralized cluster serving more than one level of service in a facility or shall be used as a supportive area within a self-contained level of service.

B) The nurse duty area shall have adequate work counters, storage areas and communication equipment.

C) A hand-washing station convenient to the nurse duty area shall be provided.

D) A lounge and toilet rooms for staff shall be provided.

E) Closets or compartments shall be provided for the safekeeping of coats and personal effects of nursing personnel.

F) Charting facilities shall be provided for nurses and doctors, including work counter and secured file storage.

G) At least one tub or shower shall be provided for each 15 beds that do not have bathing facilities within the consumer's room. Each tub or shower shall be in an individual room that provides space for the private use of the bathing fixture and for drying and dressing.

H) A nourishment station with a sink equipped for hand washing, refrigerator, storage cabinets, ice dispensing equipment, and other equipment/supplies as necessary for serving nourishment between meals shall be provided.

I) A clean utility/work room shall be provided in each nursing area. The clean utility/work room shall contain a work counter, hand-washing sink and storage. A separate designated area shall be provided for clean linen storage. If a cart system is used, an alcove for storage of the cart may be used.

J) A soiled utility/workroom shall be provided and shall contain a hand-washing sink and a waste receptacle.

K) A locked janitor's closet shall be provided for each nurse duty area. The closet shall be for the exclusive use of housekeeping staff and shall be equipped with a floor receptor or service sink and adequate storage space for housekeeping equipment and supplies.

L) Mops and other cleaning supplies used and stored in the nurse areas shall not be used or stored in the kitchen area.

7) The facility shall have a smoke detection system that complies with the Smoke Detector Act.

8) Bathrooms shall be located and equipped to facilitate independence. When needed by the consumer, special assistive devices shall be provided. Bathing and toilet facilities shall provide privacy.

9) Each single individual bedroom shall have at least 75 square feet of net floor area, not including space for closets, bathrooms and clearly definable entryway areas.

A) Each multiple bedroom shall have at least 55 square feet of net floor area per consumer, not including space for closets, bathrooms and clearly definable entryway areas. A minimum of 3 feet of clearance at the foot and sides of each bed shall be provided.

B) Each bedroom within crisis stabilization units, recovery and rehabilitation supports units, and transitional living units shall accommodate no more than two consumers, with 5% of the rooms in the first 18 months, and 10% of the rooms in the first three years, reserved for single occupancy.

C) Reasonable storage space for clothing and other personal belongings shall be provided for each consumer.

D) Each bedroom shall have walls that extend from floor to ceiling, a fire-graded bed that is suitable to the size of the consumer and that provides support and comfort, if beds are provided by the agency, and at least one outside window. The total window area to the outside shall be at least one-tenth of the floor area of the room.

E) Each toilet room shall be equipped with a water closet, a lavatory and a shower or shower/tub combination.

10) The facility shall ensure that living arrangements are free from vermin. Waste and garbage shall be stored, transferred and disposed of in a manner that does not permit the transmission of diseases. Water systems shall comply with the Drinking Water Systems Code, and the facility shall maintain copies of inspections performed by local and State inspectors in regard to health, sanitation and environment.

e) Plumbing, drainage facilities, and drinking water shall be maintained in compliance with the Illinois Plumbing Code.

1) Each facility shall be served by water from a municipal public water supply when available.

A) When a municipal public water supply is not available, the water supply shall comply with the Drinking Water Systems Code.

B) 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 Water Well Construction Code and Illinois Water Well Pump Installation Code.

C) 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.

2) Hot water temperature controls shall be maintained and regulated to prevent scalding, so that the temperature of hot water delivered to the plumbing fixtures that are used by consumers not exceed 115 degrees Farenheit.

3) Minimum hot water temperature shall be maintained at the final rinse section of dishwashing facilities as required by the Food Service Sanitation Code.

4) Suicide-resistant grab bars (for crisis stabilization and triage centers) and other bathroom fixtures shall be maintained at each community toilet, lavatory, shower and bathtub used by consumers and as needed in

individual consumer rooms.

5) Toilet, hand-washing and bathing facilities shall be maintained in operating condition and in the number and types specified in construction requirements in effect at the time the building or unit was constructed.

6) If the facility accepts physically handicapped consumers, bathing and toileting appliances in the water closets shall be equipped for use by consumers with physical handicaps. All handicapped accessible facilities shall meet the minimum requirements of the Illinois Accessibility Code and the Americans With Disabilities Act.

f) All rooms, attics, basements, passageways and other spaces shall be provided with artificial illumination in accordance with the National Electrical Code.

1) All consumer rooms and accessible areas of corridors, storerooms, stairways, ramps, exits and entrances shall have lighting for ease of reading, working and passage.

2) The facility shall provide and maintain an emergency electrical system in safe operating condition.

g) Heating, air conditioning and ventilating systems shall be maintained in normal operating condition to provide a comfortable temperature and shall meet the requirements of the American Society of Heating, Refrigerating, and Air Conditioning Engineers Handbook of Fundamental Principles and Handbook of Applications.

1) The mechanical system shall be capable of maintaining a temperature of at least 75 degrees Fahrenheit.

2) The air-conditioning system shall be capable of maintaining an ambient air temperature of between 75 degrees Fahrenheit and 80 degrees Fahrenheit.

h) The facility shall develop a written record of the maintenance history of the heating, air conditioning and ventilation systems, which shall be available for inspection by the Department.

1) A log shall be used to document all maintenance work performed.

2) When maintenance is performed by an equipment service company, the facility shall request a certification that the required work has been performed in accordance with acceptable standards. The certification shall be retained on file in the facility for review by the Department.

i) The facility shall have housekeeping procedures to routinely clean articles and surfaces such as furniture, floors, walls, ceilings, supply and exhaust grills and lighting fixtures.

j) Schedules shall be posted and implemented that indicate areas of the facility that shall be cleaned daily, weekly or monthly.

1) Cleaning supplies and equipment shall be available to housekeeping staff and shall meet the following requirements:

A) Cleaning supplies and equipment shall be stored in rooms for housekeeping use only;

B) Appropriate cleaning agents shall be used for all cleaning;

C) Mop heads shall be removable and changed at least daily; and

D) Cleaning supplies and equipment shall be kept in a secured location/area that is accessed by authorized personnel only.

2) Housekeeping personnel shall be employed to maintain the interior of the facility in a safe, clean, orderly and attractive manner free from offensive odors.

3) Janitor closets, service sinks and storage areas shall be clean and maintained to meet the needs of the facility.

k) If the facility operates a laundry that is separate from consumer-operated washers and dryers for clothes, the facility laundry area shall be located in relationship to other areas so that steam, odors, lint and objectionable noises do not reach consumer areas.

1) The facility laundry area shall be adequate in size, well lighted, ventilated to meet the needs of the facility, and kept clean and sanitary.

2) Laundry equipment shall be kept in good condition, be maintained in a sanitary condition, and have suitable capacity.

3) Laundry areas shall have, at a minimum, the following:

A) Separate rooms for the storage of clean linen and soiled linen;

B) Hand-washing facilities maintained at locations convenient for laundry personnel; and

C) Linen carts labeled "soiled" or "clean" and constructed of washable materials that shall be laundered or suitably cleaned as needed to maintain sanitation.

4) The facility shall implement written procedures for handling, storing, transporting and processing linens. The written procedures shall be posted in the laundry.

5) If the facility does not maintain a laundry service, the facility shall contract only with a commercial laundry that meets the requirements of this Section.

l) The facility, including the grounds, shall be maintained in a clean and sanitary condition and in good condition at all times to ensure the safety and well-being of consumers, staff and visitors.

1) Buildings and grounds shall be free of environmental pollutants and nuisances that may adversely affect the health or welfare of consumers to the extent that is within the reasonable control of the facility.

2) All buildings, fixtures, equipment and spaces shall be maintained in operable condition.

3) Personnel shall be employed to provide preventive maintenance and to carry out the required maintenance program.

4) Equipment shall meet all applicable Occupational Safety and Health Act requirements in effect at the time of purchase. All portable electrical medical equipment designed for 110-120 volts, 60 hertz current, shall be equipped with a 3-wire-grounded power cord with a hospital-grade

3-prong plug. The cord shall be an integral part of the plug.

5) The facility shall be maintained free from vermin and rodents through operation of a pest control program. The pest control program shall be conducted in the main consumer buildings, all outbuildings on the property and all grounds.

m) The facility shall be responsible for the regular inspection, cleaning or replacement of all filters installed in heating, air conditioning and ventilating systems, as necessary to maintain the systems in normal operating conditions.

1) A written record of inspection, cleaning or replacement shall be maintained and available for inspection by the Department.

2) When filter maintenance is performed by an equipment service company, the facility shall request a certification that the filter has been inspected, cleaned or replaced, with dates noted.

n) Emergency Electrical Requirements

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.

2) The source of this emergency electrical service shall be one of the following:

A) A Type 3 Essential Electrical System, in accordance with NFPA 99, when the normal service is supplied by only one central station transmission line; or

B) Automatic battery-operated systems or equipment that will be effective for 90 minutes and will be capable of supplying power for lighting for exit signs, exit corridors, stairways, nurses' areas, the communication system, and all alarm systems.

3) The facility shall provide emergency electrical service for:

A) Illumination of a 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 that are used for issuing instructions; and

E) Task illumination in the nurse duty area.

o) Kitchen

1) Floor material in kitchens shall be easily cleanable and shall have wear resistance that is appropriate for the location involved, and shall be water resistant and greaseproof. The kitchen wall base shall be tightly sealed to the wall and floor and shall be constructed without voids or gaps that can accumulate dirt and grime and harbor vermin. Ceiling finishes shall be smooth, sanitary and washable, and shall be able to withstand treatment with harsh chemicals. The ceiling finish shall be capable of being thoroughly cleaned, including any concealed spaces that may be present.

2) Mops and all other cleaning supplies that are used in the kitchen shall not be used or stored anywhere else in the facility. A janitor's closet, equipped with a floor receptor or service sink and adequate storage space for housekeeping equipment and supplies, shall be provided for the kitchen.

3) Equipment and furnishing installations must meet all the requirements of the following:

A) NFPA 56 National Fuel Gas Code;

B) NFPA 70 National Electrical Code; and

C) NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.

SUBPART F: LICENSURE REQUIREMENTS

Section 380.700 Licensure Application Requirements

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED RULE

a) The *Act provides for licensure of long term care facilities that are federally designated as institutions for mental disease on* July 22, 2013 *and specialize in providing services to individuals with a serious mental illness*.

b) *All consent decrees that apply to facilities federally designated as institutions for mental disease shall continue to apply to facilities licensed under* the *Act* and this Part. (Section 1-101.5 of the Act)

c) *No person may establish, operate, maintain, offer, or advertise a facility within this State unless and until he or she obtains a valid license, which license remains unsuspended, unrevoked, and unexpired. No public official or employee may place any person in, or recommend that any person be in, or directly or indirectly cause any person to be placed in any facility that is being operated without a valid license*. (Section 4-102 of the Act)

1) A facility whose license has been successfully revoked is disqualified from obtaining a provisional license under the Act and this Part.

2) A facility with a pending Notice of Revocation and Opportunity for Hearing is disqualified from obtaining a provisional license until the Notice of Revocation is resolved, including, but not limited to, a voluntary withdrawal of the Notice of Revocation by the Department or a successful appeal of the Notice of Revocation by the facility.

d) *All licenses and licensing procedures established under Article III of the Nursing Home Care Act, except those contained in Section 3-202* of the Nursing Home Care Act, *shall be deemed valid under* the *Act* and this Part *until the Department establishes licensure. The Department is granted the authority under* the *Act* and this Part *to establish provisional licensure and licensing procedures under* the *Act* and this Part. (Section 4-102 of the Act)

1) All facilities that are federally designated as institutions for mental disease, and that were previously certified under Subpart T of 77 Ill. Adm. Code 300, shall apply for provisional licensure under the Act and this Part.

2) All facilities that are federally designated as institutions for mental disease that are currently certified under Subpart S of 77 Ill. Adm. Code 300 shall apply for provisional licensure under the Act and this Part.

e) *The Department shall be the sole agency responsible for licensure*. Licensure

shall be *in accordance with* the *Act for the purpose of*:

1) *Protecting the health, welfare, and safety of consumers; and*

2) *Ensuring the accountability for reimbursed care provided in facilities.* (Section 4-101 of the Act)

f) Provisions of this Part establishing requirements for provisional licenses are effective for three years beginning on May 22, 2014, will be in effect *for a period of three years, and will not be extended beyond* May 22, 2017. (Section 4-103 of the Act)

g) The Department will issue no more than 24 licenses statewide for specialized mental health rehabilitation facilities, in accordance with the Act and this Part.

h) Pursuant to Section 4-102 of the Act, a new provisional license application is required upon initial licensure as a specialized mental health rehabilitation facility and whenever there is a change of ownership, in licensed bed capacity, in services provided, or of location.

i) The application shall be under oath, and the submission of false or misleading information shall be a Class A misdemeanor. The application, in a form prescribed by the Department, shall contain the following information:

1) The name, or proposed name, and address of the facility;

2) The name, residence and mailing address of the applicant;

3) If the applicant is a partnership, the name and principal business address of each partner;

4) If the applicant is a corporation or association, the name, title and business address of each officer and member of the governing board;

5) If, at the time of application, the applicant is associated with a clinical or operational management company, the name of the company, manager, principle business address, and written copies of consulting arrangements.

A) For the purposes of this Section, "associated" means employed by or in a contractual relationship with a clinical or operational

management company.

B) The applicant shall submit to the Department written copies of all employment agreements and contracts in effect between the applicant and a clinical or operational management company. If, following the time of application, an applicant becomes employed by or enters into a contractual relationship with a clinical or operational management company, he or she shall inform the Department and submit all required documentation to the Department;

6) The name and address of the owner or owners of the facility premises, if the applicant is leasing or renting;

7) A written plan of operation as specified in Section 380.720;

8) A financial statement setting forth the financial condition of the applicant, demonstrating that the applicant's ability to maintain *the minimum financial or other resources necessary to meet the standards established under* the *Act* and this Part (Section 2-101(7) of the Act);

9) Documentation that a needs assessment survey was performed within the community in which the facility is located, justifying the levels of service to be provided; and

10) A non-refundable license fee of $5,700.

Section 380.710 Application Process and Requirements for a Provisional License

a) *A provisional license shall be valid upon fulfilling the requirements established by the Department* in this Part. *The license shall remain valid as long as a facility remains in compliance with the licensure provisions established in* this Part. (Section 4-105 of the Act)

b) When an application for a provisional license and certification of any of the four programs identified in the Act and in Subpart B is submitted pursuant to this Part, the Department will notify the applicant in writing within 30 days after receipt of the application as to whether the application is complete and accepted for filing, or whether the application is incomplete, and what specific information or documentation is required to complete the application.

c) If the applicant fails to respond within 30 days after being notified that the Department needs additional information or documentation, the applicant shall be considered to have withdrawn the application. Any applicant considered to have withdrawn an application may reapply by submitting a new application.

d) The Department shall notify an applicant in writing, within 60 days following the acceptance of an application, of the Department's decision to approve or deny the application.

e) If the Department fails to notify an applicant by the end of the 60-day time period, the applicant may request, in writing, a review by the Director. The written request shall include:

1) An identification of the applicant;

2) The date the application was submitted;

3) A copy of any correspondence between the Department and the applicant regarding the application; and

4) Any other information the applicant wishes to submit regarding the timeliness of the Department's consideration of the application.

f) The Department shall notify an applicant immediately upon denial of any application for provisional licensure. The 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 the Act and this Part under which the application is being denied.

2) A notice of the opportunity for a hearing. If the applicant desires to contest the denial of a license, it shall provide written notice to the Department of a request for a hearing within 10 days after receipt of the notice of denial. The hearing will be conducted pursuant to Sections 3-704 through 3-712 of the Nursing Home Care Act.

g) Requirements for Provisional Licensure

1) DHS-DMH will advise the applicants of the training that shall be completed prior to the issuance of the provisional license. Limited trainings may be conducted over a three-month period following the issuance of the provisional license.

2) All staff shall be hired in accordance with the requirements for each level of service prior to the beginning of clinical operations for the respective levels of service after the issuance of the provisional license.

3) Crisis stabilization, transitional living units and recovery and rehabilitation supports units shall comply with the physical plant standards in Subpart E within three years after May 22, 2014. Triage centers shall comply with all physical plant standards prior to the beginning of clinical operations, after the issuance of a provisional license.

Section 380.720 Plan of Operation

a) The license applicant shall submit, with the license application, the plan of operation, including, but not limited to, the following components of the facility, respective of the level or levels of service to be provided:

1) A proposal of certification for each level of service to be provided by a facility;

2) A summary of administration requirements as specified in Subpart D;

3) Services and staffing:

A) Clinical level of service and staffing, as appropriate to each level of service provided, and pursuant to the respective level of service requirements in Subpart B;

B) Documentation of the required training for each staffing classification in each level of service; and

C) Any contractual arrangements;

4) Admission process and criteria;

5) Discharge planning and transition process;

6) Network linkages with community-based behavioral health providers;

7) Contents of consumer health and treatment records;

8) Consumer rights and empowerment;

9) Pharmaceutical services and self-medication program;

10) Program space allocation;

11) Restraint and therapeutic separation policies and procedures;

12) Physical plant or buildings, and fire safety;

13) Health services program;

14) Interdisciplinary treatment teams;

15) Psychiatric and psychological services; and

16) Quality improvement plan.

b) The plan of operation shall specify each target population group and service that the facility plans to offer, as referenced in Subpart A. The description shall identify:

1) Eligibility for services;

2) The number of consumers to be served;

3) An identification of the particular needs of the population;

4) How the facility's respective levels of service are designed to meet the needs of the population; and

5) The method and frequency of evaluating consumer progress.

c) The plan of operation shall include a description of how a facility's respective levels of service meet identified mental health needs in its service area. The

description shall demonstrate what makes the facility's levels of service innovative compared to existing programs in the service area pursuant to Section 380.700(i)(9).

d) The plan of operation shall specify how a facility expects to obtain accreditation via achieving the components in subsections (a), (b) and (c) for each year of provisional licensure. Each provider shall, annually, specify operational benchmarks toward achieving accreditation status for each year of the provisional license period, with the correlating documentation for verification of compliance.

1) During the provisional licensure period, the Department will conduct surveys to determine facility compliance with timetables and benchmarks, and with the facility's provisional licensure application plan of operation. Timetables and benchmarks shall comply with the requirements for accreditation by the national accreditation entities listed in Section 380.730 and shall include, but not be limited to, the following:

A) The training of new and existing staff;

B) The establishment of a data collection and reporting program for the facility's QAPI program, pursuant Sections 380.510 and 380.515; and

C) Compliance with NFPA Chapter 33 and with Section 380.670.

2) As part of the surveys required in subsection (d)(1), the Department will conduct reviews to determine compliance with timetables and benchmarks associated with the accreditation process. Facilities shall meet timetables and benchmarks in accordance with a facility's preferred accrediting entity's conformance standard and recommendations to include, but not be limited to, a comprehensive facility self-evaluation in accordance with one of the established national accreditation programs listed in Section 380.730.

3) Facilities shall submit all reporting and outcome data required by their preferred accrediting entity to the Department upon request.

4) Except for incidents involving the potential for serious harm as described in Section 380.750(c)(5), or death, or a facility's consistent and repeated failure to take necessary corrective actions as described in Section

380.750(c)(6) within 60 days, findings in the facility's root cause analysis and the facility's QAPI program in accordance with Section 4-104(22) of the Act and Section 380.510 shall not be used as a basis for non-compliance.

Section 380.730 Requirements for Accreditation

a) *At the end of the provisional licensure period established in* the *Act, the Department shall license a facility as a specialized mental health rehabilitation facility under* the *Act that successfully completes and obtains valid national accreditation in behavioral health from a recognized national accreditation entity and complies with* this Part. (Section 4-201 of the Act The license shall be good for one year and shall be renewable annually provided the facility is in substantial compliance with the Act, this Part.

b) To achieve accreditation, all levels of service that are operated by the licensee and funded in whole or in part by the State shall comply with nationally recognized standards of care as set by one of the following or their successor accreditation standards:

1) Standards for Behavioral Health Care (Joint Commission);

2) Behavioral Health Standards Manual (Commission on Accreditation of Rehabilitation Facilities (CARF)); or

3) Accreditation Requirements for Behavioral Health Centers (Healthcare Facilities Accreditation Program).

c) The facility shall demonstrate current accreditation status by submission of a certificate of accreditation and the most recent accreditation report to the certifying State agency and to the Department.

d) If the facility's accreditation is suspended, lost or discontinued, the provider shall notify the certifying State agency and the Department of that change immediately.

Section 380.740 Surveys and Inspections

a) Upon receipt of a completed application and verification of the facility's compliance with the Act and this Part, and a licensure fee of $5,700, and the completion of an initial survey as described in subsection (b), the Department will

issue a provisional license for one or more of the four levels of service identified in the Act and in Section 380.100 of this Part (definition for facility), as requested by the licensee in the application.

b) Prior to the issuance of the initial provisional license, and then at least annually, *the Department shall conduct surveys of licensed facilities and their certified programs and services. The Department shall review the records or premises, or both, as it deems appropriate for the purpose of determining compliance with* the *Act and* this Part. *The Department shall have access to and may reproduce or photocopy any books, records, and other documents maintained by the facility to the extent necessary to carry out* the *Act and* this Part. In addition, the Department will:

1) Conduct staff interviews;

2) Conduct consumer interviews; and

3) Review evidence-based program outcomes.

c) *Any holder of a license or applicant for a license shall be deemed to have given consent to any authorized officer, employee, or agent of the Department to enter and inspect the facility in accordance with* the Act. *Refusal to permit entry or inspection shall constitute grounds for denial, suspension, or revocation of a license under* the *Act*. (Section 4-108 of the Act) The Department's access to the facility's books, records and any other documents maintained by the facility includes, but is not limited to:

1) Verifying whether the facility complies with all of the requirements for authorization and review of treatment appropriateness for each consumer, based on the service level or levels for which the facility is licensed. The facility shall ensure that State-designated authorization agents and other authorized State personnel are provided with timely and unfettered access to consumers, records, facility staff and consultants who are part of the facility's treatment team; and

2) Verifying whether, for all programs except for triage centers, the facility has admitted any consumer prior to completing the required authorization. The Department may revoke a facility's license for admission of consumers into crisis stabilization units, transitional living units, or recovery and rehabilitation supports units without pre-authorization for

that program. Admission of a consumer without pre-authorization violates this Part and the Department of Healthcare and Family Services' rate requirements. Facilities will not receive retroactive payment for services provided prior to pre-authorization through the required authorization.

Section 380.750 License Sanctions and Revocation

a) *The Department may revoke a license for any failure to substantially comply with* the *Act and* this Part*, including, but not limited to, the following* behavior by a licensee:

1) *Fails to correct deficiencies identified as a result of an on-site survey by the Department and fails to submit a plan of correction within 30 days after receipt of the notice of violation*;

2) *Submits false information on Department forms, required certifications* or *plans of correction during an on-site inspection*;

3) *Refuses to permit or participate in a scheduled or unscheduled survey;*

4) *Willfully violates any rights of individuals being served* (Section 4-109(a) of the Act); or

5) Fails to comply with Section 4-107 of the Act and with Section 380.200(a)(2) of this Part.

b) *The Department may refuse to license or relicense a facility if the owner or authorized representative or licensee has been convicted of a felony related to the provision of healthcare or mental health services, as shown by a certified copy of* the order of *the court of conviction.* (Section 4-109(b) of the Act)

c) *Facilities, as a result of an on-site survey, shall be recognized according to levels of compliance with standards as set forth in* the *Act* and this Part. *Facilities with findings from Level 1 to Level 3 will be considered to be in good standing with the Department. Findings from Level 3 to Level 5 will result in a notice of violations, a plan of correction and sanctions* as defined in subsecton (f). *Findings resulting in Level 6 will result in a notice of violations and sanction* as defined in subsection (f). *The levels of compliance are*:

1) *Level* 1 is *full compliance with* the *Act and* this Part. Full compliance

means meeting the requirements except for variances from the strict and literal performance that results in unimportant omissions or defects, given the particular circumstances involved.

2) *Level 2* is *acceptable compliance with* the *Act and* this Part. *No written plan of correction will be required from the licensee.* Acceptable means enough in either quantity or quality, and within the professional standards applicable to the subject under review, to meet the needs of the consumers of a facility under the particular set of circumstances in existence at the time of review.

3) *Level 3* is *partial compliance with* the *Act and* this Part. *An administrative warning is issued* by the Department. *The licensee shall submit a written plan of correction* pursuant to subsection (a)(1). Partial compliance is a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that less than minimal physical or mental harm to a consumer will result.

4) *Level 4* is *minimal compliance with* the *Act and* this Part. *The licensee shall submit a written plan of correction* pursuant to subsection (a)(1), *and the Department will issue a probationary license. A re-survey shall occur within 90 days* after the Department receives the written plan of correction from the facility. Minimal compliance is a condition or occurrence relating to the operation and maintenance of a facility that is more likely than not to cause more than minimal physical or mental harm to a consumer.

5) *Level 5* is *unsatisfactory compliance with* the *Act and* this Part. *The facility shall submit a written plan of correction* pursuant to subsection (a)(1), *and the Department will issue a restricted license. A re-survey shall occur within 60 days* after the Department receives the written plan of correction from the facility. Unsatisfactory compliance is a condition or occurrence relating to the operation and maintenance of a facility that creates a substantial probability that the risk of death or serious mental or physical harm to a consumer will result, or has resulted in, actual physical or mental harm to a consumer.

6) *Level 6* is *revocation of the license to provide services. Revocation may occur as a result of a licensee's consistent and repeated failure to take necessary corrective actions to rectify documented violations, or the failure to protect consumers from situations that produce an imminent*

risk, creating a condition relating to the operation and maintenance of a facility that proximately caused a consumer's death. (Section 4-109(c) of the Act) Revocation also may occur for failure to comply with *all consent decrees that apply to facilities federally designated as institutions for the mentally diseased* and that *continue to apply to facilities licensed under* the *Act*, or to otherwise obstruct a consumer from transferring from a facility to a community-based setting. (Section 1-101.5(b) of the Act)

d) In determining the level of a violation, the Director or his or her designee will consider the following criteria:

1) The degree of danger to the consumer, consumers or community that 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 consumer or consumers of the facility are able to recognize conditions or occurrences that may be harmful and are able to take measures for self-preservation and self-protection. The extent of nursing care required by the consumers, as indicated by review of consumer needs, will be considered in relation to this determination.

B) Whether the consumer or consumers have access to the area of the facility in which the condition or occurrence exists and the extent of access. A facility's use of barriers, warning notices, instructions to staff and other means of restricting consumer 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 consumer or consumers of the facility were notified of the condition or occurrence and the promptness of the notice. Failure of the facility to notify consumers of potentially harmful conditions or occurrences will be considered. The adequacy of the method of the notification and the extent to which the notification reduced the potential danger to the consumers will also be considered.

2) The directness and imminence of the danger to the consumer, consumers,

or the community 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 consumer or consumers resulted from the condition or occurrence and the extent of the harm.

B) Whether available statistics and records from similar facilities indicate that direct and imminent danger to the consumer or consumers has resulted from similar conditions or occurrences, and the frequency of this danger.

C) Whether professional opinions and findings indicate that direct and imminent danger to the consumer or consumers 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 consumer or consumers who are subject to the danger would facilitate or hinder harm actually resulting from the condition or occurrence.

e) *Prior to initiating formal action to sanction a license, the Department shall allow the licensee an opportunity to take corrective action to eliminate or ameliorate a violation of* the *Act* or this Part *except in cases in which the Department determines that emergency action is necessary to protect the public or individual interest, safety or welfare*. (Section 4-109(d) of the Act)

f) *Subsequent to an on-site survey, the Department shall issue a written notice to the licensee. The Department shall specify the particular Sections of* the *Act or* this Part*, if any, with which the facility is not compliant. The Department's notice shall require any corrective actions be taken within a specified time period as required by* the *Act and* subsections (a)(1) and (c)(4) and (5) of this Section, as applicable. (Section 4-109(e) of the Act)

g) *Sanctions shall be imposed according to the following definitions*:

1) *Administrative notice – A written notice issued by the Department that specifies violations* of the Act and this Part *requiring a written plan of correction with time frames for corrections to be made and a notice that any additional violation of* the *Act and* this Part *may result in a higher level sanction. (Level 3)*

2) *Probation – Compliance with* the *Act and* this Part *is minimally acceptable and necessitates immediate corrective action. Individuals' life safety or quality of care* is *not in jeopardy. The probationary period is limited to 90 days* after the Department receives the written plan of correction from the facility. *During the probationary period, the facility must make corrective changes sufficient to bring the facility back into good standing with the Department. Failure to make corrective changes within that given time frame may result in a determination* by the Department *to initiate a higher-level sanction. The admission of new individuals shall be prohibited during the probationary period. (Level 4)*

3) *Restricted license – A licensee is sanctioned for unsatisfactory compliance. The admission of new individuals shall be prohibited during the restricted licensure period. Corrective action sufficient to bring the licensee back into good standing with the Department must be taken within 60 days* after the Department receives a written plan of correction from the facility. *During the restricted licensure period a monitor will be assigned to oversee the progress of the facility in taking corrective action. If corrective actions are not taken, the facility will be subject to a higher-level sanction. (Level 5)*

4) *Revocation – Revocation of the license is withdrawal by formal actions of the licensee. The revocation shall be in effect until the provider submits a re-application and the licensee can demonstrate its ability to operate in good standing with the Department. The Department has the right not to reinstate a license. If revocation occurs as a result of imminent risk, all individuals will be immediately relocated and all funding will be transferred. (Level 6)*

5) *Financial penalty* (fines) *– A financial penalty may be imposed upon finding of violation in any one or combination of the provisions of* the *Act* and this Part. *In determining an appropriate financial penalty, the*

Department may consider the deterrent effect of the penalty on the organization and on other providers, the nature of the violation, the degree to which the violation resulted in a benefit to the organization and/or harm to the public and any other relevant factors to be examined in mitigation or aggravation of the organization's conduct. The financial penalty may be imposed in conjunction with other sanctions or separately. Higher-level sanctions may be imposed in situations where there are repeat violations. (Section 4-109(f) of the Act) Fines for single violations and multiple violations shall be consistent with Section 3-305 of the Nursing Home Care Act.

h) The Department may revoke a facility's certification for an individual level of service without interrupting the operation of other certified levels of service offered by the facility.

Section 380.760 Citation Review and Appeal Procedures

a) *Upon receipt of Level 3 to 6 citations, the licensee may provide additional written information and argument disputing the citation within 10 working days* following the receipt of the citations. *The Department shall respond to the licensee's disputation within 20 days* following receipt of the disputation. (Section 4-110 of the Act)

b) *If a licensee contests the Department's decision regarding a Level 4 to 6 citation or penalty, it can request a hearing by submitting a written request within 20 working days* after it receives *the Department's dispute resolution decision. The Department shall notify the licensee of the time and place of the hearing not less than 14 days prior to the hearing date*. (Section 4-110 of the Act)

c) *A license may not be denied or revoked unless the licensee is given written notice of the grounds for the Department's action. Except when revocation of a license is based on imminent risk, the facility or program whose license has been revoked may operate and receive reimbursement for services during the period preceding the hearing, until a final decision is made.* (Section 4-110 of the Act)

d) All hearings will be conducted in accordance with Practice and Procedures in Administrative Hearings.

e) *Notwithstanding the existence or pursuit of any other remedy, the Director may, in the manner provided by law, upon the advice of the Attorney General who shall*

represent the Director in the proceedings, maintain an action in the name of the State for injunction or other process against any person or government unit to restrain or prevent the establishment of a facility without a license issued pursuant to the *Act* and this Part, *or to retrain or prevent the opening, conduction, operating, or maintaining of a facility without a license issued pursuant to* the *Act* or this Part. *In addition, the Director may, in the manner provided by law, in the name of the People of the State and through the Attorney General who shall represent the Director in the proceedings, maintain an action for injunction or other relief or process against any licensee or other person to enforce and compel compliance with the provisions of* the *Act and* this Part *and any order entered for any response action pursuant to* the *Act and* this Part. (Section 4-111 of the Act)

Section 380.770 Safety, Zoning and Building Clearances

a) A license will not be issued to any facility that does not conform to the State Fire Marshal's requirements for fire and life safety and for local fire safety, zoning and building ordinances. All handicapped accessible facilities shall meet the minimum requirements of the Illinois Accessibility Code and the Americans With Disabilities Act. Facilities shall maintain a written policy for reasonable modification for the admission of consumers unable to access the facility's sites due to physical inaccessibility.

b) The licensee shall maintain the facility in a safe structural condition. If the Department determines that an evaluation of the structural condition of a facility building is necessary, the licensee shall submit a report by a licensed structural engineer that shall establish a basis for eliminating or correcting the structural conditions that are found to be hazardous.

Section 380.780 Special Demonstration Programs and Services

a) All licensees shall maintain compliance with all requirements of the Act and this Part.

b) Based on data from community needs health assessments conducted by facilities, in cooperation with local health departments, the State may engage specific providers to participate in a special demonstration program.

c) When a facility initiates a special demonstration program, the facility shall obtain approval from the Department prior to the use of concepts, methods, procedures,

techniques, equipment, personnel qualifications, or the conducting of pilot projects that are alternative to the Act and this Part, provided that alternatives are carried out with provision for safe and adequate care. This approval shall provide for the terms and conditions under which the alternative is granted.

d) A written request and substantiating information and documents supporting the request, which the facility may obtain from the local health department, shall be submitted by the applicant or licensee to the Department.

e) Any approval by the Department granted under this Section shall be posted adjacent to the facility license.

f) Information concerning the availability of demonstration programs and services shall be provided to the designated assessment and authorization entity to inform the admission decisions by the consumer.