

902 KAR 20:086. Operation and services; intermediate care facilities for the mentally retarded and developmentally disabled.

RELATES TO: KRS 216B.010-216B.131, 216B.990(1), (2), 222.210 et. seq.

STATUTORY AUTHORITY: KRS 216B.042, 216B.105

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042 mandates that the Kentucky Cabinet for Human Resources regulate health facilities and health services. This administrative regulation provides licensure requirements for the operation and services of intermediate care facilities for the mentally retarded/developmentally disabled (MR/DD).

Section 1. Definitions.

- (1) "Active treatment" means daily participation, in accordance with an individual plan of care and service, in activities, experiences, or therapy which are part of a professionally developed and supervised program of health, social and/or habilitative services offered by or procured by contract or other written agreement by the institution for its residents.
- (2) "Administrator" means a person who is licensed as a nursing home administrator pursuant to KRS 216A.080.
- (3) "Aversive stimuli" means things or events that the resident finds unpleasant or painful that are used to immediately discourage undesired behavior.
- (4) "Developmental disability" means a severe chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments manifested before the person attains the age of twenty-two (22) and is likely to continue indefinitely. This disability results in substantial limitations in three (3) or more areas of major life activity including self-care, receptive and expressive language, learning, self direction, mobility, capacity for independent living and economic sufficiency and requires individually planned and coordinated services of a lifelong or extended duration.
- (5) "Developmental nursing services" means treatment of a person's developmental needs by designing interventions to modify the rate and/or direction of the individual's development especially in the areas of self-help skills, personal hygiene, and sex education while also meeting his physical and medical needs.
- (6) "Facility" means an intermediate care facility for the mentally retarded and the developmentally disabled (MR/DD).
- (7) "Induration" means a firm area in the skin which develops as a reaction to injected tuberculosis proteins when a person has tuberculosis infection. The diameter of the firm area is measured to the nearest millimeter to gauge the degree of reaction. A reaction of ten (10) millimeters or more of induration is considered highly indicative of tuberculosis infection.
- (8) "Interdisciplinary team" means the group of persons responsible for the diagnosis, evaluation and individualized program planning and service implementation for the resident. The team is composed of relevant professionals, and may include the resident, the resident's family, or the guardian.
- (9) "License" means an authorization issued by the cabinet for the purpose of offering intermediate care MR/DD services.
- (10) "MR/DD" means the mentally retarded and the developmentally disabled persons.
- (11) "Normalization principle" is the utilization of means which are as culturally normative as possible in order to establish and maintain personal behavior and characteristics which are as culturally normative as possible.
- (12) "Qualified dietician or nutritionist" means:
 - (a) A person who has a bachelor of science degree in foods and nutrition, food service management, institutional management or related services and has successfully completed a dietetic internship or coordinated undergraduate program accredited by

- the American Dietetic Association (ADA) and is a member of the ADA or is registered as a dietician by ADA; or
- (b) A person who has a masters degree in nutrition and is a member of the ADA or is eligible for registration by ADA; or
- (c) A person who has a bachelor of science degree in home economics and three (3) years of work experience with a registered dietician.
- (13) "Qualified occupational therapist" means a graduate of a program of occupational therapy approved by the Council on Medical Education of the American Medical Association and licensed in the state, if required.
- (14) "Qualified speech pathologist or audiologist" means a person who is licensed pursuant to KRS Chapter 334A who has been granted a certificate of clinical competence in the American Speech and Hearing Association or who has completed the equivalent education and experimental requirements for such a certificate.
- (15) "Qualified social worker" means a person who is licensed or exempt from licensure pursuant to KRS Chapter 335 with bachelor's degree in social work from an accredited program or a bachelor's degree in a field other than social work and at least three (3) years of social work experience under the supervision of a qualified social worker.
- (16) "A qualified mental retardation professional" means a person who has specialized training or one (1) year of experience in treating or working with the mentally retarded and/or developmental disabilities and is one (1) of the following:
- (a) A psychologist with a master's degree from an accredited program;
 - (b) A licensed physician;
 - (c) A educator with a degree in education from an accredited program;
 - (d) A social worker who is licensed or exempt from licensure pursuant to KRS Chapter 335 with a bachelor's degree in:
 - 1. Social work from an accredited program; or
 - 2. A field other than social work and at least three (3) years of social work experience under the supervision of a qualified social workers;
 - (e) A physical or occupational therapist who is a graduate of a program of physical or occupational therapy approved by the Council on Medical Education of the American Medical Association.
 - (f) A speech pathologist or audiologist who is licensed pursuant to KRS Chapter 334A who has been granted a certificate of clinical competence in the American Speech and Hearing Association or who has completed the equivalent educational and experimental requirements for such a certificate;
 - (g) A registered nurse;
 - (h) A therapeutic recreation specialist who is graduate of an accredited program and is licensed in the state, if required, or who has:
 - 1. A bachelor's degree in recreation, or in a specialty area, such as art, music, or physical education; or
 - 2. An associate degree in recreation and one (1) year of experience in recreation; or
 - 3. A high school diploma, or an equivalency certificate; and
 - a. Two (2) years of experience in recreation; or
 - b. One (1) year of experience in recreation plus completion of comprehensive in-service training in recreation; or
 - 4. Demonstrated proficiency and experience in conducting activities in one (1) or more recreation program areas; or
 - (i) A "rehabilitation/counselor" who is certified by the Committee on Rehabilitation Counselor Certification.
- (17) "Restraint" means any chemical agent or any physical or mechanical device used to restrict the movement of an individual or the movement or normal function of a portion of the individual's body, excluding only those devices used to provide support for the

achievement of functional body position or proper balance (such as positioning chairs) and devices used for specific medical and surgical (as distinguished from behavioral) treatment.

(18) "Seclusion" means the retention of a resident alone in a locked room.

(19) "Skin test" means a tuberculin skin test utilizing the intradermal (Mantoux) technique using five (5) tuberculin units of purified protein derivative (PPD). The results of the test must be read forty-eight (48) to seventy-two (72) hours after injection and recorded in terms of millimeters of induration.

(20) "Two (2) step skin testing" means a series of two (2) tuberculin skin tests administered seven (7) to fourteen (14) days apart.

(21) "Time out" means a procedure which involves removing the person from a reinforcing situation, for a period of time when the person engages in a specified inappropriate behavior.

Section 2. Scope of Operation and Services. Intermediate care facilities for mentally retarded and developmentally disabled persons provide services for all age groups on a twenty-four (24) hour basis, seven (7) days a week, in an establishment with permanent facilities including resident beds for persons whose mental or physical condition requires developmental nursing services along with a planned program of active treatment. The facility provides special programs as indicated by individual care plans to maximize the resident's mental, physical, and social development in accordance with the normalization principle. The intermediate care facilities for the mentally retarded and developmentally disabled must comply with the facility specifications for Intermediate Care Facilities, 902 KAR 20:056.

Section 3. Administration and Operation.

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

(2) Administrator. All facilities shall have an administrator who is responsible for the operation of the facility and delegating such responsibility in his absence. The administrator shall not be the nursing services supervisor.

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

(4) Administrative records.

(a) The facility shall maintain a bound, permanent, chronological resident registry showing date of admission, name of resident 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 resident (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.

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

(a) Services including medical, nursing, habilitation, 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 cases of abuse, neglect or exploitation of adults and children to the Department for Human Resources pursuant to KRS Chapters 209 and 620;

- (c) Use of restraints. The facility shall have a written policy that defines the use of restraints and supportive devices and a mechanism for monitoring and controlling their use; and
- (d) Missing resident 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 resident is determined to be lost, unaccounted for or other unauthorized absence.
- (6) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525.
- (7) Admission.
 - (a) Patients shall be admitted only upon the approval of a physician. The facility shall admit only persons who have a physical or mental condition which requires developmental nursing services and a planned program of active treatment.
 - (b) The interdisciplinary team shall consist of a physician, a psychologist, a registered nurse, a social worker and other professionals, at least one of whom is a qualified mental retardation professional. The interdisciplinary team shall:
 - 1. Conduct a comprehensive evaluation of the individual, not more than three (3) months before admission, covering physical, emotional, social, and cognitive factors; and
 - 2. Prior to admission define the need for service without regard to availability of those services. The team shall review all available and applicable programs of care, treatment, and training and record its findings.
 - (c) If admission is not the best plan but the individual must be admitted nevertheless, the facility shall clearly acknowledge that the admission is inappropriate and initiate plans to actively explore alternatives;
 - (d) Before admission, the resident and a responsible member of his family or committee shall be informed in writing of the established policies of the facility and fees, reimbursement, visitation rights during serious illness, visiting hours, type of diets offered and services offered; and
 - (e) The facility shall provide and maintain a system for identifying each resident's personal property and facilities for safekeeping of his declared valuables. Each resident's clothing and other property shall be reserved for his own use.
- (8) Discharge planning. Prior to discharge the facility shall have a postinstitutional plan which identifies the residential setting and support services which would enable the resident to live in a less restrictive alternative to the current setting. Before a resident is released, the facility shall:
 - (a) Offer counseling to parents or guardians who requests the release of a resident concerning the advantages and disadvantages of the release;
 - (b) Plan for release of the resident, to assure that appropriate services are available in the resident's new environment, including protective supervision and other follow-up services; and
 - (c) Prepare and place in the resident's record a summary of findings, progress, and plans.
- (9) Transfer procedures and agreements.
 - (a) The facility shall have written transfer procedures and agreements for the transfer of residents to other health care facilities which can provide a level of health 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 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 resident, and shall establish responsibility for notifying the other institution promptly of the impending transfer of a resident and shall arrange for appropriate and safe transportation.

(b) When the resident's condition exceeds the scope of services of the facility, the resident, upon physician's orders (except in cases of emergency), shall be transferred promptly to a hospital or a skilled nursing facility, or services shall be contracted for from another community resource.

(c) When changes and progress occur which would enable the resident 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 residents to be transferred to facilities providing appropriate services.

(d) Except in an emergency, the resident, his next of kin, or guardian, if any, and the attending physician shall be consulted in advance of the transfer or discharge of any resident.

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

(f) If the resident is transferred to another health care facility or other community resource, a transfer form shall accompany the resident. The transfer form shall include at least: physician's orders (if available), current information relative to diagnosis with a history of problems requiring special care, a summary of the course of prior treatment, special supplies or equipment needed for resident care, and pertinent social information on the resident and family.

(10) Medical records.

(a) The facility shall maintain a record for each resident for:

1. Planning and continuous evaluation of the resident's habilitation program;
2. Furnishing documentary evidence of each resident's progress and response to his habilitation program; and
3. Protecting the rights of the residents, the facility and the staff.

(b) All entries in the resident's record shall be legible, dated and signed.

(c) At the time a resident is admitted, the facility must enter in the individual's record the following information:

1. Name, date of admission, birth date and place, citizenship status, marital status, and Social Security number;
2. Father's name and birthplace, mother's maiden name and birthplace, and parents' marital status;
3. Name and address of parents, legal guardian, and next of kin if needed;
4. Sex, race, height, weight, color of hair, color of eyes, identifying marks, and recent photograph;
5. Reason for admission or referral problem;
6. Type and legal status of admission;
7. Legal competency status;
8. Language spoken or understood;
9. Sources of support, including Social Security, veterans' benefits, and insurance;
10. Religious affiliation, if any;
11. Reports of the preadmission evaluations; and
12. Reports of previous histories and evaluations, if any.

(d) Within one (1) month after the admission of each resident, the ICF/MR must enter the following in the resident's record:

1. A report of the review and updating of the preadmission evaluation;
2. A prognosis that can be used for programming and placement; and
3. A comprehensive evaluation and individual program plan, designed by an interdisciplinary team.

(e) The facility must enter the following information in a resident's record during his residence:

1. Reports of accidents, seizures, illnesses, and treatments for these conditions;

2. Records of immunizations;
3. Records of all time periods that restraints were used, with justification and authorization for each;
4. Reports of regular, at least annual, review and evaluation of the program, developmental progress, and status of each resident;
5. Observations of the resident's response to his program to enable evaluation of its effectiveness;
6. Records of significant behavior incidents;
7. Records of family visits and contacts;
8. Records of attendance and absences;
9. Correspondence pertaining to the resident;
10. Periodic updates of the information recorded at the time of admission; and
11. Appropriate authorizations and consent.

(f) The ICF/MR must enter a discharge summary in the resident's record at the time he is discharged.

(11) Personnel.

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

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

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

(d) The licensee shall have a qualified mental retardation professional who is responsible for:

1. Supervising the delivery of each resident's individual plan of care;
2. Supervising the delivery of training and habilitation services;
3. Integrating the various aspects of the facility program;
4. Recording each resident's progress; and
5. Initiating a periodic review of each individual plan of care for necessary changes.

(e) Each resident living unit, regardless of organization or design, must have, as a minimum, overall staff-resident ratios (allowing for a five (5) day work week plus holiday, vacation, and sick time) as follows unless program needs justify otherwise:

1. For units serving children under the age of six (6) years, severely and profoundly retarded, severely physically handicapped, or residents who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the overall ratio is one (1) to two (2);
2. For units serving moderately retarded residents requiring habit training, the overall ratio is one (1) to two and five tenths (2.5); and
3. For units serving residents in vocational training programs and adults who work in sheltered employment situations, the overall ratio is one (1) to five (5).

(f) When the staff/resident ratio does not meet the needs of the residents, 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.

(g) A responsible staff member shall be on duty and awake at all times to assure prompt, appropriate action in case of injury, illness, or fire or other emergencies.

- (h) Volunteers shall not be counted to make up minimum staffing requirements.
- (i) Supervision of nursing services shall be by a registered nurse or licensed practical nurse employed on the day shift seven (7) days per week. The supervisor shall have training and experience in the field of developmental disabilities and mental retardation. When a licensed practical nurse serves as the supervisor, consultation shall be provided by a registered nurse preferably with a baccalaureate degree, at regular intervals, not less than four (4) hours weekly. The responsibilities of the nursing services supervisor shall include:
1. Developing and maintaining nursing service objectives, standards of nursing practice, nursing procedure manuals, and written job description for each level of nursing personnel;
 2. Nursing service personnel at all levels of experience and competence shall be assigned responsibilities in accordance with their qualifications, delegate authority commensurate with their responsibility, and provide appropriate professional nursing supervision; and
 3. Participate in the development and implementation of resident care policies.
- (j) The facility shall retain a licensed pharmacist on a full-time, part-time or consultant basis to direct pharmaceutical services.
- (k) 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.
- (l) Supportive personnel, consultants, assistants and volunteers shall be supervised and shall function within the policies and procedures of the facility.
- (m) Health requirements. No employee contracting an infectious disease shall appear at work until the infectious disease can no longer be transmitted. The facility shall comply with the following tuberculosis testing requirements:
1. The skin test status of all staff members shall be documented in the employee's personnel record. A skin test shall be initiated on all new staff members before or during the first week of employment and the results shall be documented in the employee's personnel record within the first month of employment. No skin testing is required at the time of initial employment if the employee documents a prior skin test of ten (10) or more millimeters of induration or if the employee is currently receiving or has completed six (6) months of prophylactic therapy or a course of multiple-drug chemotherapy for tuberculosis. Two (2) step skin testing is required for new employees over age forty-five (45) whose initial test shows less than ten (10) millimeters of induration, unless they can document that they have had tuberculosis skin test within one (1) year prior to their current employment. All staff who have never had a skin test of ten (10) or more millimeters induration must be skin tested annually on or before the anniversary of their last skin test.
 2. All staff who are found to have a skin test of ten (10) or more millimeters induration, on initial employment testing or annual testing, must receive a chest x-ray unless a chest x-ray within the previous two (2) months showed no evidence of tuberculosis or the individual can document the previous completion of a course of prophylactic treatment with isoniazid. Such employees shall be advised of the symptoms of the disease and instructed to report to their employer and seek medical attention promptly, if symptoms persist.
 3. The administrator shall be responsible for ensuring that all skin tests and chest x-rays are done in accordance with paragraphs 1 and 2 of this subsection. All skin testing dates and results and all chest x-ray reports shall be recorded as a permanent part of the personnel record.
 4. The following shall be reported by the administrator to the local health department having jurisdiction immediately upon becoming known: names of staff

who convert from a skin test of less than ten (10) to a skin test of ten (10) or more millimeters of induration; names of staff who have a skin test of ten (10) millimeters or more induration at the time of employment; and all chest x-rays suspicious for tuberculosis.

5. Any staff whose skin test status changes on annual testing from less than ten (10) to ten (10) or more millimeters of induration shall be considered to be recently infected with *Mycobacterium tuberculosis*. Such recently infected persons who have no signs or symptoms of tuberculosis disease on chest x-ray or medical history should be given preventive therapy with isoniazid for six (6) months unless medically contraindicated, as determined by a licensed physician. Medications shall be administered to patients only upon the written order of a physician. If such individual is unable to take isoniazid therapy, the individual shall be advised of the clinical symptoms of the disease, and have an interval medical history and a chest x-ray taken and evaluated for tuberculosis infection every six (6) months during the two (2) years following conversion for a total of five (5) chest x-rays.

6. Any staff who can document completion of preventive treatment with isoniazid shall be exempt from further screening requirements.

(n) The facility shall have a staff training program adequate for the size and nature of the facility with a person designated the responsibility for staff development and training. The program shall include:

1. Orientation for each new employee to acquaint him with the philosophy, organization, program, practices, and goals of the facility;
2. In-service training for any employee who has not achieved the desired level of competence;
3. Continuing in-service training for all employees to update and improve their skills; and
4. Supervisory and management training for each employee who is in, or a candidate for, a supervisory position.

Section 4. Provision of Services.

(1) The professional interdisciplinary team shall assure that the health needs of the residents are met and that plans are developed for each resident which include treatments, medications, dietary requirements, and other program services. All activities shall reflect adherence to the normalization principle. The active treatment program shall assure:

(a) An individual written plan of care that sets forth measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences or therapies necessary for the individual to reach those goals or objectives. The plan is to help the individual function at the greatest physical, intellectual, social, or vocational level he can presently or potentially achieve.

(b) Regular participation, in accordance with an individualized plan, in a program of activities that are designed to attain the optimum physical, intellectual, social, and vocational functioning of which a resident is capable.

(c) Reevaluation medically, socially, and psychologically at least annually by the staff involved in carrying out the resident's individual plan of care. This must include review of the individual's progress toward meeting the plan objectives, the appropriateness of the individualized plan of care, assessment of his continuing need for institutional care, and consideration of alternate methods of care.

(2) Infection control and communicable diseases.

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

1. Policies which address the prevention of disease transmission to and from patients, visitors and employees, including:

- a. Universal blood and body fluid precautions;
 - b. Precautions for infections which can be transmitted by the airborne route; and
 - c. Work restrictions for employees with infectious diseases.
- 2. 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.
 - 1. 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.
 - 2. Needles shall not be recapped by hand, purposely bent or broken, or otherwise manipulated by hand.
 - 3. The containers of sharp wastes shall either be incinerated on or off site, or be rendered nonhazardous by a technology of equal or superior efficacy, which is approved by both the Cabinet for Human Resources and the Natural Resources and Environmental Protection Cabinet.
- (d) Disposable waste.
 - 1. 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.
 - 2. The facility shall establish specific written policies regarding handling and disposal of all wastes.
 - 3. 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.
 - 4. 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.
- (e) Patients infected with the following diseases shall not be admitted to the facility: anthrax, campylobacteriosis, cholera, diphtheria, hepatitis A, measles, pertussis, plague, poliomyelitis, rabies (human), rubella, salmonellosis, shigellosis, typhoid fever, yersiniosis, brucellosis, giardiasis, leprosy, psittacosis, Q fever, tularemia, and typhus.
- (f) A facility may admit a (noninfectious) tuberculosis patient under continuing medical supervision for his tuberculosis disease.
- (g) Patients with active tuberculosis may be admitted to the facility whose isolation facilities and procedures have been specifically approved by the cabinet.
- (3) Use of control and discipline of residents.
 - (a) The facility must have written policies and procedures for the control and discipline of residents that are available in each living unit and to parents and guardians.
 - (b) The facility shall not allow:
 - 1. Corporal punishment of a resident;
 - 2. A resident to discipline another resident, unless it is done as part of an organized self-government program conducted in accordance with written policy; or
 - 3. Seclusion of a resident.
 - (c) On orders of a physician, or in the case of an emergency until a physician is contacted, the facility may allow the use of physical restraint on a resident only if absolutely necessary to protect the resident from injuring himself or others but may not use physical restraint as punishment, for the convenience of the staff, or as a substitute for activities or treatment.

- (d) The facility must have a written policy that specifies how and when physical restraint may be used, the staff members who must authorize its use, and the method for monitoring and controlling its use.
- (e) An order for physical restraint may not be in effect longer than twelve (12) hours. Appropriately trained staff must check a resident placed in a physical restraint at least every thirty (30) minutes and keep a record of these checks. A resident who is in a physical restraint must be given an opportunity for motion and exercise for a period of not less than ten (10) minutes during each two (2) hours of restraint. Mechanical devices used for physical restraint must be designed and used in a way that causes the resident no physical injury and the least possible physical discomfort. Restraints that require lock and key shall not be used.
- (f) Mechanical supports used as protective devices must be designed and applied under the supervision of a qualified professional, and in accordance with principles of good body alignment, concern for circulation, and allowance for change of position.
- (g) The facility may not use chemical restraint excessively, as punishment, for the convenience of the staff, as a substitute for activities or treatment, or in quantities that interfere with a resident's habilitation program.
- (h) Behavior modification programs involving the use of aversive stimuli or time-out devices shall be:
 - 1. Reviewed and approved by the facility's human rights committee or a qualified mental retardation professional;
 - 2. Conducted only with the consent of the affected resident's parents or legal guardian; and
 - 3. Described in written plans that are kept on file in the ICF/MR.
- (i) A physical restraint used as a time-out device may be applied only during behavior modification exercises and only in the presence of the trainer.
- (j) Time-out devices and aversive stimuli may not be used for longer than one (1) hour, and then only during the behavior modification program and only under the supervision of the trainer.
- (4) Medical supervision of residents. The facility shall maintain policies and procedures to assure that each resident shall be under the medical supervision of a physician.
 - (a) The resident (or his guardian) shall be permitted his choice of physician.
 - (b) The physician shall visit the residents as often as necessary and in no case less often than every sixty (60) days, unless justified and documented by the attending physician.
 - (c) A complete medical evaluation to include social, physical, emotional, and cognitive factors shall be made of the person desiring or requiring institutionalization prior to, but not to exceed three (3) months before admission.
 - (d) Medical reevaluation at least annually shall be made by the resident's physician, a physician provided by a community service, or a registered visiting nurse, according to the resources for the community and the apparent needs of the resident receiving intermediate care.
 - (e) Formal arrangements shall be made to provide for medical emergencies on a twenty-four (24) hour, seven (7) days a week basis. This shall be the responsibility of the facility providing care.
- (5) Health services. Health services shall include:
 - (a) The establishment of a nursing care plan as part of the total habilitation program for each resident. Each plan shall be reviewed and modified as necessary, or at least quarterly. Each plan shall include goals, and nursing care needs;
 - (b) Nursing care to achieve and maintain the highest degree of function, self-care and independence with those procedures requiring medical approval ordered by the attending physician. Nursing care shall include:

1. Positioning and turning. Nursing personnel shall encourage and assist residents in maintaining good body alignment while standing, sitting, or lying in bed to prevent decubiti.
2. Exercises. Nursing personnel shall assist residents in maintaining maximum range of motion.
3. Bowel and bladder training. Nursing personnel shall make every effort to train incontinent residents to gain bowel and bladder control.
4. Training in habits of personal hygiene, family life, and sex education that includes but is not limited to family planning and venereal disease counseling.
5. Ambulation. Nursing personnel shall assist and encourage residents with daily ambulation unless otherwise ordered by the physician.
6. Administration of medications and appropriate treatment.
7. Written monthly assessment of the resident's general condition with any changes in the resident's condition, actions, responses, attitudes, or appetite recorded in the resident's record by licensed personnel.

(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 pharmacist.

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

(c) If the facility does not have a pharmacy department, it shall have 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) 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.

(e) Medication requirement and services.

1. Conformance with physician's orders. All medications administered to residents shall be ordered in writing. Oral orders shall be given only to a licensed nurse or pharmacist, immediately reduced to writing, and signed. 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. The pharmacist or nurse shall review the resident's medication profile on a regular basis. The resident's attending physician shall be notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the resident's therapeutic regimen is not interrupted. Medications shall be released to residents on discharge or visits only after being labeled appropriately and on the written authorization of the physician.

2. Administration of medications. All medications shall be administered by licensed nurses or personnel who have completed a state approved training program, from a state approved training provider. Each dose administered shall be recorded in the medical record. 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 a registered nurse.

a. The nursing station shall have items required for the proper administration of medication readily available.

b. Medications prescribed for one resident shall not be administered to any other resident.

- c. Self-administration of medications by residents shall not be permitted except for drugs on special order of the resident's physician and a predischARGE program under the supervision of a licensed nurse as a part of the resident's treatment plan.
 - d. Medication errors and drug reactions shall be immediately reported to the resident's physician and pharmacist and an entry thereof made in the resident's medical record as well as on an incident report.
 - 3. The facility shall provide up-to-date medication reference texts for use by the nursing staff (e.g., Physician's Desk Reference).
 - 4. Labeling and storing medications. All medications shall be plainly labeled with the resident'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 resident 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 injection. Provisions shall also be made for the locked separate storage of medications of deceased and discharge resident until such medication is surrendered or destroyed in accordance with federal and state laws and regulations.
 - 5. Controlled substances. Controlled substances shall be kept under double lock, (i.e., in a locked box in a locked cabinet). There shall be a controlled substances record, in which is recorded the name of the resident, the date, time, kind, dosage, balance remaining and method of administration of all controlled substances; the name of the physician 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.
- (7) Personal care services.
- (a) Each resident shall be trained to be as independent as possible to achieve and maintain good personal hygiene including:
 - 1. Bathing of the body to maintain clean skin and freedom from offensive odors. In addition to assistance with bathing, the facility shall provide soap, clean towels, and wash cloths for each resident. Toilet articles such as brushes and combs shall not be used in common.
 - 2. Shaving.
 - 3. Cleaning and trimming of fingernails and toenails.
 - 4. Cleaning of the mouth and teeth to maintain good oral hygiene as well as care of the lips to prevent dryness and cracking. All residents shall be provided with tooth brushes, a dentifrice, and denture containers, when applicable.
 - 5. Washing, grooming, and cutting of hair.
 - (b) Each resident who does not eliminate appropriately and independently must be in a regular, systematic toilet training program and a record must be kept of his progress in the program.
 - (c) A resident who is incontinent must be bathed or cleaned immediately upon voiding or soiling, unless specifically contraindicated by the training program, and all soiled

items must be changed.

(d) The staff shall train and when necessary assist the residents to dress in their own street clothing (unless otherwise indicated by the physician).

(8) Dental services.

(a) Comprehensive dental services shall be provided and if not available within the facility, arrangements with specialists in the dental field will be made for such service.

1. Appropriate dental services shall be provided through personal contact with all residents by dentists, dental hygienists, and dental assistants under the supervision of the dentists, health educators, and oral hygiene aids.

2. A dental professional shall participate, as appropriate on the interdisciplinary team serving the facility.

3. There shall be sufficient supporting personnel, equipment, and facilities available to the dental professional if dental services are delivered within the facility.

(b) Dental records shall be part of each resident's record.

(c) A dentist shall be responsible for insuring that direct care staff are instructed in the proper use of oral hygiene methods for residents.

(9) Social services.

(a) Social services shall be available either on staff or by formal arrangement with community resources for all residents and their families, including evaluation and counseling with referral to, and use of, other planning for community placement, discharge and follow up services rendered by or under the supervision of a social worker.

(b) The social worker of the intermediate care facility, providing services for the mentally retarded and developmentally disabled shall be under the supervision of a social worker who is a qualified mental retardation professional.

(c) Social services shall be integrated with other elements of the plan of care.

(d) A plan for such care shall be recorded in the resident's record and periodically evaluated in conjunction with resident's total plan of care.

(e) Social services records shall be maintained as an integral part of case record maintained on each resident.

(10) Recreation services. The facility shall coordinate recreational services with other services and programs provided to each resident and shall:

(a) Provide recreation equipment and supplies in a quantity and variety that is sufficient to carry out the stated objectives of the activities programs.

(b) Keep resident records that include periodic surveys of the residents' recreation interests and the extent and level of the residents' participation in the recreation program.

(c) Have enough qualified staff and support personnel available to carry out the various recreation services with the qualifications as defined in the definitions.

(11) Speech pathology and audiology services. The facility shall provide speech pathology and audiology services as needed to maximize the communication skills of residents needing such services. These services shall be provided by, or under the supervision of, a certified speech pathologist or audiologist who is a member of the interdisciplinary team.

(12) Occupational therapy.

(a) Occupational therapy shall be provided by or under the supervision of a qualified occupational therapist to residents as required by the resident's needs.

(b) The occupational therapist shall act upon the program designed by the professional interdisciplinary team of which the therapist is a member.

(13) Physical therapy.

(a) Physical therapy shall be provided by or under the supervision of a licensed physical therapist to residents as required by the resident's needs.

- (b) The physical therapist shall act upon the program designed by the professional interdisciplinary team of which the therapist is a member.
- (14) Psychological services. Psychological services as needed shall be provided by a licensed or certified psychologist pursuant to KRS Chapter 319 who shall participate in the evaluation and periodic review, individual treatment, and consultation and training of program staff as a member of the interdisciplinary team.
- (15) Transportation.
- (a) If transportation of residents is provided by the facility to community agencies or other activities, the following shall apply:
1. Special provision shall be made for residents who use wheelchairs.
 2. An escort or assistant to the driver shall be provided in transporting residents to and from the facility if necessary for the resident's safety.
- (b) The facility shall arrange for appropriate transportation in case of medical emergencies.
- (16) Residential care services. All facilities shall provide residential care services to all residents including: room accommodations, housekeeping and maintenance services, and dietary services. All facilities shall meet the following requirements relating to the provision of residential care services:
- (a) Room accommodations.
1. Each resident shall be provided a standard size bed at least thirty-six (36) inches wide, equipped with substantial spring, a clean comfortable mattress, a mattress cover, two (2) sheets and a pillow, and such bed covering as is required to keep the resident comfortable. Rubber or other impervious sheets shall be placed over the mattress cover whenever necessary. Beds occupied by residents shall be placed so that no resident 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, chests or dressers with mirrors, a night light, and storage space for clothing and other possessions.
 3. Residents shall not be housed in unapproved rooms or unapproved detached buildings.
 4. Basement rooms shall not be used for sleeping rooms for residents.
 5. Residents may have personal items and furniture when it is physically feasible.
 6. Each living room or lounge area shall have an adequate number of reading lamps, and tables and chairs or settees of sound construction and satisfactory design.
 7. Dining room furnishings shall be adequate in number, well constructed, and of satisfactory design for the residents.
 8. Each resident shall be permitted to have his own radio and television set in his room unless it interferes with or is disturbing to other residents.
- (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 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 resident shall not be used by another until it has been laundered or dry cleaned.
 3. Soiled linen shall be placed in washable or disposable containers, transported in a sanitary manner and stored in separate, well-ventilated areas in a manner to prevent contamination and odors. Equipment or areas used to transport or store soiled linen shall not be used for handling or storing of clean linen.

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

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

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

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

8. Resident's personal clothing shall be laundered by the facility as often as necessary. Resident's personal clothing shall be laundered by the facility unless the resident or the resident's family accepts this responsibility. Residents capable of laundering their own personal clothing may be provided the facilities to do so. Resident's personal clothing laundered by the facility shall be marked to identify the resident owner and returned to the correct resident.

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

a. The facility shall insure that the grounds are well kept and the exterior of the building, including the wide walks, 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) Dietary services. The facility shall provide or contract for food service to meet the dietary needs of the residents 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 resident 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 from 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 kept on file for thirty (30) days.
 - c. The daily menu shall include regular and all modified diets served within the facility based on a currently approved diet manual. The manual shall be available in the dietary department. The diet manual shall indicate nutritional deficiencies of any diet. The dietician shall correlate and integrate the dietary aspects of the resident's care with the resident and resident's chart through such methods as resident instruction, recording diet histories and through 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.
 - 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 residents. Adjustments shall be made when medically contraindicated.
 - 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 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 resident refuses the food served, nutritious 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 resident cannot be served in the dining room, trays shall be provided and shall rest on firm supports. Sturdy tray stands of proper height shall be provided for residents able to be out of bed.
- a. Correct positioning of the resident to receive his tray shall be the responsibility of the direct-care staff. Residents requiring help in eating shall be assisted according to their training plan.
 - b. Adaptive self-help devices shall be provided to contribute to the resident's independence in eating, if assessments deem necessary.
6. Sanitation. All facilities shall comply with all applicable provisions of KRS 219.011 to KRS 219.081 and 902 KAR 45:005 (Kentucky's Food Service Establishment Act and Food Service Code).
- (8 Ky.R. 606; eff. 2-1-1982; 11 Ky.R. 1186; 1421; eff. 6-4-1985; 13 Ky.R. 1292; eff. 2-10-1987; 16 Ky.R. 2504; 17 Ky.R. 84; eff. 7-18-1990; 1598; eff. 12-18-1990; Crt eff. 4-30-2019.)