Kansas Administrative Regulations

Department of Health and Environment

Article 4.—Maternal and Child Health

28-4-1259. Health care.

(a) Policies and procedures for resident health care. Each permittee and each licensee, in consultation with a physician, shall implement written policies and procedures that include provisions for the following:

(1) Completion of a health checklist and review for each resident upon admission, including the following:

(A) Current physical health status, including oral health;

(B) all allergies, including medication, food, and plant;

(C) all current pain, including cause, onset, duration, and location;

(D) preexisting medical conditions;

(E) current mood and affect;

(F) history and indicators of self-harming behaviors or suicidal tendencies;

(G) all infectious or contagious diseases;

(H) documentation of current immunizations specified in K.A.R. 28-1-20 or documentation of an exemption for medical or religious reasons pursuant to K.S.A. 65-508, and amendments thereto;

(I) all drug or alcohol use;

(J) all current medications;

(K) all physical disabilities;

(L) all sexually transmitted diseases; and

(M) if a female resident, menstrual history and any history of pregnancy;

(2) follow-up health care, including a health assessment and referrals for any concerns identified in the health checklist and review;

(3) if medically indicated, all required chronic care, convalescent care, and preventive care, including immunizations;

(4) care for minor illness, including the use and administration of prescription and nonprescription drugs;

(5) care for residents under the influence of alcohol or other drugs;

(6) infection-control measures and universal precautions to prevent the spread of blood-borne infectious diseases, including medically indicated isolation; and

(7) maternity care as required by K.A.R. 28-4-279.

(b) Physical health of residents. Each permittee and each licensee shall ensure that emergency and ongoing medical and dental care is obtained for each resident by providing timely access to basic, emergency, and specialized medical, mental health, and dental care and treatment services provided by qualified providers.

(1) Each permittee and each licensee shall ensure that a health checklist is completed for each resident at the time of admission by the staff member who admits the resident. The health checklist shall serve as a guide to determine if a resident is in need of medical or dental care and to determine if the resident is using any prescribed medications.

(2) Each permittee and each licensee shall ensure that a licensed physician, a physician's assistant operating under a written protocol as authorized by a responsible physician, or an APRN operating under a written protocol as authorized by a responsible physician and operating under the APRN's scope of practice is contacted for any resident who is taking a prescribed medication at the time of admission, to assess the need for continuation of the medication.

(3) Each change of prescription or directions for administering a prescription medication shall be ordered by the authorized medical practitioner with documentation placed in the resident's record. Prescription medications shall be administered only to the designated resident as ordered by the authorized medical practitioner.

(4) Nonprescription and prescription medication shall be administered only by a designated staff member who has received training on medication administration approved by the secretary. Each administration of medication shall be documented in the resident's record with the following information:

(A) The name of the staff member who administered the medication;

(B) the date and time the medication was given;

(C) each change in the resident's behavior, response to the medication, or adverse reaction;

(D) each alteration in the administration of the medication from the instructions on the medication label and documentation of the alteration; and

(E) each missed dose of medication and documentation of the reason the dose was missed.

(5) Within 72 hours of each resident's admission, a licensed physician, a physician's assistant operating under a written protocol as authorized by a responsible physician, an APRN, or a nurse approved to conduct health assessments shall review the health checklist. Based upon health indicators derived from the checklist, the reviewing physician, physician's assistant, APRN, or nurse shall conduct a health assessment.

(6) Each permittee and each licensee shall ensure that a licensed physician, a physician's assistant operating under a written protocol as authorized by the responsible physician, or an APRN operating under a written protocol as authorized by a responsible physician and operating within the APRN's scope of practice is contacted for each resident who has acute symptoms of illness or who has a chronic illness.

(7) Each permittee and each licensee shall ensure that the following procedures are followed for providing tuberculosis tests for residents:

(A) Each resident shall receive a tuberculosis test unless the resident has had a tuberculosis test within the last 12 months.

(B) A chest X-ray shall be taken of each resident who has a positive tuberculosis test or a history of a positive tuberculosis test, unless a chest X-ray was completed within the 12 months before the current admission to the facility.

(C) The results of the tuberculosis test, X-rays, and treatment shall be recorded in the resident's record, and the county health department shall be kept informed of the results.

(D) Compliance with the department's tuberculosis prevention and control program shall be followed for the following:

(i) Tuberculosis tests;

(ii) treatment; and

(iii) a resident's exposure to active tuberculosis disease.

(8) Each permittee and each licensee shall ensure that the use of tobacco in any form by any resident while in care is prohibited.

(c) Emergency medical treatment. Each permittee and each licensee shall ensure that the following requirements are met for the emergency medical treatment of residents:

(1) The resident's medical record and health assessment forms shall be taken to the emergency room with the resident.

(2) A staff member shall accompany the resident to emergency care and shall remain with the resident while the emergency care is being provided or until the resident is admitted. This arrangement shall not compromise the direct supervision of the other residents in the facility.

(d) Oral health of residents. Each permittee and each licensee shall ensure that the following requirements are met for the oral health of residents:

(1) Dental care shall be available for all residents.

(2) Each resident who has not had a dental examination within the 12 months before admission to the facility shall have a dental examination no later than 60 calendar days after admission.

(3) Each resident shall receive emergency dental care as needed.

(4) A plan shall be developed and implemented for oral health education and staff supervision of residents in the practice of good oral hygiene.

(e) Personal health and hygiene of residents. Each permittee and each licensee shall ensure that the following requirements are met for the personal health and hygiene of the residents:

(1) Each resident shall have access to drinking water, a lavatory, and a toilet.

(2) Each resident shall be given the opportunity to bathe upon admission and daily.

(3) Each resident shall be provided with toothpaste and an individual toothbrush.

(4) Each resident shall be given the opportunity to brush that resident's teeth after each meal.

(5) Opportunities shall be available to each resident for daily shaving and haircuts as needed.

(6) Each resident's washable clothing shall be changed and laundered at least twice a week. Clean underwear and socks shall be available to each resident on a daily basis.

(7) Each female resident shall be provided personal hygiene supplies for use during that resident's menstrual cycle.

(8) Clean, individual washcloths and bath towels shall be issued to each resident at least twice each week.

(9) Each resident shall be allowed to have at least eight hours of sleep each night.

(f) Personal health of staff members and volunteers.

(1) Each staff member and each volunteer shall meet the following requirements:

(A) Be free from all infectious or contagious disease requiring isolation or quarantine as specified in K.A.R. 28-1-6;

(B) be free of any physical, mental, or emotional health condition that adversely affects the individual's ability to fulfill the responsibilities listed in the individual's job description and to protect the health, safety, and welfare of the residents; and

(C) be free from impaired ability due to the use of alcohol, prescription or nonprescription drugs, or other chemicals.

(2) Each staff member and each volunteer who has contact with any resident or who is involved in food preparation or service shall have received a health assessment within one year before employment. This assessment shall be conducted by a licensed physician, a physician's assistant operating under a written protocol as authorized by a responsible physician, or a nurse authorized to conduct these assessments.

(3) The results of each health assessment shall be recorded on forms provided by the department and shall be kept in the staff member's or volunteer's record.

(4) A health assessment record may be transferred from a previous place of employment if the assessment occurred within one year before the staff member's employment at the facility and if the assessment was recorded on the form provided by the department.

(5) The initial health examination of each staff member and each volunteer shall include a tuberculosis test. If there is a positive tuberculosis test or a history of a previous positive tuberculosis test, a chest X-ray shall be required unless there is documentation of a normal chest X-ray within the last 12 months. Proof of proper

treatment, according to the department's tuberculosis prevention and control program's direction, shall be required. Documentation of each tuberculosis test, X-ray, and treatment results shall be kept on file in the individual's health record.

(A) Compliance with the department's tuberculosis prevention and control program shall be required following each exposure to active tuberculosis disease. The results of tuberculosis tests, X-rays, and treatment shall be recorded in the individual's health record.

(B) Each volunteer shall present documentation showing no active tuberculosis before serving in the facility.

(6) If a staff member experiences a significant change in physical, mental, or emotional health, including showing any indication of substance abuse, an assessment of the staff member's current health status may be required by the permittee, the licensee, or the secretary. A licensed health care provider who is qualified to diagnose and treat the condition shall conduct the health assessment. A written report of the assessment shall be kept in the staff member's record and shall be submitted to the secretary on request.

(g) Each permittee and each licensee shall ensure that tobacco products are not used inside the facility. Tobacco products shall not be used by staff members or volunteers in the presence of residents.

(Authorized by K.S.A. 2013 Supp. 65-508 and 65-535; implementing K.S.A. 65-507, K.S.A. 2013 Supp. 65-508, and K.S.A. 2013 Supp. 65-535; effective, T-28-12-17-13, Dec. 17, 2013; effective March 28, 2014.)