**902 KAR 20:291. Alzheimer's nursing homes.**

RELATES TO: KRS 216B.010-216B.131, 216B.990
STATUTORY AUTHORITY: KRS 216B.042, 216B.071, 216B.105
NECESSITY, FUNCTION, AND CONFORMITY: The administrative regulation establishing standards for freestanding facilities limited to the care of patients with Alzheimer's or related disorders, 902 KAR 20:290, was found deficient by the Administrative Regulation Review Subcommittee at its August 6, 1991, meeting. The finding of deficiency resulted from the staff/patient ratio specified in Section 3(10)(c)2 ("Staffing requirements"). Legislation to establish the staff/patient ratio in KRS Chapter 216B was not enacted during the 1992 regular session of the General Assembly. Therefore, pursuant to KRS 13A.333(1), 902 KAR 20:290 expired. KRS 216B.042 requires the cabinet to establish standards for health facilities and health services, and authorizes it to promulgate administrative regulations. Without an administrative regulation establishing standards for freestanding facilities for patients suffering from Alzheimer's or related disorders, the cabinet would be in violation of the legislative mandate expressed in KRS 216B.042. KRS 13A.333(6) prohibits an administrative body from promulgating an administrative regulation that is identical to or substantially the same as an administrative regulation that has expired. This administrative regulation is not identical to or substantially the same as 902 KAR 20:290, because: (1) Only the section relating to the staff/patient ratio was found deficient; (2) this administrative regulation does not establish or require a staff/patient ratio; and (3) it is required, by legislative mandate, by KRS 216B.042.

Section 1. Definitions. (1) "Activities of daily living" means activities of self-help (e.g., being able to feed, bathe and/or dress oneself), communication (e.g., being able to place phone calls, write letters and understanding instructions) and socialization (e.g., being able to shop, being considerate of others, working with others and participating in activities).

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

(3) "Facility" means a nursing home facility constructed pursuant to KRS 216B.071.

(4) "License" means an authorization issued by the Cabinet for Human Resources for the purpose of operating a nursing home and offering nursing home services.

(5) "PRN medications" means medications administered as needed.

(6) "Qualified dietician" or "nutritionist" means a person certified pursuant to KRS 310.010 or 310.030.

(7) "Patient" means any resident admitted to an Alzheimer's facility.

(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.

Section 2. Scope. (1) Facilities constructed and operated pursuant to KRS 216B.071 and this administrative regulation shall provide care to residents with a primary diagnosis of Alzheimer's disease or related disorder.

(2) Facilities constructed pursuant to KRS 216B.071 shall be constructed in accordance with 902 KAR 20:046 and this administrative regulation.

(3) These facilities shall be subject to the provisions of KRS 216.535 to 216.593.

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.

(a) All facilities shall have an administrator who is responsible for the operation of the facility and

who shall delegate such responsibility in his absence.

(b) The licensee shall contract for professional and supportive services not available in the facility as dictated by the needs of the patient. The contract shall be in writing.

(3) Administrative records.

(a) The facility shall maintain a permanent, chronological patient registry showing date of admission, name of patient, and date of discharge.

(b) The facility shall require and maintain written recommendations or comments from consultants regarding the program and its development on a per visit basis.

(c) Menu and food purchase records shall be maintained.

(d) A written report of any incident or accident involving a patient (including medication errors or drug reactions), visitor or staff shall be made and signed by the administrator or nursing services supervisor, and any staff member who witnessed the incident. The report shall be filed in an incident file.

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

(a) Patient care and services to include physician, nursing, pharmaceutical (including medication stop orders policy), and residential services.

(b) Adult and child protection. The facility shall have written policies which assure the reporting of allegations of abuse, neglect or exploitation of adults and children to the Cabinet for Human Resources pursuant to KRS Chapter 209 and KRS 620.

(c) Use of restraints. The facility shall have a written policy that addresses minimizing the use of restraints and a mechanism for monitoring and controlling their use.

(d) 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.

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

(6) Admission.

(a) Patients shall be admitted only upon the referral of a physician. Additionally, the facility shall admit only persons who have a primary diagnosis of Alzheimer's disease or related disorder. 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. Within forty-eight (48) hours after admission the facility shall obtain a medical evaluation from the patient's physician including current medical findings, medical history and physical examination. The medical evaluation may be a copy of the discharge summary or history and physical report from a hospital or long-term care facility, if done within seven (7) days prior to admission.

(c) Upon admission the patient and a responsible member of his family or legal representative shall be informed in writing of the established policies of the facility including fees, reimbursement, visitation rights during serious illness, visiting hours, type of diets offered and services rendered.

(d) The facility shall provide and maintain a system for identifying each patient's personal property and facilities for safekeeping of his declared valuables. Each patient's clothing and other property shall be reserved for his own use.

(7) 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.

(8) Transfer procedures and agreements.

(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 and establish responsibility for notifying the other institution promptly of the impending transfer of a patient and arrange for appropriate and safe transportation.

(b) When a patient's condition exceeds the scope of services of the facility, the patient, upon physician's orders (except in cases of life threatening emergency), shall be transferred promptly to an appropriate facility to meet the patient's needs, or services shall be contracted for from another community resource.

(c) If changes and progress occur which would enable the patient to function in a less structured and restrictive environment, and the less restrictive environment cannot be offered at the facility, the facility shall offer assistance in making arrangements for patients to be transferred to a setting which provides appropriate services.

(d) Except in an emergency, the patient, his next of kin, or guardian, if any, and the attending physician shall be consulted at least thirty (30) days in advance of the transfer or discharge of any patient.

(e) If the patient is transferred, a transfer form shall accompany the patient. The transfer form shall include at least: 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.

(9) 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.

(10) 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 an employment application and a record of each employee's training and experience, evidence of current licensure or registration where required by law, health records, records of in-service training and ongoing education, and the employee's name, address and Social Security number.

(c) Staffing 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. When the staff/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. Responsible staff member shall be on duty and awake at all times to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.

4. Although emergency scheduling may require substitution of staff, every effort should be made to provide residents with familiar staff members in order to minimize resident confusion.

5. Volunteers shall not be counted to make up minimum staffing requirements.

6. 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 is 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 description for each level of nursing personnel.

b. Recommending to the administrator the number and levels 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.

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 screening of prospective patients in terms of required nursing services and nursing skills available.

i. Assuring that a written monthly assessment of the patient's general condition is completed.

j. Assuring that a nursing care plan shall be established for each patient and that his plan shall be reviewed and modified as necessary.

k. Assuring that registered nurses, licensed practical nurses, nursing assistants, and certified medication aides are assigned duties consistent with their training and experience.

l. Assuring that a monthly review of each patient's medications is completed and notifying the physician when changes are appropriate.

7. Supervising nurse. Nursing care shall be provided by or under the direction of a full-time registered nurse. The supervising nurse 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 staff assignments, and whenever possible accompanying physicians when visiting patients.

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

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

10. 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 the goals and limits of the therapists' work, and prescribes modalities and frequency of therapy, persons with qualifications other than those described in clause a. of this subparagraph may be assigned duties appropriate to their training and experience.

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

12. The facility shall designate a person for the following areas who will be responsible for:

a. Medical records;

b. Arranging for social services;

c. Developing and implementing the activities program and therapeutic recreation; and

d. Developing and implementing staff training program.

13. Community family support coordinator. A social worker licensed pursuant to KRS 335.090 or who has two (2) years of social work supervised experience in a health care setting working directly with individuals; or similar professional qualifications shall be utilized whose functions shall include:

a. Evaluation of resident's initial social history on admission;

b. Utilization of community resources;

c. Conducting quarterly family support group meetings; and

d. Identification and utilization of existing Alzheimer's network.

14. Supportive personnel, consultants, assistants and volunteers shall be supervised and shall function within the policies and procedures of the facility.

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

(e) Orientation and in-service training. All staff members and consultants shall have documented training in the care and handling of Alzheimer's patients, including at least:

1. Eight (8) hours of orientation to cover the following:

a. Facility Alzheimer's policies;

b. Etiology and treatment of dementias;

c. Stages of Alzheimer's disease;

d. Behavior management; and

e. Communication.

f. Resident's rights.

2. Quarterly continuing education is required, six (6) hours of which shall be in Alzheimer's disease or related disorders.

(11) 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 by a physician 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 long-term care facility if done within seven (7) days prior to admission.)

3. The physician's dated and signed orders for medication, diet, and therapeutic services.

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, dosage, administration method, name of prescribing physician and name of person who administered the medication.

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,

mode and frequency of PRN medications administered, condition necessitating administration of PRN medication, reaction following PRN medication, visits by physician and phone calls to the physician, medically prescribed diets and preventive maintenance or rehabilitative nursing measures.

8. Written assessment of the patient's monthly general condition.

9. Reports of dental, laboratory and x-ray services (if applicable).

10. Changes in patient's response to the activity and therapeutic recreation program.

11. A discharge summary, signed and dated by the attending physician within one (1) month of discharge from the facility.

(b) Retention of records. After patient's death or discharge the completed medical record shall be placed in an inactive file and retained for five (5) years.

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

(a) The health care of every patient shall be under the 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 sixty (60) days following admission. Subsequent to the 60th day following admission, the patients shall be evaluated by a physician every sixty (60) days unless justified and documented by the attending physician in the patient's medical record. There shall be evidence in the patient's medical record of the physician visits to the patient at medically 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 and 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 or licensed practical nurses, aides, assistants, and certified medication aides. 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 or more often if necessary;

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 carry out prescribed physical therapy exercises between visits of the physical therapists.

(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) Comprehensive assessment of resident needs. Nursing personnel shall make a comprehensive assessment of a resident's needs which describes the resident's capability to perform daily life functions and significant impairments in functional capacity:

1. The comprehensive assessment must include at least the following information:

a. Medically defines conditions and prior medical history;

b. Medical status measurement;

c. Functional status;

d. Sensory and physical impairment;

e. Nutritional status and requirements;

f. Special treatments or procedures;

g. Psychosocial status;

h. Dental condition;

i. Activities potential;

j. Cognitive status; and

k. Drug therapy.

2. Assessments must be conducted no later than fourteen (14) days after the date of admission and promptly after a significant change in the resident's physical or mental condition.

3. Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment.

(3) Comprehensive assessments and care plans.

(a) Comprehensive assessments.

1. The facility shall make a comprehensive assessment of a resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

2. The comprehensive assessment shall include at least the following information:

a. Medically defined conditions and prior medical history;

b. Medical status measurement;

c. Functional status;

d. Sensory and physical impairments;

e. Nutritional status and requirements;

f. Special treatments or procedures;

g. Psychosocial status;

h. Discharge potential;

i. Dental condition;

j. Activities potential;

k. Rehabilitation potential;

l. Cognitive status; and

m. Drug therapy.

3. Frequency. Assessments shall be conducted:

a. No later than fourteen (14) days after the date of admission;

b. Promptly after a significant change in the resident's physical or mental condition; and

c. In no case less often than once every twelve (12) months.

4. Review of assessments. The nursing facility shall examine each resident no less than once every three (3) months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.

5. Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (4) of this section.

(b) Accuracy of assessments.

1. Coordination. Each assessment shall be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment with the appropriate participation of health professionals.

2. Certification. Each individual who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment.

(c) Comprehensive care plans.

1. The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment.

2. A comprehensive care plan shall be:

a. Developed within seven (7) days after completion of the comprehensive assessment;

b. Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and with the participation of the resident, the resident's family or legal representative, to the extent practicable; and

c. Periodically reviewed and revised by a team of qualified persons after each assessment.

3. The services provided or arranged by the facility shall:

a. Meet professional standards of quality; and

b. Be provided by qualified persons in accordance with each resident's written plan of care.

(d) Discharge summary. When the facility anticipates discharge, a resident shall have a discharge summary that includes:

1. A recapitulation of the resident's stay;

2. A final summary of the resident's status to include items in subsection (2)(d) of this subsection, at the time of the discharge that shall be available for release to authorized persons and agencies, with the consent of the resident or legal representative; and

3. A postdischarge plan of care that developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

(4) Specialized rehabilitative services.

(a) Rehabilitative services shall be provided upon written order of the physician which indicates anticipated goals and prescribes specific modalities to be used and frequency of physical, speech and occupational therapy services. These services may be contracted for from another community resource.

(b) If therapy services are provided they 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 perfor-

mance, using physical means such as exercise, massage, heat, water, light, and electricity.

2. Speech therapy which includes:

a. Service 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, handrails, wheelchairs, walkers, walkerettes, crutches and canes. The therapists shall advise the administrator concerning the purchase, rental, storage and maintenance of equipment and supplies.

(5) 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.

(6) Pharmaceutical services.

(a) The facility shall provide appropriate methods and procedures for obtaining, dispensing, and administering drugs and biologicals, developed with the advice of a licensed pharmacist or a pharmaceutical advisory committee which includes one (1) or more licensed pharmacists.

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

(c) If the facility does not have a pharmacy department, it shall have provision for promptly 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. Conformance with physician's orders. All medications administered to patients shall be ordered in writing by the patient's physician. 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 within fourteen (14) days. 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 on stop orders. A registered nurse or pharmacist shall review each patient's medication profile at least monthly. The prescribing physician shall review the patient's medical profile at least every two (2) months. 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 the Medical Practice Act (KRS 311.530 to 311.620) and Nurse Practice Act of (KRS Chapter 314) or by personnel who have completed a state approved training program, from a state-approved source. The administration of oral and topical medicines by certified medicine aides 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 or registered 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 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 predischarge 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 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.

4. 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 KRS 218A.230, or 21 CFR 1307.21, or sent via registered mail to the Controlled Substances Enforcement Branch of the Kentucky Cabinet for Human

Resources.

5. Use of restraints. If a patient becomes disturbed or unmanageable, the patient's physician shall be notified in order to evaluate and direct the patient's care. No form of restraints or protective devices shall be used except under written orders of the attending physician. There shall be no PRN orders for restraints. Understanding that measures to prevent wandering may infringe on patient rights, care shall be exercised in the use of physical or mechanical devices or chemical restraints.

a. Restraints shall not be used as punishment, as discipline, as a convenience for the staff, or when not required to treat the resident's medical symptoms, or as a substitute for staff.

b. Physical or mechanical restraints that require lock and key shall not be used. Restraints shall be applied only by personnel trained in the proper application and observation of this equipment. Restraints shall be checked at least every one-half (1/2) hour and released at least ten (10) minutes every two (2) hours. During the patient's normal waking hours, the patient must be exercised during release periods. The checks and releases of restraints shall be recorded in the patient's medical record as they are completed. Such reports shall document the rationale or justification for the use of the procedure, a description of the specific procedures employed, and the physician's order. Restraints shall be comfortable and easily removed in case of an emergency.

c. The specific purpose and time-limited order for any restraint shall be written and reviewed according to facility policy. The frequency of such renewal shall not exceed sixty (60) days.

6. Infection control and communicable diseases.

a. There shall be written infection control policies, which are consistent with the Center 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, broken, or otherwise manipulated by hand.

(iii) The containers for 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 Human Resources 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 pursuant to 40 CFR 403 and 401 KAR 5:055, Section 9.

(v) Any incinerator used for the disposal of waste shall be in compliance with 401 KAR 59:020 and 401 KAR 5:055.

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), rebella, 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.

(7) 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.

(8) 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.

(9) 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.

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. Subject to the requirements of KRS 216B.071, 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 casework 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.

(10) Patient activities. Activities suited to the needs and interests of patients shall be provided. Provision shall be made for activities which must be appropriate for the needs and interests of each resident, taking into consideration his or her specific impairment, state of disease. Activities programs shall be available to all residents and shall be planned and documented in the patient's interdisciplinary comprehensive assessment.

(a) The activity leader shall have specialized educational preparation concerning the care of an Alzheimer's patient, and 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) Patient's 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.

(11) Transportation.

(a) If transportation of patients is provided by the facility to community agencies or other activities, the following shall apply:

1. Special provision shall be made for patients who use wheelchairs.

2. An escort or assistant to the driver shall be provided in transporting patients to and from the facility if necessary for the patient's safety.

(b) The facility shall arrange for appropriate transportation in case of medical emergencies.

(12) 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. 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 conferences.

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.

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 leftover 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 over-bed 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 219.081 and 902 KAR 45:005 (Kentucky's Food Service Establishment Act and Food Service Code).

(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 patient shall not be used by another until it has been laundered or dry cleaned.

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

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

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

6. 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.

7. 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.

Section 5. Alzheimer's Facility Requirements. (1) The care of residents with Alzheimer's disease and other cognitive disorders require increased security and visual access. Measures to protect the residents from harm and to prevent them from leaving designated areas without supervision shall include frequent in-person observation of each resident and may also include the use of wide angle

mirrors closed-circuit television monitors, and alarm systems.

(2) In addition to the required facility specifications in 902 KAR 20:046, the following shall be provided:

(a) Control doors, if used for security of the residents, shall be forty-four (44) inches in width each leaf, and swing in opposite directions. A latch or other fastening device on a door shall be provided with a knob, handle, panic bar, or other simple type of releasing device, the method of operation of which is obvious, even in darkness.

(b) Locking devices may be used on the control doors if the following criteria are met.

1. The locking device, which shall not be a keylock device, shall be electronic and shall be released when the following occurs:

a. Upon activation of the fire alarm or sprinkler systems;

b. Power failure to the facility; and

c. By pressing a button located at the main staff station and at the monitoring station.

2. Key pad or buttons may be located at the control doors for routine use by staff or service.

(3) Access to outdoor areas shall be provided and such areas shall be enclosed by walls or fencing that do not present a hazard.

(4) Any security measures taken to provide for the safety of wandering patients shall be as unobtrusive as possible. (19 Ky.R. 2199; Am. 2466; eff. 6-7-93.)