

(B) The committee shall oversee the pharmaceutical service in the facility, make recommendations for improvement and monitor the service to ensure accuracy and adequacy.

(C) The committee shall meet at least quarterly and document its activities, findings and recommendations.

(ii) The pharmacist shall submit a written report at least quarterly to the pharmaceutical services committee on the status of the facility's pharmaceutical services and staff performance.

Section 14. Dental Services.

(a) The facility shall have an advisory dentist who shall provide consultation, develop and participate in inservice education, and recommend policies concerning oral hygiene. Records of in-service education meetings shall be in writing.

(b) Nursing personnel shall assist the resident to carry out the dentist's recommendations.

(c) All dental examinations and dental treatments shall be entered on a dental record and made a part of the resident's medical record.

(d) Oral hygiene shall be a part of each resident's care daily.

Section 15. Social Services.

(a) The medically related social and emotional needs of the resident shall be identified and services shall be provided to meet them, either by qualified staff (a social worker or social service associate), or through written procedures for referral to appropriate social agencies.

(i) Facilities shall offer social services regardless of the size of the facility.

(A) An individual on the facility staff shall be designated in writing to maintain liaison with social, health and community agencies.

(B) As appropriate, there shall be arrangements with qualified social workers or recognized social agencies for consultation and assistance on a regularly scheduled basis.

(ii) Current records and pertinent social data concerning personal and family problems medically related to the resident's illness and care shall be maintained in each resident's record by the social service personnel.

(A) Up-to-date progress notes of relevant psycho-social issues and interventions shall be maintained in each resident's record by social service personnel.

(iii) Policies and procedures shall be established for ensuring confidentiality of residents' social information.

(iv) There shall be space provided to ensure privacy for interviews by social service personnel with the resident.

(v) Provision shall be made for in-service training to facility staff directed toward understanding emotional problems and social needs of residents and the means of taking appropriate action in relation to them, and the necessity of confidentiality.

(vi) Arrangements shall be made promptly when financial assistance is indicated or personal finances are depleted, i.e., private paying residents no longer able to pay for care in the facility.

Section 16. Medical Records.

(a) Maintenance of Clinical Records. The facility shall maintain a separate and complete medical record for each resident admitted with all entries kept current, dated and signed.

(i) The medical record shall include:

(A) Identification and summary sheet(s) including resident's name, social security number, marital status, age, sex, home address, and religion; name, address, and telephone number of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnoses, final diagnoses, category of care, condition on discharge and disposition, source of payment, and any other information needed to meet State requirements.

(B) Initial medical evaluation including medical history, physical examination and diagnosis.

(C) Authentication of hospital diagnoses, in the form of a hospital discharge summary, or a written report from the physician who attended the resident in the hospital, or a transfer form used under a transfer agreement.

(D) Physician's orders, including all medications, treatments, diet, rehabilitative and special medical procedures required for the safety and well-being of the resident.

(E) Physician's progress notes describing significant changes in the resident's condition, dictated or written at the time of each visit.

(F) Nurses' notes which shall include but not be limited to the following:

(I) Concise and accurate record of nursing care administered.

(II) Record of pertinent observation of the resident including psycho-social as well as physical manifestations.

(III) Name, dosage and time of administration of medications and treatments, route of administration except if by oral medication.

(IV) Record of type of restraint and time of application and removal. The time of application and removal shall be necessary for all restraints prescribed by the physician for the support and protection of the resident.

(G) Medication and treatment record including all medications, treatments and special procedures performed for the safety and well-being of the resident.

(I) Laboratory and x-ray reports.

(II) Consultation reports.