

## **902 KAR 20:380. Operation and services; residential hospice facilities.**

RELATES TO: KRS 216B.010, 216B.015, 216B.040, 216B.042, 216B.045-216B.055, 216B.075, 216B.105-216B.131, 216B.990, 311.560(4), 314.011(8), 314.041, 314.051, Chapter 315, 40 C.F.R. 403

STATUTORY AUTHORITY: KRS 216B.042(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042(1) requires the Cabinet for Health Services to establish and enforce licensure standards and procedures for health facilities and health services. This administrative regulation establishes licensure requirements for residential hospice facility operation and services.

Section 1. Definitions. (1) "Administrator" means a person who has:

- (a) Served as an administrator for a hospice program in accordance with 902 KAR 20:140, or a residential hospice facility licensed in accordance with this administrative regulation; or
  - (b) A bachelor of arts or bachelor of science degree in a health care, human services, or administrative curriculum; or
  - (c) Equivalent administrative work experience in a health care facility.
- (2) "Bereavement" means the period of time during which a person experiences, responds emotionally and adjusts to the loss by death of another person.
- (3) "Facility" means a residential hospice facility.
- (4) "Palliative care" means care directed at reducing or abating pain and other symptoms of the disease process in order to achieve relief of distress.
- (5) "Qualified dietitian" means a person licensed pursuant to KRS 310.021.
- (6) "Residential hospice facility" means a facility licensed pursuant to this administrative regulation and providing residential care for terminally-ill patients that includes skilled nursing care for the management of pain and acute and chronic symptoms.
- (7) "Respite care patient" means a patient requiring assistance with daily living activities and medical management of pain and symptoms who is admitted to the facility in order to:
- (a) Provide relief to a patient's normal caregiver; or
  - (b) Provide care when the patient does not have a caregiver to assist him in his home.
- (8) "Sanitary sewer" is defined at KRS 220.010(1).
- (9) "Terminally ill" means a fatal condition for which therapeutic strategies directed toward cure and control are no longer effective.
- (10) "Volunteer" means a person who contributes time and talent to the facility without economic remuneration.

Section 2. Administration and Organization. (1) The licensee shall be legally responsible for the operation of the residential hospice facility and for compliance with federal, state, and local law pertaining to the operation of the facility.

(2) The licensee shall have permanent facilities for the care of patients and storage of patient records.

(3) The licensee shall establish and enforce written policies for the administration and operation of the facility. The policies shall address the following:

- (a) A description of the organizational structure of the facility, including:
  - 1. Lines of authority;
  - 2. Department organization; and
  - 3. Job descriptions;
- (b) Use of volunteers, volunteer selection criteria, training, and roles in the facility;
- (c) Admission of patients;

(d) Quality assurance;

(e) A written disaster preparedness plan which includes:

1. Procedures to be followed in the event of an internal or external disaster; and
2. A requirement that the plan is periodically rehearsed with staff;

(f) Linkage agreements with providers of services and supplies;

(g) Patient restraint practices to include:

1. Procedure for obtaining an order from the patient's physician, physician assistant, or advanced registered nurse practitioner;

2. Procedure for the assessment and reassessment of the need for patient restraint, requiring the use of the least restrictive method;

3. Procedure detailing the methods for applying a patient restraint;

4. A policy requiring monitoring the use of a patient restraint; and

5. A policy requiring direct care staff to receive training on all aspects of the use of patient restraints; and

(h) Discharge, transfer, and termination of services.

(4) Medical records.

(a) A medical record shall be maintained for each individual admitted to the facility. The medical record shall include:

1. Written admission order from a physician;

2. Medical history;

3. Nursing assessment;

4. Social and psychological information on patient and family;

5. Orders from physicians and other practitioners acting within their statutory scope of practice;

6. The approved care plan;

7. Documentation of nursing services provided; and

8. Documentation of medical services provided.

(b) Retention of medical records.

1. After the death or discharge of an adult patient, the completed medical record shall be placed in an inactive file and retained for five (5) years.

2. After the death or discharge of a minor patient, the record shall be placed in an inactive file and retained for five (5) years from the date of the event, or three (3) years after the patient reaches the age of majority, whichever is longer.

(5) Personnel.

(a) The facility shall have:

1. A medical director who is a licensed physician, available on at least a consultative basis, who shall:

a. Direct medical aspects of the facility's services; and

b. Participate in the development of medical policy and procedure;

2. An administrator who shall:

a. Direct the daily operation of the facility; and

b. Implement policies and procedures for activities and services provided by facility personnel or by contract; and

3. A patient-care coordinator who is a registered nurse who:

a. Shall have education or experience in skilled nursing services for the terminally ill; and

b. May serve as the facility administrator.

(b) The facility shall employ or have access to a sufficient number of qualified personnel as necessary to provide the services required by this administrative regulation, and as indicated by patient needs.

- (c) Current employee records shall be maintained. Each record shall include the employee's:
  1. Name, address, and Social Security number;
  2. Record of training and experience;
  3. Proof of current licensure, certification, or registration, if required by law;
  4. Results of most recent skin test for tuberculosis; and
  5. Performance evaluations.

(d) Supportive personnel, assistants and volunteers shall be supervised and shall function within the policies and procedures of the facility.

(e) An employee or volunteer shall have a test for tuberculosis prior to or within the first week of work and annually thereafter. An employee or volunteer with evidence of an infectious disease shall not be present in the facility until the infectious disease can no longer be transmitted.

(f) The facility shall conduct an orientation for new employees and volunteers.

(g) An employee of the facility who has direct patient care responsibilities shall have current cardiopulmonary resuscitation (CPR) certification from either the American Heart Association or the American Red Cross.

(6) Infection control.

(a) Each facility shall implement an infection control policy consistent with current Centers for Disease Control and Prevention (CDC) recommendations. The policy shall include:

1. Procedures for prevention, monitoring, and control of infection and communicable disease;

2. Measures for assessing and identifying a patient or health care worker at risk for infection and communicable disease;

3. Procedures for isolation of an infected or immunosuppressed patient, if applicable, which shall:

- a. Implement the least restrictive method possible;
- b. Protect others from pathogens; and
- c. Maintain the patient's privacy and dignity.

(b) A facility choosing to offer services to a patient requiring isolation pursuant to CDC guidelines shall have at least one (1) private isolation room available. The room shall:

1. Have a separate toilet room with bathtub or shower and lavatory for the exclusive use of the patient, and allowing for direct entry from the patient bed area;

2. Have a ceiling that is readily washable, and without crevices that can retain dirt particles; and

3. Have an anteroom outside and immediately adjacent to the patient room with facilities for maintaining aseptic conditions, including a sink suitable for handwashing;

4. Have a ventilation system adequate for reduction of the risk of transmission of an airborne pathogen, with filter efficiency of at least ninety (90) percent, and meeting the following requirements:

	Isolation Room	Anteroom	Toilet Room
Air Movement Relationship to Adjacent Area	In	In/Out	In
Minimum Changes of Out-	2	--	--

	Isolation Room	Ante-room	Toilet Room
door Air Per Hour			
Minimum Total Air Changes Per Hour	12	10	10
All Air Exhausted Directly To Outdoors?	Yes	Yes	Yes
Recirculated by Means of Room Units?	No	No	--

5. Be approved for use by the Office of Inspector General prior to being occupied by a patient requiring isolation.

Section 3. Patient Care Requirements. (1) A patient may be admitted to a facility only upon an order from a physician.

(2) The patient's attending physician or the medical director shall be responsible for the direct medical care of the patient's illness.

(3) The facility shall provide the following services directly:

(a) Coordination of the medical aspects of the facility;

(b) Assessment, by the interdisciplinary team, of the patient's physical, psychological, spiritual, social, and economic needs;

(c) Development and coordination of a care plan, based on the assessment required in paragraph (b) of this subsection, which includes the delineation of responsibilities of each interdisciplinary team member and provides for regularly scheduled interdisciplinary team meetings for planning, evaluation, and individual case management. This requirement may be satisfied by the continuation of the plan of care established for a patient by a hospice program, in accordance with 902 KAR 20:140, if the plan of care is reviewed and revised when the patient is admitted to the facility.

1. Care plan development shall be the responsibility of an interdisciplinary team that shall include:

a. The patient;

b. The patient's family, if the patient wants them to participate;

c. The medical director;

d. A nurse;

e. A social worker;

f. The patient's attending physician; and

g. A representative of the clergy, if the patient so chooses.

2. The care plan shall be reviewed by the patient's attending physician or the medical director, in consultation with facility personnel:

a. At such intervals as the change in the patient's condition requires; or

b. At least once every two (2) weeks.

3. The care plan shall be reviewed by the interdisciplinary team to ensure that a patient receives palliative care.

4. Verbal authorization to change the medical orders shall be reviewed and signed by the patient's attending physician or the medical director within seven (7) days after the order is issued.

5. Verbal authorization to change nonmedical orders of the care plan shall be reviewed and signed by the medical director within seven (7) days after the order was issued.

(d) Patient counseling and family bereavement counseling; and

(e) Education and training services for staff, volunteers, and family members.

#### Section 4. Services. (1) Nursing services.

(a) The facility shall provide twenty-four (24) hour nursing services that shall:

1. Be sufficient to meet total nursing needs;

2. Be provided in accordance with the patient's plan of care;

3. Ensure a patient receives prescribed:

a. Treatments;

b. Medications; and

c. Diets; and

4. Ensure a patient shall be:

a. Comfortable;

b. Clean;

c. Well groomed; and

d. Protected from accident, injury and infection.

(b) A registered nurse shall be on duty at all times.

#### (2) Pharmaceutical services.

(a) The facility shall provide appropriate methods and procedures for obtaining, directly or by contract, dispensing, and administering drugs and biologicals.

(b) If the facility has a pharmacy department it shall be operated pursuant to the requirements of KRS Chapter 315.

(c) If the facility does not have a pharmacy department it shall have an agreement for obtaining prescribed drugs and biologicals from a pharmacy holding a valid pharmacy permit issued by the Kentucky Board of Pharmacy operated pursuant to the requirements of KRS Chapter 315.

#### (d) Medication services.

1. Except in a circumstance that requires or permits a verbal order, a medication shall not be given without a written order signed by a physician, or other ordering personnel acting within their statutory scope of practice.

a. A verbal order for a medication shall be given only to a licensed practical or registered nurse or a pharmacist and shall be signed by a member of the medical staff or other ordering practitioner as soon as possible after the order is given.

b. A verbal order for a medication, at the time received, shall be:

(i) Immediately transcribed by the person receiving the order;

(ii) Repeated back to the person requesting the order to ensure accuracy; and

(iii) Annotated on the patient's medical record, by the person receiving the order, as repeated and verified.

2. Administration of medication. Medication shall be administered by licensed medical or nursing personnel in accordance with their statutory scope of practice, or by personnel who have completed a state-approved training program. An intramuscular injection shall be administered by a licensed nurse, physician's assistant, or physician. An intravenously-administered medication shall be administered by a licensed physician, physician's assistant, registered nurse, or a licensed practical nurse to whom the task has been properly delegated. Each dose

administered shall be recorded in the medical record.

a. A medication prescribed for one (1) patient shall not be administered to any other patient.

b. Self-administration of a medication by a patient shall not be permitted except on special order of the patient's physician.

c. A medication error shall be immediately reported to the patient's physician and recorded in the patient's medical record and on an incident report.

d. A drug reaction shall be immediately reported to the patient's physician and the dispensing pharmacist recorded in the patient's medical record.

e. An up-to-date medication reference text and source of information shall be provided for use by the nursing staff, for example: the American Hospital Formulary Service of the American Society of Hospital Pharmacists, or the Physicians Desk Reference.

3. Labeling and storing medications.

a. A medication shall be clearly 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 a modified unit dose system, conforming to federal and state law, is used. The medication of each patient shall be kept in the original container; transferring between containers shall be prohibited. A medicine stored by the facility shall be kept in a locked place. A medication requiring refrigeration shall be kept in the medication area's refrigerator, in a separate locked box. A drug for external use shall be stored separately from those administered by mouth, suppository, or injection. Provisions shall be made for the locked, separate storage of medication prescribed for a deceased or discharged patient until the medication is surrendered or destroyed in accordance with federal and state law.

b. A medication container having a soiled, damaged, incomplete, illegible, or makeshift label shall be returned to the issuing pharmacist or pharmacy for relabeling or disposal. A container having no label shall be destroyed in accordance with state and federal law.

c. A medication cabinet shall be well lighted and of sufficient size to permit storage without crowding.

d. Medication no longer in use shall be disposed of or destroyed in accordance with federal and state law.

e. A medication with an expired date shall be removed from usage and properly discarded.

f. Controlled substances.

(i) A controlled substance shall be kept under double lock, for example, in a locked box in a locked cabinet.

(ii) There shall be a controlled substances record maintained by the: staff pharmacist, consultant pharmacist, or nursing care coordinator.

(iii) The record shall contain the following information: the name of the patient, the date, time, kind, dosage, balance remaining and method of administration; the name of the physician who prescribed the medication; and the name of the nurse who administered it, or staff member who supervised the self-administration.

(iv) The staff pharmacist, consultant pharmacist, or nursing care coordinator shall complete a Schedule II controlled substances count at least daily, and Schedule III, IV and V controlled substances count at least once per week. Controlled substances remaining after the discharge or death of the patient shall be destroyed in accordance with federal and state law.

(3) Dietary services.

(a) The facility shall provide dietary services directly or through a written contractual agreement.

(b) If the dietary services are contracted, the facility shall ensure that the contractor complies with the requirements of this subsection.

(c) If dietary services are provided directly, the facility shall have a dietary department, orga-

nized, directed and staffed to provide quality food service and optimal nutritional care.

1. The dietary department shall be directed on a full-time basis by an individual who, by education or specialized training and experience, is knowledgeable in food service management.

2. The dietary service shall have at least one (1) qualified dietitian working full-time, part-time, or on a consultative basis, to supervise the nutritional aspects of patient care.

3. Sufficient additional personnel shall be employed to perform assigned duties to meet the dietary needs of all patients.

4. The dietary department shall have current written policies and procedures for food storage, handling, and preparation. Written dietary policy and procedure shall be available to dietary personnel.

5. An in-service training program, which shall include the proper handling of food, safety and personal grooming, shall be given at least quarterly for new dietary employees.

(d) Menus shall be planned, written and rotated to avoid repetition. Nutritional needs shall be met in accordance with recommended dietary allowances of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences and in accordance with medical orders.

(e) Each meal shall correspond with the posted menu. When a change is necessary, substitution shall provide equal nutritive value and the change shall be recorded on the menu. Each menu shall be kept on file for thirty (30) days.

(f) Every diet, regular and therapeutic, shall be prescribed in writing, dated, and signed by the attending medical staff member or other ordering personnel acting within their statutory scope of practice. Information on the diet order shall be specific and complete and shall include the title of the diet, modifications in specific nutrients stating the amount to be allowed in the diet, and specific problems that may affect the diet or eating habits.

(g) Food shall be prepared by methods that conserve nutritive value, flavor, and appearance, and shall be served at the proper temperatures and in a form to meet individual needs; for example, food shall be cut, chopped, or ground to meet individual patient needs.

(h) If a patient refuses foods served, nutritious substitutions shall be offered.

(i) Unless contraindicated in a patient's plan of care, at least three (3) meals or their equivalent shall be served daily.

(j) There shall not be more than a fifteen (15) hour span between a substantial evening meal and a breakfast unless otherwise directed by the attending medical staff member.

(k) Meals shall be served at regular times with between-meal or bedtime snacks of nourishing quality offered.

(l) If dietary services are provided directly, there shall be at least a three (3) day supply of food available in the facility at all times to prepare well-balanced palatable meals for all patients.

(m) If the dietary services are contracted, the facility shall develop a contingency plan to ensure the provision of dietary services in the case of an emergency.

(n) There shall be an identification system for each patient meal, and methods used to assure that each patient receives the appropriate diet as ordered.

(o) The facility shall comply with applicable provisions of KRS 219.011 to 219.081 and 902 KAR 45:005, the Retail Food Code.

Section 5. Facility Specifications. (1) Fire protection and security. Each facility shall:

(a) Meet the provisions of the most current edition of the Life Safety Code of the National Fire Protection Association that are applicable to a residential hospice facility;

(b) Be inspected and approved by the local certified building department with jurisdiction of the area;

(c) Not house blind, nonambulatory, or physically-handicapped patients unless the building is properly equipped with a comprehensive sprinkler system;

(d) Have portable fire extinguishers readily available on all floors and in the kitchen and food preparation area;

(e) Have an emergency power source capable of providing electrical service for communication systems, alarm systems, egress lighting, and patient care areas;

(f) Install and maintain, in accordance with the manufacturer's specifications, a single station smoke detector in every living area, bedroom, corridor, stairwell, and storage area, and in the basement;

(g) Have an adequate water supply and an adequate system for sewage disposal;

(h) Maintain sturdy and securely fastened handrails, measuring thirty-six (36) inches or more above ground or floor level, on every interior and exterior stairway;

(i) Maintain floors in good repair;

(j) Maintain corridors, entrances, exits, and outside pathways in good repair and free of obstacles;

(k) Keep sidewalks, fire escape routes, and entrances free of snow, ice, and debris;

(l) Keep the grounds in an orderly, litter-free manner, clear of refuse and discarded objects, and mowed;

(m) Provide general outdoor lighting to adequately illuminate the walkways and drive; and

(n) Establish a procedure to ensure that exterior doors are locked between the hours of 9 p.m. and 7 a.m.

(2) Patient rooms.

(a) Each patient room shall:

1. Contain a bathroom equipped with:

a. A toilet;

b. A sink suitable for handwashing; and

c. Either a shower or bathtub;

2. Be above grade level;

3. Contain, for each patient, a suitable bed and other appropriate furniture;

4. Have closet space that provides security and space for private belongings;

5. Contain no more than two (2) beds in a room occupied by a respite care patient and no more than one (1) bed in a room occupied by a nonrespite patient;

6. Measure at least 100 square feet for a single patient room and at least eighty (80) square feet per patient in a two (2) patient room; and

7. Be equipped with a suitable device for the patient to call direct care staff on duty.

(b) The facility shall allow a patient to place items for the personalization and comfort of his room.

(3) Visitation. The facility shall:

(a) Provide physical space for a patient to visit in private;

(b) Provide accommodation for family members to remain with a patient throughout the night;

(c) Provide accommodations for family privacy after the death of a patient; and

(d) Allow a patient to receive visitors, including small children, at any hour.

(4) Linens and housekeeping.

(a) The facility shall have available at all times a quantity of linen essential for proper care and comfort of patients.

(b) Linens shall be handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(c) Soiled linens and clothing shall be collected and encased in suitable bags or containers,



in a well-ventilated area, separate from clean linens. Soiled linens and clothing shall not be permitted to accumulate in the facility.

(d) The facility shall establish and implement housekeeping and maintenance policies and procedures that assure the environment is:

1. Safe;
2. Clean; and
3. Sanitary.

(e) Cleaning procedures shall provide for the prompt, thorough cleaning of:

1. Commodes;
2. Urinals;
3. Bedpans;
4. Bathrooms; and
5. Other sources of contamination or odor.

(f) Cleaning shall be performed in a manner to minimize the spread of pathogens.

(5) Waste disposal.

(a) Sharp waste.

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

2. A needle or other contaminated sharp instrument shall not be purposely bent, broken, or otherwise manipulated by hand as a means of disposal, except as permitted by Occupational Safety and Health Administration guidelines established in 29 C.F.R. 1910.1030(d)(2)(vii).

3. The containers of sharp waste shall be incinerated on or off site, or be otherwise rendered nonhazardous.

(b) Disposable waste.

1. Disposable waste shall be placed in suitable bags or closed containers to prevent leakage or spillage, and shall be handled, stored, and disposed of minimizing direct exposure of personnel to waste materials.

2. The facility shall establish specific written policies regarding handling and disposal of waste.

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

4. Wastes conveyed to a sanitary sewer shall comply with applicable federal, state, and local pretreatment law, including 40 C.F.R. 403, 401 KAR 5:557, and relevant local ordinances. (29 Ky.R. 614; 1628; eff. 12-18-2002; Crt eff. 4-30-2019; TAm eff. 3-20-2020.)