

902 KAR 20:240. Comprehensive physical rehabilitation hospital services.

RELATES TO: KRS 194A.030(1), 216B.010, 216B.015, 216B.040, 216B.045-216B.055, 216B.075, 216B.105-216B.131, 216B.990

STATUTORY AUTHORITY: KRS 216B.042(1)

CERTIFICATION STATEMENT:

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042(1) requires the Cabinet for Health and Family Services to establish administrative regulations for proper administration of the health care facility licensure function. This administrative regulation establishes minimum licensure requirements for inpatient comprehensive physical rehabilitation services, including rehabilitation services in hospital-based rehabilitation units.

Section 1. Definitions.

- (1) "Dietician" is defined at KRS 310.005(3).
- (2) "Full-time equivalent" (FTE) means:
 - (a) One (1) employee working thirty-seven and five-tenths (37.5) hours per week; or
 - (b) More than one (1) part-time employee whose combined working hours total thirty-seven and five-tenths (37.5) hours per week.
- (3) "Governing authority" means the individual, agency, partnership, or corporation that directs and establishes policy concerning the management and operation of a comprehensive physical rehabilitation program.
- (4) "Institution" means a freestanding specialty hospital or a general hospital based unit providing inpatient comprehensive physical rehabilitation services.
- (5) "Medical staff" means an organized body of physicians, and dentists if applicable, appointed by the governing authority. Members of the medical staff shall be licensed to practice medicine or dentistry in Kentucky, except for graduate physicians in the first year of facility training.
- (6) "Nutritionist" is defined at KRS 310.005(4).
- (7) "Protective device" means a device designed to protect a person from falling, including a side rail, safety vest, or safety belt.
- (8) "Registered Health Information Administrator" means a person certified as a registered records administrator by the American Health Information Management Association.
- (9) "Registered Health Information Technician" means a person certified as an Accredited Record Technician by the American Health Information Management Association.
- (10) "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. Administration and Operation.

- (1) Governing authority.
 - (a) The licensee shall be responsible for compliance with federal, state, and local law pertaining to comprehensive physical rehabilitation programs.
 - (b) The governing authority shall appoint an administrator whose qualifications, responsibilities, authority and accountability are defined in writing and approved by the governing authority, and shall designate a mechanism for the periodic performance review of the administrator.
- (2) Administrator. The administrator shall:
 - (a) Be responsible for daily management of the institution;
 - (b) Provide a liaison between the governing authority and the medical staff;
 - (c) Attend meetings of the governing authority;
 - (d) Report to the governing authority concerning the conduct of the institution;
 - (e) Hold departmental and interdepartmental meetings on a regular basis;

- (f) Attend or be represented at departmental and interdepartmental meetings; and
 - (g) Present to the departments a report of pertinent activities of the institution.
- (3) Administrative records and reports.
- (a) Administrative reports shall be established, maintained and utilized as necessary to guide the operation, measure productivity and reflect the programs of the institution. An administrative report shall include:
 - 1. Minutes of the governing authority and staff meetings;
 - 2. Financial records and reports;
 - 3. Incident investigation reports; and
 - 4. Other pertinent reports prepared in the regular course of business.
 - (b) The institution shall maintain a patient admission and discharge register.
 - (c) Licensure inspection reports and plans of correction shall be made available to the general public upon request.
- (4) Policies. The institution shall have written documents on file governing the operation of the institution and the services provided, including:
- (a) A mission statement of the comprehensive physical rehabilitation service;
 - (b) A program narrative which describes in detail the rehabilitation conditions for which the institution provides services, the delivery of these services, and the goals and treatment;
 - (c) A description of the organizational structure of the facility, including lines of authority, responsibility, and communication;
 - (d) An admission policy to assure patient admission is in accordance with medical staff protocol;
 - (e) A list of constraints imposed on admissions by limitation of service, physical facilities, staff coverage, or other relevant factors;
 - (f) The financial requirements for a patient to be admitted;
 - (g) The requirement for an informed consent by patient, parent, guardian or legal representative for diagnostic or treatment procedure;
 - (h) A procedure for:
 - 1. Recording an accident involving a patient, visitor, or staff member;
 - 2. Recording an incident of drug reaction or medication error; and
 - 3. Reporting in writing through the appropriate committees;
 - (i) A policy for the use of restraints and a mechanism for monitoring and controlling their use;
 - (j) A policy for patient discharge and termination of services; and
 - (k) A policy describing the use of volunteers in program activities.
- (5) Patient identification. The institution shall identify each patient from time of admission to time of discharge with an identification bracelet imprinted with the name of the patient, and the date of admission.
- (6) Discharge planning.
- (a) The discharge decision and plan shall be established with the participation of the patient, if possible, or a significant other person. Discharge planning shall begin early in the treatment phase. Each professional practitioner involved with the patient shall participate in formulating the discharge plan, including professionals from agencies outside the institution who have been or will be involved in the patient's care, if possible.
 - (b) A discharge authorization and summary shall be prepared for each patient who has been discharged or transferred from the institution to a supportive service. The summary shall contain:
 - 1. The reason for referral;
 - 2. The diagnosis;
 - 3. The rehabilitation problem;

4. The services provided;
 5. The results of services provided;
 6. Any referral action recommended; and
 7. Procedures and activities for patient and family to assist the patient to maintain or improve postdischarge functioning and to increase independence.
- (c) The family, appropriate staff members, the referring source, and community agencies proposed to work with the patient, shall receive advance notice of the discharge decision and plan.
- (7) Patient follow-up.
- (a) The institution shall establish a procedure for patient follow-up.
 - (b) Follow-up shall be conducted after the patient is:
 1. Discharged from the institution;
 2. Transferred to a supportive service; or
 3. Placed in an inactive status.
- (8) Transfer procedures and agreements.
- (a) The institution shall have written patient transfer procedures and agreements with other health care facilities which provide a level of inpatient care not provided by the institution. Transfer procedures and agreements shall include:
 1. Written procedures insuring prompt notification to the receiving facility;
 2. Accommodation for safe and appropriate transfer; and
 3. Specification of staff responsibilities during transfer.
 - (b) If a patient is transferred to another health care facility, a transfer form shall accompany the patient. The transfer form shall include:
 1. The attending physician's instructions for continuing care;
 2. A current summary of the patient's medical record;
 3. Information concerning special supplies or equipment needed for the patient's care; and
 4. Pertinent social information concerning the patient the patient's and family.
 - (c) A copy of the patient's signed discharge summary shall be forwarded to the receiving health care facility within thirty (30) days following the patient's discharge.
- (9) Medical staff.
- (a) The facility shall have a medical staff organized under bylaws approved by the governing authority. The medical staff shall be responsible to the governing authority for the quality of medical care provided and for the ethical and professional practice of its members.
 - (b) The medical staff shall develop and adopt policies or bylaws which shall be approved by the governing authority. The policies or bylaws shall:
 1. Establish the qualifications for medical staff membership, including professional licensure, except for graduate physicians in their first year of hospital training;
 2. Define and describe the responsibilities and duties of each category of medical staff, including each person who is designated active, associate, or courtesy;
 3. Delineate the clinical privileges of staff members and allied health professionals;
 4. Establish a procedure for granting and withdrawing staff privileges and credentials;
 5. Provide a mechanism for appeal of decisions regarding staff membership and privileges;
 6. Provide a method for the selection of officers of the medical staff;
 7. Establish requirements regarding the frequency of, and attendance at, general staff and department or service meetings of the medical staff;
 8. Provide for the appointment of standing and special committees and establish requirements for:
 - a. Composition and organization;

- b. Frequency of and attendance at meetings; and
 - c. Maintenance of minutes and reports in the permanent hospital records:
9. Standing and special committees may include:
- a. An executive committee;
 - b. A credentials committee;
 - c. A medical audit committee;
 - d. A medical records committee;
 - e. An infection control committee;
 - f. A tissue committee;
 - g. A pharmacy and therapeutics committee;
 - h. A utilization review committee; and
 - i. A quality assurance committee; and
10. Establish a policy requiring a member of the medical staff to sign the written documentation of a verbal order for diagnostic testing or treatment:
- a. As soon as possible after the order is given; or
 - b. Within thirty (30) days of the patient's discharge if the patient is discharged prior to the order being authenticated.
- (10) Director of rehabilitation. The director of rehabilitation shall:
- (a) Be a licensed physician who has completed a one (1) year facility internship and has two (2) years of training or experience in medical management of inpatients requiring rehabilitation services; and
 - (b) Provide services:
 - 1. On a full-time basis for a freestanding specialty hospital;
 - 2. At least twenty (20) hours per week for a general hospital based unit with twenty (20) or more beds; or
 - 3. At least ten (10) hours per week for a general hospital-based unit with less than twenty (20) beds.
- (11) Quality assurance and review.
- (a) The quality and appropriateness of major clinical functions shall be monitored and evaluated utilizing:
 - 1. Objective criteria that reflects current knowledge and clinical experience; and
 - 2. Information about identified aspects of rehabilitation care that is collected on a routine basis;
 - (b) Information from the quality assurance and review shall be:
 - 1. Reviewed and assessed on a periodic basis; and
 - 2. Utilized to improve clinical operations and patient care.
 - (c) The effectiveness of action taken to improve patient care shall be evaluated.
 - (d) Findings and conclusions regarding the following shall be documented and reported to the administrator and appropriate committees:
 - 1. Monitoring and evaluation;
 - 2. Problem-solving activity;
 - 3. Activity for the improvement of patient care; and
 - 4. The impact of actions taken.
 - (e) The quality and appropriateness of patient rehabilitation services provided by an outside source shall be monitored and evaluated, and identified problems resolved.
- (12) Personnel.
- (a) The institution shall employ qualified personnel sufficient to provide effective patient care and related services and shall make available to all employees written personnel policies and procedures.
 - (b) There shall be a written job description for each position which shall assure that an employee is appropriately classified and licensed for the position in which he is employed.

(c) There shall be an employee health program that includes preemployment and periodic health examinations.

(d) Each staff member shall be tested for tuberculosis, as follows:

1. The skin test status of each staff member shall be documented in the employee's personnel record.

a. A new staff member shall undergo a skin test before or during the first week of employment.

b. The results shall be documented in the employee's personnel record within the first month of employment.

c. A skin test shall not be required at the time of initial employment if the employee:

- (i) Documents a prior skin test of ten (10) or more millimeters of induration; or
- (ii) If the employee is currently receiving or has completed six (6) months of prophylactic therapy or a course of multiple-drug chemotherapy for tuberculosis.

d. A two (2) step skin test is required for a new employee over age forty-five (45) whose initial test shows less than ten (10) millimeters of induration, unless he can document that he has had a tuberculosis skin test within one (1) year prior to his current employment. An employee who has never had a skin test of ten (10) or more millimeters induration shall be skin tested annually, on or before the anniversary of his last skin test.

2. An employee whose initial or annual skin test results in ten (10) or more millimeters induration shall receive a chest x-ray, unless:

a. A chest x-ray within the previous two (2) months showed no evidence of tuberculosis; or

b. The employee can document the previous completion of a course of prophylactic treatment with isoniazid. An employee whose initial skin test shows ten (10) or more millimeters of induration shall be advised of the symptoms of the disease and instructed to report to his employer and seek medical attention promptly.

3.

a. The director of rehabilitation shall be responsible for ensuring that skin tests and chest x-rays are done in accordance with subparagraphs 1 and 2 of this paragraph.

b. Skin testing dates and results and chest x-ray reports shall be recorded as a permanent part of the employee's personnel record.

4. The administrator shall report to the local health department, immediately upon discovery, the name of an employee whose:

a. Skin test results are ten (10) millimeters or more induration at the time of employment;

b. Skin test results change from less than ten (10) millimeters induration to more than ten (10) millimeters; or

c. Chest x-rays are suspicious for tuberculosis.

5. Prophylaxis of a person with recent infection but no disease.

a. A resident or staff member whose skin test status changes upon 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*.

b. A recently infected person who has no sign or symptom of tuberculosis disease upon chest x-ray or medical history shall be given preventive therapy with isoniazid for six (6) months unless medically contraindicated by a licensed physician.

c. Medications shall be administered to patients only upon the written order of a physician or other practitioner acting within his statutory scope of practice.

d. If an infected person is unable to take isoniazid therapy, the person shall be advised of the clinical symptoms of the disease, and shall have an interval medical history and a chest x-ray taken and evaluated for tuberculosis disease every six (6) months during the two (2) years following conversion, for a total of five (5) chest x-rays.

6. A staff member who documents completion of preventive treatment with isoniazid shall be exempt from further screening requirements.

(e) A current personnel record shall be maintained for each employee which shall include the following:

1. Name, address, and Social Security number;
2. Health records;
3. Evidence of current registration, certification or licensure;
4. Records of training and experience;
5. Records of performance evaluation;
6. Evidence of completion of an orientation to the facility's written policies initiated within the first month of employment; and
7. Evidence of regular in-service training which corresponds with job duties and includes a list of training and dates completed.

(13) Physical and sanitary environment.

(a) The physical plant and premises shall be maintained to promote the safety and well-being of patients, personnel and visitors.

(b) A person shall be designated to be in charge of services and shall be responsible for the establishment of policies and procedures for plant maintenance, laundry, and housekeeping.

(c) The institution's buildings, equipment and surroundings shall be in good repair and shall be neat, clean, free from accumulations of dirt and rubbish, and free from foul, stale, or musty odors.

(d) The institution shall be free of insects and rodents.

(e) Garbage receptacles and trash cans shall be kept clean and shall be stored away from areas used for preparation and storage of food and the contents shall be regularly removed from the premises.

(f) Hazardous cleaning solutions, compounds, and substances shall be labeled, stored in closed containers and shall not be stored with nonhazardous items.

(g) The institution shall have a supply of clean linen available at all times for the proper care and comfort of patients.

1. Linens shall be handled, stored and processed to prevent the spread of infection.
2. Clean linen and clothing shall be stored in clean, dry, dust-free areas.
3. Soiled linen and clothing shall be placed in suitable bags or closed containers and stored in separate areas.

(h)

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. A needle or other contaminated sharp 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 at 29 C.F.R. 1910.1030(d)(2)(vii).

3. A sharp waste container shall be incinerated on or off site, or shall be rendered nonhazardous.

4. Nondisposable sharps, such as large-bore needles or scissors, shall be placed in a puncture resistant container for transport to the Central Medical and Surgical Supply Department, in accordance with 902 KAR 20:009, Section 22.

(14) Patient medical records.

(a) The institution shall have a health information management service that is responsible for the integrity and confidentiality of a patient's medical records. A medical record shall be maintained, in accordance with accepted professional principles, for each patient admitted to the facility or receiving outpatient services.

(b) The health information management service shall be under the direction of a Registered Health Information Administrator, either on a full-time, part-time, or consultative basis, or by a Registered Health Information Technician on a full-time basis and shall have available a sufficient number of regularly-assigned employees to insure that records are stored and retrieved efficiently.

(c) Medical records shall be retained for a minimum of five (5) years from date of discharge or, in the case of a minor, three (3) years after the patient reaches age eighteen (18).

(d) The facility shall designate a location and maintain medical records there in the event the facility ceases to operate for any reason.

(e) Medical record contents shall be pertinent and current and shall include the following:

1. Identification data and signed consent forms, including name and address of next of kin and of person or agency responsible for patient;
2. Date of admission, name of attending medical staff member, and allied health professional responsible for the provision of therapy services;
3. Chief complaint;
4. Medical history including present illness, past history, family history, and physical examination results;
5. Report of special examinations or procedures performed and results;
6. Provisional diagnosis or reason for admission;
7. Orders for diet, diagnostic tests, therapeutic procedures, and medications, including patient limitations, signed and dated by the medical staff member or other ordering personnel acting within the limits of his statutory scope of practice if applicable, including records of all medication administered to the patient;
8. Complete surgical record signed by attending surgeon or oral surgeon, to include anesthesia record signed by anesthesiologist or anesthetist, preoperative physical examination and diagnosis, description of operative procedures and findings, postoperative diagnosis, and tissue diagnosis by qualified pathologist on tissue surgically removed;
9. Patient care plan which addresses the comprehensive care needs of the patient, to include the coordination of the facility's service departments that impact patient care;
10. Nurses' observations and progress notes of a physician, dentist, or other ordering personnel acting within his statutory scope of practice;
11. Record of temperature, blood pressure, pulse, and respiration;
12. Final diagnosis using terminology in the current version of the International Classification of Diseases or the American Psychiatric Association's Diagnostic and Statistical Manual, as applicable; and
13. Discharge summary, including condition of patient on discharge and date of discharge.

(f) Records shall be indexed according to disease, operation, and attending medical staff member. Any recognized indexing system may be used.

1. The disease and operative indices shall:

- a. Use recognized nomenclature;
 - b. Include each specific disease diagnosed and each operative procedure performed; and
 - c. Include essential data on each patient having that particular condition.
2. The attending medical staff index shall include all patients attended or seen for consultation by each medical staff member.
 3. Indexing shall be current, within six (6) months following discharge of the patient.
- (g) Medical record review.
1. The institution shall regularly review and evaluate records maintenance and retention policies and shall propose improvements if necessary and appropriate.
 2. The institution shall establish and maintain a medical records committee, which shall include a representative from each service department and which shall report to the administrator. The committee shall:
 - a. Review at least quarterly a sampling of records to measure their adequacy and compliance with established record maintenance policies and procedures; and
 - b. Review at least annually the medical records policies and procedures and make recommendations for consideration by the administrator.
- (h) A statement of professional judgment and a report of services to an individual shall be signed by the person qualified by professional competency and official position. The medical record shall record that services recommended and planned were received by the patient at the time stated.
- (i) Clinical information shall be recorded as soon as practicable, but no later than forty-eight (48) hours after the event.
- (j) Discharge summaries shall be recorded within thirty (30) days of discharge.
- (k) A completed medical record shall include:
1. Name, address and next of kin;
 2. The name and address of the personal representative, conservator, guardian, or representative payee, if one has been appointed for the person served;
 3. Pertinent history, diagnosis of disability, rehabilitation problem, goals, and prognosis;
 4. Reports from referring sources;
 5. Reports of service referrals;
 6. Reports from outside consultation, and from laboratory, radiology, orthotic and prosthetic services;
 7. Designation of the case manager for the patient, unless there is a written policy identifying who is responsible for the plan management of specified groups;
 8. Evidence of the patient's participation in devising his own plan;
 9. Evaluation reports from each service;
 10. Reports of staff conferences;
 11. The patient's total treatment plan;
 12. Treatment plans from each service;
 13. Signed and dated service and progress reports from each service;
 14. Correspondence pertinent to the person being served;
 15. A signed and dated authorization from the patient, his parent or guardian, if information or photographs have been released or used;
 16. Discharge report; and
 17. Follow-up reports.

Section 3. Provision of Services.

(1) General requirements.

- (a) A medication or treatment shall not be given without a written or verbal order signed by a physician, dentist, or other ordering practitioner acting within his statutory scope of practice.
- (b) A verbal order for a medication shall be given only to a licensed practical or registered nurse, paramedic, or pharmacist and shall be signed by a member of the medical staff or other ordering practitioner:
1. As soon as possible after the order is given; or
 2. Within thirty (30) days of the patient's discharge if the patient is discharged prior to the order being authenticated.
- (c) A verbal order for a diagnostic test or treatment order may be given to a licensed practitioner acting within his statutory scope of practice and the institutions' protocols.
- (d) At the time received, verbal orders from medications, diagnostic tests, and treatments shall be:
1. Immediately transcribed by the person receiving the order;
 2. Repeated back to the person requesting the order to ensure accuracy; and
 3. Annotated on the patient's medical record by the person receiving the order as repeated and verified.
- (e) Medications shall be administered by a physician, registered nurse, dentist, or a licensed practical nurse under the supervision of a registered nurse, advanced practice registered nurse, physician's assistant, or a paramedic acting within his scope of practice.
- (f) A restraint or protective device, other than bed rails and wheelchair safety belts shall not be used, except in an emergency until the attending medical staff member can be contacted, or upon written or telephone orders of the attending medical staff member. If restraint is necessary, it shall be the least restrictive protective device which affords the patient the greatest possible degree of mobility and protection. A locking restraint shall not be used under any circumstances.
- (g) Patient physical. A physician shall conduct a physical examination and determine whether the patient can benefit from a rehabilitation program through the use of therapies provided by the institution within twenty-four (24) hours after admission.
- (h) Psychosocial history. Each patient shall have a history and assessment interview within seventy-two (72) hours after admission. The following resultant data shall be entered on the patient record:
1. A determination of current emotional state;
 2. Vocational history;
 3. Familial relationships;
 4. Educational background;
 5. Social support system; and
 6. A determination of whether the patient can benefit from a rehabilitation program through the use of therapies provided by the institution.
- (i) Basic cardiopulmonary resuscitation shall be available within the institution twenty-four (24) hours a day, seven (7) days a week.
- (2) Staffing requirements.
- (a) The program shall have personnel adequate to meet the needs of 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 individual treatment plans. If the staff to patient ratio does not meet the needs of the patients, the Office of Inspector General shall determine and inform the program administrator in writing how many additional personnel are to be added and of what job classification, and shall give the basis for this determination.
- (b) The staffing ratio of therapists and pathologists to patients shall be equal to or greater than one (1) full-time equivalent for every three (3) patients. Only licensed or

certified therapists or speech and language pathologists in the areas of physical therapy, occupational therapy, speech and language pathology, or psychology shall be utilized in the computation of this ratio. Certified or licensed assistants shall not be utilized in the computation of this ratio. The staffing for the facility shall be utilized in the computation of the ratio.

(c) There shall be no more than one (1) aide or assistant for each licensed or certified therapist or speech and language pathologist on staff.

(3) Medical staff services.

(a) Medical care provided in the institution shall be under the direction of the medical director or a medical staff member in accordance with staff privileges granted by the governing authority.

(b) Physician services shall be available twenty-four (24) hours a day on at least an on-call basis.

(c) There shall be sufficient medical staff coverage for services provided in the institution in keeping with the size of the institution, the scope of services provided and the types of patients admitted to the facility.

(d) An individual rehabilitation program plan shall be developed for each patient under the supervision of a physician. The attending physician shall attend and actively participate in conferences concerning those served.

(e) The attending physician shall complete the discharge summary and sign the records within thirty (30) days of discharge.

(f) The physician responsible for the patient's rehabilitation program shall have specialized training or experience in rehabilitation.

(g) There shall be direct individual contact by a physician on any day there is an active interdisciplinary treatment program.

(4) Nursing services.

(a) Nursing services shall be directed toward prevention of complications of disability, restoration of optimal functioning, and adaptation to an altered lifestyle.

1. The institution shall have a nursing department organized to provide basic nursing services and rehabilitation nursing services. A registered nurse with training and experience in rehabilitative nursing shall serve as director of the nursing department.

2. A registered nurse shall be on duty at all times.

a. Nursing staff for each nursing unit shall be supervised by a registered nurse in order to insure immediate availability of a registered nurse with rehabilitation experience on a twenty-four (24) hour basis.

b. Other nursing personnel shall be present in sufficient numbers to provide nursing care not requiring the services of a registered nurse.

c. Nursing care shall be documented on each shift by staff members rendering care to patients. This documentation shall describe the nursing care provided and shall include information and observations significant to the continuity of patient care.

(b) Rehabilitation nursing services shall include physical and psychosocial assessment of the following:

1. Body systems related to the patient's physical rehabilitation nursing needs, with special emphasis on skin integrity, bowel and bladder function, and respiratory and circulatory systems function;

2. Self-care skills development;

3. Interpersonal relationships;

4. Adaptation mechanisms and patterns used to manage stress; and

5. Sleep and rest patterns.

(c) Nursing services shall include the following interventions:

1. Health maintenance and discharge teaching;

2. Prevention of the complications of immobility;
 3. Physical care including hygiene, skin care, physical transfer from one place to another, positioning, and bowel and bladder care;
 4. Psychosocial care including socialization, adaptation to an altered lifestyle; and
 5. Reinforcement of the multidisciplinary treatment plan.
- (d) A nurse shall collaborate with the patient, family, and other disciplines and agencies in discharge planning and teaching.
- (e) Rehabilitation shall monitor the degree of achievement of individualized nursing patient care goals.
- (5) Multidisciplinary team. A multidisciplinary team shall develop individual treatment plans and discharge plans and shall conduct quality assurance reviews. The multidisciplinary team shall include a physician, rehabilitation nurse, social worker or psychologist, and a therapist involved in the patient's care.
- (6) Case manager.
- (a) A single case manager shall be designated for each patient served. The provision of services by the institution to each patient shall be organized through the patient's case manager. The case manager shall:
1. Assume responsibility for the patient during the course of treatment;
 2. Coordinate the treatment plan; and
 3. Cultivate the patient's participation in the program.
- (b) If more than one (1) major program is being provided simultaneously, there shall be only one (1) case manager. If the patient's plan changes sequentially from one (1) program area to another, a new case manager may be assigned.
- (c) The patient's case manager shall evaluate regularly the appropriateness of the treatment plan in relation to the progress of the patient toward the attainment of stated goals. The case manager shall assure that:
1. The patient is adequately oriented;
 2. The plan proceeds in an orderly, purposeful, and timely manner; and
 3. The discharge decision and arrangements for follow-up are properly made.
- (7) Treatment plan.
- (a) The multidisciplinary team, with the participation of the patient shall, within seven (7) days after admission for rehabilitation, develop an individual treatment plan based on the patient's medical evaluation and psychosocial history and assessment, which shall be reviewed at least biweekly. The treatment plan shall include:
1. An assessment of the biological, social and psychological needs of the patient, performed by qualified health care professionals;
 2. A description of the patient's capacities, strengths, disabilities, and weaknesses;
 3. Identification of the patient's rehabilitation goals stated in functional, performance and behavioral objectives relative to the performance of life tasks and capabilities, with criteria for termination of treatment or discharge from the program;
 4. Participation of the patient and his family, to the extent possible;
 5. Physician input relative to both the general medical and rehabilitation medical needs of the patient;
 6. Discharge planning addressed as part of goal setting as early as possible in the rehabilitation process;
 7. Time intervals at which treatment or service outcomes will be reviewed;
 8. Anticipated time frames for accomplishment of the individual's specified goals;
 9. The measures to be used to assess the effects of treatment or services; and
 10. The person responsible for implementation of the plan.
- (b) The institution shall obtain and retain a signed consent form if applicable.
- (c) The institution shall adopt a procedure to protect against release of a patient to an unauthorized individual if a patient is unable to represent his own interests.

(8) Therapeutic services.

(a) The institution shall provide allied services directly or under contract. Skilled therapy shall be provided to a patient at an intensity appropriate to the disability and to the patient's ability to tolerate treatment, at least three (3) hours per person per day, and at least five (5) times per week, or, if the patient's medical condition limits participation, an equivalent amount of combined therapy, medical, nursing, and other professional care that shall be provided.

(b) Occupational therapy services shall be provided by or under the supervision of an individual certified by the American Occupational Therapy Association as an occupational therapist. Services shall include:

1. Assessment and treatment of functional performance; independent living skills; prevocational or work adjustment skills; educational, play or leisure and social skills.
2. Assessment and treatment of performance components; neuromuscular, sensori-integrative, cognitive and psychosocial skills.
3. Therapeutic interventions, adaptations and prevention.
4. Individualized evaluations of past and current performance, achieved through observation of individual or group tasks, standardized tests, record review, interviews, or activity histories.
5. Assessment of architectural barriers in home and workplace, and recommendation for equipment, adaptations, and different arrangements.
6. Treatment goals, achieved by modalities and techniques which include:
 - a. Task oriented activities; simulation or actual practice of work, self-care, home management, leisure and social skills and their components, creative media, games, computers and other equipment;
 - b. Prevocational training;
 - c. Sensorimotor activities;
 - d. Patient and family education and counseling;
 - e. Design, fabrication and application of orthotic devices;
 - f. Guidance in use of adaptive equipment and prosthetic devices;
 - g. Adaptation to physical and social environment, and use of therapeutic milieu;
 - h. Joint protection and body mechanics;
 - i. Positioning;
 - j. Work simplification and energy conservation; and
 - k. Cognitive remediation.
7. Occupational therapy services that monitor the extent to which goals are met relative to assessing and increasing the patient's functional ability in daily living skills.

(c) Physical therapy services shall be provided by or under the supervision of a licensed physical therapist employed on a full-time basis by a freestanding specialty hospital, or at least twenty (20) hours per week for a general hospital based unit.

1. Services shall include the following:
 - a. An initial physical therapy evaluation and assessment of the patient prior to the provision of services;
 - b. Development of treatment goals and plans in accord with the initial evaluation findings, with treatment aimed at preventing or reducing disability or pain and restoring lost function; and
 - c. Therapeutic interventions which focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and restoring loss of function.
2. Physical therapy services shall monitor the extent to which services have met therapeutic goals relative to the initial and all subsequent examinations, and the

degree to which improvement occurs relative to the identified movement dysfunction or reduction of pain associated with movement.

(d) Psychological services shall be provided by or under the supervision of a licensed psychologist.

1. Assessment areas shall include psychological, vocational, and neuropsychological functioning.

2. Interventions include individual and group psychotherapy; family consultation and therapy; and design of specialized psychological intervention programs including behavior modification, behavioral treatment regimens for chronic pain, and biofeedback and relaxation procedures.

3. Psychological services shall monitor the cognitive and emotional adaptation of the patient and family to the patient's disability.

(e) Speech-language services shall be provided by or under the supervision of a licensed speech-language pathologist certified in clinical competency by the American Speech-Language-Hearing Association. Services shall include the following:

1. Screening to identify individuals who require further evaluation to determine the presence or absence of a communicative disorder;

2. Speech and language competency evaluation resulting in the pathologist's plan, direction, and conduct of habilitative, rehabilitative, and counseling programs to improve language, voice, cognitive linguistic skills, articulation, fluency, and adjustment to hearing loss, and an assessment and provision of alternative and augmentative communicative devices;

3. A plan for discharge and provision for the patient's understanding of communication abilities and prognosis; and

4. Monitoring of services for effectiveness of actions taken to improve communication skills of patients.

(9) The institution shall provide the following services directly or through a contractual arrangement with other providers, as needed, in accordance with the institution's program narrative:

(a) Social work services shall be provided by an individual with a masters degree in social work from a curriculum accredited by the Council for Social Work Education.

1. The scope of rehabilitation social services shall include the following areas related to work assessment and interventions to facilitate rehabilitation:

a. Assessment of the personal coping history and current psychosocial adaptation to the disability;

b. Assessment of immediate and extended family and other support persons relative to increasing support networks; and

c. Assessment of housing, living arrangements, and stability and source of income relative to facilitating discharge plans.

2. Intervention strategies, aimed at increasing effectiveness of coping, strengthening informal support systems, and facilitating continuity of care, shall include at least the following:

a. Discharge planning;

b. Casework with individual patients;

c. Family counseling and therapy;

d. Group work focused on both education and therapy; and

e. Community service linkage referrals.

3. Social work services shall monitor the achievement of goals relative to discharge planning activities designed to meet the basic sustenance, shelter, and comfort needs of patients and their families.

(b) Audiology services shall be provided by or under the supervision of a licensed audiologist who is certified by the American Speech-Language-Hearing Association.

The audiologist shall direct and conduct required aural habilitation and rehabilitation programs after determination of the patient's range, nature, and degree of auditory and vestibular function using instrumentation such as audiometers, electroacoustic emittance equipment, brain stem evoked response equipment, and electronystagmographic equipment. Programs shall include:

1. Hearing aid and assistive listening device selection and orientation;
2. Counseling, guidance and auditory training; and
3. Speech reading.

(c) Vocational and vocational rehabilitation services shall provide assessment and evaluation of the patient's or client's need for services to enable return to productive activity through the use of testing, counseling, and other service-related activities. Identified needs are met either directly or through referral. Services shall include:

1. Evaluation and assessment focusing on maximizing the independent, productive functioning of the individual;
2. Comprehensive services to include at least the following areas:
 - a. Physical and intellectual capacity evaluation;
 - b. Interest and attitudes;
 - c. Emotional and social adjustment;
 - d. Work skills and capabilities;
 - e. Vocational potential and objectives; and
 - f. Job analysis;
3. The use of instruments, equipment and methods, under supervision of a qualified therapist;
4. Preparation of a written report, with interpretation and recommendations, to be shared with the individual and referral source; and
5. Monitoring the degree to which appropriate work skills are achieved; the improvement in independent functioning relative to work skill capability; and, the achievement of vocational objectives.

(d) Prosthetic or orthotic services.

1. Prosthetic and orthotic services shall be provided by a specialist who is qualified to manage the orthotic or prosthetic needs of a patient by:
 - a. Performing an examination;
 - b. Participating in the prescribing of specialized equipment;
 - c. Designing and fitting specialized equipment; and
 - d. Following up to ensure that the equipment is properly functioning and fitting.
2. Monitoring of prosthetic or orthotic services shall include:
 - a. Documented evidence of communication with the prescribing physician; and
 - b. Patient satisfaction with the function and fit of the equipment.

(e) Therapeutic recreation services shall be provided by or under the supervision of a therapeutic recreation specialist or an occupational therapist. The services may be provided in conjunction with occupational therapy services. Services shall include the following:

1. Assessment of the patient's leisure or social or recreational abilities, deficiencies, interests, barriers, life experiences, needs, and potential;
2. Treatments designed to improve social, emotional, cognitive and physical functional behaviors as a necessary prerequisite to future leisure or social involvement;
3. Leisure education designed to help the patient acquire knowledge, skills and attitudes needed for independent leisure or social involvement, community adjustment, responsible decision-making, and use of free time; and
4. Monitoring which measures the extent to which goals are achieved relative to the use of leisure time and socialization skills.

(f) Pharmaceutical services. The institution shall provide for handling, storing, recording, and distributing pharmaceuticals in accordance with state and federal law. A supply of medicinal agents adequate to meet institutional needs shall be available on site. They shall be stored in a safe manner and kept properly labeled and accessible. Controlled substances and other dangerous or poisonous drugs shall be handled in a safe manner to protect against their unauthorized use. Controlled substances shall be under double lock. There shall be adequate refrigeration for biologicals and drugs which require refrigeration.

1. An institution which maintains a pharmacy for the compounding and dispensing of drugs shall provide pharmaceutical services under the supervision of a registered pharmacist on a full-time or part-time basis, according to the size and demands of the program.

a. The pharmacist shall be responsible for supervising and coordinating the activities of the pharmacy department.

b. Additional personnel competent in their respective duties shall be provided in keeping with the size and activity of the department.

2. An institution not maintaining a pharmacy shall have a drug room utilized only for the storage and distribution of drugs, drug supplies and equipment. Prescription medications shall not be dispensed in this area. The drug room shall be operated under the supervision of a pharmacist employed at least on a consultative basis.

a. The consulting pharmacist shall assist in establishing procedures for the distribution of drugs, and shall visit the institution on a regular schedule.

b. The drug room shall be kept locked and the key shall be in the possession of a responsible person on the premises, as designated by the administrator.

c. A record shall be kept of each transaction of the pharmacy or drug room and shall be correlated with other institution records if indicated.

3. The pharmacist shall establish and maintain a system of records and bookkeeping, in accordance with policies of the institution, for maintaining control over requisitioning and dispensing of drugs and drug supplies, and for charging patients for drugs and pharmaceutical supplies.

4. A record of the stock on hand and of the dispensing of all controlled substances shall be maintained in such a manner that the disposition of any particular item may be readily traced.

5. The medical staff in cooperation with the pharmacist and other disciplines, as necessary, shall develop policies and procedures that govern the safe administration of drugs, including:

a. The administration of medications only upon the order of an individual who has been assigned medical clinical privileges or who is an authorized member of the house medical staff;

b. Review of the ordering practitioner's original order, or a direct copy, by the pharmacist dispensing the drugs;

c. The establishment and enforcement of automatic stop orders;

d. Proper accounting for and disposition of unused medications or special prescriptions returned to the pharmacy as a result of the patient being discharged, or if such medications or prescriptions do not meet requirements for sterility or labeling;

e. Provision for emergency pharmaceutical services; and

f. Provision for reporting adverse medication reactions to the appropriate committee of the medical staff.

6. Therapeutic ingredients of medications dispensed shall be included in the United States Pharmacopeia- National Formulary (USP-NF), the United States Pharmacopeia-Drug Information (USP_DI), or the American Dental Association

(ADA) Guide to Dental Therapeutics except for those drugs and biologicals unfavorably evaluated in the ADA Guide to Dental Therapeutics, or shall be approved for use by the appropriate committee of the medical staff.

a. A pharmacist shall be responsible for determining specifications and choosing acceptable sources for all drugs, with approval of the appropriate committee of the medical staff.

b. There shall be available a formulary or list of drugs accepted for use in the institution which shall be developed and amended at regular intervals by the appropriate committee of the medical staff.

(g) Radiology services.

1. The institution shall provide diagnostic radiology services directly or through arrangements with a radiology service that has a current license or registration pursuant to KRS 211.842 to 211.850 and associated administrative regulations. If the institution provides radiology services directly, the institution shall have:

a. A radiologist, on at least a consulting basis, to function as medical director of the department and to interpret films that require specialized knowledge for accurate reading; and

b. Personnel adequate to supervise and conduct the services.

2. Written policies and procedures governing radiologic services shall be in accordance with 902 KAR 100:115.

3. The radiology department shall be free of hazards for patients and personnel. Proper safety precautions shall be maintained against fire and explosion hazards, electrical hazards and radiation hazards.

(h) Laboratory services. The institution shall provide laboratory services directly or through arrangements with a licensed facility which has the appropriate laboratory facilities, or with an independent laboratory licensed pursuant to KRS 333.030 and associated administrative regulations.

1. Laboratory facilities and services shall be available at all times.

a. Emergency laboratory services shall be available twenty-four (24) hours a day, seven (7) days a week, including holidays, either in the institution or through a contractual arrangement as specified in subsection (10) of this section.

b. The conditions, procedures, and availability of services provided by an outside laboratory shall be in writing and available in the institution.

2. Dated reports of laboratory services provided shall be filed with the patient's medical record and duplicate copies shall be kept in the department.

a. The original report from work performed by an outside laboratory shall be filed in the patient's medical record.

b. The laboratory report shall have the name of the technologist who performed the test.

c. A request for a laboratory test shall be ordered and signed by an ordering practitioner acting within his statutory scope of practice.

3. If laboratory services are provided directly, there shall be a basic clinical laboratory which provides services necessary for routine examinations.

a. Equipment necessary to perform the basic tests shall be provided by the facility.

b. Equipment shall be in good working order, routinely checked, and precisely calibrated.

c. Clinical laboratory examinations shall include chemistry, microbiology, hematology, serology, and clinical microscopy.

d. There shall be a clinical laboratory director and a sufficient number of supervisors, technologists and technicians to perform promptly and proficiently the tests requested of the laboratory. Laboratory services shall be under the direction of a pathologist on a full-time, part-time, or a consultative basis. The

laboratory shall not perform procedures and tests which are outside the scope of training of the laboratory personnel.

(i) Dietary services.

1. The institution shall provide dietary services directly or by contract.
2. The dietary service shall be organized, directed and staffed to provide quality food service and optimal nutritional care.
 - a. 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.
 - b. The dietary service shall have at least one (1) dietician or nutritionist, either full time, part time, or on a consultative basis, to supervise the nutritional aspects of patient care.
 - c. Sufficient additional personnel shall be employed to perform assigned duties to meet the dietary needs of all patients.
 - d. The dietary department shall have available for all dietary personnel current written policies and procedures for food storage, handling, and preparation.
 - e. 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.
3. 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 the medical staff member's orders.
4. Meals shall correspond with the posted menu. If changes in menu are necessary, substitutions shall provide equal nutritive value and the changes shall be recorded on the menu. Menus shall be kept on file for thirty (30) days.
5. Each diet, regular or therapeutic, shall be prescribed in writing, dated, and signed by the attending medical staff member or other ordering practitioner acting within his statutory scope of practice. Ordering information 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 diet or eating habits.
6. Food shall be:
 - a. Prepared by methods that conserve nutritive value, flavor, and appearance;
 - b. Served at the proper temperature; and
 - c. Served in a form to meet individual patient needs, including cut, chopped, or ground.
7. If a patient refuses foods served, nutritious substitutions shall be offered.
8. At least three (3) meals or their equivalent shall be served daily with not more than a fifteen (15) hour span between a substantial evening meal and breakfast, unless otherwise directed by the attending medical staff member. Meals shall be served at regular times. Between-meal or bedtime snacks of nourishing quality shall be offered.
9. The dietary service shall comply with KRS 217.015 to 217.045 and 902 KAR 45:005.

(10) If a service is provided under contract, the contract shall:

- (a) Require that the service is in accordance with the plan of care approved by the physician responsible for the patient's care, except in the case of an adverse reaction to a specific treatment.
- (b) Specify the geographical area in which the service is to be furnished;
- (c) Provide that personnel and services contracted for meet the same requirements as those which would be applicable if the personnel and services were furnished directly;

- (d) Provide that personnel will participate in conferences required to coordinate the care of an individual patient, as needed;
- (e) Provide for the preparation of treatment records, with progress notes and observations, and their prompt incorporation into the clinical records of the institution; and
- (f) Specify the period of time the contract is to be in effect and the manner of termination or renewal.

(11) Outpatient services.

(a) An institution which has an organized outpatient department shall have written policies and procedures relating to the staff, functions of service, and outpatient medical records.

(b) The outpatient department shall be organized in sections or clinics, the number of which shall depend upon the size and degree of departmentalization of the medical staff, the available facilities, patient needs, and the program narrative.

(c) The outpatient department shall have appropriate cooperative arrangements and communications with community agencies such as home health agencies, the local health department, social and welfare agencies, and other outpatient departments.

(d) Services offered by the outpatient department shall be under the direction of a physician who is a member of the medical staff.

1. A registered nurse shall be responsible for the nursing services of the department.

2. The number and type of other personnel employed shall be determined by the volume and type of services provided and type of patient served in the outpatient department.

(e) Necessary laboratory and other diagnostic tests shall be available either through the facility or a laboratory in a licensed facility or a laboratory licensed pursuant to KRS 333.030 and associated administrative regulations.

(f) Medical case records shall be maintained and, if appropriate, coordinated with other institution case records.

1. The outpatient medical record shall be filed in a location which ensures ready accessibility to the medical staff members, nurses, and other personnel of the outpatient department.

2. Information in the medical record shall be complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis, and treatment to facilitate continuity of care.

(902 KAR 020:240. 14 Ky.R. 105; 452; eff. 9-10-1987; 18 Ky.R. 852; eff. 10-16-1991; 25 Ky.R. 2971; 26 Ky.R. 1161; eff. 12-15-1999; 33 Ky.R. 1159; 1849; 2306; eff. 3-1-2007; TAm eff. 3-11-2011; Crt eff. 4-30-2019; TAm eff. 3-20-2020; Crt eff. 2-17-2026.)