Illinois Long-Term Care
OMBUDSMAN PROGRAM

CARE PLANS

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STATE CARE PLAN REQUIREMENTS

Skilled and Intermediate Care:
https://ilga.gov/commission/jcar/admincode/077/077003000F12100R.html

Assisted Living:
https://www.ilga.gov/commission/jcar/admincode/077/077002950D40100R.html

Sheltered Care:
https://www.ilga.gov/commission/jcar/admincode/077/077003300H17100R.html

IL Veterans Homes:
https://www.ilga.gov/commission/jcar/admincode/077/077003400D15050R.html

Specialized Mental Health Rehab Facilities:
https://www.ilga.gov/commission/jcar/admincode/077/077003800E06200R.html

Intermediate Care for Facilities or the Developmentally Disabled:
https://www.ilga.gov/commission/jcar/admincode/077/077003500H16100R.html

Medically Complex for the Developmentally Disabled Facilities: (Under 22's)
https://www.ilga.gov/commission/jcar/admincode/077/077003900E10100R.html

Supportive Living Facilities:
https://www.ilga.gov/commission/jcar/admincode/089/089001460B02450R.html

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BASICS

The care plan should be the instruction manual explaining how to care for each person as the individual that they are.

- Every person in a long-term care facility has a right to good care.
- To accomplish this, staff must:
  - assess residents
  - plan care to support life-long patterns, current interests, strengths and needs
- Care planning is most important tool for assuring residents are receiving adequate care.
- Resident and family involvement is essential.

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FEDERAL CARE PLAN REQUIREMENTS

- The State Operations Manual clarifies what "Facility" means under F540 which is the Definition Section for the Federal regs
  - The Requirements of Participation only applies to Skilled and Intermediate Care Facilities.
- Link to Federal Regulation:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

- The Care Plan Regulations are referenced in F655- F659

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STEPS FOR CARE PLANNING

- Part 1:
  - Baseline Care Plan
- Part 2:
  - Comprehensive Care Plan
    - Resident Assessment
    - Care Plan Development
    - Care Plan Conference

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NEED TO KNOW'S

- Baseline Care plans need to be completed within 48 hours of admission
  - Summary must be provided to resident and their representative a summary of this
- Comprehensive Care Plan must be completed 7 days after the completion of the comprehensive assessment process (RAI/MDS process)
- Must be person centered, include measurable goals and timeframes to meet these.
- Can include refusal treatment due to resident exercising their rights

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MORE NEED TO KNOW'S

- Must include the following as the Interdisciplinary team:
  - Attending physician
  - RN with responsibility for the resident
  - NA with responsibility of the resident
  - Member of Food and Nutrition staff
  - To the extent practicable, the resident and the resident's representative(s). If it is determined that it is not practicable then this must be explained in the resident's medical record
  - Other appropriate staff or professionals as determined by the resident's needs or by resident request.
- Review of the Care Plan must occur quarterly and after each assessment.

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HOW TO USE CARE PLANS/SERVICE PLANS EFFECTIVELY

- Involved the resident in the care conversation; have them help set their own goals and approaches
- Include the Nurses Aide to help articulate care needs and how the resident is doing
- Use the care plan when the facility may "disagree" with the residents desires
- Stay away from computer generated problems goals and approaches.

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WHAT IT SHOULDN'T LOOK LIKE

- People talking about the person and the person has no input into the care conversation
- A lot of technical language that may be intimidating to the person
- A bunch of department heads sitting in a room who don't really now who the person is
- A long and involved conversation; these need to be succinct. If the person needs more time, schedule another meeting where the individual can dive deeper into their needs, wants and desires.

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QUESTIONS, COMMENTS, IDEAS

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