**Section 300.7020 Assessment and Care Planning**

a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident's abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission.

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

2) Assessments shall include at least the following:

A) daily routine;

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

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

D) ambulation and transferring abilities;

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

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

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

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

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

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

2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan.

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

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

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

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

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

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

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

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

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

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

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