

Chapter 6

Medical and Nursing Care

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Introduction

Almost 50% of all individuals over the age of 65 will spend some time in a long term care facility in their lifetime. Nursing homes serve the dual function of providing care as well as shelter. The primary reason for admission into a facility is the need for care that the person is unable to obtain in an alternative setting. The care that is provided can be both low tech as well as more sophisticated at levels that can only be provided by licensed professionals. Long term care encompasses help with activities of daily living (ADLS) such as bathing, dressing, eating, and toileting. Services also include instrumental activities of daily living (IADLs) such as: shopping, managing medication, meal preparation, household chores, money management, and transportation. The clients that are in nursing homes today generally need help in three or more activities of daily living and have multiple medical diagnoses. Nursing care encompasses more high tech procedures and treatments including medication management, complex treatments, and complex equipment needs such as a ventilator or dialysis care. The services in long term care are designed to rehabilitate or compensate for loss of physical and/or mental functioning. Nursing homes are widely considered to be the most restrictive long term care environment and clients are universally reluctant to have a nursing home as their primary residence.

Most care of the elderly is done in the community with nursing homes being reserved as a final alternative. As treatments for diseases improve, people are living longer, however they are also accumulating more comorbidities requiring more medical attention. Today's advancements in technology have made it possible for all long term care to be provided in the home environment. The limiting factor is the resources that it takes to continue exercising this option. The necessary resources include both financial means and almost constant staffing. The primary caregivers in our society are families, but families also have limited abilities to manage the care of an elderly or disabled person as well as their own family obligations and jobs. When the care escalates, the cost and manpower needs run a parallel course as well. For example, the cost of having private duty, skilled (registered nurse) care runs \$50 per hour for 24 hours for 365 days per year. This is a cost of over \$350,000 per year, which few clients can afford. When the needs of the individual, both skilled and unskilled, exceed the resources in alternative settings, the nursing home becomes the most prudent choice and the role of the nursing home will always be an integral part of meeting the needs of the aging population.

Who's Who in the Nursing Home Setting?

Residents of long term care facilities are there because of a need for care. To evaluate whether or not the needs are being met in an appropriate and timely manner one must understand the development of the plan of care, how the care is executed, and who is responsible for each aspect. There are a variety of staff members in a nursing home and it is important to determine the titles and roles of each staffing category. The nomenclature for different roles is confusing with multiple titles being applied for each role. Nursing homes also utilize terms and titles that appear deliberately confusing to the consumer so that one believes he or she is receiving professional service when it is actually provided by a paraprofessional. For example, the Director of Social Services may not be an actual licensed social worker. When they introduce themselves to the client and their families they identify themselves as "from social services." This is consistent across the board in many departments such as pharmacy,

dietary, physical therapy etc. The main service that is provided in a nursing home centers on “nursing care. Nursing homes are required to have a nurse on duty 24 hours a day and this is the factor that differentiates them from assisted living, supportive care, retirement villages and the like. However, not everyone in the nursing home is a nurse and the role of each player must be identified. Furthermore, the term “nurse” is very overused and misused with a plethora of educational backgrounds, certifications, and licensure requirements that confuse the clients and those who advocate for them.

Nursing Defined

The idea that "a nurse is a nurse" is not accurate. Nursing has a variety of educational preparations that allow them to be licensed as a “nurse” and there are different levels of licensure. It is important to be aware of these differences when evaluating quality of care. A nurse needs to obtain licensure in the state in which they practice, which is the same for physicians, dietitians, pharmacists, etc. To become licensed an individual must take a licensure exam (nursing boards) and follow the rules and regulations delineated in their state’s nursing practice act. There is reciprocity in many states but a nurse must register in each state, pay licensure fees, and meet continuing education requirements that are state specific. States that are highly populated may include requirements for reciprocity that are more difficult to obtain (extra educational requirements) to discourage migration to their state (California and Florida are examples). There is no reciprocity for other countries and individuals who have obtained degrees in other countries must still pass the licensure exam. They frequently work in lower level positions such as nursing assistant until such time as they can pass the exam. Many never pass the exam and continue on as direct caregivers. For the purposes of this writing the rules of Illinois are utilized to describe nursing practice (10).

Classifications of Nurses

“There are three types of nurses specifically educated and trained to provide nursing care in Illinois. They are classified as follows:

Licensed Practical Nurse (LPN)

An LPN is a person who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical nursing and whose qualifications have been examined by a state board of nursing. An LPN must be legally authorized to practice as a licensed practical nurse and must have the basic nursing knowledge, judgment, and skill acquired by means of completion of an approved practical nursing education program. Practical nursing includes assisting in the nursing process as delegated by and under the direction of a registered professional nurse. The practical nurse may work under the direction of a licensed physician, dentist, podiatrist, or other health care professional.

Registered Nurse (RN)

A RN is specifically prepared and promotes health and the prevention of disease, and helps patients cope with illness. When providing direct patient care they observe, assess and record symptoms, reactions and progress, assist physicians during surgery, treatments, and examinations, administer medications and help in the convalescence and rehabilitation of patients.

Advanced Practice Nurse (APN) is licensed as a registered professional nurse and meets the requirements for licensure as an advanced practice nurse. An APN cares for patients by using advanced diagnostic skills, by interpreting the results of diagnostic tests and procedures ordered by the advanced practice nurse, a physician assistant, a dentist, a podiatrist, or a physician, and professional judgment to initiate and coordinate the care of patient. An APN can also order diagnostic tests, prescribe medications and drugs, and administer medications and drugs. Categories include certified nurse midwife (CNM), certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), certified clinical nurse specialist (CNS), nurse practitioner (NP), and clinical nurse specialist (CNS). “

Educational preparation

LPNS (also called LVNs) are the first level of nurse and have usually attended a junior college for approximately one year. The training is technical in nature and does not include educational courses aimed at theoretical comprehension of diseases, medications, or treatments. They are very limited in their role and need advanced certifications to distribute medications. They have limited job availability and are found primarily in doctors' offices, home care and long term care facilities.

RNs have to undertake a variety of education paths to have the ability to sit for the same licensure exam.

- **ADN (associate degree in nursing)** is a two year educational program that is in a community college setting. The focus is technical in nature with limited theory. Most hospitals require further education for management positions but they may hold management positions in home care and nursing homes dependent on specific facility requirements.
- **Diploma Nurses** are mostly nonexistent at this point but there are still many nurses that have this educational base. They were hospital based programs that were intensive in nature without summer breaks. They did not offer a college degree and have closed due to lack of attendance based on the lack of the degree even though the time and costs were similar to a college program.
- **BSN (bachelor's degree in the science of nursing)** are actual four year college degree programs. They are science based programs that have an emphasis on pharmacology, nursing theory, pathophysiology as well as clinical nursing. Many employers require this level of preparation to enter into management positions. The graduates take their licensure exam after the completion of their degree.
- **Advance Degree Nurses** can hold masters degrees in nursing (**MSN**) or programs with a master's degree with a major in nursing. These programs are precursors to the advanced practice nurse programs available today. Many nurses also hold masters degrees in other disciplines such as education or business. There are also **PhD (DSN)** programs with the majority of graduates working in colleges and universities.
- **APNs** generally require a master's degree in a clinically focused program such as midwifery, gerontology, oncology etc. They are granted prescriptive and diagnostic powers in specific, limited situations. Many gerontologists employ **Nurse Practitioners** to provide rounds and care to clients in long term care facilities.

- **Physician Assistants (PA)** are not nurses but have similar prescriptive and diagnostic powers as the APNs. The educational component was developed by medicine and was designed to assist physicians in their practices using the medical model versus the nursing model. There is no role in a nursing home staff for this level but they may be part of a geriatric program.
- There are a plethora of **Certifications** available for nurses such as diabetic educator, professional geriatric care manager, surgical nurse etc. They are not degree based and generally require completion of an educational course and/or an exam for the certificate and require periodic renewal. They do not take the place of advanced education but are helpful in job specific roles.

It is readily apparent that nurse classifications are confusing. It is essential to know the basics when looking at the quality of care. Nurses are generally paid 17% less in nursing homes than other settings. This can adversely affect the quality of care provided in the nursing home setting with nurses with college degrees and advanced preparation gravitating toward jobs in alternative settings such as hospitals and universities (6).

Long Term Care Staffing

Director of Nursing, sometimes called a **Resident Services Director**, is a full time **registered nurse** who is immediately responsible for supervision of all nursing services. In facilities of less than 50 beds, some of the nurse's time may be included in staffing ratios. The Director of Nursing assures that residents' plans of care are individualized, written in terms of short and long-range goals, understandable and utilized; their needs are met through appropriate staff interventions and community resources; and residents are involved, whenever possible, in the preparation of their plan of care.

Charge Nurse is the nurse responsible for the care of the clients during a specific time period or shift. This can be an RN or LPN. In smaller facilities the DON may have the dual function of being the director and the charge nurse on a particular shift.

Assistant Director of Nursing is required in facilities of 100 beds or more and has the same requirements of the DON.

Resident Care Assistants are also termed care aides, personal attendants, aides, rehabilitation aides, orderlies and various other titles. They must be at least 16 years of age, have attended eight years of school or an equivalent, must speak reasonable English, and must attend some training on personal care within 120 days of hire if they do not already have such training. The training can be in other venues or facilities such as junior colleges or other facilities. They perform their duties under the guidance of a registered nurse. The aides provide the majority of hands on, low tech care of individuals. Their care centers on activities of daily living (ADLS), specifically dressing, feeding, toileting, and ambulation. They are not allowed to administer medications, perform treatments, or other procedures that are outlined in the nursing practice act. The education and training requirements for this group are minimal with only a graduation from eighth grade and minimal English skills. They are required to document the direct care of residents but their written skills are extremely limited. The facilities tend to develop checklists and forms that require minimal written skills to complete. The turnover rate in this employee population is very high and there is little continuity among this level of worker. This results in inconsistencies in the

delivery of care to the individual. If a personal injury does occur one can expect that the aide staff is the most difficult to reach due to their transient nature.

Nursing Home Administrator is required in all nursing home facilities and must be full time and licensed. The administrator is responsible to see that all regulations are met and that all staff is aware of such regulations. They are directly responsible for the operation and administration of the facility. The requirements to take the test are a bachelor's degree in any field, an associate degree plus two years of experience, or years of experience as an assistant administrator or DON. The nursing home administrator needs to pass a licensure exam and have continuing education requirements to maintain their licensure. Any change in the nursing home administration requires notification to the department of health within five days of the event.

Director of Social Services does not have to be a licensed social worker, but a licensed social worker has to be available in a consultative arrangement and needs to respond to questions on short notice. Nursing homes traditionally hire social service representatives to address the residents' needs and they are not necessarily social workers.

Dietitian or registered dietitian is licensed by the state. Nursing homes hire this service with a consultative arrangement. The dietary staff addresses the day to day needs of the clients, calling in a dietitian when problems arise. If a client loses over 5% of their body weight over a 30 day period a dietitian is called to review the nutritional needs of the client in depth.

Medical Director or Medical Advisor: The facility is required to have a medical director or advisor or a medical advisory board who shall be responsible for advising the administrator on the overall medical management of the residents and the staff of the facility. If the facility employs a house physician, he or she, may be the advisory physician. The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: cardiac emergencies, traumatic injuries, toxicology emergencies, convulsions etc. If there is any question from the staff in regards to the medical plan provided by another physician the medical director is consulted.

State of Illinois Administrative Code ([17](#))

Resident's Physician is the **primary physician** that is chosen by the client or their alternative decision maker (POA or guardian or surrogate decision maker) to manage their medical care. Physicians are not generally willing to follow clients in facilities in which they are not on staff. It is a geographic impossibility to follow clients in multiple facilities and physicians will tell their clients which facilities they cover. If the client goes to another facility then a new physician needs to be engaged. The facilities frequently assign the **medical director** or a physician "on staff" or "attending" to care for the client but they cannot require that the client utilize that physician. There are some physicians that practice exclusively in the nursing home setting, forgoing the need for private medical offices and related expenses. They are able to see multiple clients on their "rounds" which makes it cost effective and efficient for the physician and the staff. If a private physician chooses to follow a client in a facility in

which he or she is not “on staff”, then he or she must comply with the facility’s requests for documentation of licensure etc.

The Nursing Home Care Act states (210 ILCS 45/2-104) (from Ch. 111 1/2, par. 4152-104A):
“resident shall be permitted to retain the services of his own personal physician at his own expense or under an individual or group plan of health insurance, or under any public or private assistance program providing such coverage. However, the facility is not liable for the negligence of any such personal physician. Every resident shall be permitted to obtain from his own physician or the physician attached to the facility complete and current information concerning his medical diagnosis, treatment and prognosis in terms and language the resident can reasonably be expected to understand.”

Consulting Physicians are physicians that consult with the primary care physician or resident physician in their areas of specialization. The most common consulting physicians include psychiatrists, cardiologists, oncologists, and GI specialists. These doctors come to the facility periodically and as needed (PRN), but do not assume the primary responsibility for providing care to the client. The client always has the ability to leave the facility and go to their specialist’s office. This is more common in the assisted living facilities where the client is willing and able to do outside visits as long as transportation is provided.

Admission to Discharge

The process of being admitted into a nursing home follows some general patterns. Individuals cannot be admitted to nursing homes without having identified needs. The Illinois Department of Aging requires all persons under consideration for admission to a nursing home undergo a prescreening called a determination of need (**DON**). The Community Care Program was created in 1979 and they are responsible for this screening. The screening can be done in the hospital, home, or the actual nursing home if done in a timely manner. The following are components of the screening and are beginning components of the nursing care plan.

- The Mini-Mental State Examination (MMSE) assesses an individual's level of cognitive impairment.
- The Determination of Need (DON) assesses an individual's functional ability to perform basic and instrumental activities of daily living, identifies unmet needs, and serves as the mechanism to develop a plan of care.
- The Documentation for DON (Doc for DON) summarizes an individual’s impairments, formal supports, service arrangements, and provides instructions to the provider ([18](#)).

Preadmission screening also includes screening for **criminal background**. The facility checks the potential client on the Illinois department sex offenders’ web site prior to accepting the client ([9](#)). Since 2006, the facilities are required to notify the Illinois Department of Human Services of clients that are

admitted who were convicted of a felony. If a client is admitted he or she also has to register with the local law enforcement departments as does any other resident in a community. This is new since 2006 and makes placement for convicted felons and sex offenders extremely difficult, if not impossible. Felonies that date back 30 years can cause placement issues for a client who may be in great need of care (14).

It is important to note that many facilities are now requesting criminal background checks on visitors, families, and service providers that clients hire directly as companions. This is clearly difficult to enforce but it may become a part of a routine practice or even part of the administrative code in the future. During the prescreening process there is a category that can be rejected or involuntarily discharged. Those who are a **danger to themselves or others or to property** cannot be admitted. Clients who have had recent suicide attempts are difficult placements. Clients who attempt suicide in a facility are rarely readmitted to the same facility after their acute hospital stay for such an event. Nursing homes also need to have identified and approved programs with clients with special diagnoses: alcoholism, Alzheimer's, mental illness, and developmental delays.

Admission

The client is **admitted** to the facility after the prescreening process. Every resident is under the care of a physician and has the right to choose the physician. They must have a physical exam by a physician within five days before being admitted or within 72 hours after the actual admission. The exam should be a review of systems but must also include a Tuberculosis screening (TB), a statement regarding presence or absence of decubitus ulcers (bed sores), admitting weight and frequency of weighing client post admission. Physicians are to be notified of changes in condition, accidents, decubitus ulcers, or a weight loss of over 5% of their body weight over a thirty day period. The medical plan of care must be documented and updated when any significant changes have occurred or at minimum annually (12).

The client and/or his or her substitute decision maker will be provided a multitude of papers, including a contract, which facilities require as part of the admission process. The client has to be competent to "sign themselves in" or an alternate decision maker must complete the transaction. This person can be a guardian, power of attorney, or a family member utilizing the surrogate decision maker act. There must be a decision maker or the client cannot be admitted except under special circumstances for the mentally ill or developmentally disabled. An emergency guardianship hearing is the solution if the client has "no one" and a temporary guardian can be appointed for the purpose of placement. The courts consider need for discharge and placement emergencies. (3)

The Nursing Home Care Act (210 ILCS 45/2-202) (from Ch. 111 1/2, par. 4152-202) states (2):

"If there is no guardian, agent or member of the person's immediate family available, able or willing to execute the contract required by this Section and a physician determines that a person is so disabled as to be unable to consent to placement in a facility, or if a person has already been found to be a 'disabled person', but no order has been entered allowing residential placement of the person, that person may be admitted to a facility before the execution of a

contract required by this Section; provided that a petition for guardianship or for modification of guardianship is filed within 15 days of the person's admission to a facility, and provided further that such a contract is executed within 10 days of the disposition of the petition.”

The nursing care process begins at this point. The care is outlined in the administrative code as:

“The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.” [\(13\)](#)

Ongoing Care

Medical Treatment Plan and Medical Orders

Each client that is in a facility is under the medical treatment plan of a physician. In reality, clients may have multiple physicians writing multiple orders that at times may be conflicting in nature. The nurse should evaluate idiosyncrasies and report them to the primary (resident’s doctor) for final determination. All facilities have consulting pharmacists and periodic drug reviews for evaluating drug interactions (i.e.: ordering a diuretic (water pill) when a client has chronic diarrhea). All facilities are required to have a medical director and/or a medical advisory board. If a nurse cannot get adequate response by the attending (primary) physician, the matter needs to be brought to the attention of the medical advisor. Nurses are to report changes in client status to the attending physician such as injury, accident, significant weight loss or a decline in condition. The physician determines if the medical treatment plan needs to be altered. A long term care facility does not have the staff or equipment to handle acute emergencies. In emergency situations the nurse may activate the Emergency response system (EMS) and notify the physician after the event.

Nursing and Personal Care

Nurses are responsible for overseeing all care provided to the client including medical, mental, and personal care (ADLS). Ultimately, the DON is accountable for all the plans of care for the residents in a facility. The DON is also responsible for assessing the level of competence of the staff to perform the duties assigned. Educational programs and in-services are scheduled to educate staff and assure clinical competencies. The DON is also required to create policies and procedures for the nursing care provided at the facility. The Nurse Practice Act guides what nurses can and cannot do in their practice of care. The DON also guides the care provided by the aides. The aides **cannot** provide care that is prohibited by the Nurse Practice Act or any other professional act that encompasses the care that a client could require. This includes procedures such as medication administration, wound care, respiratory therapy procedures and the like. **Licensed Practical Nurses** must have special certifications to provide intravenous therapy, such as dialysis. Medical orders that violate the practice act can be refused and the physician informed. For example, asking the nurse to stitch up a wound which is a procedure not included in the act should be refused. Policies and Procedure are essential to prevent treatments that

may be unsafe in the long term care setting and are essential for protecting the client as well as the staff, for example, giving intravenous dopamine (blood pressure medicine) without cardiac monitoring.

The resident's **care plan** is created from the **Minimum Data Set (MDS)** which incorporates the information gained from the determination of need assessment, the medical plan, rehabilitation needs, and activities of daily living needs. The MDS is submitted electronically to the state database, which is then stored in a national MDS database at the Centers for Medicare and Medicaid Services (CMS). A new MDS and a review of the care plan should be performed if there are significant changes in the resident's status. The care plan is reviewed quarterly by a multidisciplinary team and the family (and/or substitute decision maker) who must be informed and invited to attend. Families can request a care plan review at any time if they feel the needs are not being clearly identified or met. If the client is his or her own decision maker then he or she must be invited. Each resident needs to be **comprehensively assessed within 14 days of admission** or readmission after a hospital stay.

End of Life Issues

All clients have the right to refuse treatments. End of Life issues have been increasingly complex as medical care has improved rendering it possible to sustain life against sometimes undeniable odds and often times counterproductive to quality of life. The health care community frequently terms this dilemma as "quantity versus quality." The National Care Planning Council states it well and succinctly:

"In the first half of the 20th century, most people who died had an accident or contracted a disease or they had a physical disorder that inevitably leads to death. Life-saving medical interventions such as sophisticated resuscitation, complicated surgeries, life-saving treatments, ventilators, feeding tubes and other life-support were rarely used or even available. Nowadays there is great emphasis on curing medical problems sometimes to the exclusion of recognizing that death might be a more welcome outcome.

Surveys indicate that older people are often more afraid of death than younger people. But for all Americans -- young and old -- there is a great fear of death and oftentimes the families of those loved ones, who are near the end-of-life, will go to great lengths to try interventions that may be ineffective in prolonging life. We need only look to the Terri Schiavo case as a reflection of the attitude of many Americans who are unwilling to let loved ones pass on. Estimates are that about 30% of Medicare reimbursements are spent on people in the last year of their life. It is a fact that much of this medical care did little to prevent death and prolong life. [\(21\)](#)

End of life decisions are delicate and complicated as we are dealing with human behavior, familial history and the proverbial "emotional baggage" that we, as individuals and as members of families learn over the course of our lifetimes. Quality of life is a subjective measure that differs to a great extent across individuals, families and cultures. Decisions that to one may seem necessary; to others appear futile and even tortuous given the window through which we view them.

It is important to recognize that end of life care has less to do with medical interventions and treatment than it does with treatment of the human spirit. The resolution of "unfinished business" (i.e.: wrapping up estate matters, saying goodbyes, resolving past conflicts) plays an important part in resolving some of this fear. The uncertainty of having not made a difference, not feeling loved, not being remembered

contributes to the fear of dying. When time and opportunity exist, life review, reminiscence, open and frank discussions can be important in working through these fears towards reaching an acceptance of one's life and at times, an acceptance of one's eventual death.

Deciding how and when care ends should or should not be provided. This "non-decision", exposes the individual to unnecessary and futile treatment efforts as the health care community scrambles to find the "right" answers for the person.

Advanced Directives have become a term to encompass the tools utilized to facilitate end of life decisions **prior to** an event. These include the **Living Will, orders not to intervene such as DNR (do not resuscitate), and health care powers of attorney**. There are other tools that have been utilized by individuals that further clarify their wishes such as the "five wishes." (7)

The American Bar association publishes a tool kit for planning your wishes. (5)

Each facility reviews residents' choices upon admission in regards to end of life decisions. They require copies of Living Wills, DNRs, and powers of attorney. The Living Will and the orders not to intervene outline what the client wants in certain medical situations. Do not intervene orders can be expanded and be made are more specific than simple DNRs and include such things as Do Not Leave the Home, Do Not Start Dialysis, etc. The Illinois Department of Public Health has created a specific DNR form that is a physician's order and therefore must have a doctor's signature. It cannot become part of a record unless the client or the surrogate decision maker is made aware. It must be witnessed by two adults. They have developed a standard form that is available on their web site. (23)

The health care power of attorney is necessary because it is impossible to prepare for all conceivable scenarios. The agent named under the power of attorney has an ability to evaluate the current situation and make treatment determinations based on available options and knowledge of the principle's desires. It is essential that these documents are shared with the facility for in the absence of such documents treatments are initiated that may not be wanted by the client.

Discharge

Clients may be in facilities for extended periods of time or for short stays aimed at rehabilitation. Clients may go home to their community settings when they have reached their maximum rehabilitation potential. Facilities can also initiate a discharge for the following reasons: medical necessity (such as admission to a hospital), for the residents own safety (suicide attempts), for the safety of others (danger to others), or for nonpayment of funds. The nursing home has the right to refuse re-admittance of those individuals that are dangerous to themselves or others. It is also the nursing home's responsibility to evaluate the medical and nursing care required and to determine if they are able to provide the needed care. Clients can and are discharged for nonpayment. The client has the right to appeal such a decision but ultimately they do have to pay their bill or allow the assignment of government entitlements (Public Aid and Social Security).

Summary

Long term care facilities provide much needed care and shelter to elderly and disabled clients. There is a plethora of rules and regulations that guide the care provided in these facilities. The majority of service provided is guided by nursing and includes personal care as well as complex procedures, both skilled and unskilled. The nomenclature of nursing is confusing with multiple levels of educational preparation but only limited levels of licensure. The consumer is well served to better comprehend the qualifications of the staff providing care. Understanding the different levels of service, education, and care that can be provided will help the consumer choose the appropriate facility and advocate for the best care possible. Since the majority of the service is under the umbrella of “nursing care” the consumer must understand that the common belief that “a nurse is a nurse” is inaccurate.

Works Cited

1. "(210 ILCS 45/) Nursing Home Care Act Context" Illinois General Assembly Home Page.
<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1225&ChapAct=210%20ILCS%20A04>

[5/&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Nursing+Home+Care+Act](#)
(accessed February 8, 2008).

2. "(210, ILCS, 45/) Nursing Home Care Act..." Illinois General Assembly Home Page.
<http://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=021000450HArt%2E+II&ActID=1225&ChapAct=210%2C%A0ILCS%2C%A045%2F&ChapterID=21&ChapterName=HEALTH+FACILITIES&SectionID=19709&SeqStart=5190&SeqEnd=9990&ActName=Nursing+Home+Care+Act%2E>
(accessed February 8, 2008).
3. "(755 ILCS 40/) Health Care Surrogate Act." Illinois General Assembly Home Page.
<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111&ChapAct=755%26nbsp%3BILCS%26nbsp%3B40%2F&ChapterID=60&ChapterName=ESTATES&ActName=Health+Care+Surrogate+Act>
(accessed February 8, 2008).
4. "All Nursing Schools - A Complete Directory of U.S. Nursing Programs and Your #1 Resource for Nursing Programs Admissions Info." Your Guide to Nursing Education and Careers.
<http://www.allnursingschools.com/> (accessed February 8, 2008).
5. "Consumer's Tool Kit for Health Care Advance Planning - Commission on Law and Aging." American Bar Association - Defending Liberty, Pursuing Justice.
<http://www.abanet.org/aging/toolkit/> (accessed February 8, 2008).
6. Errold, Moody F. "Nursing Home Statistics." 2007. Feb. 2008
<http://www.efmoody.com/longterm/nursingstatistics.html> (accessed February 6, 2008).
7. "Five Wishes." Aging With Dignity. <http://www.agingwithdignity.org/5wishes.html> (accessed February 8, 2008).
8. "Medicare.gov - Nursing Home Overview." Medicare.gov - The Official U.S. Government Site for People with Medicare. <http://www.medicare.gov/Nursing/Overview.asp> (accessed February 8, 2008).
9. "Parolee Sex Offender Search." State of Illinois | Department of Corrections.
http://www.idoc.state.il.us/subsections/so_search/default.asp (accessed February 8, 2008).
10. "Nursing In Illinois." State of Illinois, Illinois Center for Nursing.
<http://nursing.illinois.gov/nursinginillinois.htm> (accessed February 8, 2008).
11. Rehnquist, Janet. "Psychotropic Drug Use in Nursing Homes." Department of Health and Human Services Office of Inspector General. <http://oig.hhs.gov/oei/reports/oei-02-00-00490.pdf>
(accessed February 8, 2008).
12. "Section 300.1010 Medical Care Policies." Illinois General Assembly Home Page.
<http://www.ilga.gov/commission/jcar/admincode/077/077003000E10100R.html> (accessed February 8, 2008).

13. "Section 300.1210 General Requirements for Nursing and Personal Care." Illinois General Assembly Home Page.
<http://www.ilga.gov/commission/jcar/admincode/077/077003000F12100R.html> (accessed February 8, 2008).
14. "Section 300.624 Criminal History Background Checks for Persons Who Were Residents on May 10, 2006." Illinois General Assembly Home Page.
<http://www.ilga.gov/commission/jcar/admincode/077/077003000C06240R.html> (accessed February 8, 2008).
15. Stone, Robyn. "Long-Term Care for the Elderly with Disabilities." Milbank Memorial Fund (index). <http://www.milbank.org/0008stone/> (accessed February 8, 2008).
16. "The Admissions Process - What to Expect." IHCA Indiana Health Care Association.
<http://www.ihca.org/admissions.aspx> (accessed February 8, 2008).
17. "PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE: Sections Listing." Illinois General Assembly Home Page.
<http://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html> (accessed Feb. 8, 2008).
18. "Older Adult Services Overview." Illinois Department of Aging.
www.state.il.us/aging/1athome/oasa/resources/oasa_presentation.pdf (accessed February 8, 2008).

Advanced directives

19. "Coping with the 5 stages of grief and bereavement." York Hotels - Travel Guide to York England UK. <http://www.york-united-kingdom.co.uk/funerals/grief/> (accessed February 8, 2008).
20. "Grief and Loss, Funeral Arrangements, End of Life - AARP." AARP: Baby Boomers Elections, Health, Travel, Financial Planning, Family, Games, Volunteer, Retirement & Discounts, Seniors.
http://www.aarp.org/families/grief_loss/ (accessed February 8, 2008).
21. "Medical Care at the End-of-Life." Long Term Care Link - A Comprehensive Resource for Long Term Care. <http://www.longtermcarelink.net/article-2007-7-10.htm> (accessed February 8, 2008).
22. "Normal Reactions to Loss." AARP: Baby Boomers Elections, Health, Travel, Financial Planning, Family, Games, Volunteer, Retirement & Discounts, Seniors.
http://www.aarp.org/families/grief_loss/a2004-11-15-reactions.html (accessed February 8, 2008).
23. "STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES." Illinois Department of Public Health Home Page. <http://www.idph.state.il.us/public/books/advdir4.htm> (accessed February 8, 2008).

Professional Societies

24. "AGS Missions and Goals Statement." The American Geriatrics Society - Home Page.
http://www.americangeriatrics.org/education/cpe_mission.shtml (accessed February 8, 2008).
25. "NGA Guardianship for the Elderly." National Guardianship Association, Inc...
<http://www.guardianship.org/> (accessed February 8, 2008).
26. "Trained and Experienced Help in Geriatric Care." National Association of Professional Geriatric Care Managers, Inc... <http://www.caremanager.org/> (accessed February 8, 2008).