



Long Term Care Regulation Interpretation Manual



**Kansas Department of Health and Environment
Bureau of Health Facilities
1000 SW Jackson, Suite 330
Topeka, Kansas 66612-1365 (785) 296-1240**

Long Term Care REGULATION INTERPRETATIONS

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LONG TERM CARE
REGULATION INTERPRETATION
BUREAU OF HEALTH FACILITIES

SUBJECT: Interpretation Guidelines

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-1

INTERPRETATION: All regulation interpretations issued before November 1, 1993 are null and void. This includes 88-1 through 88-69; 89-1 through 89-14; 90-1 through 90-6; 91-1 and 91-2; and 92-1 through 92-5.

DISCUSSION: The Regulation Interpretation Manual was updated to reflect new Adult Care Home regulations effective October, 2001.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
REGULATION INTERPRETATION
BUREAU OF HEALTH FACILITIES

K.A.R. 28-39-145a (d) (2)

SUBJECT: Fast Track Construction

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-2

INTERPRETATION: The owner shall be allowed to commence construction for the phase of construction for which final plans and specifications have been submitted. A registered architect must submit certification that the plans and specifications are in compliance with applicable regulation as those regulations relate to the phase of construction being commenced.

DISCUSSION: This interpretation assures that K.A.R. 28-39-145 (b) (1) (C) allows for the construction management practice of constructing projects in definite identifiable phases and the practice of commencing construction prior to completion of final plans.

This application meets regulatory intent of assuring that completed facilities meet all regulations and does not relieve the owner of complying with all requirements.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-145a (h) and (i)

SUBJECT: Resident Room Usage in Nursing Facilities

DATE: November 1, 1993

REVISED: March 14, 1997, **February 15, 2002**

NUMBER: 93-3

INTERPRETATION: Resident rooms in nursing facilities can be utilized as private or multi-bed within the licensed capacity of the facility at the discretion of the facility. Resident rooms shall be in compliance with K.A.R. 28-39-162a (b) (1) (B).

DISCUSSION: The issue of using rooms as either private or multi-bed is one of compliance with applicable regulation. As long as standards contained in the regulations noted above are complied with, a resident room can be utilized as deemed appropriate by the facility to satisfy resident requests or facility need.

K.A.R. 28-39-145a (h) speaks to resident capacity of the entire facility, not individual rooms. Rooms designed for more than one resident does not preclude it's use as a single bedroom and such use does not alter the capacity of the facility.

This shall not be interpreted to allow a facility to be out of compliance with requirements for a minimum number of private rooms with a private toilet required by K.A.R. 28-39-162a (b).

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-145a (h)
K.A.R. 28-39-254
K.A.R. 28-39-289
K.A.R. 28-39-437

SUBJECT: Change in Resident Capacity

DATE: May 17, 1999

REVISED: February 15, 2002

NUMBER: 99-1

INTERPRETATION: Adult care homes may choose to decrease the resident capacity in the facility after initial licensure. If the facility chooses to increase the licensed capacity at a later time, they may do so without meeting new construction standards as long as the resident bedrooms, individual living units and apartments meet construction standards in effect at the time of the initial license.

DISCUSSION: The construction requirements found in K.A.R. 28-39-162a for nursing facilities clearly state that the requirements for resident bedrooms are based on the date facility was constructed. Therefore when a facility decides to increase the resident capacity, they must ensure that resident bedrooms meet the requirements which were in effect at the time the building or section of the building was licensed. Other adult care homes must ensure that resident bedrooms, individual living units and apartments meet the requirements in effect at the time the building was licensed.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-147 (e) (5)

SUBJECT: Choice of Pharmacy

DATE: November 1, 1993

REVISED: February 15, 2002, **January 11, 2003**

NUMBER: 93-4

INTERPRETATION: When a facility utilizes a unit dose or similar medication distribution system, the facility may require the resident to choose a pharmacy that uses the same or similar system.

DISCUSSION: Attorney General's Opinion 79-177 sets forth that K.S.A. 39-936 does not prohibit a requirement by an adult care home that its residents use the unit dose system in providing for medication needs. Facilities may choose to require all residents to use pharmacies that provide medications in unit dose packaging. Facilities who use unit dose systems may choose to allow residents to use pharmacies that do not supply medications in unit dose packaging such as the Veterans' Administration. The fundamental issue is that medications are administered accurately and safely.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-147 (e) (3)
K.A.R. 28-39-147 (h)
42 C.F.R. 483.75 (l)

SUBJECT: Clinical Photographs

DATE: November 1, 1993

NUMBER: 93-5

INTERPRETATION: The taking of photographs of a resident to supplement the written medical record is acceptable professional practice when the following criteria are met:

1. The facility has developed written policies and procedures for the taking of photographs.
2. Photographs shall not replace written records but supplement them.
3. The photographs shall be considered part of the resident's clinical record.
4. Each photograph shall be identified with the resident's name, the date the photograph was taken and signed by the person taking the photograph.
5. Appropriate draping of the resident shall be used to protect the resident's privacy and dignity.
6. Written consent by the resident for taking of the photograph is not required, however, a resident has the right to refuse the taking of a photograph.

DISCUSSION: The taking of a photograph to record resident information for medical record purposes is not substantively different from making a direct observation and making detailed notes of that observation in a clinical record. Both procedures require that certain areas of the body be exposed to staff and the consent issue is the same in both procedures. Photographs taken to document support or assistance in treating a resident's condition is appropriate. Photographs of pressure ulcers, bruises, cuts and abrasions provide pertinent information related to the resident's condition at the time of the admission or after a specific event. Periodic photographs have been used as a method for evaluating the effectiveness of care provided.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-147 (h) (1) (2)
42 C.F.R. 483.75 (l) (4) (ii)

SUBJECT: Photocopying of Resident Clinical Records by Survey Staff

DATE: November 1, 1993

NUMBER: 93-6

INTERPRETATION: Photocopying items from a resident's clinical record may be necessary in selected instances. When photocopying residents' records, the confidentiality of the records shall be maintained and the facility shall be informed in writing of the photocopied records taken from the facility.

1. Facility administrator or designated employee shall be notified that the surveyor has need to photocopy selected items from a resident's clinical record. The facility may provide the photocopies or authorize the surveyor to make photocopies.
2. The surveyor shall offer to pay for the photocopying.
3. The surveyor shall provide the administrator with a written list of the items photocopied, signed and dated by the surveyor.
4. The number of items photocopied shall be kept to a minimum. If the surveyor believes there is a need to copy more than ten pages of material, permission must be obtained from their supervisor.
5. Photocopies of clinical records shall be handled in manner which assures confidentiality. Copies shall be placed in an envelope identified with the name of the facility. The surveyor shall assure that the envelopes containing the photocopies are maintained in a manner which prevents access by unauthorized persons.

DISCUSSION: During the course of a survey or investigation conducted in a nursing facility or intermediate care facility for the mentally retarded, a surveyor may need to photocopy selected items from the clinical record of a resident. Photocopies should be obtained only when the information from the clinical record is essential for an investigation or compliance decision and surveyor notes referring to the record would not be sufficient.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-147(b)(2)

SUBJECT: Notifying residents and legal representatives of change in level of care charges

DATE: July 9, 1998

NUMBER: 98-2

INTERPRETATION: Changes in level of care charges does not require a thirty day notice if the rates for each level of care were identified in writing at the time of admission or in any subsequent written notices of changes in rates and services.

DISCUSSION: Facilities may develop a level of care system to determine the charges to residents for services provided in addition to the basic room and board charge. Information concerning level of care charges must be provided to residents and/or their legal representatives at the time of admission and whenever there is a change in level of care charge rates.

At admission, the facility must provide the following information in relation to a level of care charge system:

- (1) Criteria for each level of care.
- (2) How often the resident's level of care will be evaluated. For example every month or whenever a significant change in condition is identified.
- (3) When the change in charges for levels of care will take place. This could be with the next monthly billing or on the day the level of care change was identified.

A thirty day written notice must be provided when the facility decides to change the charges for levels of care. A thirty day notice is not required each time facility staff determine that the resident is in need of a higher level of care or a lower level of care based on the criteria provided to the resident and/or their legal representative.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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42 C.F.R. 483.10(c)(3)(i)(ii)
K.A.R. 28-39-149 (c) (4)

SUBJECT: Resident Fund Accounts

DATE: May 19, 1999

REVISED: February 15, 2002

NUMBER: 99-2

INTERPRETATION: Nursing facilities may choose to place all resident funds deposited by residents in an interest bearing account. Monies from this account may be used by the facility to maintain a petty cash fund for the benefit of the residents whose funds are handled by the facility. The amount transferred from the interest bearing account to the petty cash fund shall represent \$50 or less for each resident with funds in the pooled account.

DISCUSSION: The regulations related to resident funds were intended to ensure that residents with funds in excess of \$50 would have the opportunity to receive interest for their funds in the pooled accounts. Federal regulations require that the facility make residents' personal funds available on the day requested up to \$50.00. A facility may choose to maintain a petty cash fund. Nothing in the regulations prohibits the facility from using monies from a pooled resident fund account for a resident petty cash fund.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-150 (a)
K.A.R. 28-39-152 (i)
42 C.F.R. 483.13 (a)
42 C.F.R. 483.25 (h)

SUBJECT: Side Rails

DATE: November 1, 1993

REVISED: February 18, 2002

NUMBER: 93-7

INTERPRETATION: Side rails may be a safety device for residents who are comatose or an enabling device for residents who are alert and oriented and use the side rails to assist in repositioning. Side rails are considered a restraint when they are used to keep a resident in bed who wants out of bed, but are not a restraint when used to keep residents from falling out of bed.

DISCUSSION: The issue of side rails being considered a restraint is a long standing question which is commonly misunderstood. Side rails used to keep a resident in bed who wants out of bed is a significant safety issue and is considered a physical restraint. If the resident wants out of bed and climbs over the side rails or over the foot of the bed, they will fall from a greater distance. Side rails may be used to prevent a comatose resident from falling out of bed. Alert and oriented residents also use side rails to assist them in repositioning themselves. When a side rail is used to keep a resident from falling out of bed or for an alert resident to reposition, a physician's order is not required.

It is very important that when a facility uses side rails that it has ensured that the side rail is designed specifically for the make or type of bed and that the mattress fits tightly against the side rail on both sides. Mattresses as they age may no longer fit a bed with side rails. Mattresses which do not fit tightly against the side rail can cause entrapment of the resident's head and may result in death. Residents have died from chest compression when they have tried to exit a bed with both half side rails in place. It is very important when side rails are used, that the resident has been assessed for the safe use of this device and the side rails are appropriate for the bed and mattress.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.S.A. 39-1401-1411
K.A.R. 28-39-150 (d) (3),(4),(6)
K.A.R. 28-39-240 (f)
K.A.R.28-39-275(f)
K.A.R. 28-39-425 (e)
42 C.F.R. 483.13 (c)
42 C.F.R. 483.420 (d) (2)

SUBJECT: Adult Abuse, Neglect, and/or Exploitation Reporting and Investigation

DATE: March 15, 1994

REVISED: March 14, 1997, **February 15, 2002**

NUMBER: 94-1

INTERPRETATION: Adult care home administrators and other health care professionals who have reasonable cause to believe that a resident is being or has been abused, neglected or exploited shall report **immediately** the information to the Kansas Department of Health and Environment.

The report must include the required information listed below.

- a. Name and address of the person making the report.
- b. Name and address of the caretaker caring for the resident.
- c. Name and current address of the resident(s) involved.
- d. Information regarding the nature and extent of the abuse, neglect or exploitation.
- e. Name of the next of kin of the resident(s) if known.
- f. Any additional information which might be helpful in the investigation of the allegation and protection of the resident(s) at risk.

All adult care homes are required to:

- a. Develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property;

- b. Not use verbal, mental, sexual, physical abuse, corporal punishment, or involuntary seclusion;
- c. Not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
- d. Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authority.

The facility staff must ensure that there is an investigation of all allegations. Immediate action to prevent further abuse, neglect or exploitation of residents must be taken. When and if the allegation is verified by the facility or the Department, there must be appropriate corrective action taken.

A thorough investigation must be conducted by the facility. Injuries of an unknown source must be reported to KDHE if the facility's immediate investigation demonstrates reasonable cause to believe that abuse or neglect has occurred or is occurring. There must be evidence of these investigations and they must be made available to the Kansas Department of Health and Environment.

Failure to report when reasonable cause exists that abuse, neglect or exploitation has occurred can result in the facility receiving a deficiency or an enforcement action. Health care professionals who fail to report when reasonable cause exists could be referred to the appropriate regulatory board.

DISCUSSION: It is the responsibility of adult care home administrators and other health care professionals to report immediately when there is reasonable cause to believe abuse, neglect, and exploitation has occurred or is occurring. The adult care home administrator is responsible for assuring that a thorough investigation has been conducted and appropriate action has been taken to protect residents.

It is incumbent upon facilities to develop personnel policies, procedures and staff training which ensure the prevention of abuse, neglect and exploitation and when ANE occurs, that prompt action is taken to prevent further ANE.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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REGULATION INTERPRETATION
BUREAU OF HEALTH FACILITIES

K.A.R. 28-39-152 (a) (b) (e) (f)
42 C.F.R. 483.25 (a) (d) (e)

SUBJECT: Restorative Nursing Services

DATE: November 1, 1993

NUMBER: 93-9

INTERPRETATION: A physician's order is not required for restorative nursing services. Restorative nursing services assist or promote the resident's ability to attain the highest practicable level of physical functioning and self-care. These activities are carried out and/or supervised by licensed nurses. Restorative nursing activities include, but are not limited to, range of motion, training and skill practice in transfer, eating, walking, toileting, and grooming activities.

DISCUSSION: Each resident must be assessed to determine their level of functioning in activities of daily living. A care plan shall be developed for restorative services based on the comprehensive assessment.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-152 (e)
42 C.F.R. 483.25 (e)

SUBJECT: Restorative Nursing - Range of Motion

DATE: November 1, 1993

NUMBER: 93-10

INTERPRETATION: Range of motion is considered to be a restorative nursing function. It is not necessary that a physician's order be obtained for restorative services.

DISCUSSION: The generally accepted definition for range of motion is that active range of motion is performed by the resident themselves and passive range of motion is when someone provides assistance. Either can be done within licensed nursing judgment and does not require specific physician's order.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-152 (j)
42 C.F.R. 483.75 (l)

SUBJECT: Documentation of Nutritional Intake

DATE: November 1, 1993

NUMBER: 93-11

INTERPRETATION: The method used to document nutritional intake of residents is to be determined by facility policy.

DISCUSSION: State and federal regulations require that the nursing staff be aware of the nutritional needs and fluid and food intake of residents. Nursing facilities must develop a consistent method for monitoring and reporting nutritional information to the licensed nurse and when appropriate, the attending physician. Documentation which reflects the facility policy must be available for review by surveyors. One commonly used method is the documentation of the percentage of the diet consumed. It would be appropriate for those residents who are at risk for nutritional problems to have additional evaluations of food eaten. This assessment process could include documentation of the percentage of foods eaten from each of the major food groups for a specific time period. Regardless of the methodology, the information must be available for the staff and surveyors to review.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-152 (m)
K.A.R. 28-39-436 (c)
K.A.R. 28-39-247 (c)
K.A.R. 28-39-282 (c)
42 C.F.R. 483.460(k)
42 C.F.R. 483.60(a)

SUBJECT: Administration of Medication

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-12

INTERPRETATION: The licensed nurse, certified medication aide or licensed mental health technician who administers medications is responsible to see that the resident receiving the medication ingests the medication. It is not acceptable to leave medications on bedside tables, meal trays, dining room tables or a other locations.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-152 (m) (3) (4)
K.A.R. 247(c)
K.A.R. 28-39-436 (c)
K.A.R. 28-39-282 (c)
42 C.F.R. 483.60 (a)
42 C.F.R. 483.75 (l)

SUBJECT: Documenting Medication Administration

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-14

INTERPRETATION: Recording of the administration of medication may be performed at the time medication is removed from a unit dose package or after the medication has been administered.

DISCUSSION: K.A.R. 28-39-152 (m) (3) (4) requires that the facility assure safe and accurate administration and recording of all medications. K.A.R. 28-39-163 (m) (9) (B) requires a facility to maintain a clinical record system in accordance with accepted professional standards.

There are two accepted methods for documentation of medications. The accepted practice for many years is that of documentation in the clinical record immediately after the drug was administered.

With the use of unit dose systems, a second acceptable method has been developed. When the drug is removed from the unit dose package, the person administering the drug(s) would initial the drug administration record. The drug(s) would be taken to the resident for administration. In the event the resident did not take the drug(s), the initial on drug administration record would be circled and an entry be placed in the clinical record indicating the reason the drug(s) was not administered. This practice is an acceptable method when performed for each resident individually. It is not acceptable to "set up" drugs for more than one resident at a time and document in the record prior to administration.

The facility shall be responsible for determining the accepted procedure for administration of medications. All staff responsible for administering medications shall receive inservice education to assure that documentation of medications is in conformance with acceptable standards of practice.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-155 (a) (1)
42 CFR 483.40 (a)

SUBJECT: Thickened liquids

DATE: September 2, 1997

NUMBER: 97-5

INTERPRETATION: The use of thickened liquids requires a physician order.

DISCUSSION: Thickening liquids with commercial thickeners is a modality used to prevent aspiration of liquids by residents with swallowing deficits. Facility staff should request an order from the resident's physician for a swallowing evaluation conducted by a speech language pathologist or another health care professional to determine the extent of the deficit. Based on the information from the evaluation, the physician must order the consistency of the liquids provided to the resident. All liquids provided to the resident must be the consistency ordered by the physician. The order should state if water is to be thickened.

The care plan for a resident with swallowing difficulties must include specific interventions to prevent lung aspiration. All staff assisting residents with swallowing difficulties must be aware of and follow the interventions found in the care plan. Licensed nurses delegating the task of feeding residents with swallowing difficulties to nurse aides must follow the delegation process found in Regulation Interpretation 93-16.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-155 (a) (1)
42 CFR 483.40 (a)

SUBJECT: Feeding residents with syringes

DATE: September 2, 1997

NUMBER: 97-6

INTERPRETATION: Feeding residents with an oral syringe requires a physician order.

DISCUSSION: Feeding residents with an oral syringe places the resident at significant risk for lung aspiration. Current literature indicates that feeding with an oral syringe should be limited to individuals who are cognitively oriented or have oral cancer. Feeding residents who have dementia with an oral syringe places that resident at high risk for a number of clinical problems. A review of the Minimum Data Set information for the first quarter of 1997 indicated that 150 residents in nursing facilities in Kansas are fed with an oral syringe.

Before a decision is made to use an oral syringe, the resident must be evaluated by a health care professional to determine that normal oral tongue function, swallowing function and a gag reflex is present. An evaluation by a speech language pathologist would be appropriate. Documentation of the evaluation must be present in the resident's chart.

After an evaluation is completed, the physician must review the findings and make the determination as to whether feeding with an oral syringe can be performed safely by staff. The consistency of the food fed via the oral syringe must be included in the order.

Licensed nurses responsible for residents who are fed with an oral syringe should perform the task of feeding. If the licensed nurse believes a nurse aide can safely perform this task, the licensed nurse must follow the protocols for delegation of a nursing task to unlicensed direct care staff.

It is essential that specific care interventions are developed for residents who are fed with an oral syringe. These interventions should include correct positioning the resident, size of the syringe, and the amount of food to be placed on the resident's tongue. Staff who feed a resident with an oral syringe must demonstrate the ability to perform this task competently and safely.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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42 CFR 483.25(h)
KAR 28-39-152(i)

SUBJECT: Prevention of accidents - Hot beverages

DATE: July 9, 1998

NUMBER: 98-1

INTERPRETATION: Allowing residents to self-serve hot coffee or similar beverages is allowed.

DISCUSSION: Providing a system which allows residents the ability to self serve coffee or other hot beverages can add to the resident's quality of life. The issue is that the system is designed to function in a safe manner taking into consideration the needs of residents. Most residents, including those with dementia are aware that coffee pots and urns are hot. Facility staff must evaluate the needs of their residents and select appropriate equipment to dispense self-serve coffee or other hot beverages.

Surveyors have identified situations in which residents have been burned by hot coffee. These situations occurred because coffee urns were located on the edge of a counter top. A reservoir was not available below the spigot to catch the hot liquid which did not go into the cup held by the residents and residents were burned. Although this and similar circumstances could result in a finding of deficient practice, the availability of hot beverages for self-service by residents is not in itself a deficient practice.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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K.A.R. 28-39-154
K.A.R. 28-39-249(a)
K.A.R. 28-39-435(a)
K.A.R. 28-39-284(a)

SUBJECT: Graduate Nurses

DATE: November 1, 1993

REVISED: February 18, 2002

NUMBER: 93-15

INTERPRETATION: Pending the results of the first licensing examination scheduled by the Board of Nursing following graduation, a graduate nurse will be considered to meet requirements for a licensed nurse.

DISCUSSION: The Kansas State Board of Nursing has advised that graduates of accredited practical and registered nurse programs in Kansas may carry out responsibilities of a licensed nurse pending the result of the first licensing examination scheduled by the Board of Nursing following graduation. Unless policies of the employing agency so direct, the graduate need not work under the supervision of a licensed nurse nor have charting co-signed by a licensed nurse. The above interpretation is consistent with the Nurse Practice Act and Kansas State Board of Nursing policy.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.S.A. 65-1124 (n)
K.A.R. 28-39-154
K.A.R. 28-39-246 (e)
K.A.R. 28-39-281 (e)
K.A.R. 28-39-430 (e)
42 C.F.R. 483.75 (f)
42 C.F.R. 483.460 (d) (3) (5)

SUBJECT: Delegation of Nursing Tasks to Medication Aides and Nurse Aides

DATE: November 1, 1993

REVISED: March 14, 1997, Revised February 15, 2002

NUMBER: 93-16

INTERPRETATION: Delegation of nursing tasks (beyond tasks identified in state approved curriculums) to designated medication aides and nurse aides in adult care homes shall comply with the following:

- (a) Each licensed nurse shall assess the resident's nursing care needs and formulate a written plan before delegating a nursing task to a nurse aide or medication aide.
- (b) The selected nursing task to be delegated shall be one that a reasonable and prudent licensed nurse would determine to be within the scope of sound nursing judgment and which can be performed properly and safely by a nurse aide or medication aide.
- (c) Specialized nursing tasks such as, but not limited to, catheterization, ostomy care, and administration tube feedings, care of skin with damaged integrity, shall be assessed and delegated as appropriate.
- (d) The selected nursing task shall not require the designated nurse aide or medication aide to exercise nursing judgment or intervention such as assessment.
- (e) In an anticipated health crisis identified in the care plan by the licensed nurse, the nurse aide or medication aide may provide care for which instruction has been provided.

- (f) The designated nurse aide or medication aide to whom the nursing task is delegated shall be adequately identified by name, in writing, for each delegated task.
- (g) The licensed nurse shall orient and instruct the nurse aide or medication aide in the performance of the nursing task. The nurse aide's or medication aide's demonstration of the competency necessary to perform the delegated task shall be documented in writing. The designated nurse aide or medication aide shall co-sign the documentation indicating the person's concurrence with this competency evaluation.
- (h) The licensed nurse will:
 - (1) be accountable and responsible for the delegated nursing task;
 - (2) participate in periodic and joint evaluations of the services rendered;
 - (3) record and monitor recorded services; and
 - (4) adequately supervise the performance of the delegated nursing task in accordance with the following conditions.

The degree of supervision required shall be determined by the licensed nurse after an assessment of appropriate factors including:

- (i) the health status and mental and physical stability of the resident;
- (ii) the complexity of the task to be delegated;
- (iii) the training and competency of the nurse aide or medication aide to whom the task is delegated; and
- (iv) the proximity and availability of the licensed nurse to the designated nurse aide or medication aide when the selected task will be performed; and
- (v) the delegation of the nursing task is not prohibited by statute or regulation.

DISCUSSION:: A change in the Kansas Nurse Practice Act in 1992 provided for the delegation of nursing tasks to unlicensed persons. Nurse aides and medication aides may perform tasks included in the nurse aide and medication aide state curriculums. K.S.A. 65-1124 (i) limits the administration of medications by unlicensed staff to residents in adult care homes, long term care units in hospitals, and state operated institutions for the mentally retarded to persons who have a medication aide certificate. Therefore, licensed nurses may not delegate the administration of medications to nurse aides.

Licensed nurses in adult care homes may delegate selected nursing tasks to specific nurse aides or medication aides under the conditions listed above. Documentation related to the delegation of nursing tasks must be found in the resident's plan of care or individual program plan and in the personnel file of the designated nurse aide or medication aide.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-152 (m) (1)
K.A.R. 60-7-105
K.S.A. 65-1, 120
K.S.A. 65-4202 (b)
42 C.F.R. 483.30

SUBJECT: Licensed Mental Health Technicians

DATE: November 1, 1993

NUMBER: 93-13

INTERPRETATION: A licensed mental health technician (LMHT) may provide direct care and administer medications in intermediate care facilities for the mentally retarded (ICF/MR) or intermediate care facilities for mental health (ICF/MH). A LMHT may work in a nursing facility if he/she has successfully passed the Kansas nurse aide examination. A LMHT may administer oral and topical medications in a nursing facility after successfully passing the Kansas nurse aide examination and medication aide examination.

DISCUSSION: Existing educational standards for the LMHT are equivalent to the nurse aide and medication aide courses. However, the state nurse aide and medication aide examinations must be passed in order for the LMHT to be certified to function as a nurse aide or as a nurse aide and medication aide in a nursing facility. For a LMHT to be certified as a nurse aide, the LMHT must pass the state written nurse aide examination. If the examination is not passed on the first attempt, then a 90-hour state-approved nurse aide course must be satisfactorily completed and the examination successfully passed. Once the LMHT holds a Kansas nurse aide certificate, he/she may take the medication aide examination. If the examination is not passed on the first attempt, then the 60-hour medication aide course will have to be satisfactorily completed and the examination passed. Upon successfully passing the medication aide examination, the LMHT will be issued an initial medication aide certificate by the educational facility administering the examination. The initial medication aide certificate issued by the educational facility is valid for two years from the date of issuance. All certified medication aides must comply with the continuing education requirements to update their medication aide certificates (10 CEUs completed every two years, update application, and fee).

K.S.A. 65-4202(b) defines the practice of mental health technology as caring for and treating the mentally ill, emotionally disturbed, or mentally retarded. ICF/MR and ICF/MH residents fall under the category of mentally ill, emotionally disturbed, or mentally retarded. Therefore, a LMHT can provide resident care in ICF/MR and ICF/MH settings but not in nursing facilities. In addition, K.A.R. 60-7-105 states that a LMHT's function would be primarily in a psychiatric-mental retardation setting and shall not substitute for RNs or LPNs in nursing facilities

K.A.R. 28-39-152 (m) (1) requires all medications in a nursing facility to be administered by a physician, licensed nursing personnel, a certified nurse aide/medication aide or a licensed mental health technician in a nursing facility for mental health.

1. The scope of practice of a LMHT is limited to the facility providing services to the mentally retarded and the mentally ill.
2. LMHTs may administer injectable medications as defined by their scope of practice in an ICF/MR and ICF/MH.
3. LMHTs working as medication aides in nursing facilities may not administer injectable medications because working in a nursing facility is not within the scope of practice of a LMHT.

CFR 483.75 (e) and K.S.A. 36-396 require successful completion of a state-approved nurse aide course and state examination to be certified as a nurse aide. According to K.S.A. 65-1,120 to become a certified medication aide one must first be a Kansas certified nurse aide and must satisfactorily take the state-prescribed medication aide course and pass the medication aide examination.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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KAR 28-39-154(a)(5)

SUBJECT: Direct Care Staff Performing Laundry and Dietary Functions

DATE: December 20, 2003

NUMBER: 02-1

INTERPRETATION:

Direct care staff may perform tasks considered to be dietary and/or laundry functions as long as the time spent performing these tasks is limited and does not adversely affect the care and services needed by residents. Staff must be able to perform these tasks on the nursing unit.

DISCUSSION:

The intent of this regulation is to ensure that direct care nursing staff did not leave the nursing unit to work in the laundry or dietary sections of the building. This practice could have an adverse effect on resident care. Less staff is available to meet the needs of residents. This regulation was not intended to prevent direct care nursing staff from performing duties such as assisting with food preparation and using laundry equipment located on the nursing unit. The time spent in these activities must be limited. It is the responsibility of the facility to ensure that there is adequate staffing to meet the needs of residents.

When reporting staffing hours in the Adult Care Home Semi-annual report, facilities do not need to deduct a percentage of time direct care staff spend doing laundry and dietary tasks. If these tasks are performed on the nursing unit, the staff person is available to residents.

Patricia A. Maben, RN, MN, Director
Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facility Regulation

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K.A.R. 28-39-155 (a)
42 C.F.R. 483.460 (e)
42 C.F.R. 483.40 (a)

SUBJECT: Physician Orders

DATE: November 1, 1993

Revised: February 18, 2002

NUMBER: 93-17

INTERPRETATION: A physician order is not required for a resident to be examined and/or treated by a health care professional licensed to practice without the supervision of a physician, i.e., dentist, optometrist, or podiatrist. It is appropriate to notify the resident's attending physician that the resident has requested to be seen by another health care professional and to provide the physician with the information concerning medications and treatments ordered as a result of the examination and treatment. In certain instances, it would be appropriate for the staff of the facility to ensure that pertinent health care information is provided to the health care professional. This information could include current medications or past medical problems which could affect the outcome of the treatment, i.e., resident is on coumadin or has had a heart valve replacement. The resident and/or the resident's legal representative must give permission for release of this information to the health care professional.

DISCUSSION: Nothing in state and federal regulations requires an order from an attending physician prior to examination and treatment of a resident by a health care professional licensed to practice without the supervision of a physician, i.e., dentist, optometrist, and podiatrist. It is very important however that the attending physician be aware of the medications and treatments provided to a resident by another health care professional. It is also important the physician be given the opportunity to provide pertinent related to the resident's clinical condition and medical regimen when appropriate.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-155 (a)
K.A.R. 28-39-436 (c)
K.A.R. 28-39-247 (c)
K.A.R. 28-39-282 (c)
42 C.F.R. 483.40 (a)(b)(3)
42 C.F.R. 483.460

SUBJECT: Standing Orders

DATE: November 1, 1993

REVISED: March 14, 1997, Revised February 15, 2002, **Revised October 8, 2002**

NUMBER: 93-18

INTERPRETATION: As used in this interpretation, a standing order is one formulated and signed by a physician, containing specific instructions for nursing actions for the conduct of resident care and which requires nursing judgement to implement. Standing orders are to be used in stipulated clinical situations when a physician is not readily available and the physician has determined that a licensed nurse may use clinical judgement without direct consultation prior to the nursing intervention.

DISCUSSION: Standing orders are acceptable for specified medications and treatments. The use of physical restraints may not be included on standing orders. The following shall be included in facility policy and procedures:

1. Standing orders are issued only by the resident's attending physician and are signed and dated by that physician.
2. Standing orders are reviewed at the same intervals as the physician plan of care.
3. A licensed nurse is responsible for implementing standing orders.
4. Choices of similar treatments or medications shall be kept to a minimum.
5. Standing orders are to be written in accordance with accepted professional standards and are specific, understandable and complete.
6. Medications included in standing orders may include over the counter drugs and a limited number of prescription drugs. Schedule II drugs and psychopharmacologic drugs are not appropriate selections for standing orders. It is appropriate to include influenza and pneumococcal vaccines in standing orders as long as a licensed nurse has performed an assessment to identify possible contraindications for each resident.

7. A limitation of the number of times a medication can be used in close succession without notifying the physician must be stated.
8. A copy of the signed and dated standing orders shall be placed in the resident's clinical record.

Standing orders are an accepted interdependent intervention providing for continuous physician direction in the physician's absence. They are commonly used in settings in which the physician is not readily available and, thus provide the licensed nurse certain legal protection to intervene appropriately in the resident's best interest.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-155 (f)
42 C.F.R. 483.75 (1)

SUBJECT: Procedures in the Event of Resident Death

DATE: November 1, 1993

NUMBER: 93-19

INTERPRETATION: The above regulation does not require written permission of the physician to remove the body.

DISCUSSION: The intent of this regulation is to provide for situations when the physician is unable or chooses not to go to the facility to pronounce death.

When it is apparent that death has occurred, the licensed nurse shall notify the attending physician, report the absence of vital signs and lack of response to verbal or painful stimuli. The decision of whether or not the physician will immediately respond to the call is the choice of the physician. The physician may give permission for the body to be removed to the hospital or the mortuary for the pronouncement of death.

If the physician responds to the call and goes to the facility to pronounce death, it is not necessary for the physician to specifically state the body may be removed as long as the statement that death has occurred is entered into the clinical record by the physician.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-156
K.A.R. 28-39-247
K.A.R. 28-39-436
K.A.R. 28-39-282
42 C.F.R. 483.60 (a)

SUBJECT: Crushing Medication

DATE: November 1, 1993

REVISED: March 14, 1997, **February 15, 2002**

NUMBER: 93-20

INTERPRETATION: A physician's order for crushing of medication is not required.

DISCUSSION: The decision on whether or not to crush medication is in the purview of the pharmacist or licensed nurse in the delivery of medication. In all adult care homes (nursing facility, assisted living/residential health care, home plus and adult day care) a pharmacist should establish a listing of what medication should and should not be crushed. Staff responsible for administering medications should be trained and be aware of the facility policy regarding crushed medications. This listing should be readily available at the place medications are prepared. The decision to crush medications for a resident must be made by a licensed nurse and communicated in writing on the medication administration record. Medication aides must receive permission from their supervising licensed nurse before crushing a medication for a resident when that direction is not found on the medication administration record.

When a facility has found it necessary to crush certain medications, it is expected that communication regarding this need is reported to the resident's attending physician. This notification would allow the resident's physician the option of ordering the medication in a different form that the resident could more easily swallow.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-156 (b) (3)
42 C.F.R. 483.460 (m) (1)
42 C.F.R. 483.60 (d)

SUBJECT: Stock Medication Supplies

DATE: November 1, 1993

NUMBER: 93-21

INTERPRETATION: Stock medications as provided by the Department of Social and Rehabilitation Services' reimbursement policy are not considered individual medications.

DISCUSSION: The occasional use of stock medications, such as over the counter drugs (i.e. acetaminophen or milk of magnesia) by a particular resident does not require that the stock supply container be labeled as required by the above regulation.

The purpose of a stock supply is to provide commonly used over the counter medications for occasional use by a resident. The use of stock medications is provided for in the state reimbursement policy of the Department of Social and Rehabilitation Services. Regulations of the Department of Health and Environment do not preclude their use.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-156 (d) (3)
K.A.R. 28-39-247 (b) (7)
K.A.R. 28-39-247 (f)
K.A.R. 28-39-282 (f)
K.A.R. 28-39-436 (f)
42 C.F.R. 483.60 (e) (1)
42 C.F.R. 483.460 (d)

SUBJECT: Storage of Topical and Oral Medications

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-22

INTERPRETATION: No state or federal law prohibits storage of topical and oral medications together in a drawer or on a shelf.

DISCUSSION: Storage of oral and topical medications together is permissible as long as techniques are used to maintain the integrity and cleanliness of the medications. Storage of groups of oral and topical medications in the same drawer or on a shelf could be facilitated by using boxes or containers to group oral and topical medications. Topical medications packaged in tubes or small plastic bottles, i.e. eye medications, are to be stored in the box or plastic bag on which its dispensing label has been attached. The surveyor must use independent judgement to determine that the medications are maintained in a sanitary condition.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-156 (f) (3)
K.A.R. 28-39-247(f)(1)
K.A.R. 28-39-282(f)(1)
K.A.R. 28-39-436(f)(1)
42 C.F.R. 483.460 (m) (1)
42 C.F.R. 483.60 (d)

SUBJECT: Medication Expiration Dates

DATE: November 1, 1993

REVISED: February 8, 2002

NUMBER: 93-23

INTERPRETATION: When an expiration date is dated only in terms of the month and the year, it is a representation that the intended expiration date is the last day of the stated month.

DISCUSSION: The Kansas Board of Pharmacy uses the United States Pharmacopeia (USP) which is the official compendia in the Pharmacy profession in the United States. The above interpretation is quoted from the USP and provided by the Kansas Board of Pharmacy.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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K.A.R. 28-39-156 (b) and (d)
K.A.R. 28-39-247 (b) (7)
K.A.R. 28-39-436 (f)
K.A.R. 28-39-247 (f)
K.A.R. 28-39-282 (f)
42 C.F.R. 483.60 (d) (e)
42 C.F.R. 483.460 (l) (m)

SUBJECT: Storage and Labeling of Multi-dose Vials of Biologicals

DATE: March 15, 1994

REVISED: February 15, 2002

NUMBER: 94-2

INTERPRETATION: Nothing in federal and state regulations prohibits the storage of multi-dose vials of biologicals used for immunizations and tuberculin skin testing in the medication room.

DISCUSSION: Facilities may store multi-dose vials of the tuberculin antigen to be used for skin testing of residents and employees as well as other biologicals such as the flu vaccine in the medication room. The facility is responsible for the storage and handling of these biologicals as directed by the manufacturer.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-156 (b)(2)
K.A.R. 68-7-14
42 CFR 483.60 (d) and (k) (7)

SUBJECT: Drugs and Biologicals Without Expiration Dates

DATE: March 15, 1994

NUMBER: 94-3

INTERPRETATION: The above regulations require that drug labels contain an expiration date **if applicable**. There are a number of drugs which will not have an expiration date on the label. These drugs may be maintained in a nursing facility. The consultant pharmacist should develop a policy for storage and disposal of drugs without expiration dates on the labels. The facility should develop a policy for storage and disposal of drugs.

DISCUSSION: Some drugs and biologicals will not be labeled with an expiration date. Examples would be cough syrup repackaged by a pharmacist or certain brands of vitamins. It is acceptable for these drugs to be administered. The Food and Drug Administration does not require an expiration date on all drug labels. Drugs labeled with an expiration date should be disposed of by the pharmacist when outdated.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-158 (b) (1)
K.A.R. 28-39-252 (b) and (c)
K.A.R. 28-39-252(c)
K.A.R. 28-39-287(b)
K.A.R. 28-39-431(c)
42 C.F.R. 483.35 (e)

SUBJECT: Diet Modification - Sodium

DATE: November 1, 1993

NUMBER: 93-24

INTERPRETATION: Without a physician's prescription, indiscriminate sodium restriction is unacceptable.

DISCUSSION: Sodium restriction is a diet modification for therapeutic purposes. Elimination of salt as a seasoning agent where it is traditionally used in the preparation of foods may decrease consumption and, thereby, adversely affect nutritional intake. A reduction in the total amount of salt added to foods may be prudent but this should be done without sacrificing palatability.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-158 (g) (1) (2)
K.A.R. 28-39-252(c)
K.A.R. 28-39-287(c)
K.A.R. 28-39-431(c)
42 C.F.R. 483.15 (e)(1)
42 C.F.R. 483.35 (h)(1)(2)

SUBJECT: Donated Foods

DATE: November 1, 1993

REVISED: February 18, 2002

NUMBER: 93-25

INTERPRETATION: The use of donated foods is not prohibited, however, donated foods must meet all federal, state and local regulations. Food provided by family or friends for individual residents is not considered donated food and is also allowed.

DISCUSSION: A facility must ensure that all regulations are followed.

1. Donated food shall meet the following:
 - a. Meat and poultry shall be slaughtered and processed in a fully licensed and inspected facility and labeled "Inspected and Passed." Each package shall be identified as to contents and date of processing.
 - b. Milk shall be grade A, pasteurized and in the original unopened container.
 - c. Eggs shall be fresh, whole, clean, shell eggs without cracks or checks.
 - d. Food packaged, cooked, or processed shall be prepared in an inspected food processing establishment. Packaged food shall be in the original unopened container in good condition.
 - e. Homegrown fresh fruits and vegetables that smell and appear of good quality may be used. A facility shall be assured that the donated produce has met the pre-harvest interval between the last application of pesticide and the date of harvest.
2. Regulations require temperature control of potentially hazardous food. Cold food shall be 45°F or below. Hot food shall be 140°F or above. Frozen food shall remain frozen and be stored at 0°F or below. It is the facility's responsibility to assure proper food temperature is maintained any time the food is not the responsibility of an inspected establishment.
3. Food shall be used within code dates.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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K.A.R. 28-39-158 (g)(2)
K.A.R. 28-39-252(c)
K.A.R. 28-39-287(c)
K.A.R. 28-39-431(c)
CFR 483.35 (h) (2)

SUBJECT: Damaged Cans

DATE: November 1, 1993

NUMBER: 93-26

INTERPRETATION: It is acceptable to use cans with insignificant defects which would not prohibit the can from being sold through regular distribution systems. Insignificant defects include:

- 1) Slight to moderate dents on or near the double seam or slight dents involving the side seam juncture.
- 2) Slight to moderate paneling on the sides of the cans, i.e., paneling is distortion of the sides of a can that affects the appearance but does not have sharp creases or change the contour.
- 3) Flat rim dents on the double seam that do not significantly alter the contour of the container.
- 4) Cans with slight rust, stains, or deposits which are easily removed.

DISCUSSION: It is extremely important that food from significantly damaged cans not be served or used. However, to prohibit the use of cans with insignificant defects would waste acceptable food. It takes skill to evaluate damaged food containers. The National Food Processors Association publishes Guidelines for Evaluation and Disposition of Damaged Food Containers Bulletin 38-L, third edition, December, 1990. The above policy is in accordance with this guideline.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
REGULATION INTERPRETATION
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28-39-158 (g) (2) (8)
K.A.R. 28-39-252(c)
K.A.R. 28-39-287(c)
K.A.R. 28-39-431(c)
42 CFR 483.35 (h)

SUBJECT: Milk Containers

DATE: November 1, 1993

REVISED: February 18, 2002

NUMBER: 93-27

INTERPRETATION: It is acceptable for milk to be drained from a polypac container and stored for use in another container.

DISCUSSION: The above interpretation applies only when the container used for receiving milk from the polypac is nonporous and cleanable by use of a dish machine or sanitizing sink. Milk so stored shall only be used for cooking.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-158 (k) (2)
K.A.R. 28-39-2559(d)
K.A.R. 28-39-290(d)
K.A.R. 28-39-431(i)

SUBJECT: Automatic Dishwashers - Spot Removing After Sanitizing

DATE: November 1, 1993

NUMBER: 93-28

INTERPRETATION: The application of rinse or spot removing processes after the sanitizing process is not acceptable

DISCUSSION: Regulations speaking to the sanitizing of equipment or utensils by either machine or three sink method or based upon a sanitizing function being the final process. We are not aware of any rinse or spot removing process applied after sanitizing that does not compromise the sanitizing process.

It should be noted that if the manufacturer has written directions to provide for such a rinse or spot removal process without compromising the sanitation, it would be acceptable.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
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BUREAU OF HEALTH FACILITIES

K.A.R. 28-39-161
42 CFR 483.65

SUBJECT: Labeling of Resident Care Equipment

DATE: November 1, 1993

NUMBER: 93-29

INTERPRETATION: Regulation does not require bed pans, urinals, commodes, water pitchers, glasses and other resident care equipment to be labeled with the individual resident's name.

DISCUSSION: There is no specific requirement for resident care equipment to be labeled with an individual resident's name. Infection control principles would indicate that use of certain equipment should be restricted to only one resident. Therefore, personal care items in bedrooms containing more than one resident may need to be labeled. There are instances when this would not be required. For example, if facility procedure is to place a water pitcher and glass at the bedside of residents and these items are recycled on a routine basis, individual labeling is not indicated.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-161
K.A.R. 28-39-253
K.A.R. 28-39-288
K.A.R. 28-39-433

SUBJECT: Animals and Birds

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-30

INTERPRETATION: Animals, birds and other pets are not excluded by regulation from being in an adult care home.

DISCUSSION: If the facility chooses to house and care for an animal, policies and procedures shall be developed to assure that the animals are cared for, sanitation issues are addressed and the animal is not a safety hazard.

The facility should be aware of and be in compliance with any local codes that may apply.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-161 (b) (4)
42 CFR 483.65 (b) (3)

SUBJECT: Handwashing

DATE: November 1, 1993

NUMBER: 93-31

INTERPRETATION: Handwashing policies in accordance with the Center for Disease Control Guidelines for Handwashing in Hospitals will be found in compliance with the above regulations.

Personnel should always wash their hands:

1. before performing invasive procedures;
2. before taking care of particularly susceptible residents such as those who are severely immunocompromised;
3. before and after touching wounds, whether surgical, traumatic, or associated with an invasive device (catheter, gastrostomy tubes, etc.);
4. after situations during which microbial contamination of hands is likely to occur, especially those involving contact with mucous membranes, blood or body fluids, secretions, or excretions;
5. after touching equipment likely to be contaminated such as urine measuring devices or secretion-collecting equipment;
6. after taking care of a resident with an infection;
7. between contacts with different residents when providing direct care such as bathing, perineal care and oral care.

Most routine or brief resident care activities involving direct resident contact such as taking a blood pressure, handing a resident medications, food or other objects do not require handwashing between residents.

DISCUSSION: Handwashing is the single most important procedure in preventing nosocomial infections. Staff members must be encouraged to wash their hands to protect themselves and the residents to whom they provide care. However, one must remember, that with the exceptions stated above, brief touching of residents does not present a danger to staff or to other residents. The only exception to the previous statement would be a resident with a communicable disease as identified in the *CDC Guideline for Isolation Precautions in Hospitals*.

The nursing facility is the resident's home. Handwashing must be performed to protect staff and residents. However, residents must not be made to believe that they are "contaminated" or cannot be touched. It is important that a balance be maintained between good infection control and an appropriate home like atmosphere.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-161 (b) (3)
K.A.R. 28-39-253 (b) (7)
K.A.R. 28-39-288 (b) (6)
K.A.R. 28-39-433 (b) (7)
42 C.F.R. 483.460 (a) (3) (10)
42 C.F.R. 483.470 (l) (4)

SUBJECT: Tuberculin Testing of Residents and Employees in Adult Care Homes Licensed as Nursing Facilities, Assisted Living Facilities and Residential Health Care Facilities.

DATE: March 15, 1994

NUMBER: 94-4

REVISED: March 17, 1997, **February 15, 2002**

INTERPRETATION: K.A.R. 28-39-161(b)(3) provides for tuberculin skin testing program based on the Centers for Disease Control recommendations. To be in compliance with this requirement, facilities should incorporate the following facility policies and procedures.

1. Skin test all new residents and employees as soon as their residency or employment begins using the two-step method unless there is documentation of a previous significant reaction.
 - a. Testing should be performed within seven days of admission or employment. If the first skin test is read as **insignificant** (induration of less than 10 mm) repeat the skin test anytime in 7 to 30 days.
 - b. If the first test is read as **significant** (induration 10 mm or greater), **DO NOT REPEAT THE TEST**. Refer individual to their physician or the local health department for further evaluation.
 - c. If the repeat test is read as **significant**, refer the individual to their physician or local health department for further evaluation.
 - d. Documentation of testing dates, dates tests were read, and size of indurations in millimeters shall be maintained in employee files and resident clinical records.
2. New residents and employees with a history of a significant reaction to a tuberculin skin test should provide documented evidence, including date of test, and any preventative treatment provided. If this information is not available, the individual must provide evidence of a chest x-ray after the significant skin test and a physician statement that the individual does not have active tuberculosis infection.
3. **New employees who can provide documentation of two negative tuberculin skin tests performed within the past two years do not have to be retested if the second test was done not longer than six months ago. The documentation must include:**
 - a) **date of the initial and second skin tests.**
 - b) **date the tests were read and**
 - c) **measurements of area of induration in millimeters.****If the information is not available, the employee will need to be retested following the procedure outlined in paragraph 1.a. If the information is available, but the second test was given longer than six months ago, the person shall be re-tested with only one test.**

4. If an employee refuses the skin tests, the employee must be examined by a physician for tuberculosis. This examination should include a chest x-ray. The results of this examination must be documented in the employee record. Additional x-rays are not required unless employee develops symptoms of tuberculosis.
5. Residents who refuse the skin tests must be examined for tuberculosis by their physician and the results of this examination must be documented in the clinical record within 30 days of admission. A chest x-ray should be included in the examination. Additional x-rays are not required unless the resident develops symptoms of tuberculosis.
6. Skin testing may not be appropriate for some residents due to aging changes in the skin. A physician must examine the resident for the presence of tuberculosis within 30 days of admission. A chest x-ray should be included in the examination. Additional x-rays are not required unless the resident develops symptoms of tuberculosis (e.g., weight loss, cough, fever).
7. Employees with skin tests determined to be insignificant should be retested at least every two years. The usual recommended interval between tests is one year. Nursing facilities should contact the local health department for the incidence of tuberculosis in the county. There will be situations when skin testing will be recommended as frequently as every six months. If the time between testing exceeds two years in employees, the two step method described in paragraph 1 must be administered.
8. Residents who do not leave the nursing facility and who have not been exposed to individuals with tuberculosis do not need to be retested unless they develop symptoms of tuberculosis (e.g., weight loss, cough, fever). Residents who go out into the community should be retested at least every two years or as recommended by the local health department.
9. When follow-up testing is performed within a two year period, a skin test conversion is identified if the induration is found to be 10 mm or more than the previous test in those persons less than 35 years of age and 15 mm increase in induration for those persons age 35 years or more. If the induration meets this criteria, the employee or resident should be referred for appropriate examination and treatment.
10. Cases of skin conversion should be reported to the local health department or to the Kansas Department of Health and Environment, Tuberculosis Section, (785) 296-5589.
11. It is the responsibility of the facility to ensure that the licensed nurses performing tuberculin skin testing can do so accurately. Local health departments or the Kansas Department of Health and Environment should be contacted for assistance in training staff.

DISCUSSION: The incidence of tuberculosis has increased in the general population in the last few years. Elders residing in nursing facilities are at greater risk for tuberculosis than elders living in the community. Employees of Adult Care Homes are also at increased risk for tuberculosis when compared to other employed adults. The *CDC Guideline for Prevention and Control of Tuberculosis in Facilities Providing Long-Term Care to the Elderly* and information from the staff of the Bureau of Disease Control was used to develop this Regulation Interpretation.

Patricia A. Maben, R.N., M.N.
Director, Adult Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (c) (2) (A) (iii)

SUBJECT: Automatic Door Closures - Medicine Preparation Room Doors

DATE: November 1, 1993

NUMBER: 93-32

INTERPRETATION: Each medicine preparation room door shall be equipped with a device which causes an unattended door to close, latch and lock without manual assistance. It is acceptable for a medicine preparation room door to be held open by a door stop or similar means when occupied.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 29-39-162a (c) (3)

SUBJECT: Use of Clean Utility Workrooms

DATE: November 1, 1993

NUMBER: 93-33

INTERPRETATION: Intent of the requirement for clean utility workrooms is to provide a suitable location for preparation and storage of clean or sterile supplies. An example would be preparation of urinary catheter equipment prior to usage. Cleaning functions such as pre-rinsing of soiled linens is not to take place in a clean utility room.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (c) (9) (B) (G)

SUBJECT: Resident Bathing Facilities

DATE: November 1, 1993

NUMBER: 93-34

INTERPRETATION: If the toilet in bathing facilities is a portable toilet, the facility must also have a toilet accessible to residents who are physically disabled. A cabinet with a lock shall be provided in the bathing area for storage of supplies. This does not mean that the cabinet has to be locked at all times but only when staff are not present in the area. It is not expected that the cabinet be locked and unlocked each time a bath is given.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (d) (2)

SUBJECT: Required Dining Area Space

DATE: November 1, 1993

NUMBER: 93-35

INTERPRETATION: One-half of the required space shall be utilized as dining area, not half of the total space provided.

DISCUSSION: The above regulation requires living, dining, and recreation space at a rate of 20 square feet in facilities constructed before February 15, 1977. One half of the required space, 10 square feet, shall be utilized as dining area. A facility may exceed 20 square per resident for living, dining and recreation areas as long as at least 10 square feet per resident is provided for dining. This same logic applies to the requirement for facilities approved for licensing after May 1, 1982 found in 28-39-162a (d) (1).

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (g) (3)

SUBJECT: Storage Area - Rehabilitation Therapy Room

DATE: November 1, 1993

NUMBER: 93-36

INTERPRETATION: The room designated for rehabilitation therapy in a facility constructed prior to February 15, 1977 must provide an enclosed storage area for therapeutic devices. The storage area may be enclosed by using a curtain.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (m) (1) (A)

SUBJECT: Control Area for Receiving Food Supplies

DATE: November 1, 1993

NUMBER: 93-37

INTERPRETATION: The control area for receiving food supplies required by the above regulation does not have to be a separate room. It does have to be an area that the food and supplies can be brought into the dietary department without going through the food preparation area. A counter or table located in the dietary department where supplies may be received without going through the food preparation area is acceptable. A counter, table or shelf is desired but not required.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (m) (1) (H)

SUBJECT: Three-compartment Pot Washing Sink

DATE: November 1, 1993

NUMBER: 93-38

INTERPRETATION: In facilities constructed prior to February, 1977, provision for a three-compartment sink for pot washing could be satisfied by a two-compartment sink supplemented by a portable deep container or sink compartment accessible to the pot-rinsing sink.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (m) (l) (H)

K.A.R. 28-39-253 (b) (4)

K.A.R. 28-39-290(d) (l)

K.A.R. 28-39-431 (i)

SUBJECT: Sanitizing in a Three Compartment Sink

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-39

INTERPRETATION: Equipment and utensils shall be sanitized in the third compartment of a sink according to one of the methods included in the Food and Drug Administration's *Food Service Sanitation Manual*, 1976.

The food contact surfaces of all immersible equipment and utensils shall be sanitized by:

- (1) Immersion for at least one-half (1/2) minute in clean water of at least 170°F, or
- (2) Immersion in a clean solution of any chemical sanitizing agent allowed by the Food and Drug Administration that will provide the equivalent bactericidal effect of a solution containing at least 50 parts per million of available chlorine as a hypochlorite at a temperature of at least 75°F for one minute; or if equipment is too large to sanitize by immersion, rinsing, spraying or swabbing with a chemical sanitizing solution of at least twice the strength required.

DISCUSSION: When following manufacturer's directions for use of chemical sanitizers, it is important to follow both minimum and maximum standards for concentration and temperatures. Effective sanitization of food contact surfaces also requires proper washing and rinsing before sanitizing.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (n) (1) (C)

K.A.R. 28-39-162a (n) (2) (A)

SUBJECT: Laundry Processing Room

DATE: November 1, 1993

NUMBER: 93-40

INTERPRETATION: The laundry processing rooms referred to in the above regulation means those rooms which contain both washing and drying equipment. Those facilities governed by 28-39-162a (n) (2) (A) must provide functional separation between soiled and clean laundry. This means the washing and drying equipment must be arranged to provide an uninterrupted flow of laundry from the soiled laundry holding area or space through the laundry processing room to the clean laundry holding storage room. Those facilities governed by K.A.R. 28-39-162a (n) (1) (C) must provide physical separation between the laundry processing room, the soiled laundry room and clean laundry room. It is not required to provide physical separation between the washing and drying equipment.

Physical separation means separation of functions by partitions or rooms. Functional separation means an organization and work flow of the various functions that constitute laundry process. The separation of all soiled and clean functions, cleanliness and proper ventilation are major concerns. The air should be exhausted from the room with the direction of air flow from clean to soiled to the outside.

The clean laundry processing room required by K.A.R. 28-39-162a (n) (2) (D) can be provided by an enclosed laundry cart with shelves located in the clean workroom or one or more linen closets adequate in size to store sufficient linen for the facility.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (n) (2) (D)

SUBJECT: Laundry Facilities - Clean Laundry Processing and Storage Rooms

DATE: November 1, 1993

NUMBER: 93-41

INTERPRETATION: Compliance with the above regulation could be by provision of closets sufficient in number or space to accommodate need.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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KAR 28-39-162a(c)(4)(A)

SUBJECT: Flushing Rim Sinks in Soiled Utility Rooms

DATE: June 2, 2003

NUMBER: 03-1

INTERPRETATION: Current infection control standards of practice and Center for Disease Prevention and Control guidelines for handling soiled linen do not allow for pre rinsing. Continuing to require flushing rim sinks in soiled utility rooms only perpetuates an out dated standard of practice.

DISCUSSION: New facilities may choose not to install flushing rim sinks. Licensed nursing facilities may choose to disconnect the water supply or remove flushing rim sinks. It will be important for nursing facilities to revise policies and procedures for the handling of soiled linen to reflect the current standard of practice.

Since 1977, all new nursing facilities are required to have a toilet room accessible from the resident's bedroom. This change allows staff to empty bedpans and urinals in the resident's toilet room instead in a soiled utility room. It is recommended that disposable bedpans and urinals be used. These items should be labeled with the resident's name and disposed when the resident no longer requires their use.

Patricia A. Maben, RN, MN
Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162a (n) (3) (B)

SUBJECT: Off-Site Laundry Facilities - Clean Laundry Receiving, Holding, Inspection and Storage Rooms

DATE: November 1, 1993

NUMBER: 93-42

INTERPRETATION: Compliance with the above regulation could be by provision of the space or area for receiving clean laundry. This may be achieved by an enclosed laundry cart with shelves located in the clean work room or one or more linen closets adequate in size to store sufficient linen for the facility if linen is delivered folded and/or packaged.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162b (a) (11)

SUBJECT: Glass Barriers

DATE: November 1, 1993

NUMBER: 93-43

INTERPRETATION: Glass barriers installed in lieu of safety glass shall be installed in a manner that protects all glazing within 18 inches of the floor. This does not mean the entire 18 inch area must be covered; it does mean that a single rail located 18 inches above the floor does not meet the intent of the requirement.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162c (h) (1) (D) (iii)

K.A.R. 28-39-162c (h) (2) (C)

SUBJECT: Resident Room Lighting

DATE: November 1, 1993

NUMBER: 93-44

INTERPRETATION: Electrical regulations require general lighting of 10 foot candle power three feet above the floor. This general lighting can be provided by fixtures located on the ceiling, walls, or in combination.

In addition, each resident must have a reading light fixture which provides at least 30 foot candle of light at the head of each bed at mattress level.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-162c (i) (4)
42 C.F.R. 483.70 (b) (2)

SUBJECT: Life-Support Systems

DATE: November 1, 1993

NUMBER: 93-45

INTERPRETATION: The determination of whether certain equipment constitutes life support systems is an evaluation of both the equipment and the condition of the resident being supported by the equipment. A ventilator is always considered a life-support system. An oxygen concentrator is only considered a life-support system if interruption in its service results in a direct and immediate threat to the life of the person using it. Assistive devices such as nasal gastric pumps, suction machines, and IV therapy equipment do not constitute life support equipment.

DISCUSSION: The provision that emergency electric service for life support systems be provided only by a generator set confirms the intent of this regulation was not to include routine assistive devices within the definition of life support systems.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-163 (m) (1)
K.A.R. 28-39-250(a)
K.A.R. 28-39-285(a)
K.A.R. 28-39-434(a)
42 C.F.R. 483.75 (l)

SUBJECT: Rubber Stamp Signatures

DATE: November 1, 1993

REVISED: February 18, 2002

NUMBER: 93-46

INTERPRETATION: A rubber stamp signature is a valid, authorized signature provided the person affixing the stamp indicates in writing that this is their practice.

DISCUSSION: Accepting the use of rubber stamps when certain conditions are met is in accordance with accepted professional medical records standards as well as Joint Commission on Accreditation of Healthcare Organizations. The surveyor should verify that the facility or agency has a written statement from the person using the stamp documenting that they alone have the right to use the stamp and it is continually in their possession.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-163 (m) (1)
K.A.R. 28-39-250 (e) (8)
K.A.R. 28-39-285 (d) (8)
K.A.R. 28-39-434 (f) (8)
42 CFR 483.75 (l)

SUBJECT: Use of Facsimile Machines (FAX) for the Transmittal of Physician Orders

DATE: November 1, 1993

REVISED: February 15, 2002

NUMBER: 93-47

INTERPRETATION: Facsimile machines (FAX) may be used to transmit physician orders and other resident related information to the adult care home. When the facsimile machine is used, it will not be necessary for the physician to countersign the document at a later date.

DISCUSSION: The adult care home shall develop policies and procedures to assure the accuracy and confidentiality of the information transmitted by facsimile machines. Included in the policies and procedures shall be a requirement that each item transmitted by a facsimile machine shall be photocopied before being placed on the resident's clinical record as the original created by the facsimile machine will fade over a period of time.

Current regulations are silent on the issue of transmitting physician orders and other information by facsimile machine. Therefore, nothing in the current regulations prohibits their use. In fact, the use of such a transmittal system could be superior to telephone orders which would have a greater probability of error in translation than written orders transmitted by a facsimile machine.

NOTE: The Drug Enforcement Agency prohibits the use of facsimile copies in ordering all controlled substances.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-163 (m) (4)
K.A.R. 28-39-250 (c)
K.A.R. 28-39-285(c)
K.A.R. 28-39-434(e)
42 C.F.R. 483.410 (c) (2)
42 C.F.R. 483.75 (l) (3)

SUBJECT: Temporary Removal of Clinical Record from Facility

DATE: November 1, 1993

REVISED: March 17, 1997, February 18, 2002

NUMBER: 93-48

INTERPRETATION: It is an acceptable practice for resident clinical records to be taken with the resident to the physician or other medical professional when accompanied by a facility staff member.

DISCUSSION: Allowing the resident's medical record to be taken from the facility when accompanied by a facility staff member to assist the resident in obtaining treatment or care does not compromise the security or confidentiality of the medical record. This practice is acceptable to the American Medical Records Association and, therefore, within accepted professional standards and practices.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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OBRA 1819(b)(5)(C)
1919(b)(5)(A)
K.S.A. 39-936 (c) (5)

SUBJECT: Facility Responsibility to Contact the Nurse Aide Registry

DATE: November 1, 1993

REVISED: March 17, 1997

NUMBER: 93-50

INTERPRETATION: It is the adult care home's sole responsibility to contact the registry about any person used by the facility on a full-time, part-time, temporary, permanent, or other basis as a certified nurse aide. A temporary employment or placement agency, certified nurse aide, member of the public, regional or central office or other organization may not contact the registry on behalf of an adult care home.

DISCUSSION: There will be instances when a facility may need to use a nurse aide from a staffing agency or in an emergency and the nurse aide is not open. The adult care home shall contact the registry the following work day. All nursing care facilities have a state assigned identification number which is to be given to the registry operator when making an inquiry. This number is required to produce a confirmation letter that is addressed to the facility. Any confirmation letter from the registry for use in documenting contact with the registry about a specific person must be obtained by the facility using the person and the confirmation letter must be addressed to the facility.

The facility need only have on file one confirmation letter about a nurse aide who is a permanent employee or from a temporary employment or placement agency to be able to use the person as an aide. If the temporary or placement person is hired on a permanent basis or makes a change to another temporary employment or placement agency, then a new confirmation letter must be on file.

Any temporary employment or placement agency, nurse aide, member of the public, regional or central office or other organization may contact the registry. However, no written confirmation letters will be issued for these inquiries except upon receipt of a written request. Written requests should list the aide's certificate identification or registration number; the aide's last name, first name, and middle initial; the aide's address; and the aide's social security number.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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42 CFR 483.75 (e) (8)
K.S.A. 39-936 (c) (3)

SUBJECT: Provision of Direct Care by Volunteers in Adult Care Homes

DATE: November 1, 1993

REVISED: March 17, 1997

NUMBER: 93-51

INTERPRETATION: Volunteers may provide direct care to residents in adult care homes when the volunteer is trained on how to conduct the task properly. The facility shall have policies and procedures related to the use of volunteers. When delegating a task to a volunteer, the facility shall assure that:

1. The volunteer has been trained and demonstrates the ability to perform the task properly.
2. Policies and procedures of the facility are followed.
3. A specific staff person has the responsibility for supervising the services provided by the volunteer.
4. The resident and/or legal representative has agreed that the service can be provided by a volunteer.
5. Volunteers do not replace required facility staff.

DISCUSSION: Volunteers can be an important supplement in meeting the needs of residents in adult care homes. The decision to delegate a task to a volunteer must be done in a manner which assures that the task will be performed safely and appropriately and the resident is willing to have a volunteer perform the task. K.S.A. 39-936 (c) (3), which sets forth the requirement for direct care staff training, is limited to employees, and therefore volunteers are not required to hold a nurse aide training certificate. Facilities do have a responsibility to assure volunteers can perform direct care tasks safely. Staffing requirements must be maintained at all times, regardless of the level of volunteer support.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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REGULATION INTERPRETATION
BUREAU OF HEALTH FACILITIES

KAR 28-39-241

SUBJECT: Community Governance

DATE: February 21, 1997

NUMBER: 97-1

INTERPRETATION: A community governance organization that provides for resident involvement in a continuing care residential community will meet the requirements of this regulation.

DISCUSSION: Many continuing care residential communities have established community governance organizations. This organization can fulfill the requirements for community governance in an assisted living or residential health care facility as long as residents in the licensed facility are provided the opportunity to participate in the community organization.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

LONG TERM CARE
REGULATION INTERPRETATION
BUREAU OF HEALTH FACILITIES

KAR 28-39-241

SUBJECT: Storage and preparation of food in a resident's individual living unit or assisted living apartment

DATE: February 21, 1997

NUMBER: 97-2

INTERPRETATION: Residential health care or assisted living facilities may limit the ability of residents to prepare and store food in the resident's unit, if the resident is unable or will not do so in a safe manner.

DISCUSSION: This regulation allows facilities to develop criteria for allowing individual residents to prepare and store food in their kitchens or units. There will be some residents, who, due to cognitive deficits or personal practices, should not be allowed to prepare and store food. The following are examples: leaving a stove unattended and causing a fire hazard; or, not maintaining a clean food preparation and storage area which could cause insect infestation or odors.

Facilities should develop a policy related to preparation and storage of food. If residents are unable or refuse to follow the policy, the ability to store and prepare foods can be withdrawn.

Residents will not be required to date food stored in a refrigerator; nor will the facility be expected to "inspect" the food preparation area on a routine basis. Staff should be aware of the need for maintaining general good housekeeping in a unit and report any problems identified to the operator or administrator.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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KAR 28-39-244 (j) (3)

SUBJECT: Monitoring of outside resources in assisted living and residential health care facilities

DATE: February 21, 1997

NUMBER: 97-3

INTERPRETATION: Assisted living and residential health care facilities are required to monitor the services provided to residents by outside resources such as a home health agency or a hospice.

DISCUSSION: Included in the definitions for assisted living and residential health care facilities is the statement the facilities “**provide or coordinate** a range of services.” Coordinating a range of services includes monitoring those services.

When an outside resource provides care and services to a resident under the negotiated service agreement, the facility must develop methods to ensure that the services are delivered. When there is evidence that the services are either not being provided or that care does not meet standards of practice, facility staff have the obligation to discuss these issues with the resident and/or the legal representative. Facility staff should offer to act as an advocate for the resident with the service provider or assist the resident in arranging for another service provider. Residents have the right to refuse the offer. In that instance, the facility should inform the resident of the potential negative outcomes.

KSA 39-939 states that:

“It shall be unlawful in any adult care home to house, care for or permit:
.... (b) Abuse, neglect, or cruel treatment of any residents.”

When an outside resource fails to provider services as agreed to or the services provided do not meet standards of practice, potential or actual neglect may occur. Prevention of neglect is a very important role of staff in an assisted living or residential health care facility.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R.28-39-279(c)(e)
K.A.R. 28-39-244(c)(e)
K.A.R. 28-39-428(c)(e)

SUBJECT: Negotiated Service Agreement - Name of licensed nurse responsible for health care services

DATE: February 21, 1997

REVISED: February 15, 2002

NUMBER: 97-4

INTERPRETATION: The name of the licensed nurse responsible for the development of the health care plan and/or skilled nursing plan shall be included in the plan.

DISCUSSION: The regulations related to the negotiated service plan and the health care plans focus on involving the resident, the resident's legal representative and the resident's family, when agreed to by the resident in the development of the agreement and plans. It is very important for the resident to know who is responsible for the development and implementation of the nursing plan. This process would be analogous to primary nursing. Other nurses employed by the facility may implement the plan and provide supervision of the nurse aides providing direct care. Knowing who to contact about the care provided by nurse aides is an important component of the assisted living philosophy.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-251(a)
K.A.R. 28-39-286 (a)
K.A.R. 28-39-432 (a)

SUBJECT: Staffing requirement for Assisted Living/Residential Health Care Facilities, Adult Day Care, and Home Plus

DATE: December 2, 1997

REVISED: February 15, 2002

NUMBER: 97-8

INTERPRETATION: An adequate number of staff must be available at all times to assist residents promptly in the event of an emergency. Egress from the building or to a place of safety of all residents should be accomplished in five minutes or less.

DISCUSSION: Staff of assisted living, residential health care facilities, adult day care and home plus must be able to assist all residents out of the building or to a place safety promptly in the event of an emergency. In determining staffing levels facilities must take into consideration the following issues:

1. The number of residents who will need physical assistance in exiting the building or evacuation to a place of safety.
2. The number of residents who will need guidance by staff members in an emergency. Guidance maybe necessary due to cognitive impairment, poor decision making skills or deficits in hearing and/or vision.
3. The periods during a day with the fewest staff members available to assist residents in an emergency.

The facility is responsible for being able to demonstrate that evacuation during an emergency can be safely accomplished with the staff equal to that used during nighttime hours or other periods of lowest staffing.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-246
K.A.R. 28-39-281
K.A.R. 28-39-430

Subject: Supervision of Nurse Aides and Medication Aides

Date: December 7, 2001

Number: 01-1

Interpretation: If the resident receives health care services, the negotiated service agreement must include a health care plan prepared by a licensed nurse. The health care plan must include a description of the nursing services to be provided including directions to nurse aides and medication aides by a licensed nurse responsible for the care of the resident. The health care plan provides evidence that nurse aides and medication aides are supervised by a licensed nurse.

A home health agency or licensed nurse employed by the resident or family to provide nursing care must develop a health services plan related to the services to be provided.

Discussion: KSA 39-923 defines supervised nursing care as the “services provided by or under the guidance of a licensed nurse with initial direction for nursing procedures and periodic inspection of the actual act of accomplishing the procedures, administration of medications and treatments as prescribed by a licensed physician or dentist; and assistance of residents with the performance of activities of daily living”. A licensed nurse responsible for a resident’s care in the facility must develop a health care plan which provides direction to nurse aides and medication aides who will deliver care. The plan should reflect the resident’s needs and preferences determined by the functional capacity screen and any assessments performed by the licensed nurse. The licensed nurse must provide initial direction for nursing procedures to be performed by nurse aides and medication aides. The nurse aides and medication aides should be able to identify from the plan the circumstances under which they need to consult with a licensed nurse. Periodically, the licensed nurse should record the resident’s response to the health care plan in the resident’s clinical record. This documentation fulfills the requirement for periodic inspection of the nursing procedures performed by nurse aides and medication aides.

The health care plan developed by an outside entity (home health agency or licensed nurse employed by the resident or family) may be attached to or included in the negotiated service agreement. Home health agencies may use a copy of their agency’s plan of care for the resident.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-244
K.A.R. 28-39-279
K.A.R. 28-39-428

SUBJECT: Negotiated Service Agreement

DATE: December 7, 2001

NUMBER: 01-2

INTERPRETATION: Developing the negotiated service agreement provides a mechanism for the facility to communicate to the resident the services the facility believes meet the needs and preferences of the resident. The resident or the resident's legal representative have the right to fully understand the services being offered by the facility, those provided by another entity such as a home health agency, the cost of those services and who is responsible for payment. The resident or the resident's legal representative must be active participants in the development of the negotiated service agreement. A copy of the negotiated service agreement, signed by all participants in the process, must be provided to the resident or the resident's legal representative each time an agreement is developed.

DISCUSSION: The regulations require that the process for developing a negotiated service agreement must be interactive between facility staff and the resident or the resident's legal representative. Surveyors will review the negotiated service agreement of a sample of residents. They will focus on whether the facility identified the needs and preferences of the resident based on the functional capacity screen and assessments performed by staff. The facility is responsible for ensuring the functional capacity screen and other assessments accurately reflect the resident's functional status. It is the responsibility of the facility to ensure that those services identified on the negotiated service agreement are delivered.

When legal representatives live outside the community or are unable to come to the facility, the interactive process in developing the negotiated service agreement can be done through telephone conferences, e mail etc. It is important that the legal representative is an active participant in the process. A copy of the negotiated service agreement can be mailed or faxed to the legal representative for their signature.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities

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K.A.R. 28-39-244(f)
K.A.R. 28-39-279(f)
K.A.R. 28-39-428(f)

Subject: Refusal of a service

Date: December 7, 2001

Number: 01-3

Interpretation: The resident has the right to exercise their autonomy and choice within the confines of state law and regulations, community standard of care and the rights of other residents in the facility. Residents or the resident's legal representative must be informed of the ramifications of their refusal of service. The negotiated service agreement must include evidence of the information provided to the resident or the resident's legal representative and the agreement to assume those risks.

Discussion: Residents may choose not to follow a prescribed diet, take a prescribed medication, or participate in recommended programs offered by or coordinated by the facility. Facilities cannot agree to risk agreements that include situations that have the potential to adversely affect the health and safety of other residents, are against statutes and regulations, or alleviate the facility from responsibility for providing accepted standards of clinical care. Residents with impaired cognition are unable to give informed consent and therefore cannot enter into a risk agreement.

Patricia A. Maben, RN, MN
Director, Long Term Care Program

Joseph F. Kroll, Director
Bureau of Health Facilities