

Subchapter 9 - Resident Care Services

310:675-9-1.1. Nursing and personal care services

- (a) The facility shall ensure that resident rights are respected in the provision of care.
- (b) Basic nursing and personal care shall be provided for residents as needed.
 - (1) Nursing care shall include, but not be limited to:
 - (A) Encouraging residents to be active and out of bed for reasonable time periods.
 - (B) Measuring resident temperature, blood pressure, pulse and respirations at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record.
 - (i) Measuring resident weight at least once every thirty days and more frequently if warranted by the resident's condition, with the results recorded in the clinical record.
 - (ii) Measuring resident pain whenever vital signs are taken and more frequently if warranted by the resident's condition, with the results recorded in the clinical record.
 - (C) Offering fluids, and making fluids available, to maintain proper hydration.
 - (D) Following proper nutritional practices for diets, enteral and parenteral feedings and assistance in eating.
 - (E) Providing proper skin care to prevent skin breakdown.
 - (F) Providing proper body alignment.
 - (G) Providing supportive devices to promote proper alignment and positioning.
 - (H) Turning bed residents every two hours or as needed, to prevent pressure areas, contractures, and decubitus.
 - (I) Performing range of motion exercises in accordance with individual assessment and care plans.
 - (J) Ensuring that residents positions are changed every two hours or as needed when in a chair and are toileted as needed.
 - (K) Establishing and implementing bowel and bladder programs to promote independence, or developing toileting schedules to promote continence.
 - (L) Performing catheter care with proper positioning of bag and tubing at all times.
 - (M) Recording accurate intake and output records for residents with tube feedings or catheters.
 - (N) Assessing the general mental and physical condition of the resident on admission.
 - (O) Updating the assessment and individual care plan when there is a significant change in the resident's physical, mental, or psychosocial functioning.
 - (P) Recognizing and recording signs and symptoms of illness or injury with action taken to treat the illness or injury, and the response to treatments and medications.
 - (2) Personal care shall include, but not be limited to:
 - (A) Keeping residents clean and free of odor.
 - (B) Keeping bed linens clean and dry.
 - (C) Keeping resident's personal clothing clean and neat.
 - (D) Ensuring that residents are dressed appropriately for activities in which they participate; bedfast/chairfast residents shall be appropriately dressed and provided adequate cover for comfort and privacy.
 - (E) Ensuring that the resident's hair is clean and groomed.
 - (F) Providing oral hygiene assistance at least twice daily with readily available dental floss, toothbrush and dentifrice. A denture cleaning/soaking device and brush shall be available and maintained for each resident as needed.
 - (G) Keeping toenails and fingernails clean and trimmed.
- (c) The facility shall assist the resident in securing other services recommended by a physician such as, but not limited to, optometry or ophthalmology, audiology or otology, podiatry, laboratory,

radiology or hospital services. The administration shall, through social services or other means, assist each resident desiring or needing medical related services.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 23 Ok Reg 156, eff 10-6-05 (emergency); Amended at 23 Ok Reg 2415, eff 6-25-06]

310:675-9-2.1. Dental and oral hygiene services

(a) A dental history shall be obtained as part of the medical history on admission. The dental history shall include past dental problems, description of any prosthetic appliance used, current assessment and the resident's current dentist.

(b) The facility shall have all dental prosthetic appliances such as dentures and partial dentures, marked and identified as belonging to that resident at the time of admission. A resident shall be promptly referred to a dentist when prosthetics are lost or damaged.

(c) The facility shall arrange for one or more dentists to be available in an emergency and to act in an advisory capacity to the facility. The dentist notified for any emergency shall be recorded in the clinical record. If unable to contact the resident's dentist, the emergency physician or dentist shall be notified.

(d) The facility shall maintain a list of referral dentists.

(e) The facility shall assist the resident with, or make arrangements for the resident's transportation to and from the dentist's office.

(f) All residents shall have oral hygiene procedures provided at least daily, and as needed. Oral hygiene procedures shall include, but not be limited to, the resident's teeth being brushed and dentures and partial dentures being cleaned. Any exception shall be ordered by the resident's dentist or physician.

(g) Oral hygiene supplies and equipment shall be available in sufficient quantities to meet the residents needs including but not limited to, toothbrushes, toothpaste, dental floss, lemon glycerin swabs or equivalent products, denture cleaners, denture adhesives, and containers for dental prosthetic appliances, such as dentures and partial dentures.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-3.1. Rehabilitative or restorative nursing services

(a) Rehabilitative services promote restoration of the resident's maximum potential. Rehabilitative services shall be provided or obtained by the facility or an outside source according to the resident assessment. An evaluation shall address the residents rehabilitative needs, on admission, annually, and as the resident's condition indicates. Rehabilitative services shall be ordered by the physician, and provided under the direction of licensed or qualified staff. These services shall include, but not be limited to, the following:

- (1) Physical therapy.
- (2) Speech therapy.
- (3) Audiology.
- (4) Occupational therapy.
- (5) Psychological or psychiatric counseling/therapy.
- (6) Nutritional counseling.

(b) Restorative nursing services may be provided by the nursing staff according to the care plan. These services shall include, but not be limited to, the following:

- (1) Range of motion to prevent contracture.
- (2) Bowel and bladder training to restore continence.
- (3) Self-help skill training.
- (4) Behavioral modification under the direction of a qualified consultant.
- (5) Ambulation.
- (6) Remotivation.

- (7) Reality orientation.
 - (8) Reminiscent therapy.
 - (c) There shall be an ongoing in-service education program for all restorative nursing staff.
- [Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-4.1. Supplies and equipment

- (a) There shall be a sufficient quantity of supplies and, equipment in working condition, to meet the residents' medical, nursing, nutritional, social and activity needs.
 - (b) The minimum level of supplies including but not limited to food and other perishables is a three (3) day supply.
- [Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 20 Ok Reg 2399, eff 7-11-03]

310:675-9-5.1. Assessment and care plans

- (a) A resident assessment and an individual care plan shall be completed and implemented for each resident. The care plan shall indicate the resident's current status and accurately identify the resident's needs.
- (b) The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates.
- (c) Efforts shall be made to include the resident and resident's representative in development and implementation of the care planning process.

(1) Resident assessment

- (A) The facility shall conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment for each resident's functional capacity.
- (B) Each resident shall have an assessment coordinated or conducted by a registered nurse.
- (C) Each individual completing a portion of the assessment shall sign, date, and certify the accuracy of that portion.
- (D) An assessment shall be completed within fourteen days after admission of the resident.
- (E) The resident assessment shall include a minimum data set (MDS) in the form required under 42 CFR 483.20. Each facility, with the exception of Intermediate Care Facilities for the Mentally Retarded (ICF/MR), accurately shall complete the MDS for each resident in the facility, regardless of age, diagnosis, length of stay or payment category.
- (F) The MDS form shall require the following, as applicable:
 - (i) Admission assessment;
 - (ii) Annual assessment;
 - (iii) Significant change in status assessment;
 - (iv) Significant correction of prior full assessment;
 - (v) Significant correction of prior quarterly assessment;
 - (vi) Quarterly review; and
 - (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.

(2) Resident pain assessment

- (A) Residents shall be screened for the presence of pain at least once every 30 days and whenever vital signs are taken.
 - (i) Licensed nursing staff shall perform the screening at least once every 30 days. Certified nurse aides may perform the screening more frequently as needed.
 - (ii) The screening instrument shall grade the intensity and severity of pain using a resident-specific pain scale;
- (B) An individualized pain assessment shall be conducted by a registered nurse for each resident:
 - (i) In conjunction with the admission, quarterly and annual assessments required at OAC 310:675-9-5.1.(c)(1)(F); and

- (ii) With onset of pain not previously addressed in a care plan or physician's orders.
- (C) The goal is to alleviate or minimize pain while assisting the resident to maintain as high a level of functioning as possible. The pain assessment shall include, but not be limited to:
 - (i) A statement of how the resident describes the pain;
 - (ii) Intensity and severity of pain graded using a resident-specific pain scale;
 - (iii) Recent changes in pain;
 - (iv) Location(s);
 - (v) Onset and duration of pain, such as new pain within the last 3 days, recent pain within the last 3 months, or more distant pain greater than 3 months;
 - (vi) Type of pain reported or represented by resident, such as constant or intermittent, and duration or frequency of pain;
 - (vii) Current pain measured at its least and greatest levels;
 - (viii) Aggravating and relieving factors;
 - (ix) Treatment including a review of all therapies, including medication, and the regimen used to minimize pain;
 - (x) Effects of pain and effectiveness of therapy on physical and social functions;
 - (xi) Resident's treatment preferences and emotional responses to pain, including resident's expectations and how resident coped with pain; and
 - (xii) If applicable, refer to pain assessment tool for the cognitively impaired.
- (D) Results shall be recorded in the resident's clinical record showing changes in pain scale and changes in level of functioning. The physician shall be contacted as necessary.
- (E) Pain shall be treated promptly, effectively and for as long as necessary.

(3) Individual care plan

- (A) An individual care plan shall be developed and implemented for each resident to reflect the resident's needs.
- (B) The care plan shall be developed by an interdisciplinary team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines determined by the resident's needs.
- (C) The care plan shall include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the assessment.
- (D) The care plan shall be available to appropriate personnel providing care for the resident.
- (E) An initial care plan shall be completed at the time of admission. The individualized care plan shall be completed within twenty-one days after admission.
- (F) A care plan shall be completed within seven calendar days after the completion of the assessment.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 16 Ok Reg 3493, eff 7-30-99 (emergency); Amended at 17 Ok Reg 2072, eff 6-12-00; Amended at 20 Ok Reg 2399, eff 7-11-03; Amended at 23 Ok Reg 156, eff 10-6-05 (emergency); Amended at 23 Ok Reg 2415, eff 6-25-06; Amended at 27 Ok Reg 2545, eff 7-25-10

310:675-9-6.1. Restraints

- (a) The resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience. Restraints may be used in emergency situations, or for the purpose of treating a resident's medical condition. All physical restraints shall allow for quick release. Locked restraints shall not be used.
- (b) In an emergency situation, physical restraints may be used only to ensure the physical safety of the resident, staff, or other residents. When restraints are used in an emergency, the facility shall comply with the following process:
 - (1) A licensed nurse may use physical restraints, without a physician's order, if necessary to prevent injury to the resident, or to other residents, when alternative measures are not effective.

The licensed nurse shall document in the clinical record the application of the physical restraint and the alternative measures that were not effective. A licensed nurse shall contact the physician for physical restraint orders within six hours after application.

(2) The facility staff shall continually monitor the resident during the restraint period. An interdisciplinary team shall evaluate alternative placement if the resident requires physical restraints for longer than forty-eight consecutive hours.

(3) Circumstances requiring the physical restraints shall be re-evaluated every thirty minutes and documented in the clinical record.

(4) A resident who is physically restrained shall have the restraints released for at least ten minutes every two hours. Such residents shall also be repositioned, exercised and toileted as needed.

(c) In an emergency situation, chemical restraints may be used only to ensure the physical safety of the resident, staff, or other residents. When chemical restraints are used, the facility shall comply with the following process:

(1) The written order for the use of a chemical restraint shall be signed by a physician who specifies the duration and circumstances under which the chemical restraint is to be used.

(2) The physician's orders may be oral when an emergency necessitates parenteral administration of the chemical restraint but is valid only until a written order can be obtained within forty-eight hours.

(3) An emergency order for chemical restraints shall not be in effect for more than twelve hours and may be administered only if the resident is continually monitored for the first thirty minutes after administration and every fifteen minutes until such time as the resident appears stable to ensure that any adverse side effects are noticed and appropriate action taken as soon as possible. The clinical record shall accurately reflect monitoring.

(4) A licensed nurse shall document in the resident's clinical record any alternative measures that were not effective and precipitated the use of the chemical restraint.

(5) An interdisciplinary evaluation shall be made to consider alternative placement if the resident requires chemical restraints for longer than twelve continuous hours.

(d) When restraints are required for the resident's medical symptoms, the nursing staff shall ensure that physical and chemical restraints are administered only in accordance with the resident's care plan and under the following circumstances.

(1) When restraints are used to prevent falling, or for the purpose of positioning the resident, the resident and resident's representative shall be informed of the risk and benefits, and written consent shall be obtained.

(2) Restraints may be applied only on a physician's written order and shall identify the type and reason for the restraint. The physician shall also specify the period of time, and the circumstances under which the restraint may be applied.

(3) Alternative measures to the use of restraints shall be evaluated prior to their use. Circumstances requiring the restraints, and alternative measures, shall be re-evaluated and documented in the clinical record every thirty days.

(4) A restrained resident shall have the restraints released every two hours for at least ten minutes; and the resident shall be repositioned, exercised, or provided range of motion and toileted as necessary.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-7.1. Physician services

Each resident shall be under the care of a licensed physician, who shall be responsible for the resident's overall medical care. The physician's duties shall include but not be limited to:

- (1) Completing an admission history and physical that includes chief complaints, course of present illness, past medical history, and examination findings by body systems and diagnosis within two weeks of admission unless a physical was conducted within the previous sixty days.
 - (2) Prescribing diet, treatments and medications.
 - (3) Noting the resident's specific advance directives, if known.
 - (4) Continuing supervision, as required by the resident's care including, but not limited to:
 - (A) Writing progress notes at each visit.
 - (B) Visiting as needed.
 - (C) Participating in developing, and reviewing, the resident's care plan.
- [Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-8.1. Clinical laboratory

- (a) The facility shall provide, or obtain, clinical laboratory services to meet the resident's needs. The facility shall be responsible for the quality and timeliness of the services. If the facility provides clinical laboratory services, the services shall meet the applicable conditions of the services furnished by independent laboratories. If the facility provides blood bank and transfusion services, it shall meet the applicable conditions for independent laboratories and hospitals.
 - (b) If the laboratory refers specimens for testing to another laboratory, the receiving laboratory shall meet applicable conditions as an independent laboratory.
 - (c) If the facility does not provide laboratory services on site, it shall have an agreement to obtain such services only from a laboratory that meets applicable conditions as an independent laboratory, either as a hospital or an independent laboratory.
 - (d) The facility shall:
 - (1) Provide or obtain laboratory services only when ordered by the physician.
 - (2) Promptly notify the physician of the findings.
 - (3) Assist the resident in arranging transportation to and from the source of service, if the resident needs assistance.
 - (4) File signed and dated reports of clinical laboratory services in the resident's clinical record.
- [Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-9.1. Medication services

- (a) **Storage.**
 - (1) Medications shall be stored in a medication room, a locked cabinet, or a locked medication cart, that is convenient to the nursing station and used exclusively for medication storage.
 - (2) The medication storage area temperature shall be maintained between 60° F. (15.5° C.) to 80° F. (26.6° C.)
 - (3) The medication room, the medication storage cabinet, and medication cart shall be locked when not in use.
 - (4) The key to the medication storage areas shall be in the possession of the person responsible for administering medications.
 - (5) Scheduled medications shall be in a locked box within the locked medication area or cart.
 - (6) Medications for external use shall be stored separately from medications for internal use.
 - (7) Medications requiring refrigeration shall be kept within a temperature range of 36° F. (2.2° C.) to 48° F. (8.8° C.) and separated from food and other items. There shall be a method for locking these medications.
 - (8) The medication areas shall have a work counter; the counter and cabinet shall be well lighted, clean and organized.
 - (9) Running water shall be in close proximity to the medication area.
 - (10) Powdered over-the-counter medication for topical use may be kept in the resident's room for administration by a nurse aide if:

(A) The facility submits its policies and procedures for safe and appropriate storage and application of the powder to the Department and receives written approval from the Department prior to implementation; and

(B) Each aide who applies the over-the-counter topical medication is trained in accordance with the established policies and procedures of the facility.

(b) **Emergency medications.** Emergency medication, policies and equipment shall include but not be limited to:

(1) An electric suction machine with necessary aseptic aspirator tips.

(2) An emergency tray or cart with the following items labeled and accessible to licensed personnel only: resuscitation bag; tongue depressors; and assorted airways; sterile hypodermic syringes in 2 cc, 5 cc, and 20 cc or larger sizes and appropriate needles. The content shall be limited to emergency medications and contain no scheduled medications. Only two single dose vials of the following medications may be on the tray or cart: 50% Dextrose, respiratory stimulant, a cardiac stimulant, injectable lasix, injectable dilantin and injectable benadryl.

(3) A certified medication aide shall not administer injectable medications from any emergency tray or cart, but shall have access to resuscitation bags, tongue depressors, and assorted sizes of airways.

(c) **Medication accountability.**

(1) Medications shall be administered only on a physician's order.

(2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour of administration.

(3) An accurate written record of medications administered shall be maintained. The medication record shall include:

(A) The identity and signature of the person administering the medication.

(B) The medication administered within one hour of the scheduled time.

(C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method.

(D) Adverse reactions or results.

(E) Injection sites.

(F) An individual inventory record shall be maintained for each Schedule II medication prescribed for a resident.

(G) Medication error incident reports.

(4) A resident's adverse reactions shall be reported at once to the attending physician.

(d) **Medication labels and handling.**

(1) All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of medication, dosage, directions for use, date of issue and expiration, and name, address and telephone number of pharmacy or physician issuing the medication, and the quantity. If a unit dose system is used, medications shall indicate, at least, the resident's full name, physician's name and strength of medication, and directions for use.

(2) When over-the-counter medications are prescribed and obtained in the original manufacturers container, the package directions shall be considered part of the label. The resident's name shall be on the package.

(3) Each resident's medications shall be kept or stored in the originally received containers. Paper envelopes shall not be considered containers.

(4) Medication containers having soiled, damaged, illegible or makeshift labels shall be relabeled by the issuing pharmacy or physician. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label on a medication container except for over-the-counter medication containers.

(5) No person shall change labels on medication containers. If the attending physician orders a change of directions, there shall be a procedure to mark the container indicating a label change is needed at the next prescription refill.

(6) A pharmacist shall dilute, reconstitute and label medications, whenever possible. If not possible, a registered nurse may reconstitute, dilute and label medications. A distinctive, indelible, supplementary label shall be affixed to the medication container when diluted or reconstituted for other than immediate use. A licensed practical nurse may reconstitute oral medications only. The label shall include the following: resident's name, dosage and strength per unit/volume, nurse's initials, expiration date, and date and time of dilution or reconstitution.

(7) When a resident is discharged, or is on therapeutic leave, the unused medication shall be sent with the resident, or with the resident's representative, unless there is a written physician's order to the contrary, or the medication has been discontinued, or unless the resident or the resident's representative donates unused prescription medications for dispensation to medically indigent persons in accordance with the Utilization of Unused Prescription Medications Act. The clinical record shall document the quantity of medication sent, and returned or donated, and the signature of the person receiving or transferring the medications.

(8) All medication orders shall be automatically stopped after a given time period, unless the order indicates the number of doses to be administered, or the length of time the medication is to be administered. The automatic stop order may vary for different types of medications. The facility shall develop policies and procedures, in consultation with the medical director and pharmacist, to review automatic stop orders on medications. The policy shall be available to personnel administering medications.

(9) No resident shall be allowed to keep any medications unless the attending physician or interdisciplinary team has indicated on the resident's clinical record that the resident is mentally and physically capable of self-administering medications.

(10) A resident who has been determined by the physician or interdisciplinary team as capable of self-administering medication may retain the medications in a safe location in the resident's room. The facility shall develop policies for accountability. Scheduled medications shall not be authorized for self-administration, except when delivered by a patient controlled analgesia pump.

(11) A physician's telephone orders shall be conveyed to, recorded in the clinical record, and initialed by the licensed nurse receiving the orders.

(12) Medications shall be administered only by a physician, registered nurse, a licensed practical nurse, or a certified medication aide. The only injectables which a certified medication aide may administer are insulin and vitamin B-12 and then only when specifically trained to do so.

(13) A pharmacy, operating in connection with a facility, shall comply with the State pharmacy law and the rules of the Oklahoma State Board of Pharmacy.

(14) Powdered over-the-counter medication for topical use may be administered by a trained nurse aide when designated in writing by the attending physician and delegated by a licensed nurse. The licensed nurse shall ensure that the aide demonstrates competency in reporting skin changes, storage, application and documentation policies and procedures. The licensed nurse or the attending physician shall document in the resident's record a skin assessment at least twice each week and more often if required by the facility's approved policy.

(e) Medication destruction.

(1) Medications prescribed for residents who have died and medications which have been discontinued shall be destroyed by the director of nursing and the consultant pharmacist, except that the facility may transfer unused prescription drugs to city-county health department pharmacies or county pharmacies in compliance with the Utilization of Unused Prescription Medications Act and all rules promulgated thereunder. Medications shall not be returned to the family or resident representatives. The destruction and the method used shall be noted on the clinical record.

(2) Medications prescribed for one resident may not be administered to, or allowed in the possession of, another resident.

(3) There shall be policies and procedures for the destruction of discontinued or other unused medications within a reasonable time. The policy shall provide that medications pending destruction shall not be retained with the resident's current medications. The destruction of medication shall be carried out in the facility jointly by the director of nursing and the licensed pharmacist who shall sign a record of destruction that is retained in the facility.

(f) **Medication regimen review.** The facility shall ensure that each resident's medications are reviewed monthly, by a registered nurse or a licensed pharmacist. The reviewer shall notify the physician and director of nursing, in writing, when irregularities are evident.

(g) **Consultant pharmacist.** The facility shall have a consultant licensed pharmacist to assist with the medication regimen review and medication destruction. The consultant pharmacist shall discuss policies and procedures for the administration, storage, and destruction of medications with the administrator, director of nursing and other appropriate staff.

(h) **Emergency pharmacist.** The facility shall have a contract, or letter of agreement, with a licensed pharmacist or a hospital pharmacy, that agrees to serve as the emergency pharmacist. This licensed pharmacist shall practice in a licensed pharmacy within a ten-mile radius of the facility, and shall be available twenty-four hours a day. If a licensed pharmacist is not available within a ten mile radius, the Department may approve a licensed pharmacist beyond the ten mile radius.

(i) **Bulk nonprescription drugs.** A facility may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished.

(1) **Policy of facility.** The facility must have and follow a written policy and procedure to assure safety in dispensing and documentation of medications given to each resident.

(2) **Acquisition.** The facility shall maintain records which document the name of the medication acquired, the acquisition date, the amount and the strength received for all medications maintained in bulk.

(3) **Dispensing.** Only licensed nurses, physicians, pharmacists or certified medication aides (CMA) may dispense for administration these medications and only upon the written order for as needed (p.r.n.) or nonscheduled dosage regimens dosing from a physician as documented in the clinical record of the resident.

(4) **Storage.** Bulk medications shall be stored in the medication area and not in resident rooms.

(5) **Records.** The facility shall maintain records of all bulk medications which are dispensed on an individual signed medication administration record (MAR).

(6) **Labeling.** The original labels shall be maintained on the container as it comes from the manufacturer or on the unit-of-use (blister packs) package.

(7) **Package size.** The maximum size of packaging shall be established by the facility in its policy and procedures and shall insure that each resident receives the correct dosage; provided however, that no liquid medications shall be acquired nor maintained in a package size which exceeds 16 fluid ounces.

(8) **Allowed nonprescription drugs.** Facilities may have only oral analgesics, antacids, and laxatives for bulk dispensing. No other categories of medication may be maintained as bulk medications.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 11 Ok Reg 907, eff 12-17-93 (emergency); Amended at 11 Ok Reg 2645, eff 6-25-94; Amended at Ok Reg 2521, eff 6-25-99; Amended at 18 Ok Reg 2533, eff 6-25-01; Amended at 19 Ok Reg 524, eff 1-3-02 (emergency); Amended at 19 Ok Reg 2099, eff 6-27-02]

310:675-9-10.1. Activity services

(a) **Activities program.** The facility shall provide an ongoing activities service designed to meet the resident's interests and physical, mental, and psycho-social needs based on a comprehensive assessment and care plan.

(b) **Activities director.** There shall be a designated staff member, qualified by experience or training, responsible for the direction and supervision of the activities service. The activities director shall develop appropriate activities for each resident with identified needs. Activities staff hours shall be sufficient to meet the resident's needs.

(c) **Clinical record.** The activities rendered shall be recorded in the clinical record. Progress notes shall be written at least monthly or when a significant change in the resident's condition occurs.

(d) **Program requirements.**

(1) All activities shall be resident related.

(2) The program shall be designed to encourage rehabilitation and restoration to self care and normal activity.

(3) There shall be at least two organized group activities, daily, Monday through Friday and at least one organized group activity on Saturday and Sunday provided or coordinated by staff.

(4) The activities program shall recognize the resident's right to choose to participate in social, community and religious activities, as long as that choice does not interfere with other facility residents.

(5) Varied and specific programs shall be developed for all residents, including those that are room bound, comatose or who demonstrate symptoms of dementia, mental illness or developmental disabilities.

(6) Socialization and self-help skills shall be addressed in the care plan based on resident's needs.

(7) Provisions shall be made to address each resident's spiritual needs.

(8) The program shall provide remotivation, reality orientation or sensory stimulation programs to orient and stimulate residents.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-11.1. Social services

(a) **Service.** The facility shall provide medically related social services to identify and meet the resident's social and emotional needs, and assist each resident and family in adjusting to the effects of the illness, treatment, and stay in the facility.

(b) **Director.** There shall be a designated staff member, qualified by training or experience, responsible for directing and supervising the social services. The social services director shall develop appropriate social services for each resident with identified needs.

(c) **Clinical record.** The social services rendered shall be recorded in the resident's record. Progress notes shall be written at least monthly, or when a significant change in a resident's condition occurs.

(d) **Program requirements.**

(1) Assist the resident in identifying issues and conditions related to admission to the facility.

(2) Assist the resident in obtaining needed services within the facility or the community.

(3) Assist the resident in obtaining needed transportation.

(4) Assist the resident in maintaining and developing relationships with family and other significant persons.

(5) Assist the staff in understanding the resident's actions and behavior.

(6) Assist the staff in treating the residents with respect, and promote resident independence.

(7) Counsel with the resident and his family in securing and enhancing participation in the resident's care.

(8) Engage in related activities as determined by the resident's individual needs.

(9) Encourage the resident to express his/her rights as United States citizens.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-12.1. Dietary services

(a) **Services.** The facility shall provide dietary services to meet the resident's nutritional needs. There shall be a designated staff person qualified by experience or training, responsible for directing or supervising the dietary services. The food service supervisor, in conjunction with a qualified nutritionist or registered/licensed dietitian, shall develop a dietary care plan for each resident. There shall be sufficient dietary staff to meet the needs of all residents.

(b) **Clinical record.** The dietary services provided to residents needing dietary intervention shall be recorded in the clinical record. Progress notes for these residents shall be written at least monthly, or when a significant change in the resident's condition occurs.

(c) **Nutritional assessment.** A nutritional assessment shall be completed for each resident that addresses all pertinent dietary problems such as chewing or swallowing, elimination, appetite or eating habits, pertinent lab results, weight and height, diet and medication interactions, food preferences and assistive devices. The dietary staff shall have input into the resident's individual care plan.

(d) **Diet.** The facility shall provide a nourishing, palatable, well-balanced diet that meets the resident's daily nutritional and special dietary needs.

(1) Meals.

(A) The facility shall serve at least three regularly scheduled meals, or their equivalent daily. There shall be at least four hours between each meal.

(B) Diets shall be prescribed by the resident's physician and shall be planned, in writing, reviewed, approved and dated by a qualified nutritionist or registered/licensed dietitian. A therapeutic diet shall be served with skillful attention to the diet control system. Portioning of menu servings shall be accomplished with portioned control serving utensils.

(C) Substitutes of similar nutritive value shall be offered when a resident refuses served menu items.

(D) Residents at nutritional risk shall have timely and appropriate nutrition intervention.

(E) Nourishments shall be available and may be offered at any time in accordance with approved diet orders and resident preference. Bedtime nourishment shall be offered to all residents.

(F) There shall be an identification system established and updated, as needed, to ensure that each resident receives the prescribed diet.

(G) The percentages of consumed meals, supplements and meal replacements ingested shall be observed and recorded in the clinical record at the time of observation.

(2) Menus.

(A) Menus shall be posted, planned, and followed to meet the resident's nutritional needs in accordance with the physician's orders.

(B) The menus shall, to the extent medically possible, be in accordance with the daily recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(C) Menus covering all prescribed diets shall be approved, dated, and periodically reviewed by a qualified nutritionist or registered/licensed dietitian. The facility shall maintain a thirty day record of past menus.

(D) The facility shall maintain a file of tested recipes that includes therapeutic alterations for quantity food preparation for menu items.

(e) **Tube feeding.** Tube feeding orders shall be evaluated for nutritional adequacy. The requirements for caloric intake, protein, fluid and percentage of the daily recommended dietary allowances shall be calculated to determine nutritional adequacy.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93]

310:675-9-13.1. Food storage, supply and sanitation

(a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements.

(b) Ice machines available to the residents, or the public, shall be a dispenser type, or have a locking enclosure.

(c) A whole, intact, fruit or vegetable is an approved food source. The food supply shall be sufficient in quantity and variety to prepare menus for three (3) days. Leftovers that are potentially hazardous foods shall be used, or disposed of, within twenty-four (24) hours. Non-potentially hazardous leftovers that have been heated or cooked may be refrigerated for up to forty-eight (48) hours.

(d) **Milk, milk products and eggs.**

(1) Only grade A pasteurized fluid milk, as defined by the Oklahoma Grade A Milk and Milk Products Act, Title 2 O.S. §7-401 through 2 O.S. §7-421, shall be used for beverage and shall be served directly into a glass from a milk dispenser or container.

(2) Powdered or evaporated milk products approved under the U.S. Department of Health and Human Services' Grade "A" Pasteurized Milk Ordinance (2003 Revision), may be used only as additives in cooked foods. This does not include the addition of powdered or evaporated milk products to milk or water as a milk for drinking purposes. Powdered or evaporated milk products may be used in instant desserts and whipped products, or for cooking. When foods, in which powdered or evaporated milk has been added, are not cooked, the foods shall be consumed within twenty-four (24) hours.

(3) Milk for drinking shall be stored at a temperature of 41° or below and shall not be stored in a frozen state.

(4) Only clean, whole eggs with shell intact, pasteurized liquid, frozen, dry eggs, egg products and commercially prepared and packaged hard boiled eggs may be used. All eggs shall be thoroughly cooked except pasteurized egg products or pasteurized in-shell eggs may be used in place of pooled eggs or raw or undercooked eggs.

(e) **Applicability.** This section shall only apply to food prepared or served by the facility, within the licensed facility.

[Source: Added at 9 Ok Reg 3163, eff 7-1-92 (emergency); Added at 10 Ok Reg 1639, eff 6-1-93; Amended at 24 Ok Reg 2030, eff 6-25-07¹; Amended at 25 Ok Reg 2482, eff 7-11-08]

EDITOR'S NOTE: ¹See Editor's Note at beginning of this Chapter.

310:675-9-31. Influenza and pneumococcal vaccinations

(a) Each facility shall document evidence of the offering of annual vaccination against influenza for each resident and for each employee, in accordance with the Recommendations of the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention most recent to the time of vaccination.

(b) Each facility shall document evidence of the offering of vaccination against pneumococcal disease for each resident, in accordance with the Recommendations of the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention most recent to the time of vaccination.

(c) The immunizations provided for in this section may be waived because of medical contraindication or may be refused. Documentation of the vaccination, medical contraindication or refusal shall be recorded in the resident's medical or care record. If the resident is not vaccinated, the documentation in the resident record shall include a statement signed by the resident, the resident's representative, or the resident's physician as appropriate.

(d) Attending physicians may establish standing orders for the administration of influenza and pneumococcal immunizations in accordance with the Recommendations of the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention most recent to the time of vaccination.