**Section 390.3220 Medical Care**

a) *A resident shall be permitted to retain the services of his* or her *own personal physician at his* or her *own expense under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage.* (Section 2-104(a) of the Act)

b) *The Department shall not prescribe the course of medical treatment provided to an individual resident by the resident's physician in a facility.* (Section 3-201 of the Act)

c) *Every resident shall be permitted to obtain from his* or her *own physician or the physician attached to the facility complete and current information concerning his* or her *medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand.* (Section 2-104(a) of the Act)

d) *Every resident shall be permitted to participate in the planning of his* or her *total care and medical treatment to the extent that his* or her *condition permits*. (Section 2-104(a) of the Act)

e) *No resident shall be subjected to experimental 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 committee appointed by the administrator of the facility where such research and treatment is conducted.* (Section 2-104(a) of the Act)

f) *All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.* (Section 2-104(b) of the Act)

g) *Every woman resident of child-bearing age shall receive routine obstetrical and gynecological evaluations as well as necessary prenatal care.* (Section 2-104(b) of the Act) In addition, women residents shall be referred immediately for diagnosis whenever pregnancy is suspected.

1) "Routine obstetrical evaluations" and "necessary prenatal care" shall include, at a minimum, the following:

A) Early diagnosis of pregnancy;

B) A comprehensive health history, including menstrual history, methods of family planning that the patient has used, a detailed record of past pregnancies, and data on the current pregnancy that allow the physician to estimate the date of delivery;

C) Identification of factors in the current pregnancy that help to identify the patient at high risk, such as maternal age, vaginal bleeding, edema, urinary infection, exposure to radiation and chemicals, ingestion of drugs and alcohol, and use of tobacco;

D) A comprehensive physical examination, including an evaluation of nutritional status; determination of height, weight and blood pressure; examination of the head, breasts, heart, lungs, abdomen, pelvis, rectum, and extremities;

E) The following laboratory tests, as early in pregnancy as possible. Findings obtained from the history and physical examination may determine the need for additional laboratory evaluations:

i) Hemoglobin or hematocrit measurement;

ii) Urinalysis, including microscopic examination or culture;

iii) Blood group and Rh type determination;

iv) Antibody screen;

v) Rubella antibody titer measurement;

vi) Syphilis screen;

vii) Cervical cytology; and

viii) Viral hepatitis (HBsAg) testing;

F) A risk assessment that, based on the findings of the history and physical examination, shall indicate any risk factors that may require special management, such as cardiovascular disease, maternal age less than 15 years, neurologic disorder, or congenital abnormalities;

G) Return visits, the frequency of which will be determined by the patient's needs and risk factors. A woman with an uncomplicated pregnancy shall be seen every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter;

H) Determinations of blood pressure, measured fundal height, fetal heart rate, and, in later months, fetal presentation, and urinalysis for albumin and glucose. Hemoglobin or hematocrit level shall be measured again early in the third trimester;

I) Evaluation and monitoring of nutritional status and habits;

J) Education for health promotion and maintenance;

K) Counseling concerning exercise and child birth education programs;

L) Postpartum review and evaluation four to eight weeks after delivery, including determination of weight and blood pressure and assessment of status of breasts, abdomen, and external and internal genitalia.

2) "Routine gynecological evaluations" shall include, at a minimum, the following:

A) An initial examination, the basic components of which are:

i) History; any present illnesses; menstrual, reproductive, medical, surgical, emotional, social, family, and sexual history; medications; allergies; family planning; and systems review;

ii) Physical examination, including height, weight, nutritional status, and blood pressure; head and neck, including thyroid gland; heart; lungs; breasts; abdomen; pelvis, including external and internal genitalia; rectum; extremities, including signs of abuse; lymph nodes; and

iii) Laboratory tests, including urine screen; hemoglobin or hematocrit determination and, if indicated, complete blood cell count; cervical cytology; rubella titer.

B) Annual updates, including, but not limited to:

i) History, including the purpose of the visit; menstrual history; interval history, including systems review; emotional history;

ii) Physical examination, including weight, nutritional status and blood pressure; thyroid gland; breasts; abdomen; pelvis, including external and internal genitalia; rectum; other areas as indicated by the interval history;

iii) Laboratory, including urine screen; cervical cytology, unless not indicated; hemoglobin or hematocrit determinations; and

iv) Additional laboratory tests, such as screening for sexually transmitted disease, as warranted by the history, physical findings, and risk factors.

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

h) Cancer screening. Cancer screening for women shall include the following:

1) A periodic Pap test. The frequency and administration of Pap tests 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; and

2) Mammography. The frequency and administration of mammograms shall be according to the guidelines set forth in the Guidelines for Women's Health Care.

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

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

k) *A resident shall be permitted respect and privacy in his* or her *medical and personal care program. Every resident's case discussion, consultation, examination and treatment shall be confidential and shall be conducted discreetly, and those persons not directly involved in the resident's care must have his* or her *permission to be present.* (Section 2-105 of the Act)

(Source: Amended at 35 Ill. Reg. 3495, effective February 14, 2011)