

902 KAR 20:026. Operations and services; skilled nursing facilities.

RELATES TO: KRS 216B.010-216B.131, 216B.990

STATUTORY AUTHORITY: KRS 216B.042, 216B.105, 311.560(3), (4), 314.011(8), 314.042(8), 320.210(2), EO 96-862

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042 and 216B.105 mandate that the Cabinet for Health Services regulate health facilities and health services. This administrative regulation establishes licensure requirements for the operation of skilled nursing facilities. Executive Order 96-862, effective July 2, 1996, reorganizes the Cabinet for Human Resources and places the Office of Inspector General and its programs under the Cabinet for Health Services.

Section 1. Definitions. (1) "Administrator" means a person who is licensed as a nursing home administrator pursuant to KRS 216A.080.

(2) "Facility" means a skilled nursing facility.

(3) "License" means an authorization issued by the cabinet for the purpose of operating a skilled nursing facility and offering skilled nursing services.

(4) "Occupational therapist" means a person who is registered by the American Occupational Therapy Association or a graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and who is engaged in or has completed the required supervised clinical experience period prerequisite to registration by the American Occupational Therapy Association.

(5) "Qualified dietician" or "nutritionist" means:

(a) A person who has a bachelor of science degree in foods and nutrition, food service management, institutional management or related services and has successfully completed a dietetic internship or coordinated undergraduate program accredited by the American Dietetic Association (ADA) and is a member of the ADA or is registered as a dietician by ADA; or

(b) A person who has a masters degree in nutrition and is a member of ADA or is eligible for registration by ADA; or

(c) A person who has a bachelor of science degree in home economics and three (3) years of work experience with a registered dietician.

(6) "Qualified medical record practitioner" means a person who has graduated from a program for medical record administrators or technicians accredited by the Council on Medical Education of the American Medical Association and the American Medical Record Association; and who is certified as a Registered Records Administrator or an Accredited Record Technician by the American Medical Record Association.

(7) "Qualified social worker" means a person who is licensed pursuant to KRS 335.090, if applicable, and who is a graduate of a school of social work accredited by the Council on Social Work Education.

(8) "Restraint" means any pharmaceutical agent or physical or mechanical device used to restrict the movement of a patient or the movement of a portion of a patient's body.

(9) "Speech pathologist" means a person who:

(a) Meets the education and experience requirements for a certificate of clinical competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association; or

(b) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Section 2. Scope of Operations and Services. Skilled nursing facilities are establishments with permanent facilities including inpatient beds. Services provided include medical services, and continuous nursing services to provide treatment for patients. Patients in a skilled nursing facility are patients who require inpatient care but are not in an acute phase of illness, and who currently require primarily convalescent or rehabilitative services and have a variety of medical conditions.

Section 3. Administration and Operation. (1) Licensee. The licensee shall be legally responsible for the facility and for compliance with federal, state and local laws and regulations pertaining to the operation of the facility.

(2) Administrator. All facilities shall have an administrator who is responsible for the operation of the facility and who shall delegate such responsibility in his absence.

(3) Policies. The facility shall establish written policies and procedures that govern all services provided by the facility. The written policies shall include:

(a) Personnel policies, practices and procedures that support sound patient care.

(b) Notification of changes in patient status and service cost. There shall be written policies and procedures relating to notification of responsible person(s) in the event of significant changes in patient status, patient charges, billings, and other related administrative matters.

(c) Patient care policies. The facility shall have written policies to govern the skilled nursing care and related medical and other services provided, which shall be developed with the advice of professional personnel, including one (1) or more physicians and one (1) or more registered nurses and other health personnel (e.g., social workers, dietitians, pharmacists, speech pathologists and audiologists, physical and occupational therapists and mental health personnel). Pharmacy policies and procedures shall be developed with the advice of a subgroup of physicians and pharmacists who serve as a pharmacy and therapeutics committee. A physician or a registered nurse shall be responsible for assuring compliance with and annual review of these policies. In addition to written policies for services, the facility shall have written policies to include:

1. Admission, transfer, and discharge policies including categories of patients accepted and not accepted by the facility.

2. Medication stop orders;

3. Medical records;

4. Transfer agreement;

5. Utilization review ; and

6. Use of restraints.

(d) Adult and child protection. The facility shall have written policies which assure the reporting of cases of abuse, neglect or exploitation of adults and children pursuant to KRS Chapters 209 and 620.

(e) Missing patient procedures. The facility shall have a written procedure to specify in a step-by-step manner the actions which shall be taken by staff when a patient is determined to be lost, unaccounted for or on other unauthorized absence.

(4) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525.

(5) Admission.

(a) Patients shall be admitted only upon the referral of a physician. Additionally, the facility shall admit only persons who require medical and continuous skilled nursing care and who currently require primarily convalescent or rehabilitative services for a variety of medical conditions. The facility shall not admit persons whose care needs exceed the capability of the facility.

(b) Upon admission the facility shall obtain the patient's medical diagnosis, physician's orders for the care of the patient and the transfer form. The facility shall obtain a medical evaluation within forty-eight (48) hours of admission, unless an evaluation was performed within five (5) days prior to admission. The medical evaluation shall include current medical findings, rehabilitation potential, a summary of the course of treatment followed in the hospital or intermediate care facility (a current hospital discharge summary containing the above information shall be acceptable).

(c) If the physician's orders for the immediate care of a patient are unobtainable at the time of admission, the facility shall contact the physician with responsibility for emergency care to obtain temporary orders.

(d) Before admission the patient and a responsible member of his family or committee shall be informed in writing of the established policies of the facility to include: fees, reimbursement, visitation rights during serious illness, visiting hours, type of diets offered and services rendered.

(6) Discharge planning. The facility shall have a discharge planning program to assure the continuity of care for patients being transferred to another health care facility or being discharged to the home.

(7) Transfer and discharge. The facility shall comply with the requirements of 900 KAR 2:050 when transferring or discharging residents.

(a) The facility shall have written transfer procedures and agreements for the transfer of patients to other health care facilities which can provide a level of inpatient care not provided by the facility. Any facility which does not have a transfer agreement in effect but which documents a good faith attempt to enter into such an agreement shall be considered to be in compliance with the licensure requirement. The transfer procedures and agreements shall specify the responsibilities each institution assumes in the transfer of patients, shall establish responsibility for notifying the other institution promptly of the impending transfer of a patient, and shall arrange for appropriate and safe transportation.

(b) When the patient's condition exceeds the scope of services of the facility, the patient, upon physician's orders (except in cases of emergency), shall be transferred promptly to an appropriate level of care.

(c) The agreement shall provide for the transfer of personal effects, particularly money and valuables, and for the transfer of information related to these items.

(d) When a transfer is to another level of care within the facility, the complete patient record or a current summary thereof shall be transferred with the patient.

(e) If the patient is transferred to another health care facility or home to be cared for by a home health agency, a transfer form shall accompany the patient. The transfer form shall include at least the following: physician's orders (if available), current information relative to diagnosis with history of problems requiring special care, a summary of the course of prior treatment, special supplies or equipment needed for patient care, and pertinent social information on the patient and his family.

(f) Except in an emergency, the patient, his next of kin, or responsible person if any, and the attending physician shall be consulted in advance of the transfer or discharge of any patient.

(8) Tuberculosis testing. All employees and patients shall be tested for tuberculosis in accordance with the provisions of 902 KAR 20:200, tuberculosis testing in long term care facilities.

(9) Personnel.

(a) Job descriptions. Written job descriptions shall be developed for each category of personnel to include qualifications, lines of authority and specific duty assignments.

(b) Employee records. Current employee records shall be maintained and shall include a resume of each employee's training and experience, evidence of current licensure or registration where required by law, health records, evaluation of performance, records of in-service training and ongoing education, along with employee's name, address and Social Security number.

(c) Health requirements. No employee contracting an infectious disease shall appear at work until the infectious disease can no longer be transmitted.

(d) Staffing classification requirements.

1. The facility shall have adequate personnel to meet the needs of the patients on a twenty-four (24) hour basis. The number and classification of personnel required shall be based on the number of patients, and the amount and kind of personal care, nursing care, supervision, and program needed to meet the needs of the patients, as determined by medical orders and by services required by this administrative regulation.

2. If the staff to patient ratio does not meet the needs of the patients, the Division for Licensing and Regulation shall determine and inform the administrator in writing how many additional personnel are to be added and of what job classification, and shall give the basis for this determination.

3. The facility shall have a director of nursing service who is a registered nurse and who works full time during the day, and who devotes full time to the nursing service of the facility. If the director of nursing has administrative responsibility for the facility, there shall be an assistant director of nursing, who shall be a registered nurse, so that there shall be the equivalent of a full-time director of nursing service. The director of nursing shall be trained or experienced in areas of nursing service, administration, rehabilitation nursing, psychiatric or geriatric nursing. The director of the nursing service shall be responsible for:

a. Developing and maintaining nursing service objectives, standards of nursing practice, nursing procedure manuals, and written job

descriptions for each level of nursing personnel;

- b. Recommending to the administrator the number and level of nursing personnel to be employed, participating in their recruitment and selection, and recommending termination of employment when necessary;
- c. Assigning and supervising all levels of nursing personnel;
- d. Participating in planning and budgeting for nursing care;
- e. Participating in the development and implementation of patient care policies and bringing patient care problems requiring changes in policy to the attention of the professional policy advisory group;
- f. Coordinating nursing services with other patient care services;
- g. Planning and conducting orientation programs for new nursing personnel and continuing in-service education for all nursing personnel;
- h. Participating in the selection of prospective patients in terms of nursing services they need and nursing competencies available;
- i. Assuring that a nursing care plan shall be established for each patient and that his plan shall be reviewed and modified as necessary;
- j. Assuring that registered nurses, licensed practical nurses, nurses' aides and orderlies are assigned duties consistent with their training and experience.

4. Supervising nurse. Nursing care shall be provided by or under the supervision of a full-time registered nurse. The supervising nurse shall be a licensed registered nurse who may be the director of nursing or the assistant director of nursing and shall be trained or experienced in the areas of nursing administration and supervision, rehabilitative nursing, psychiatric or geriatric nursing. The supervising nurse shall make daily rounds to all nursing units performing such functions as visiting each patient, and reviewing medical records, medication cards, patient care plans, and staff assignments, and whenever possible accompanying physicians when visiting patients.

5. Charge nurse. There shall be at least one (1) registered nurse or licensed practical nurse on duty at all times and who is responsible for the nursing care of patients during her tour of duty. When a licensed practical nurse is on duty, a registered nurse shall be on call.

6. Pharmacist. The facility shall employ a licensed pharmacist on a full-time, part-time or consultant basis to direct pharmaceutical services.

7. Therapists.

a. If rehabilitative services beyond rehabilitative nursing care are offered, whether directly or through cooperative arrangements with agencies that offer therapeutic services, these services shall be provided or supervised by qualified therapists to include licensed physical therapists, speech pathologists and occupational therapists.

b. When supervision is less than full time, it shall be provided on a planned basis and shall be frequent enough, in relation to the staff therapist's training and experience, to assure sufficient review of individual treatment plans and progress.

c. In a facility with an organized rehabilitation service using a multidisciplinary team approach to meet all the needs of the patient, and where all therapists' services are administered under the direct supervision of a physician qualified in physical medicine who will determine goals and limits of the therapists' work, and prescribes modalities and frequency of therapy, persons with qualifications other than those described in subsection (8)(d)7a of this section may be assigned duties appropriate to their training and experience.

8. Dietary. Each facility shall have a full-time person designated by the administrator, responsible for the total food service operation of the facility and who shall be on duty a minimum of thirty-five (35) hours each week.

9. The administrator shall designate a person for each of the following areas who will be responsible for:

a. Medical records. The person responsible for the records shall maintain, complete and preserve all medical records. If the person is not a qualified medical record practitioner he shall be trained by and receive regular consultation from a qualified medical record practitioner.

b. Social services. There shall be a full-time or part-time social worker employed by the facility, or a person who has training and experience in related fields to find community resources, to be responsible for the social services. If the facility does not have a qualified social worker on its staff, consultation shall be provided by a qualified social worker. The person responsible for this area of service shall have information promptly available on health and welfare resources in the community.

c. Patient activities. This person shall have training or experience in directing group activities.

(e) In-service educational programs.

1. There shall be an in-service education program in effect for all nursing personnel at regular intervals in addition to a thorough job orientation for new personnel. Opportunities shall be provided for nursing personnel to attend training courses in rehabilitative nursing and other educational programs related to the care of long-term patients. Skill training for nonprofessional nursing personnel shall begin during the orientation period, to include demonstration, practice and supervision of simple nursing procedures applicable in the individual facility. It shall also include simple rehabilitative nursing procedures to be followed in emergencies. All patient care personnel shall be instructed and supervised in the care of emotionally disturbed and confused patients, and shall be assisted to understand the social aspects of patient care.

2. Social services training of staff. There shall be provisions for orientation and in-service training of staff directed toward understanding emotional problems and social needs of sick and infirm aged persons and recognition of social problems of patients and the means of taking appropriate action in relation to them. Either a qualified social worker on the staff, or one (1) from outside the facility, shall participate in training programs, case conferences, and arrangements for staff orientation to community services and patient needs.

(10) Medical records.

(a) The facility shall develop and maintain a system of records retention and filing to insure completeness and prompt location of each patient's record. The records shall be held confidential. The records shall be in ink or typed and shall be legible. Each entry shall be dated and signed. Each record shall include:

1. Identification data including the patient's name, address and Social Security number (if available); name, address and telephone number of referral agency; name and telephone number of personal physician; name, address and telephone number of next of kin or other responsible person; and date of admission.

2. Admitting medical evaluation including current medical findings, medical history, physical examination and diagnosis. (The medical evaluation may be a copy of the discharge summary or history and physical report from a hospital, or an intermediate care facility if done within five (5) days prior to admission.)

3. Orders for medication, diet, and therapeutic services. These shall be dated and signed by the prescribing physician, advanced

registered nurse practitioner as authorized in KRS 314.011(8) and 314.042(8), therapeutically-certified optometrist in the practice of optometry as defined in KRS 320.210(2), or physician assistant as authorized in KRS 311.560(3) and (4).

4. Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit.
5. Findings and recommendations of consultants.
6. A medication sheet which contains the date, time given, name of each medication or prescription number, dosage and name of prescribing physician, advanced registered nurse practitioner, therapeutically-certified optometrist, or physician assistant.
7. Nurse's notes indicating changes in patient's condition, actions, responses, attitudes, appetite, etc. Nursing personnel shall make notation of response to medications, response to treatments, visits by physician and phone calls to the physician, medically prescribed diets and restorative nursing measures.
8. Nursing supervisor's written assessment of the patient's monthly general condition.
9. Reports of dental, laboratory and x-ray services.
10. Changes in patient's response to the activity and therapeutic recreation program.
11. A discharge summary completed, signed and dated by the attending physician within one (1) month of discharge from the facility.
 - (b) Retention of records. After death or discharge the completed medical record shall be placed in an inactive file and retained for five (5) years or in case of a minor, three (3) years after the patient reaches the age of majority under state law, whichever is the longest.

Section 4. Provision of Services. (1) Physician services.

(a) The health care of each patient shall be under supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatments, rehabilitative services, diet, special procedures recommended for the health and safety of the patient, activities, plans for continuing care and discharge.

(b) Patients shall be evaluated by a physician at least once every thirty (30) days for the first ninety (90) days following admission. Subsequent to the 90th day following admission, the patients shall be evaluated by a physician every sixty (60) days. There shall be evidence in the patient's medical record of the physician's visits to the patient at appropriate intervals.

(c) There shall be evidence in the patient's medical record that the patient's attending physician has made arrangement for the medical care of the patient in the physician's absence.

(d) Availability of physicians for emergency care. The facility shall have arrangements with one (1) or more physicians who will be available to furnish necessary medical care in case of an emergency if the physician responsible for the care of the patient is not immediately available. A schedule listing the names and telephone numbers of these physicians and the specific days each shall be on call shall be posted in each nursing station. There shall be established procedures to be followed in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

(2) Nursing services.

(a) Twenty-four (24) hour nursing service. There shall be twenty-four (24) hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients. Nursing personnel shall include registered nurses, licensed practical nurses, aides and orderlies. The amount of nursing time available for patient care shall be exclusive of nonnursing duties. Sufficient nursing time shall be available to assure that each patient:

1. Shall receive treatments, medication, and diets as prescribed;
2. Shall receive proper care to prevent decubiti and shall be kept comfortable, clean and well-groomed;
3. Shall be protected from accident and injury by the adoption of indicated safety measures;
4. Shall be treated with kindness and respect.

(b) Rehabilitative nursing care. There shall be an active program of rehabilitative nursing care directed toward assisting each patient to achieve and maintain his highest level of self-care and independence.

1. Rehabilitative nursing care initiated in the hospital shall be continued immediately upon admission to the facility.

2. Nursing personnel shall be taught rehabilitative nursing measures and shall practice them in their daily care of patients. These measures shall include:

- a. Maintaining good body alignment and proper positioning of bedfast patients;
- b. Encouraging and assisting bedfast patients to change positions at least every two (2) hours, day and night to stimulate circulation and prevent decubiti and deformities;
- c. Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physician's orders, and encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities;
- d. Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests if necessary;
- e. Assisting patients to carry out prescribed physical therapy exercises between visits of the physical therapist.

(c) Dietary supervision. Nursing personnel shall assure that patients are served diets as prescribed. Patients needing help in eating shall be assisted promptly upon receipt of meals. Food and fluid intake of patients shall be observed and deviations from normal shall be reported to the charge nurse. Persistent unresolved problems shall be reported to the physician.

(d) Nursing care plan. There shall be written nursing care plans for each patient based on the nature of illness, treatment prescribed, long and short term goals and other pertinent information.

1. The nursing care plan shall be a personalized, daily plan for individual patients. It shall indicate what nursing care is needed, how it can best be accomplished for each patient, what are the patient's preferences, what methods and approaches are most successful, and what modifications are necessary to insure best results.

2. Nursing care plans shall be available for use by all nursing personnel.

3. Nursing care plans shall be reviewed and revised as needed.

4. Relevant nursing information from the nursing care plan shall be included with other medical information when patients are transferred.

(3) Specialized rehabilitative services.

(a)1. Rehabilitative services shall be provided upon written order of the physician; or

2. An advanced registered nurse practitioner as authorized in KRS 314.011(8) and 314.042(8), therapeutically-certified optometrist in the practice of optometry as defined in KRS 320.210(2), or physician assistant as authorized in KRS 311.560(3) and (4), may write an order for rehabilitative services limited to their scope of practice; and

3. A written order shall indicate anticipated goals and prescribe specific modalities to be used and frequency of therapy services.

(b) Therapy services shall include:

1. Physical therapy which includes:

a. Assisting the physician in his evaluation of patients by applying muscle, nerve, joint, and functional ability tests;

b. Treating patients to relieve pain, develop or restore functions, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

2. Speech therapy which include:

a. Services in speech pathology or audiology;

b. Cooperation in the evaluation of patients with speech, hearing, or language disorders;

c. Determination and recommendation of appropriate speech and hearing services.

3. Occupational therapy services which includes:

a. Assisting the physician in his evaluation of the patient's level of function by applying diagnostic and prognostic tests;

b. Guiding the patient in his use of therapeutic creative and self-care activities for improving function.

(c) Therapists shall collaborate with the facility's medical and nursing staff in developing the patient's total plan of care.

(d) Ambulation and therapeutic equipment. Commonly used ambulation and therapeutic equipment necessary for services offered shall be available for use in the facility such as parallel bars, hand rails, wheelchairs, walkers, walkerettes, crutches and canes. The therapists shall advise the administrator concerning the purchase, rental, storage and maintenance of equipment and supplies.

(4) Personal care services. Personal care services shall include: assistance with bathing, shaving, cleaning and trimming of fingernails and toenails, cleaning of the mouth and teeth, and washing, grooming and cutting of hair.

(5) Pharmaceutical services.

(a) Procedures for administration of pharmaceutical services. The facility shall provide appropriate methods and procedures for obtaining, dispensing and administering of drugs and biologicals, which have been developed with the advice of a staff pharmacist, or a consultant pharmacist, in cooperation with the facility's pharmacy and therapeutics committee.

(b) If the facility has a pharmacy department, a licensed pharmacist shall be employed to administer the pharmacy department.

(c) If the facility does not have a pharmacy department, it shall have provisions for promptly and conveniently obtaining prescribed drugs and biologicals from a community or institutional pharmacy holding a valid pharmacy permit issued by the Kentucky Board of Pharmacy, pursuant to KRS 315.035.

(d) If the facility does not have a pharmacy department, but does maintain a supply of drugs:

1. The consultant pharmacist shall be responsible for the control of all bulk drugs and maintain records of their receipt and disposition.

2. The consultant pharmacist shall dispense drugs from the drug supply, properly label them and make them available to appropriate licensed nursing personnel.

3. Provisions shall be made for emergency withdrawal of medications from the drug supply.

(e) An emergency medication kit approved by the facility's professional personnel shall be kept readily available. The facility shall maintain a record of what drugs are in the kit and document how the drugs are used.

(f) Medication services.

1. All medications administered to patients shall be ordered in writing by the patient's physician, advanced registered nurse practitioner as authorized in KRS 314.011(8) and 314.042(8) and limited to their scope of practice, therapeutically-certified optometrist in the practice of optometry as defined in KRS 320.210(2) and limited to their scope of practice, or physician assistant authorized in KRS 311.560(3) and (4) and limited to their scope of practice. Telephone orders shall be given only to a licensed nurse or pharmacist immediately reduced to writing, signed by the nurse and countersigned by the physician, advanced registered nurse practitioner, therapeutically-certified optometrist, or physician assistant within forty-eight (48) hours. Medications not specifically limited as to time or number of doses, when ordered, shall be automatically stopped in accordance with the facility's written policy or stop orders. The registered nurse or the pharmacist shall review each patient's medication profile at least monthly. The patient's physician shall review each patient's medications at the time of the medical evaluation pursuant to subsection (1)(b) of this section. The patient's attending physician shall be notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted. Medications are to be released to patients on discharge only on the written authorization of the physician.

2. Administration of medications. All medications shall be administered by licensed medical or nursing personnel in accordance with KRS 311.530 to 311.620 and KRS Chapter 314, or by personnel who have completed a state approved training program from a state approved training provider. The administration of oral and topical medicines by certified medicine technicians shall be under the supervision of licensed medical or nursing personnel. Intramuscular injections shall be administered by a licensed nurse or a physician. If intravenous injections are necessary they shall be administered by a licensed physician, a registered nurse or a properly trained licensed nurse. Each dose administered shall be recorded in the medical record.

a. The nursing station shall have readily available items necessary for the proper administration of medications.

b. In administering medications, medication cards or other state approved systems shall be used and checked against the physician's orders.

c. Medications prescribed for one (1) patient shall not be administered to any other patient.

d. Self-administration of medications by patients shall not be permitted except on special order of the patient's physician or in a pre-discharge program under the supervision of a licensed nurse.

e. Medication errors and drug reactions shall be immediately reported to the patient's physician and an entry thereof made in the patient's medical record as well as on an incident report.

f. Up-to-date medication reference texts and sources of information shall be provided for use by the nursing staff (e.g., the American Hospital Formulary Service of the American Society of Hospital Pharmacists, Physicians Desk Reference or other suitable references).

3. Labeling and storing medications.

a. All medications shall be plainly labeled with the patient's name, the name of the drug, strength, name of pharmacy, prescription number, date, physician name, caution statements and directions for use except where accepted modified unit dose systems conforming to federal and state laws are used. The medications of each patient shall be kept and stored in their original containers and transferring between containers shall be prohibited. All medicines kept by the facility shall be kept in a locked place and the persons in charge shall be responsible for giving the medicines and keeping them under lock and key. Medications requiring refrigeration shall be kept in a separate locked box of adequate size in the refrigerator in the medication area. Drugs for external use shall be stored separately from those administered by mouth and injection. Provisions shall also be made for the locked separate storage of medications of deceased and discharged patients until such medication is surrendered or destroyed in accordance with federal and state laws and regulations.

b. Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels shall be returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers having no labels shall be destroyed in accordance with state and federal laws.

c. Cabinets shall be well lighted and of sufficient size to permit storage without crowding.

d. Medications no longer in use shall be disposed of or destroyed in accordance with federal and state laws and regulations.

e. Medications having an expiration date shall be removed from usage and properly disposed of after such date.

f. Controlled substances. Controlled substances shall be kept under double lock (e.g., in a locked box in a locked cabinet). There shall be a controlled substances record, in which is recorded the name of the patient, the date, time, kind, dosage, balance, remaining and method of administration of all controlled substances; the name of the physician who prescribed the medications; and the name of the nurse who administered it, or staff who supervised the self-administration. In addition, there shall be a recorded and signed schedule II controlled substances count daily, and schedule III, IV and V controlled substances count once per week by those persons who have access to controlled substances. All controlled substances which are left over after the discharge or death of the patient shall be destroyed in accordance with.

4. Use of restraints.

a. No restraints shall be used except as permitted by KRS 216.515(6).

b. Restraints that require lock and key shall not be used.

c. Restraints shall be applied only by appropriately trained personnel.

d. Restraints shall not be used as a punishment, as discipline, as a convenience for the staff, or as a mechanism to produce regression.

5. Infection control and communicable diseases.

a. There shall be written infection control policies, which are consistent with the Centers for Disease Control guidelines including:

(i) Policies which address the prevention of disease transmission to and from patients, visitors and employees, including:

i. Universal blood and body fluid precautions;

ii. Precautions for infections which can be transmitted by the airborne route; and

iii. Work restrictions for employees with infectious diseases.

(ii) Policies which address the cleaning, disinfection, and sterilization methods used for equipment and the environment.

b. The facility shall provide in-service education programs on the cause, effect, transmission, prevention and elimination of infections for all personnel responsible for direct patient care.

c. Sharp wastes.

(i) Sharp wastes, including needles, scalpels, razors, or other sharp instruments used for patient care procedures, shall be segregated from other wastes and placed in puncture resistant containers immediately after use.

(ii) Needles shall not be recapped by hand, purposely bent or broken, or otherwise manipulated by hand.

(iii) The containers of sharp wastes shall either be incinerated on or off site, or be rendered nonhazardous by a technology of equal or superior efficacy, which is approved by both the Cabinet for Health Services and the Natural Resources and Environmental Protection Cabinet.

d. Disposable waste.

(i) All disposable waste shall be placed in suitable bags or closed containers so as to prevent leakage or spillage, and shall be handled, stored, and disposed of in such a way as to minimize direct exposure of personnel to waste materials.

(ii) The facility shall establish specific written policies regarding handling and disposal of all wastes.

(iii) The following wastes shall be disposed of by incineration, autoclaved before disposal, or carefully poured down a drain connected to a sanitary sewer: blood, blood specimens, used blood tubes, or blood products.

(iv) Any wastes conveyed to a sanitary sewer shall comply with applicable federal, state, and local pretreatment regulations.

e. Patients infected with the following diseases shall not be admitted to the facility: anthrax, campylobacteriosis, cholera, diphtheria, hepatitis A, measles, pertussis, plague, poliomyelitis, rabies (human), rubella, salmonellosis, shigellosis, typhoid fever, yersiniosis, brucellosis, giardiasis, leprosy, psittacosis, Q fever, tularemia, and typhus.

f. A facility may admit a noninfectious tuberculosis patient under continuing medical supervision for his tuberculosis disease.

g. Patients with active tuberculosis may be admitted to the facility whose isolation facilities and procedures have been specifically approved by the cabinet.

h. If, after admission, a patient is suspected of having a communicable disease that would endanger the health and welfare of other patients the administrator shall assure that a physician is contacted and that appropriate measures are taken on behalf of the patient with the communicable disease and the other patients.

(6) Diagnostic services. The facility shall have provisions for obtaining required clinical laboratory, x-ray and other diagnostic services. Laboratory services may be obtained from a laboratory which is part of a licensed hospital or a laboratory licensed pursuant to KRS 333.030 and any administrative regulations promulgated thereunder. Radiology services shall be obtained from a service licensed or registered pursuant to KRS 211.842 to 211.852 and any administrative regulations promulgated thereunder. If the facility provides its own diagnostic services, the service shall meet the applicable laws and administrative regulations. All diagnostic services shall be provided only on the request of a physician. The physician shall be notified promptly of the test results. Arrangements shall be made for the transportation of patients, if necessary, to and from the source of service. Simple tests, such as those customarily done by nursing personnel for diabetic

patients may be done in the facility. All reports shall be included in the medical record.

(7) Dental services. The facility shall assist patients to obtain regular and emergency dental care. Provision for dental care: patients shall be assisted to obtain regular and emergency dental care. An advisory dentist shall provide consultation, participate in in-service education, recommend policies concerning oral hygiene, and shall be available in case of emergency. The facility, when necessary, shall arrange for the patient to be transported to the dentist's office. Nursing personnel shall assist the patient to carry out the dentist's recommendations.

(8) Social services.

(a) Provision for medically related social needs. The medically related social needs of the patient shall be identified, and services provided to meet them, in admission of the patient, during his treatment and care in the facility, and in planning for his discharge.

1. As a part of the process of evaluating a patient's need for services in a facility and whether the facility can offer appropriate care, emotional and social factors shall be considered in relation to medical and nursing requirements.

2. As soon as possible after admission, there shall be an evaluation, based on medical, nursing and social factors, of the probable duration of the patient's need for care and a plan shall be formulated and recorded for providing such care.

3. Where there are indications that financial help will be needed, arrangements shall be made promptly for referral to an appropriate agency.

4. Social and emotional factors related to the patient's illness, to his response to treatment and to his adjustment to care in the facility shall be recognized and appropriate action shall be taken when necessary to obtain case work services to assist in resolving problems in these areas.

5. Knowledge of the patient's home situation, financial resources, community resources available to assist him, and pertinent information related to his medical and nursing requirements shall be used in making decisions regarding his discharge from the facility.

(b) Confidentiality of social data. Pertinent social data, and information about personal and family problems related to the patient's illness and care shall be made available only to the attending physician, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's care, or to recognized health or welfare agencies. There shall be appropriate policies and procedures for assuring the confidentiality of such information.

1. The staff member responsible for social services shall participate in clinical staff conferences and confer with the attending physician at intervals during the patient's stay in the facility, and there shall be evidence in the record of such conferences.

2. The staff member and nurses responsible for the patient's care shall confer frequently and there shall be evidence of effective working relationships between them.

3. Records of pertinent social information and of action taken to meet social needs shall be maintained for each patient. Signed social service summaries shall be entered promptly in the patient's medical record for the benefit of all staff involved in the care of the patient.

(9) Patient activities. Activities suited to the needs and interests of patients shall be provided as an important adjunct to the active treatment program and to encourage restoration to self-care and resumption of normal activities. Provision shall be made for purposeful activities which are suited to the needs and interests of patients.

(a) The activity leader shall use, to the fullest possible extent, community, social and recreational opportunities.

(b) Patients shall be encouraged but not forced to participate in such activities. Suitable activities are provided for patients unable to leave their rooms.

(c) Patients who are able and who wish to do so shall be assisted to attend religious services.

(d) Patients' request to see their clergymen shall be honored and space shall be provided for privacy during visits.

(e) Visiting hours shall be flexible and posted to permit and encourage visiting friends and relatives.

(f) The facility shall make available a variety of supplies and equipment adequate to satisfy the individual interests of patients. Examples of such supplies and equipment are: books and magazines, daily newspapers, games, stationery, radio and television and the like.

(10) Residential services.

(a) Dietary services. The facility shall provide or contract for food service to meet the dietary needs of the patients including modified diets or dietary restrictions as prescribed by the attending physician, advanced registered nurse practitioner as authorized in KRS 314.011(8) and 314.042(8), or physician assistant as authorized in KRS 311.560(3) and (4). When a facility contracts for food service with an outside food management company, the company shall provide a qualified dietician on a full-time, part-time or consultant basis to the facility. The qualified dietician shall have continuing liaison with the medical and nursing staff of the facility for recommendations on dietetic policies affecting patient care. The company shall comply with all of the appropriate requirements for dietary services in this administrative regulation.

1. Therapeutic diets. If the designated person responsible for food service is not a qualified dietician or nutritionist, consultation by a qualified dietician or qualified nutritionist shall be provided.

2. Dietary staffing. There shall be sufficient food service personnel employed and their working hours, schedules of hours, on duty and days off shall be posted. If any food service personnel are assigned duties outside the dietary department, the duties shall not interfere with the sanitation, safety or time required for regular dietary assignments.

3. Menu planning.

a. Menus shall be planned, written and rotated to avoid repetition. Nutrition needs shall be met in accordance with the current recommended dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity, and in accordance with physician's orders.

b. Meals shall correspond with the posted menu. Menus must be planned and posted one (1) week in advance. When changes in the menu are necessary, substitutions shall provide equal nutritive value and the changes shall be recorded on the menu and all menus shall be kept on file for thirty (30) days.

c. The daily menu shall include daily diet for all modified diets served within the facility based on an approved diet manual. The diet manual shall be a current manual with copies available in the dietary department that has the approval of the professional staff of the facility. The diet manual shall indicate nutritional deficiencies of any diet. The dietician shall correlate and integrate the dietary aspects of the patient care with the patient and patient's chart through such methods as patient instruction, recording diet histories, and participation in rounds and conference.

4. Food preparation and storage.

a. There shall be at least a three (3) day supply of food to prepare well-balanced palatable meals. Records of food purchased for preparation shall be on file for thirty (30) days.

b. Food shall be prepared with consideration for any individual dietary requirement. Modified diets, nutrient concentrates and supplements shall be given only on the written orders of a physician, advanced registered nurse practitioner as authorized in KRS 314.011(8) and 314.042(8), or physician assistant as authorized in KRS 311.560(3) and (4).

c. At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the substantial evening meal and breakfast. Between-meal snacks to include an evening snack before bedtime shall be offered to all patients. Adjustments shall be made when medically indicated.

d. Foods shall be prepared by methods that conserve nutritive value, flavor and appearance and shall be attractively served at the proper temperatures, and in a form to meet the individual needs. A file of tested recipes, adjusted to appropriate yield shall be maintained. Food shall be cut, chopped or ground to meet individual needs. If a patient refuses foods served, nutritional substitutions shall be offered.

e. All opened containers or left over food items shall be covered and dated when refrigerated.

5. Serving of food. When a patient cannot be served in the dining room, trays shall be provided for bedfast patients and shall rest on firm supports such as overbed tables. Sturdy tray stands of proper height shall be provided for patients able to be out of bed.

a. Correct positioning of the patient to receive his tray shall be the responsibility of the direct patient care staff. Patients requiring help in eating shall be assisted within a reasonable length of time.

b. Adaptive self-help devices shall be provided to contribute to the patient's independence in eating.

6. Sanitation. All facilities shall comply with all applicable provisions of KRS 219.011 to KRS 219.081 and 902 KAR 45:005.

(b) Housekeeping and maintenance services.

1. The facility shall maintain a clean and safe facility free of unpleasant odors. Odors shall be eliminated at their source by prompt and thorough cleaning of commodes, urinals, bedpans and other obvious sources.

2. An adequate supply of clean linen shall be on hand at all times. Soiled clothing and linens shall receive immediate attention and shall not be allowed to accumulate. Clothing or bedding used by one (1) patient shall not be used by another until it has been laundered or dry cleaned.

3. Soiled linen shall be placed in washable or disposable containers, transported in a sanitary manner and stored in separate, well-ventilated areas in a manner to prevent contamination and odors. Equipment or areas used to transport or store soiled linen shall not be used for handling or storing of clean linen.

4. Soiled linen shall be sorted and laundered in the soiled linen room in the laundry area. Hand-washing facilities with hot and cold water, soap dispenser and paper towels shall be provided in the laundry area.

5. Clean linen shall be sorted, dried, ironed, folded, transported, stored and distributed in a sanitary manner.

6. Clean linen shall be stored in clean linen closets on each floor, close to the nurses' station.

7. Personal laundry of patients or staff shall be collected, transported, sorted, washed and dried in a sanitary manner, separate from bed linens.

8. Patients' personal clothing shall be laundered as often as is necessary. Laundering of patients' personal clothing shall be the responsibility of the facility unless the patient or the patient's family accepts this responsibility. Patient's personal clothing laundered by or through the facility shall be marked to identify the patient-owner and returned to the correct patient.

9. Maintenance. The premises shall be well kept and in good repair. Requirements shall include:

a. The facility shall insure that the grounds are well kept and the exterior of the building, including the sidewalks, steps, porches, ramps and fences are in good repair.

b. The interior of the building including walls, ceilings, floors, windows, window coverings, doors, plumbing and electrical fixtures shall be in good repair. Windows and doors shall be screened.

c. Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises regularly. Containers shall be cleaned regularly.

d. A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. The compounds shall be stored under lock.

(c) Room accommodations.

1. Each patient shall be provided a standard size bed or the equivalent at least thirty-six (36) inches wide, equipped with substantial springs, a clean comfortable mattress, a mattress cover, two (2) sheets and a pillow, and such bed covering as is required to keep the patients comfortable. Rubber or other impervious sheets shall be placed over the mattress cover whenever necessary. Beds occupied by patients shall be placed so that no patient may experience discomfort because of proximity to radiators, heat outlets, or by exposure to drafts.

2. The facility shall provide window coverings, bedside tables with reading lamps (if appropriate), comfortable chairs, chest or dressers with mirrors, a night light, and storage space for clothing and other possessions.

3. Patients shall not be housed in unapproved rooms or unapproved detached buildings.

4. Basement rooms shall not be used for sleeping rooms for patients.

5. Patients may have personal items and furniture when it is physically feasible.

6. There shall be a sufficient number of tables provided that can be rolled over a patient's bed or be placed next to a bed to serve patients who cannot eat in the dining room.

7. Each living room or lounge area and recreation area shall have an adequate number of reading lamps, and tables and chairs or settees of sound construction and satisfactory design.

8. Dining room furnishings shall be adequate in number, well constructed and of satisfactory design for the patients.

9. Each patient shall be permitted to have his own radio and television set in his room unless it interferes with or is disturbing to other patients. (8 Ky.R. 383; Am. 885; eff. 4-7-82; 11 Ky.R. 811; eff. 12-11-84; 13 Ky.R. 342; eff. 9-4-86; 1133; eff. 2-10-87; 16 Ky.R. 2477; 17 Ky.R. 58; 7-18-90; 1572; 1998; 2193; eff. 12-18-90; 24 Ky.R. 2218; 25 Ky.R. 315; eff. 8-17-98.)