Section 300.APPENDIX D Forms for Day Care in Long-Term Care Facilities

SAMPLE

APPLICATION FOR DAY CARE

FORM A

NAME _____ AGE _____ BIRTH DATE _____

ADDRESS _____ PHONE _____

SOCIAL SECURITY NUMBER _____

MEDICARE NUMBER _____

WITH WHOM DO YOU LIVE? _____

RELATIONSHIP? _____

PERSON TO CONTACT IN AN EMERGENCY _____

ADDRESS _____

PHONE _____ BUSINESS PHONE _____

PHYSICAL LIMITATIONS (please list)

1. _____
2. _____
3. _____
4. _____

SPECIAL PHYSICAL NEEDS (medications during day, special rest periods, etc. please list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICAL PROBLEMS (circle)

1. diabetic
2. subject to seizures
3. heart disease
4. dizziness
5. urinary control problem
8. hearing
9. eyesight
10. assistance with meals
11. any paralysis
12. difficulty in walking

6. bowel control problem
7. special diet
13. periodic confusion
14. allergies (list)
15. others

ARE YOU PRESENTLY UNDER A DOCTOR'S CARE? _____

NAME AND ADDRESS OF PHYSICIANS _____
_____
_____
_____

SPECIAL INTEREST OR HOBBIES _____
_____

DAYS ENTERED IN PROGRAMMING

	A.M.	P.M
Monday	_____	_____
Tuesday	_____	_____
Wednesday	_____	_____
Thursday	_____	_____
Friday	_____	_____

DOYOU HAVE TRANSPORTATION? _____

(Source added at 9 Ill. Reg. 11049, effective July 1, 1985)

FORM B SAMPLE

PHYSICIAN PERMISSION FORM

_____ has applied for admittance to the day care program at _____. Please supply the following information and also give written permission for _____ to participate in the activity program.

Physical Limitations _____

_____

Degree of activity _____

_____

Can day care resident be involved in activities outside of the facility (in the community)? _____

Has _____ been evaluated within the last 30 days and found to be free of communicable and infectious disease? _____

Medications and/or treatments and diet needed by day care resident during the period of time spent in the facility. _____

_____

_____

Can day care resident take own medication? _____

Allergies _____

_____

Date: _____ Signature of Physician: _____

(Source: Added at 9 Ill. Reg. 11049, effective July 1, 1985)

Section 300.APPENDIX F Guidelines for the Use of Various Drugs

A. Long-Acting Benzodiazepine Drugs

Long-acting benzodiazepine drugs should not be used in residents unless an attempt with a shorter-acting drug (i.e., those listed under B. Benzodiazepine or Other Anxiolytic/Sedative Drugs, and under C. Drugs Used for Sleep Induction) has failed.

After an attempt with a shorter-acting benzodiazepine drug has failed, a long-acting benzodiazepine drug should be used only if:

1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out;

2. Its use results in maintenance or improvement in the resident's functional status;

3. Daily use is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful; and

4. Its use is less than, or equal to, the following listed total daily doses unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for the maintenance or improvement in the resident's functional status.

EXAMPLES OF LONG-ACTING BENZODIAZEPINES (not maximum doses)

Generic	Brand	Daily Oral Dosage
Flurazepam	(Dalmane)	15mg
Chlordiazepoxide	(Librium)	20mg
Clorazepate	(Tranxene)	15mg
Diazepam	(Valium)	5mg
Clonazepam	(Klonopin)	1.5mg
Quazepam	(Doral)	7.5mg
Halazepam	(Paxipam)	40mg

NOTES:
When diazepam is used for neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia or seizure disorders), this Guideline does not apply.

When long-acting benzodiazepine drugs are being used to withdraw residents from short-acting benzodiazepine drugs, this Guideline does not apply.

When clonazepam is used in bi-polar disorders, management of tardive dyskinesia, nocturnal myoclonus or seizure disorders, this Guideline does not apply.

The daily doses listed under Long-Acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is "clinically contraindicated."

B. Benzodiazepine or other Anxiolytic/Sedative Drugs

Use of the listed Anxiolytic/Sedative drugs for purposes other than sleep induction should only occur if:

1. Evidence exists that other possible reasons for the resident's distress have been considered and ruled out;

2. Use results in a maintenance or improvement in the resident's functional status;

3. Daily use (at any dose) is less than four continuous months unless an attempt at a gradual dose reduction is unsuccessful;

4. Use is for one of the following indications as defined by the Diagnostic and Statistical Manual of Mental Disorders; Fourth Edition (DSM-IV):

    Generalized anxiety disorder;

    Organic mental syndromes (now called dementia, delirium and amnestic and other "cognitive disorders" by DSM-IV) with associated agitated states which are quantitatively and objectively documented, which are persistent and not due to preventable reasons and which constitute sources of distress or dysfunction to the resident or represent a danger to the resident or others;

    Panic disorder;

Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder (e.g., depression, adjustment disorder); and

5. Use is equal to or less than the following listed total daily doses, unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for the improvement or maintenance in the resident's functional status.

EXAMPLES OF SHORT-ACTING BENZODIAZEPINES (not maximum doses)

Generic	Brand	Daily Oral Dosage
Lorazepam	(Ativan)	2mg
Oxazepam	(Serax)	30mg
Alprazolam	(Xanax)	0.75mg

EXAMPLES OF OTHER ANXIOLYTIC AND SEDATIVE DRUGS

Generic	Brand	Daily Oral Dosage
Diphenhydramine	(Benadryl)	50mg
Hydroxyzine	(Atarax, Vistaril)	50mg
Chloral Hydrate	(Many Brands)	750mg

NOTES:
This documentation is often referred to as "behavioral monitoring charts" and is necessary to assist in: (a) assessing whether the resident's behavioral symptom is in need of some form of intervention, (b) determining whether the behavioral symptom is transitory or permanent, (c) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (d) ruling out environmental causes such as excessive heat, noise, overcrowding, etc., (e) ruling out medical causes such as pain, constipation, fever, infection.

The daily doses listed under Short-Acting Benzodiazepines are doses (usually administered in divided doses) for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

For drugs in this category, a gradual dose reduction should be attempted at least twice within one year before one can conclude that a gradual dose reduction is "clinically contraindicated."

Diphenhydramine, hydroxyzine and chloral hydrate are not necessarily drugs of choice for treatment of anxiety disorders. They are only listed here in the event of their potential use.

C. Drugs Used for Sleep Induction

Drugs used for sleep induction should only be used if:

1. Evidence exists that other possible reasons for insomnia (e.g., depression, pain, noise, light, caffeine) have been ruled out;

2. The use of a drug to induce sleep results in the maintenance or improvement of the resident's functional status;

3. Daily use of the drug is less than ten continuous days unless an attempt at a gradual dose reduction is unsuccessful;

4. The dose of the drug is equal to or less than the following listed doses unless higher doses (as evidenced by the resident's response and/or the resident's clinical record) are necessary for maintenance or improvement in the resident's functional status.

EXAMPLES OF HYPNOTIC DRUGS (not maximum doses)

Generic	Brand	Oral Dosage
Temazepam	(Restoril)	7.5mg
Triazolam	(Halcion)	0.125mg
Lorazepam	(Ativan)	1mg
Oxazepam	(Serax)	15mg
Alprazolam	(Xanax)	0.25mg
Estazolam	(ProSom)	0.5mg
Diphenhydramine	(Benadryl)	25mg
Hydroxyzine	(Atarax, Vistaril)	50mg
Chloral Hydrate	(Many Brands)	500mg
Zolipiden	(Ambien)	5mg

NOTES:

Diminished sleep in the elderly is not necessarily pathological.

The doses listed are doses for "geriatric" or "elderly" residents. The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides

evidence to show why it was necessary for the maintenance or improvement in the resident's functional status.

Diphenhydramine, hydroxyzine, and chloral hydrate are not necessarily drugs of choice for sleep disorders. They are listed here only in the event of their potential use.

For drugs in this category, a gradual dose reduction should be attempted at least three times within six months before one can conclude that a gradual dose reduction is "clinically contraindicated."

D. Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs

The initiation of the following hypnotic/sedative/anxiolytic drugs should not occur in any dose for any resident. (See Notes for exceptions.) Residents currently using these drugs or residents admitted to the facility while using these drugs should receive gradual dose reductions as part of a plan to eliminate or modify the symptoms for which they are prescribed. A gradual dose reduction should be attempted at least twice within one year before one can conclude that the gradual dose reduction is clinically contraindicated. Newly admitted residents using these drugs may have a period of adjustment before a gradual dose reduction is attempted.

(Caution: The rapid withdrawal of these drugs might result in severe physiological withdrawal symptoms.)

EXAMPLES OF BARBITURATES

Generic	Brand
Amobarbital	(Amytal)
Amobarbital-Secobarbital	(Tuinal)
Butabarbital	(Butisol, others)
Pentobarbital	(Nembutal)
Secobarbital	(Seconal)
Phenobarbital	(Many Brands)
Barbiturates with other drugs	(e.g., Fiorinal)

EXAMPLES OF MISCELLANEOUS HYPNOTIC/SEDATIVE/ANXIOLYTICS

Generic	Brand
Ethchlorvynol	(Placidyl)
Glutethimide	(Doriden)
Meprobamate	(Equinal, Miltown)

Methprylon	(Noludar)
Paraldehyde	(Many Brands)

NOTES:
Any sedative drug is excepted from this Guideline when used as a single dose sedative for dental or medical procedures.

Phenobarbital is excepted from this Guideline when used in the treatment of seizure disorders.

When Miscellaneous Hypnotic/Sedative/Anxiolytic Drugs are used outside these Guidelines, they may be unnecessary drugs as a result of inadequate indications for use.

E. Antipsychotic Drugs

The following examples of antipsychotic drugs should not be used in excess of the listed doses for residents with organic mental syndromes (now called dementia, delirium, and amnestic and other "cognitive disorders" by DSM-IV) unless higher doses (as evidenced by the resident's response or the resident's clinical record) are necessary to maintain or improve the resident's functional status.

EXAMPLES OF ANTIPSYCHOTIC DRUGS FOR RESIDENTS WITH ORGANIC MENTAL SYNDROMES (not maximum dose)

Generic	Brand	Daily Oral Dosage
Chlorpromazine	(Thorazine)	75mg
Promazine	(Sparine)	150mg
Triflupromazine	(Vesprin)	20mg
Thioridazine	(Mellaril)	75mg
Mesoridazine	(Serentil)	25mg
Acetophenazine	(Tindal)	20mg
Perphenazine	(Trilafon)	8mg
Fluphenazine	(Prolixin, Permitil)	4mg
Trifluoperazine	(Stelazine)	8mg
Chlorprothixene	(Taractan)	75mg
Thiothixene	(Navane)	7mg
Haloperidol	(Haldol)	4mg
Molindone	(Moban)	10mg
Loxapine	(Loxitane)	10mg
Clozapine	(Clozaril)	50mg
Prochlorperazine	(Compazine)	10mg
Risperidone	(Resperdal)	4mg

NOTES:

The doses listed are daily doses (usually administered in divided doses) for residents with organic mental syndromes (now called dementia, delirium, and amnestic and other "cognitive disorders" by DSM-IV). The facility is encouraged to initiate therapy with lower doses and when necessary only gradually increase doses. The facility may exceed these doses if it provides evidence to show why it is necessary for the maintenance or improvement in the resident's functional status.

The "specific conditions" for use of antipsychotic drugs are listed under this Guideline G.

The dose of prochlorperazine may be exceeded for short term (seven day) treatment of nausea and vomiting. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can also be treated with higher doses for longer periods of time.

When antipsychotic drugs are used outside these Guidelines, they may be deemed unnecessary drugs as a result of excessive doses.

F. Monitoring for Antipsychotic Drug Side Effects

The facility assures that residents who are undergoing antipsychotic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on the following:

1. Tardive dyskinesia;

2. Postural (orthostatic) hypotension;

3. Cognitive/behavior impairment;

4. Akathisia; and

5. Parkinsonism.

When antipsychotic drugs are used without monitoring for these side effects, they may be unnecessary drugs because of inadequate monitoring.

G. Use of Antipsychotic Drugs

Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following "specific conditions":

1. Schizophrenia;

2. Schizo-affective disorder;

3. Delusional disorder;

4. Psychotic mood disorders (including mania and depression with psychotic features);

5. Acute psychotic episodes;

6. Brief reactive psychosis;

7. Schizophreniform disorder;

8. Atypical psychosis;

9. Tourette's disorder;

10. Huntington's disease;

11. Organic mental syndromes (now called dementia, delirium, and amnestic and other "cognitive disorders" by DSM-IV) with associated psychotic and/or agitated behaviors:

Which have been quantitatively (number of episodes) and objectively (e.g., biting, kicking, scratching) documented. This documentation is necessary to assist in: (a) assessing whether the resident's behavioral symptom is in need of some form of intervention, (b) determining whether the behavioral symptom is transitory or permanent, (c) relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine), (d) ruling out environmental causes such as excessive heat, noise, overcrowding, (e) ruling out medical causes such as pain, constipation, fever, infection;

Which are persistent;

Which are not caused by preventable reasons; and

Which are causing the resident to:

Present a danger to her/himself or to others,

Continuously cry, scream, yell, or pace if these specific behaviors cause an impairment in functional capacity, or

Experience psychotic symptoms (hallucinations, paranoia, delusions) not exhibited as dangerous behaviors or as

crying, screaming, yelling, or pacing but which cause the resident distress or impairment in functional capacity; or

12. Short term (seven days) symptomatic treatment of hiccups, nausea, vomiting or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if one or more of the following is/are the only indication:

1. Wandering,
2. Poor self care,
3. Restlessness,
4. Impaired memory,
5. Anxiety,
6. Depression (without psychotic features),
7. Insomnia,
8. Unsociability,
9. Indifference to surroundings,
10. Fidgeting,
11. Nervousness,
12. Uncooperativeness, or
13. Agitated behaviors which do not represent danger to the resident or others.

H. Antipsychotic Drug Gradual Dose Reduction

Residents must, unless clinically contraindicated, have gradual dose reductions of the antipsychotic drug. The gradual dose reduction should be under close supervision. If the gradual dose reduction is causing an adverse effect on the resident and the gradual dose reduction is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether.

"Behavioral interventions" means modification of the resident's behavior or the resident's environment, including staff approaches to care, to the largest degree possible to accommodate the resident's behavioral symptoms.

"Clinically contraindicated" means that a resident need not undergo a "gradual dose reduction" or "behavioral intervention" if the resident has a "specific condition" (as listed in these Guidelines under G, 1-11) and has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects (e.g., tardive dyskinesia). In residents with organic mental syndromes (now called dementia, delirium, and amnestic and other "cognitive disorders" by DSM-IV), "clinically contraindicated" means that a gradual dose reduction has been attempted twice in one year and that attempt resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction, or a return to previous dose levels, was necessary. The resident's physician provides a justification why the continued use of the drug and the dose of the drug is clinically appropriate. This justification should include: (a) a diagnosis, but not simply a diagnostic label or code, but the description of symptoms, (b) a discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be a result of a dementia with associated psychosis and/or agitated behaviors, and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor), (c) a description of the justification for the choice of a particular treatment, or treatments, and (d) a discussion of why the present dose is necessary to manage the symptoms of the resident. This information need not necessarily be in the physician's progress notes, but must be a part of the resident's clinical record.

I. Antidepressant Drugs

The facility is not required to use behavioral monitoring charts when antidepressant drugs are used. "Behavioral monitoring charts" include such records as quantitative evidence (number of episodes) and objective evidence (e.g., withdrawn behavior such as the resident staying in his/her room, refusal to speak, etc.) of patient behavior necessitating the use of the antidepressant drug. The following is a list of commonly used antidepressant drugs:

EXAMPLES OF ANTIDEPRESSANT DRUGS

Generic	Brand
Amitriptyline	(Elavil)
Amoxapine	(Asendin)
Desipramine	(Norpramin, Pertofrane)
Doxepin	(Sinequan)
Imipramine	(Tofranil)
Maprotiline	(Ludiomil)

Nortriptyline	(Aventyl, Panelor)
Protriptyline	(Vivactil)
Trimipramine	(Surmontil)
Fluoxetine	(Prozac)
Sertaline	(Zoloft)
Trazodone	(Desyrel)
Clomipramine	(Anafranil)
Paroxetine	(Paxil)
Bupropion	(Wellbutrin)
Isocarboxazid	(Marplan)
Phenelzine	(Nardil)
Tranylcypromine	(Parnate)
Venlafaxine	(Effexor)
Nefazadone	(Serzone)
Fluvoxamine	(Luvox)

J. Exceptions to These Guidelines

The facility shall have the opportunity to provide a rationale for the use of drugs prescribed outside these Guidelines. The facility may not justify the use of a drug prescribed outside these Guidelines solely on the basis of "the doctor ordered it." The rationale must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug.

The unnecessary drug criterion of "adequate indications for use" does not simply mean that the physician's order must include a reason for using the drug (although such order writing is encouraged). It means that the resident lacks a valid clinical reason for use of the drug as evidenced by the evaluation of some, but not necessarily all, of the following: resident assessment, plan of care, reports of significant change, progress notes, laboratory reports, professional consults, drug orders, observation and interview of the resident, and other information.

In determining whether an antipsychotic drug is without a "specific condition" or that "gradual dose reduction and behavioral interventions" have not been performed, the facility shall justify why using the drug outside these Guidelines is in the best interest of the resident.

Examples of evidence that would support a justification of why a drug is being used outside these Guidelines but in the best interests of the resident may include, but are not limited to:

1. A physician's note indicating, for example, that the dosage, duration, indication, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate; this note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using drugs outside these Guidelines;

2. A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) that confirms the physician's judgment that use of a drug outside these Guidelines is in the best interest of the resident;

3. Physician, nursing, or other health professional documentation indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;

4. Documentation confirming that previous attempts at dosage reduction have been unsuccessful;

5. Documentation (such as MDS documentation) showing resident's subjective or objective improvement, or maintenance of function while taking the medication;

6. Documentation showing that a resident's decline or deterioration is evaluated by the interdisciplinary team to determine whether a particular drug, or a particular dose, or duration of therapy, may be the cause;

7. Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, monitoring; and

8. Other evidence which may be appropriate.

(Source: Added at 20 Ill. Reg. 12208, effective September 10, 1996)

Section 300.APPENDIX G Facility Report

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Facility Name _____ Phone _____

Address _____ City _____ Zip _____

Facility-wide occurrence? Yes No Resident Name_____

Age _____ M ___ F ___

Were other residents involved? Yes No (Complete this form for each resident unless occurrence is facility wide.)

Type of occurrence:

1. Suspected abuse/neglect
2. Missing person
3. Communicable disease
4. Medication error
5. Unexplained death
6. Loss of essential staff
7. Fire
8. Bldg. emergency
9. Loss of essential utilities
10. Bomb threat
11. Serious injury
12. Sexual assault
13. Other _____

Evacuation:

Yes ____ No ____
# of residents _____
evacuated from _____
_____
Expected return _____
_____

Status of resident:

Witness to occurrence:

Police Notified?		
Doctor Notified?	Yes	No
Resident sent to hospital?	Yes	No
Resident Hospitalized?	Yes	No
Family/Guardian Notified?	Yes	No

Comment:
_____
Comment:
_____
Comment:
_____
Date:
_____ Hospital: _____
Comment:
_____

Complete Description of Occurrence:

Further description attached?

Person completing form: _____ Title: _____	
Form Faxed? Yes No by whom? _____ by whom? _____ date: _____ time: _____	Reported by phone? Yes No date: _____ time: _____

(Source: Added at 26 Ill. Reg. 3113, effective February 15, 2002)

Section 300.TABLE A Sound Transmission Limitations in New Skilled Nursing and Intermediate Care Facilities

	Airborne Sound Transmission Class (STC)[a]		Impact Insulation Class (11C)[b]
	Partitions	Floors	Floors
Residents' Room to Residents' Room	40 to 44	40 to 44	44
Public space to Residents' Room [c]	45 to 49	45 to 49	49 [d]
Service areas to Residents' Room [e]	50 to 54	50 to 54	49 [d]

Notes

[a] Sound transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM Standard E 90 and ASTM Standard E 413.

[b] Impact insulation class (11C) shall be determined in accordance with criteria set forth in HUD FT/TS-24, "A Guide to Airborne, Impact and Structure Borne Noise-Control in Multi-Family Dwellings."

[c] Public space includes Lobbies, Dining Rooms, Recreation Rooms, and similar spaces.

[d] Impact noise limitation applicable only when Corridor, Public Space, Service are, or Play or Recreation Area is over patients' room.

[e] Service areas include Kitchens, Elevator Machine Rooms, Laundries, Garages, Maintenance Rooms, Boiler and Mechanical Equipment Rooms, and similar

spaces of high noise. Mechanical equipment located on the same floor or above Patients; Rooms, Offices, Nurses Stations, and similar occupied spaces shall be effectively isolated from the floor.

(Source: Amended at 12 Ill. Reg. 1052, effective December 24, 1987)

Section 300.TABLE A Sound Transmission Limitations in New Skilled Nursing and Intermediate Care Facilities

	Airborne Sound Transmission Class (STC)[a]		Impact Insulation Class (11C)[b]
	Partitions	Floors	Floors
Residents' Room to Residents' Room	40 to 44	40 to 44	44
Public space to Residents' Room [c]	45 to 49	45 to 49	49 [d]
Service areas to Residents' Room [e]	50 to 54	50 to 54	49 [d]

Notes

[a] Sound transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM Standard E 90 and ASTM Standard E 413.

[b] Impact insulation class (11C) shall be determined in accordance with criteria set forth in HUD FT/TS-24, "A Guide to Airborne, Impact and Structure Borne Noise-Control in Multi-Family Dwellings."

[c] Public space includes Lobbies, Dining Rooms, Recreation Rooms, and similar spaces.

[d] Impact noise limitation applicable only when Corridor, Public Space, Service are, or Play or Recreation Area is over patients' room.

[e] Service areas include Kitchens, Elevator Machine Rooms, Laundries, Garages, Maintenance Rooms, Boiler and Mechanical Equipment Rooms, and similar spaces of high noise. Mechanical equipment located on the same floor or above Patients; Rooms, Offices, Nurses Stations, and similar occupied spaces shall be effectively isolated from the floor.

(Source: Amended at 12 Ill. Reg. 1052, effective December 24, 1987)

Section 300.TABLE B Pressure Relationships and Ventilation Rates of Certain Areas for New Intermediate Care Facilities and Skilled Nursing Facilities

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes Per Hour Supplied To Room	All Air Exhausted Directly Outdoors	Recirculated within Room Units
Resident Rm	0	2	Optional	Optional
Medication Rm.	+	4	Optional	Optional
Clean Utility Rm.	+	4	Optional	Optional
Clean Linen Storage	+	2	Optional	Optional
Examination and Treatment Rm.	0	2	Optional	Optional
Physical Therapy	-	4	Optional	Optional
Occupational Therapy	-	2	Optional	Optional
Dietary Day Storage	0	2	Optional	No
Soiled Utility	-	6	Yes	No
Soiled Linen Holding Rm.	-	6	Yes	No
Soiled Linen & Trash Chute Rm.	-	6	Yes	No
Toilet Rm.	-	6	Yes	No
Shower Rm.	-	6	Yes	No
Bathroom	-	6	Yes	No
Janitors' Closet	-	6	Yes	No
Food Preparation Areas	0	6	Yes	No
Dishwashing	-	6	Yes	No
Laundry, General	0	6	Yes	No
Soiled Linen Sorting & Storage	-	6	Yes	No

\+ = Positive
\- = Negative
0 = Equal

The ventilation rates shown in the above TABLE shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

Section 300.TABLE C Construction Types and Sprinkler Requirements for Existing Skilled Nursing Facilities/Intermediate Care Facilities

Construction Type	Stories			
	1	2	3	Over 3
2-hour Fire Resistive	X	X		X
1-hour Protected Noncombustible	X	X*	X*	
Noncombustible	X*	X*	X*	
Heavy Timber	X*	X*		
1-hour Protected Ordinary	X*	X*		
1-hour Protected Wood Fram	X*	X*		
Ordinary	X*			
Frame	X*			

Key: X = Allowed types of construction
* = Building requires automatic fire extinguishment protection

Section 300.TABLE D Heat Index Table/Apparent Temperature

Air Temperature (degrees Fahrenheit)

(Relative Humidity Percent)	70	75	80	85	90	95	100	105	110	115	120	125	130	135
5	64	69	74	79	84	88	93	97	102	107	111	116	122	128
10	65	70	75	80	85	90	95	100	105	111	116	123	131	
15	65	71	76	81	86	91	97	102	108	115	123	131		
20	66	72	77	82	87	93	99	105	112	120	130	141		
25	66	72	77	83	88	94	101	109	117	127	139			
30	67	73	78	84	90	96	104	113	123	135	148			
35	67	73	79	85	91	98	107	118	130	143				
40	68	74	79	86	93	101	110	123	137	151				
45	68	74	80	87	95	104	115	129	143					

50	69	75	81	88	96	107	120	135	150					
55	69	75	81	89	98	110	126	142						
60	70	76	82	90	100	114	132	149						
65	70	76	83	91	102	119	138							
70	70	77	85	93	106	124	144							
75	70	77	86	95	109	130								
80	71	78	86	97	113	136								
85	71	78	87	99	117									
90	71	79	88	102	122									
95	71	79	89	105										

(Table is from the National Oceanic and Atmospheric Administration)

(Source: Amended at 22 Ill. Reg. 7218, effective April 15, 1998)