CHAPTER 661. HOSPICE

[**Authority:** 63 O.S., §§ 1-103a.1, 1-104, 1-860.1 et seq., and 1-862]
[**Source:** Codified 6-11-92]

SUBCHAPTER 1. GENERAL PROVISIONS

310:661-1-1. Purpose

This Chapter establishes the minimum criteria for the issuance and renewal of a hospice license and the procedure for enforcement of the Act.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92]

310:661-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Act" means the Oklahoma Hospice Licensing Act, 63 O.S. 1991, §§ 1-860.1 et seq.

"Alternate Administrative Office" means an approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued, stores supplies, and/or is used for documentation and meets the requirements of 310:661-2-1(f)(2). Each location shall meet all of the applicable requirements of Chapter 661. Hospice.

"Attending physician" means a doctor of medicine or osteopathy, identified by the patient or representative at the time the patient or representative elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care.

"Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

"Clinical note" means a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

"Comprehensive assessment" means an evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes an evaluation of the caregiver's and family's willingness and capability to care for the patient.

"Continuous care" means nursing care that is provided by a skilled nurse or a qualified hospice aide for as much as 24-hours a day during periods of medical crisis as necessary to maintain a hospice patient at their place of residence.

"Department" means the Oklahoma State Department of Health.

"Dietary counseling" means education and interventions provided to the patient and family regarding nutritional intake as the patient's condition changes. Dietary counseling is provided by qualified individuals, which may include a registered nurse or dietitian, when identified in the patient's plan of care.

"Employed" means contracting with a person for services, regardless of compensation. This term also includes volunteers.

"Employee" means a person who: (1) Works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice.

"Fast-track" The process where advance approval may be secured for construction starts while design details are completed.

"First-year license" means a license issued for the initial twelve (12) month license period.

"Follow-up inspection" means the inspection by representatives of the Department that shall occur after a hospice has provided hospice services for at least six (6) months.

"Governing body" means a person, persons, or legal entity that is legally responsible for the conduct of the facility as an institution and carries out the functions, ownership, and governance in accordance with these regulations and the laws of this state.

"Initial assessment" means an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

"License" means a first-year or permanent hospice license issued pursuant to the Act and these rules.

"Licensed independent practitioner" means any individual permitted by law and by the licensed hospice to provide care and services, without direct supervision, within the scope of the individual's license and consistent with clinical privileges individually granted by the licensed hospice. Licensed independent practitioners may include advanced practice nurses with prescriptive authority, physician assistants, dentists, podiatrists, optometrists, chiropractors, and psychologists.

"Medical Crisis" means an event or situation in which a registered nurse, through direct assessment of the hospice patient, determines that the patient has entered into a period of crisis which requires a physician's intervention and continuous nursing care to achieve palliation or management of acute medical symptoms. Peaceful symptom controlled death is an expected patient outcome and is not considered a medical crisis. A medical crisis would include, but not be limited to the following: uncontrolled terminal agitation as demonstrated by hallucinations, confusion, and combativeness; uncontrolled pain; uncontrolled respiratory distress; uncontrolled nausea and vomiting; hemorrhaging; uncontrolled seizures; family distress as a result of ongoing symptom management for the patient requiring administration of medications to maintain the patient's comfort; and, any uncontrolled symptom that requires the administration of medications with ongoing assessment of the effectiveness and adjustment of the medication regimen to achieve control of symptoms.

"Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

"Permanent license" means a license first issued to a hospice program after the first-year license period has been completed and the required follow-up inspection has been conducted.

"Physician designee" means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical advisor when the medical advisor is not available.

"Registered nurse" means a person who is currently licensed to practice registered nursing in the State of Oklahoma.

"Representative" or **"Court appointed guardian"** means a person who is authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.

"Skilled nurse" means a person who is currently licensed to practice registered nursing or practical nursing in the State of Oklahoma.

"Social worker" means a person who has a degree from a school accredited or approved by the Council on Social Work Education and conforms to the requirements of the State Licensure Laws of Oklahoma for Social Workers.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 19 Ok Reg 2094, eff 6-27-02; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 40 Ok Reg 1582, eff 9-11-23]

310:661-1-3. Applicability

No public or private agency or person shall establish, conduct or maintain a hospice or hold itself out to the public as a hospice without first obtaining a license from the State Department of Health.

[**Source:** Added at 10 Ok Reg 77, eff 10-5-92 (emergency); Added at 10 Ok Reg 1705, eff 6-1-93; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97]

SUBCHAPTER 2. LICENSES

310:661-2-1. Licensure

(a) **Applicant.** Any public or private agency or person desiring to establish a hospice in Oklahoma shall apply for and obtain a license from the Department.

(b) **Application.** An application for a hospice license shall be filed on a form prescribed by the Department and shall be accompanied by the information required by the Act.

(c) **Plan of delivery.** The initial application shall be accompanied by a plan of delivery of home and inpatient hospice services to patients and their families. The plan shall include, but not be limited to, those items listed in the Act.

(d) **Expiration/renewal.**

(1) **First-year license.**

(A) The first-year license shall expire one (1) year from the date of issuance unless suspended or revoked. A hospice holding a first-year license is required to successfully complete an initial inspection by representatives of the Department prior to the provision of services and shall be subject to a follow-up inspection after providing hospice services for at least six (6) months. The Department may require any hospice to renew the first-year license for one additional year. A hospice shall not hold a first-year license for more than twenty-four (24) months.

(B) A follow-up survey that demonstrates compliance with the Act and these rules shall be required prior to a hospice program being issued a permanent license.

(2) **Permanent license.** The permanent license shall expire one (1) year from the date of issuance, unless suspended or revoked. An application for renewal shall be submitted according to the Act. Only hospice programs in compliance with the Act and these rules shall be issued a permanent license.

(e) **Base of operation.** Every hospice providing hospice services shall operate from a place of business which is accessible to the public and physically located in Oklahoma. Staff providing services from the hospice shall be supervised.

(f) **Eligibility for license.**

(1) A hospice making appropriate application that has been determined to be compliant with this Chapter and the Act is eligible for a license.

(2) A hospice may operate alternate administrative offices under one (1) license as long as the following requirements are met:

(A) The alternate administrative offices shall be operated under the same administration and governing body as an extension site for services of the main hospice. These offices shall operate under the same name(s) as the licensee.

(B) An application for license, or renewal thereof, to establish or operate each hospice alternate administrative office of an agency licensed in the State of Oklahoma shall be accompanied by a nonrefundable licensing fee of five hundred dollars ($500.00) and application at least thirty (30) days before beginning operations.

(g) **Compliance with Federal, State and local laws and regulations.** The hospice and its staff shall operate and furnish services that comply with all applicable Federal, State, and local laws and rules. The hospice shall ensure that staff comply with applicable State practice acts and rules in the provision of hospice services.

(h) **Hospice inpatient facility.**

(1) Each licensed hospice program may operate one (1) hospice inpatient facility with twelve (12) or fewer inpatient beds as long as the facility complies with hospice inpatient facility service requirements at OAC 310:661-6 and hospice inpatient facility physical plant requirements at OAC 310:661-8.

(2) A hospice inpatient facility may not be independently licensed as a hospice unless the hospice provides a full continuum of hospice program services to patients in their homes and temporary places of residence including the inpatient hospice facility.

[**Source:** Amended at 40 Ok Reg 1582, eff 9-11-23; Amended at 39 Ok Reg 1375, eff 9-11-22; Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended and renumbered from 310:661-3-1 at 14 Ok Reg 2269, eff 6-12-97; Amended and renumbered from 310:661-3-1 at 14 Ok Reg 2106, eff 4-7-97 (emergency)]

310:661-2-2. Deadlines for applications

The license application must be filed in accordance with the following deadlines:

(1) A first-year hospice license is filed at least thirty (30) days before beginning operations.

(2) License application following a transfer of ownership or operation, is filed at least thirty (30) days prior to the transfer. If the Department finds that an emergency exists which threatens the welfare of patients, the thirty (30) day advance filing notice may be waived.

(3) Renewal of an existing licensed hospice is filed at least sixty (60) days prior to the expiration date of the license.

(4) If relocation is considered, the hospice must file an amended application with the address change at least thirty (30) days prior to the intended relocation. No fee for processing the license address change will be required.

(5) Incomplete first-year license applications received by the Department will be summarily dismissed after thirty (30) days of applicant notification of an incomplete application. Thereafter, a new application and initial fee will be required.

[**Source:** Added at 14 Ok Reg 2106, eff 4-7-97 (emergency); Added at 14 Ok Reg 2269, eff 6-12-97; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-2-3. Where to file

The application and the license fee must be submitted to the Department. The effective date will be the date a complete application and fee are received. All fees are non-refundable.

[**Source:** Added at 14 Ok Reg 2106, eff 4-7-97 (emergency); Added at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-2-4. Transfer of ownership of a licensed hospice

(a) The license of a hospice shall not be subject to sale, assignment, or other transfer, voluntary or involuntary.

(b) If an entity is considering acquiring a licensed hospice, then it must submit to the Department 30 days before the effective date of the acquisition:

(1) an application [See OAC 310:661-2-5];

(2) a non-refundable two thousand dollars ($2,000) fee [See OAC 310:661-2-6];

(3) a copy of the executed sales agreement; and

(4) an additional five hundred dollars ($500) for each alternate administrative office operated by the agency, if applicable.

(c) The following actions will not be considered a transfer of ownership or change in control requiring this subsection to apply:

(1) Change of a corporate or limited liability company licensee's name through amendments of the articles of incorporation or membership agreement.

(2) Sale of stock of a corporation.

(3) Sale or merger of a corporation that owns the hospice operating entity.

(4) Sale of membership interest of a limited liability company.

[**Source:** Added at 14 Ok Reg 2106, eff 4-7-97 (emergency); Added at 14 Ok Reg 2269, eff 6-12-97; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-2-5. License application form

The applicant for a license must file the following application form: Application for License to Operate a Hospice (ODH Form 924). This form requests: amount of fee submitted; name of hospice; location and mailing address of hospice; name and title of chief executive officer; fiscal year ending date; operating entity name and address; type of operating entity; board of directors; complete disclosure of ownership including name, finding and mailing address, and percentage of ownership for every stockholder having at least five percent (5%) ownership in the hospice; name, signature, and title of position of persons making the application; and an affidavit attesting to the information provided.

[**Source:** Added at 14 Ok Reg 2106, eff 4-7-97 (emergency); Added at 14 Ok Reg 2269, eff 6-12-97; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-2-6. Licensure fees

(a) There is a non-refundable $500 fee for an application for a first-year license to establish or operate a hospice and a non-refundable $1,500 fee for a first-year license.
(b) There is a non-refundable $2,000 fee for a renewal application for an existing permanent hospice license.
(c) A late renewal fee of $50 will be charged for any hospice submitting an application for renewal within 30 days after the expiration date of the license.

[**Source:** Amended at 39 Ok Reg 1375, eff 9-11-22; Amended at 24 Ok Reg 2004, eff 6-25-07; Amended at 23 Ok Reg 2412, eff 6-25-06; Amended at 21 Ok Reg 1303, eff 5-27-04; Added at 16 Ok Reg 2518, eff 6-25-99]

310:661-2-7. Plan review fees

(a) Each hospice inpatient facility construction project will be charged a review fee based on the cost of the design and construction of the building project as follows:

(1) Project cost less than $10,000.00: $250.00 Fee
(2) Project cost $10,000.00 to $50,000.00: $500.00 Fee
(3) Project cost $50,000.00 to $250,000.00: $1000.00 Fee
(4) Project cost $250,000.00 to $1,000,000.00: $1500.00 Fee
(5) Project Cost greater than $1,000,000.00: $2000.00 Fee

(b) The review fee must be paid when stage one project plans are submitted to the Department for review. The fee will cover the cost of review for up to two (2) stage one and two (2) stage two submittals. If a stage one or stage two submittal is not approved after two (2) submissions, another review fee based on the cost of the project will be required for the third submittal. Fast-track projects will be allowed two (2) reviews for each package submitted. If a fast-track stage package is not approved after the second submittal, another review fee based on the cost of the project will be required with the third submittal of the package.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

SUBCHAPTER 3. ADMINISTRATION

310:661-3-1. Licensure [AMENDED AND RENUMBERED TO 310:661-2-1]

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended and renumbered to 310:661-2-1 at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended and renumbered to 310:661-2-1 at 14 Ok Reg 2269, eff 6-12-97]

310:661-3-2. Organization

(a) **Organization and administration of services.** The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.
(b) **Serving the hospice patient and family.** The hospice must provide hospice care that:

(1) Optimizes comfort and dignity; and
(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.

(c) **Continuation of care.** A hospice cannot discontinue or reduce care provided because of the inability to pay for that care.
(d) **Professional management responsibility.** A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be:

(1) Authorized by the hospice;
(2) Furnished in a safe and effective manner by qualified personnel; and
(3) Delivered in accordance with the patient's plan of care.

(e) **Narrative program.** Each Hospice must provide a narrative program with its application which describes the functions, staffing, services available to the patient and other basic information relating to the fulfillment of the facility's objectives.

(f) **Governing body.** A hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the total operations of the hospice. The governing body will designate an individual who is responsible for the day-to-day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice.

(g) **Hospice team.** A hospice team must be developed and function according to the Act. The hospice team is responsible for all of the following:

(1) Participation in the establishment of the plan of care.

(2) Provision or supervision of hospice care and services.

(3) Periodic review and updating of the plan of care for each individual receiving hospice care.

(4) Implementation of policies governing the day-to-day provisions of hospice care and services.

(h) **Medical advisor.** The medical advisor must be a medical doctor or osteopathic physician and is responsible for the medical component of the patient care program for the hospice. The physician must also serve as medical advisor to the hospice, possess a license free of sanctions, and be a doctor of medicine or osteopathy who is an employee, or under contract with the hospice. When the medical advisor is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical advisor.

(1) **Medical advisor contract.** When contracting for medical advisor services, the contract must specify the physician who assumes the medical advisor responsibilities and obligations. A hospice may contract with either of the following:

(A) A self-employed physician; or

(B) A physician employed by a professional entity or physician's group.

(2) **Initial certification of terminal illness.** The medical advisor or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is one (1) year or less if the illness runs its normal course. The physician must consider the following when making this determination:

(A) The primary terminal condition;

(B) Related diagnosis(es), if any;

(C) Current subjective and objective medical findings;

(D) Current medication and treatment orders; and

(E) Information about the medical management of any of the patient's conditions unrelated to the terminal illness.

(3) **Medical advisor responsibility.** The medical advisor or physician designee has responsibility for the medical component of the hospice's patient care program.

(i) **Patient care coordinator.** A registered nurse must be appointed and approved by the hospice governing body and employed by the hospice as patient care coordinator to supervise and coordinate the palliative and supportive care for patients and families provided by a hospice team.

(j) **Medical social services.** Medical social services must be provided by a social worker employed by the hospice.

(k) **Support services.** Support services must be available to both the individual and the family. These services include bereavement support provided before the patient's death, spiritual support and any other support or service needed by the patient or family. These services may be provided by members of the interdisciplinary group as well as other qualified professionals as determined by the hospice.

(l) **Training.** A hospice must:

(1) provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact;

(2) provide an initial orientation for each employee that addresses the employee's specific job duties.

(3) assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice shall have written policies and procedures describing its method(s) of

assessment of competency and maintain a written description of the in-service training provided during the previous twelve (12) months.

(m) **Volunteers.** Volunteers must be used in defined roles and under the supervision of a designated hospice employee. The hospice must provide appropriate orientation and training.

(1) **Training.** The hospice will maintain, document, and provide volunteer orientation and training.

(2) **Role.** Volunteers will be used in day-to-day administrative and/or direct patient care roles.

(3) **Recruiting and retaining.** The hospice will document and demonstrate viable and ongoing efforts to recruit and retain volunteers.

(4) **Utilization.** The hospice must document

(A) The identification of each position that is occupied by a volunteer.

(B) The work time spent by volunteers occupying those positions.

(n) **Criminal background checks.**

(1) The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

(2) Each such criminal background check must meet the criteria established for certified nurse aides as provided for in Title 63 O.S. Section 1-1950.1 and be obtained in accordance with State requirements.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-3. Medical records

(a) The hospice must establish and maintain a medical record for each individual receiving care and services. The record must be complete, timely and accurately documented, and readily accessible.

(b) The medical record must contain sufficient information to justify the diagnosis and warrant the treatment and services provided. Entries are made and signed by the person providing the services. The record must include all care and services whether furnished directly or under arrangements by the hospice. Each record must contain at least the following:

(1) Identification data;

(2) Initial and subsequent assessments;

(3) Plan of care;

(4) Consent, authorization and election forms;

(5) Medical history; and

(6) Complete documentation of all care, services and events including evaluations, treatments, progress notes, laboratory and x-ray reports, and discharge summary.

(c) The hospice must safeguard the medical record against loss, destruction, and unauthorized use.

(d) Current records must be completed promptly. A plan of care must be completed within forty-eight (48) hours following admission. Records of discharged patients must be completed within thirty (30) days following discharge.

(e) Medical records must be retained at least five (5) years beyond the date the patient was last seen or at least three (3) years beyond the date of the patient's death.

(f) A hospice may microfilm medical records in order to conserve space. Records reconstituted from microfilm will be considered the same as the original and retention of the microfilmed record constitutes compliance with preservation laws.

(g) The hospice must advise the Department in writing at the time of cessation of operation as to where hospice records will be archived and how these records can be accessed.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-3.1. Clinical records

(a) **General.** A clinical record containing past and current findings is maintained for each hospice patient. The clinical record contains accurate clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.
(b) **Content.** Each patient's record must include the following:
(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes;
(2) Signed copies of the notice of patient rights;
(3) Responses to medications, symptom management, treatments, and services;
(4) Outcome measure data elements, as described in 310:661-5-3.1;
(5) Physician certification of terminal illness;
(6) Any advance directives; and
(7) Physician orders.
(c) **Authentication.** All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy.
(d) **Protection of information.** The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. Additionally, the hospice is subject to all Federal and State privacy laws.
(e) **Discharge or transfer of care.**
(1) If the care of a patient is transferred to another licensed hospice, the hospice will forward to the receiving hospice within twenty-four (24) hours, a copy of:
(A) The hospice discharge summary; and
(B) The patient's clinical record, as requested.
(2) If a patient revokes the election of hospice care, or is discharged from hospice, the hospice will forward to the patient's attending physician within twenty-four (24) hours, a copy of:
(A) The hospice discharge summary; and
(B) The patient's clinical record, if requested.
(3) The hospice discharge summary as required above must include:
(A) A summary of the patient's stay including treatments, symptoms and pain management;
(B) The patient's current plan of care;
(C) The patient's current physician orders; and
(D) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving hospice.
(f) **Retrieval of clinical records.** The clinical record, whether hard copy or in electronic form, must be made readily available on request.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-4. Confidentiality

(a) Medical records must be kept confidential. Only authorized personnel have access to the record. Written consent of the patient, patient representative, the court appointed guardian or a court order will be accepted as authority for release of medical information.
(b) An individual who is, or has been, a patient of a physician, hospital, or other medical facility, except psychiatric, is entitled to access information contained in the individual's own medical records upon request. A request for minors may be made by parents or legal guardian. The hospice must furnish a copy of the medical record upon payment for the charge of such copy.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-5. Continuing education

The section implements the provisions of Title 63 O.S. 1-862 concerning hospice administrator continuing education.

[**Source:** Added at 36 Ok Reg 1728, eff 9-13-19]

310:661-3-5.1. Number of continuing education hours required

(a) All hospice administrators operating a hospice program in this state are required to complete eight (8) hours of continuing education each calendar year.
(b) Hours of continuing education may be completed in person or online.
(c) Membership in a statewide organization relating to hospice care will be considered as completion of one (1) hour of ethics credit each year.

[**Source:** Added at 36 Ok Reg 1728, eff 9-13-19; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-5.2. Acceptable continuing education

(a) Continuing education curriculum content is acceptable when it includes at least one of the following components:
(1) Administrative skills, duties, and responsibilities;
(2) Administrative procedures and strategic planning;
(3) Community relations and public information;
(4) Fiscal and information data management;
(5) Human relations;
(6) Ethics; or
(7) State and federal statutes and rules applicable to Hospice service delivery.
(b) Continuing education hours may be offered through a graduate or undergraduate course, seminar, workshop, conference, or professional association meeting for the purpose of enhancing professional competency. This excludes independent reading and informal meetings that are informational in nature and are offered as a public service and not for the offering of continuing education.
(c) An acceptable instructor or entity offering continuing education courses must have:
(1) Experience in hospice administration; or
(2) Expertise in teaching and instructional methods suitable to the subject presented; or
(3) Academic qualifications and experience for the subject.

[**Source:** Added at 36 Ok Reg 1728, eff 9-13-19; Amended at 39 Ok Reg 1375, eff 9-11-22; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-5.3. Documentation of attendance

(a) A hospice administrator must maintain in their personal records verification of course attendance, completion, or membership documents. Acceptable documents include the following:
(1) A continuing education validation form furnished by the presenter;
(2) A certificate or letter of attendance or completion with an agenda or content outline; or
(3) An official college transcript showing courses completed with credit issued or audit credit.
(b) The presenting organization must be identified in the verification documents through documentation identifying the sponsoring entity, the name of the program, location, dates, subject taught, total number of hours, participant's name and presenter's name and credentials.
(c) Presentation of fraudulent continuing education documentation is a violation of this Chapter and applicable to the hospice license.

[**Source:** Added at 36 Ok Reg 1728, eff 9-13-19; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-3-5.4. Penalty for failure to fulfill continuing education

Failure to meet the continuing education requirements is a violation of Title 63, Section 1-862 and this Chapter and therefore, subject to a written notice of violation.

[**Source:** Added at 36 Ok Reg 1728, eff 9-13-19]

SUBCHAPTER 5. MINIMUM STANDARDS

310:661-5-1. Admission

(a) Admission to a hospice will be in accord with the Act.
(b) Hospice services will be available twenty-four (24) hours a day, seven (7) days a week.

(c) A hospice program will not impose the dictates of any value or belief system on its patients and their families.
(d) A hospice will coordinate its service with those of the patient's primary or attending physician, all hospice caregivers, and nursing facility staff if a patient resides in a nursing facility.
(e) The hospice team will be responsible for coordination and continuity between inpatient and home care aspects of care.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-1.1. Admission to hospice care

(a) The hospice admits a patient only on the recommendation of the medical advisor in consultation with, or with input from, the patient's attending physician (if any).
(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical advisor must consider at least the following information:
(1) Diagnosis of the terminal condition of the patient;
(2) Other health conditions, whether related or unrelated to the terminal condition; and
(3) Current clinically relevant information supporting all diagnoses.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-1.2. Discharge from hospice care

(a) **Reasons for discharge.** A hospice may discharge a patient if:
(1) The patient moves out of the hospice's service area or transfers to another hospice;
(2) The hospice determines that the patient is no longer terminally ill; or
(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(A) through (a)(3) (D) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice will do the following before it seeks to discharge a patient for cause:
(A) Advise the patient that a discharge for cause is being considered;
(B) Document efforts to resolve the problem(s) presented by the patient's behavior or situation;
(C) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
(D) Document the problem(s) and efforts made to resolve the problem(s)and enter this documentation into its medical records.
(b) **Discharge order.** Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical advisor. Any attending physician involved in the patient's care must be consulted before discharge and his or her review and decision included in the discharge note.
(c) **Discharge planning.**
(1) The hospice must have a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
(2) The discharge planning process will include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-1.3. Initial and comprehensive assessment of the patient

(a) **General.** The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

(b) **Initial assessment.** The hospice registered nurse must complete an initial assessment within forty-eight (48) hours after the physician's order for hospice care is received (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)

(c) **Timeframe for completion of the comprehensive assessment.** The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than five (5) calendar days after the election of hospice care .

(d) **Content of the comprehensive assessment.** The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that will be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following:

(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints);

(2) Complications and risk factors that affect care planning;

(3) Functional status, including the patient's ability to understand and participate in his or her own care;

(4) Imminence of death;

(5) Severity of symptoms;

(6) A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

(A) Effectiveness of drug therapy;

(B) Drug side effects;

(C) Actual or potential drug interactions;

(D) Duplicate drug therapy; and

(E) Drug therapy currently associated with laboratory monitoring.

(7) An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment is incorporated into the plan of care and considered in the bereavement plan of care; and

(8) The need for referrals and further evaluation by appropriate health professionals.

(e) **Update of the comprehensive assessment.** The update of the comprehensive assessment must:

(1) be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any);

(2) consider changes that have taken place since the initial assessment;

(3) include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care; and

(4) be accomplished as frequently as the condition of the patient requires, but no less frequently than every fifteen(15) days.

(f) **Patient outcome measures.**

(1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.

(2) The data elements must be:

(A) an integral part of the comprehensive assessment;

(B) documented in a systematic and retrievable way for each patient;

(C) used in individual patient care planning and in the coordination of services; and

(D) used in the aggregate for the hospice's quality assessment and performance improvement program.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-2. Plan of care

(a) A written plan of care must be established and maintained for each patient admitted to a hospice program and the care provided to an individual is in accordance with the plan.

(b) The plan must be established by the attending physician, the medical advisor, and the interdisciplinary group.

(c) The plan of care must be reviewed and updated by the hospice team at intervals specified in the plan and documented by the team members.

(d) The content of the plan must include an assessment of the patient's needs and identify the services provided. The plan must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(e) Continuous care must be provided under a plan of care that is developed specifically to resolve the patient's medical crisis. These plans must include:

(1) Caregiver education;
(2) Anticipated duration of the continuous care;
(3) Necessity of continuous care;
(4) Interventions required;
(5) Identification of interdisciplinary team members developing the plan; and,
(6) Physician orders for continuous care.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 19 Ok Reg 2094, eff 6-27-02; Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-2.1. Interdisciplinary group, care planning, and coordination of services

(a) **General.** The hospice must designate an interdisciplinary group or groups which, in consultation with the patient's attending physician, will prepare a written plan of care for each patient. The plan of care will specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(b) **Approach to service delivery.**

(1) The hospice must designate in writing an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice will designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include individuals who are qualified and competent to practice in the following professional roles:

(A) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice);
(B) A registered nurse;
(C) A social worker; and
(D) A pastoral or other counselor.

(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

(c) **Plan of care.** All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs. The hospice will ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

(d) **Content of the plan of care.** The hospice must develop an individualized written plan of care for each patient. The plan of care will reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must

include all services necessary for the palliation and management of the terminal illness and related conditions, including at least the following:

(1) Interventions to manage pain and symptoms;

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs;

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care;

(4) Drugs and treatment necessary to meet the needs of the patient;

(5) Medical supplies and appliances necessary to meet the needs of the patient; and

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(e) **Review of the plan of care.** The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every fifteen (15) calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and note the patient's progress toward outcomes and goals specified in the plan of care.

(f) **Coordination of services.** The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to:

(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided;

(2) Ensure that the care and services are provided in accordance with the plan of care;

(3) Ensure that the care and services provided are based on all assessments of the patient and family needs;

(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement; and

(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-2.2. Core Services

(a) **General.** A hospice must provide substantially all core services directly by hospice trained and oriented employees. These services include nursing services, medical social services, and bereavement and spiritual counseling. The hospice may contract for physician services.

(b) **Physician services.** The hospice medical advisor, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

(1) All physician employees and those under contract, must function under the supervision of the hospice medical advisor.

(2) All physician employees and those under contract must meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.

(3) If the attending physician is unavailable, the medical advisor, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.

(c) **Nursing services.**

(1) The hospice must provide nursing care by licensed nurses under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.

(2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to patients receiving hospice care.

(3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.

(d) **Medical social services.** Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.
(e) **Counseling services.** Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services will include, but are not limited to, the following:
(1) **Bereavement counseling.** The hospice must:
(A) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling;
(B) Make bereavement services available to the family and other individuals in the bereavement plan of care up to one (1) year following the death of the patient. Bereavement counseling also extends to residents of a care facility when appropriate and identified in the bereavement plan of care;
(C) Ensure that bereavement services reflect the needs of the bereaved; and
(D) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.
(2) **Dietary counseling.** Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.
(3) **Spiritual counseling.** The hospice must:
(A) Provide an assessment of the patient's and family's spiritual needs;
(B) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires;
(C) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability; and
(D) Advise the patient and family of this service.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-2.3. Physical therapy, occupational therapy, speech-language pathology

Physical therapy services, occupational therapy services, and speech-language pathology services must be available.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-2.4. Licensed Professional Services

(a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified by the State and who practice under the hospice's policies and procedures.
(b) Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education.
(c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-3. Quality assurance

(a) The hospice must develop, maintain, and conduct a comprehensive quality assurance program that includes an evaluation of services, quarterly clinical record audits, and organizational review.

(b) The hospice must ensure that appropriate and quality care is provided to include inpatient care, home care, and care provided under arrangements.
(c) The quality assurance program must be reviewed at least once a year. Policies and procedures will be revised as needed, reviewed, and approved annually. Goals will be established and problems identified with documented results.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-3.1. Quality Assessment/Performance Improvement

(a) The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to the Department of Health.

(b) **Program scope.**

(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(c) **Program data.**

(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.

(2) The hospice must use the data collected to do the following:

(A) Monitor the effectiveness and safety of services and quality of care; and

(B) Identify opportunities and priorities for improvement.

(3) The frequency and detail of the data collection must be approved by the hospice's governing body.

(d) **Program activities.**

(1) The hospice's performance improvement activities must:

(A) Focus on high risk, high volume, or problem-prone areas;

(B) Consider incidence, prevalence, and severity of problems in those areas; and

(C) Affect palliative outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice shall measure its success and track performance to ensure that improvements are sustained.

(e) **Performance improvement projects.** Hospices must develop, implement, and evaluate performance improvement projects.

(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(f) **Executive responsibilities.** The hospice's governing body is responsible for ensuring the following:

(1) An ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually;

(2) The hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for

effectiveness; and
(3) One or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-4. Rights and responsibilities

(a) Every hospice must provide, before or at the time of admission, a written statement of rights and responsibilities to each patient, or patient representative, or available family member. The hospice shall ensure that all staff members are familiar with and observe the rights and responsibilities enumerated in the statement.

(b) The statement must inform the patient that he/she has a right to:
(1) A listing of available services, charges, billing process, and services that may be covered by private payment, private insurance, or state or federal medical care payment programs, including Medicaid or Medicare;
(2) Advance notice of any change in fees or billing as soon as possible but no later than thirty (30) calendar days before the effective date of the change;
(3) Receive information explaining the Medicare, Medicaid and insurance benefits which are no longer available to the patient while the patient receives hospice care, any applicable benefit periods, length of time of each benefit period, and the process of revoking and transferring from one hospice to another if the patient desires;
(4) Be informed of the right to participate in the planning of care, the right to be advised in advance of any changes in the plan of care, the disciplines that shall furnish care, the proposed frequency of care, the title of the person supervising the patient's care and the manner in which that person may be contacted;
(5) Revoke the hospice benefit, without coercion from the hospice;
(6) Expect that the hospice shall enter no further into family life and affairs than is required to meet the goals of the hospice care plan;
(7) A grievance procedure that includes the right to register a grievance with the hospice regarding treatment or care received or lack of treatment or care without reprisal or discrimination from the hospice; and
(8) File a complaint with the Oklahoma State Department of Health at its current mailing address.

(c) The statement must include the following hospice responsibilities:
(1) Accepting patients for service only if they meet hospice admission criteria and have been determined to be terminally ill by a licensed medical doctor or osteopathic physician;
(2) Providing services regardless of payment;
(3) Providing services if the patient is a nursing facility resident and indicating that care will be provided according to the hospice plan of care and that the nursing facility will be provided with the plan of care and all subsequent changes to ensure care is coordinated;
(4) Informing the patient representative or family of the patient's condition and what future changes may occur in the patient's condition and encouraging the patient or patient representative to express feelings and emotions without fear of reprisal;
(5) Providing caregivers who are non-judgmental and conduct themselves in a professional manner;
(6) Making and accepting referrals solely in the best interest of the patient;
(7) Ensuring that hospice owners, employees, and contractors do not knowingly initiate contact with a patient currently treated by another hospice for the purpose of attempting to persuade the patient to change hospice providers, and ensuring that a hospice which has knowledge of contacts initiated by its employees, owners or contractors will take reasonable and necessary steps to cease such contacts;
(8) Respecting and being sensitive to the ethnic, cultural, socioeconomic, religious and lifestyle diversity of the patients and their families;
(9) Ascertaining and honoring the wishes, concerns, priorities and values of the patient and the patient's family including refusal of routine care and treatment consistent with the organization's

values as stated by hospice policy;
(10) Complying with the patient's advance directive, informing the patient of the right to revoke the advance directive at any time, and discussing the procedures required to revoke;
(11) Providing qualified personnel to meet the patient's needs;
(12) Supporting, affirming, and empowering families as caregivers while acknowledging and responding with sensitivity to the interruption of privacy that is necessitated by hospice care in the patient's residence; and
(13) Ensuring that contracted providers and volunteers are qualified and properly trained and provide care consistent with the values and philosophy of hospice.
(14) Ensuring hospice care is established to meet the patient's needs and not to supplement facility staffing if the patient resides in an inpatient facility.

[**Source:** Amended at 39 Ok Reg 1375, eff 9-11-22; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended at 19 Ok Reg 2094, eff 6-27-02; Added at 14 Ok Reg 2269, eff 6-12-97; Added at 14 Ok Reg 2106, eff 4-7-97 (emergency)]

310:661-5-4.1. Additional rights of the patient

(a) **General.** The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

(b) **Notice of rights and responsibilities.**

(1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.
(2) The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.
(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

(c) **Exercise of rights and respect for property and person.**

(1) The patient has the right:
(A) To exercise his or her rights as a patient of the hospice;
(B) To have his or her property and person treated with respect;
(C) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and
(D) To not be subjected to discrimination or reprisal for exercising his or her rights.
(2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.
(3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
(4) The hospice must:
(A) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;
(B) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations shall be conducted in accordance with established procedures;
(C) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and
(D) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming

aware of the violation.

(d) **Rights of the patient.** The patient has a right to the following:

(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;

(2) Be involved in developing his or her hospice plan of care;

(3) Refuse care or treatment;

(4) Choose his or her attending physician;

(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with State and Federal law.

(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;

(7) Receive information about the services covered under the hospice benefit; and

(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-5. Continuous care

Every hospice must provide continuous care as necessary to meet the medical crisis needs of the hospice patient and family. The provision of continuous care must meet the following requirements:

(1) A skilled nurse provides at least 51% of the care in a 24-hour period, and a qualified home health aide must provide the balance of care.

(2) A registered nurse reassesses the patient at least every 24-hours to determine the effectiveness of interventions and the need for continued care.

(3) Continuous care is ordered by a physician upon initiation of the care and every 24-hour period thereafter of the uncontrolled medical crisis.

[**Source:** Added at 19 Ok Reg 2094, eff 6-27-02; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-6. Infection Control

(a) **General.** The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.

(b) **Prevention.** The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.

(c) **Control.** The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that:

(1) Is an integral part of the hospice's quality assessment and performance improvement program; and

(2) Includes the following:

(A) A method of identifying infectious and communicable disease problems; and

(B) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.

(d) **Education.** The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-7. Supervision of hospice aides

(a) A registered nurse must make an on-site visit to the patient's home:

(1) No less frequently than every fourteen (14) calendar days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.

(2) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.

(3) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation.

(b) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

(c) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to:

(1) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse;

(2) Creating successful interpersonal relationships with the patient and family;

(3) Demonstrating competency with assigned tasks;

(4) Complying with infection control policies and procedures; and

(5) Reporting changes in the patient's condition.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-8. Drugs and Biologicals, Medical Supplies, Durable Medical Equipment

(a) **General.** Medical supplies and appliances; durable medical equipment; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.

(b) **Managing drugs and biologicals.**

(1) The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs.

(2) A hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The provided pharmacist services must include evaluation of a patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.

(c) **Ordering of drugs.**

(1) Only a licensed independent practitioner with prescriptive authority, in accordance with the plan of care and State law, may order drugs for the patient.

(2) If the drug order is verbal or given by or through electronic transmission:

(A) It must be given only to a licensed health care practitioners within their scope of practice under state law and authorized by hospice policy to receive verbal orders; and

(B) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.

(d) **Dispensing of drugs and biologicals.** The hospice must obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself.

(e) **Administration of drugs and biologicals.** The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home.

(f) **Labeling, disposing, and storing of drugs and biologicals.**

(1) **Labeling.** Drugs and biologicals must be labeled in accordance with currently accepted professional practice and include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).

(2) **Disposing.** The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered the hospice must:

(A) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;

(B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and
(C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.

(g) **Use and maintenance of equipment and supplies.**

(1) The hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the patient's environment. Where a manufacturer recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment.

(2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons under contract to ensure patient and family instruction. The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-5-9. Short-term inpatient care

(a) Inpatient care must be available for pain control, symptom management, and respite purposes.
(b) If the hospice has an arrangement with another facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice, and at a minimum specifies that:

(1) the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;
(2) the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;
(3) the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;
(4) the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement; and
(5) the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented.

[**Source:** Added at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22]

SUBCHAPTER 6. HOSPICE INPATIENT SERVICE REQUIREMENTS

310:661-6-1. General

(a) Each hospice program that operates a hospice inpatient facility must comply with service requirements specified in this subchapter.
(b) Patients are allowed to receive visitors at any hour, including small children and house pets.
(c) Smoking or possessing a lighted tobacco product is prohibited in a hospice inpatient facility and within fifteen (15) feet of each entrance to a facility and of any air intakes; provided however, the facility may provide a smoking room for use by patients and their visitors. The walkway to the main entrance must also be smoke free. Ashtrays cannot be located closer than fifteen (15) feet to an entrance, except in an indoor smoking room. An indoor smoking room may be provided if:

(1) It is completely enclosed;

(2) It is exhausted directly to the outside and maintained under negative pressure sufficient to prevent any tobacco smoke from entering non-smoking areas of the building;
(3) It allows for visual observation of the patients from outside of the smoking room; and
(4) The plans are reviewed and approved by the Department.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-6-2. Compliance with health and safety requirements

(a) Each hospice inpatient facility must comply with all Federal, State, and local laws, regulations, codes and ordinances as required.
(b) The facility must have written policies and procedures relating to advance directives with respect to all patients receiving care. These policies and procedures will comply with existing Federal and State laws.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-6-3. Nursing services

(a) The facility must provide twenty-four (24) hour nursing services sufficient to meet the needs of the hospice inpatients.
(b) Each patient must receive treatments, medications, and diet as prescribed, and kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.
(c) Each shift must include at least one (1) registered nurse to supervise the facility and provide direct patient care.
(d) There must be adequate numbers of other licensed nurses and support staff to provide services established in the patient's plan of care while the patient is in the facility.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-6-4. Dietary services

(a) The facility must provide dietary service adequate to meet the dietary needs of the patients. Services may be provided on a contract basis as long as dietary needs of patients are met.
(b) Each facility must serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between a substantial evening meal and breakfast.
(c) Menus must be planned and followed to balance patient choice with nutritional needs of patients, in accordance with physicians' orders and to the extent medically possible, in accordance with the Dietary Reference Intakes (DRIs) of the Food and Nutrition Board of the Institute of Medicine, National Academy of Sciences.
(d) The facility must procure, store, prepare, distribute, and serve all food under sanitary conditions in compliance with Chapter 257 of this Title.
(e) Nourishments are available for all patients at anytime in accordance with approved diet orders.
(f) There must be adequate trained staff available to manage and provide dietary services. A licensed/registered dietitian must be available to provide consultation on patients' dietary needs, supervise services, and ensure medically prescribed special diets are provided as ordered.
(g) The system to be used for dishwashing must be approved by the Department and operated in accordance with approved procedures and requirements of Chapter 257 of this Title.
(h) Garbage and refuse must be kept in durable, easily cleanable, insect-proof and rodent-proof containers that do not leak and do not absorb liquids. Adequate carriers and containers will be provided for the collection and transportation, in a sanitary manner, of garbage and refuse from food service areas of the hospice to the place of disposal in accordance with the requirements of Chapter 257 of this Title.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 24 Ok Reg 2004, eff 6-25-07; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-6-5. Pharmaceutical services

(a) The hospice inpatient facility must provide appropriate methods and procedures for dispensing and administering drugs and biologicals. Whether drugs and biologicals are obtained from community or

institutional pharmacies or maintained and stocked by the facility, the facility is responsible for the pharmaceutical services and ensure services are provided in accordance with accepted professional standards of practice in compliance with Federal, State, and local laws.
(b) Each facility must employ or contract with a licensed pharmacist to supervise services and ensure drugs and biologicals are obtained, stored, administered and disposed of as required by Federal and State law.
(c) A physician or licensed independent practitioner must order all medications for each patient. If the physician or practitioner's order is verbal, the physician or practitioner must give the order to a licensed nurse or other individual authorized by State law to receive the order. The individual receiving the order must record and sign the order immediately and have the prescribing physician or practitioner sign as soon as possible in a manner consistent with good medical practice. Another covering or attending physician or practitioner may sign another physician or practitioner's verbal order if the facility allows this practice and specific procedures are approved by the governing body to permit the practice. If a covering or attending physician or practitioner authenticates the ordering physician or practitioner's verbal order, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's order and verifies the order is complete, accurate, appropriate, and final.
(d) Drugs and biologicals must be administered only by a physician, licensed nurse, an individual authorized by State law to administer, or the patient if his or her attending physician has approved.
(e) The pharmaceutical service must have procedures for control and accountability of all drugs and biologicals in the facility. Drugs are dispensed in compliance with Federal and State law. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist must ensure the drug records are in order and that an account of all controlled drugs is maintained and reconciled.
(f) The labeling of drugs and biologicals is based on currently accepted professional principles in compliance with State law, and includes the appropriate accessory and cautionary instructions, as well as the expiration date and lot number when applicable.
(g) All drugs and biologicals must be stored in locked compartments under proper temperature controls. Only authorized personnel must have access. Separately locked compartments must be provided for storage of Schedule II controlled drugs. All stores of Schedule II drugs not individually dispensed to a patient must be accounted for at regular intervals to ensure the drugs are not diverted.
(h) If the facility only maintains drugs and biologicals by individual patient prescription, an emergency medication kit approved by the Medical advisor must also be maintained.
(i) Controlled drugs no longer needed by the patient must be disposed of in compliance with Federal and State requirements. The pharmacist and a facility registered nurse or two (2) facility registered nurses must document disposal and maintain a record.

[**Source:** Amended at 26 Ok Reg 2042, eff 6-25-09; Amended at 39 Ok Reg 1375, eff 9-11-22 [1]; Added at 21 Ok Reg 1303, eff 5-27-04]
EDITOR'S NOTE: *[1]When published in the Register, these permanent amendments to this Section (310:661-6-5) were incorrectly numbered as amendments to 310:661-6-7. This error was editorially corrected, and the amendments were codified as amendments to the correct number (310:661-6-5).*

310:661-6-6. Disaster preparedness

The hospice inpatient facility must have an acceptable written plan, periodically rehearsed with staff, with procedures to be followed in the event of an internal or external disaster and for the care of casualties arising from such disasters.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-6-7. Infection control

310:661-6-7.[1] Infection control

Each hospice inpatient facility must establish an infection control program to provide a sanitary environment and avoid sources and transmission of infections. The program must include written policies and procedures for identifying, reporting, evaluating and maintaining records of infections among patients and personnel, for ongoing review and evaluation of all aseptic, isolation and sanitation techniques

employed in the facility, and development and coordination of training programs in infection control for all facility personnel.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

EDITOR'S NOTE: *[1]In 2009, permanent amendments were incorrectly promulgated as amendments to this section number (310:661-6-7) instead of 310:661-6-5, as intended [see 26 Ok Reg 2042, effective 6-25-09]. This error was editorially corrected, and the amendments were codified as amendments to the correct number (310:661-6-5).*

SUBCHAPTER 7. INFRACTIONS

310:661-7-1. Inspections

Any duly authorized representative of the Department has the right to conduct such inspections as necessary in order to determine compliance with the provisions of the Act and this Chapter. The right of inspection also extends to any hospice the Department has a reason to believe is advertising or operating a hospice service without a license.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-7-2. Complaints and investigations

(a) A complaint may be registered by any person who believes a hospice is operating contrary to the Act or is posing a serious threat to the health and welfare of a patient in its care. The complaint may be registered verbally or in writing to the Department. An investigation will be conducted by the Department to determine the validity of the complaint and to instigate necessary action thereto. The Department must notify the complainant in writing of the findings, if a name and address is furnished.
(b) If the Department determines there are reasonable grounds to believe that a hospice is operating in violation of the Act or the rules, the Department must follow the notice and hearing procedure established by the Act and the Procedures of the Department, Chapter 2 of this Title.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 21 Ok Reg 1303, eff 5-27-04; Amended at 39 Ok Reg 1375, eff 9-11-22]

310:661-7-3. Penalties

After notice and hearing pursuant to the Act, the Department may use any and all of the remedies provided by the Act and by the general statutory authority of the Commissioner of Health.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92]

310:661-7-4. Appeals

Final orders of the Department may be appealed to the Supreme Court. Appeals must be in accordance with 63 O.S. § 1-860.11.

[**Source:** Added at 9 Ok Reg 1985, eff 6-11-92; Amended at 14 Ok Reg 2106, eff 4-7-97 (emergency); Amended at 14 Ok Reg 2269, eff 6-12-97; Amended at 39 Ok Reg 1375, eff 9-11-22]

SUBCHAPTER 8. HOSPICE INPATIENT FACILITY PHYSICAL PLANT

310:661-8-1. General

(a) These requirements are intended as minimum standards for constructing and equipping a hospice inpatient facility of twelve beds (12) beds or less. Inpatient hospice facilities containing three (3) beds or less shall only be required to comply with the physical plant requirements contained in Section 310:661-8-14 of this subchapter. Insofar as practical, these rules relate to desired performance or results or both. Details of construction and engineering are assumed to be part of good design practice and local building regulations. Design and construction shall conform to the requirements of these rules. Requirements set forth in these rules shall be considered as minimum. For aspects of design and construction not included, local governing building codes shall apply. Where there is no local governing building code, the prevailing

model code used within the geographic area is hereby specified for all requirements not otherwise specified in these rules.

(b) These rules are not intended to restrict innovations and improvements in design or construction techniques. Accordingly, the Department may approve plans and specifications which contain deviations if it is determined that the respective intent or objective has been met.

(c) All facilities shall comply, insofar as practical, with applicable sections of these standards and with appropriate parts of NFPA 101, 2000 edition, covering Health Care Occupancies which is incorporated by reference. Where major structural elements make total compliance impractical or impossible, exceptions may be considered by the Department. This does not guarantee that an exception shall be granted, but does attempt to minimize restrictions on those improvements where total compliance would not substantially improve safety, but would create an unreasonable hardship. This subchapter shall not be construed as prohibiting a single phase of improvement. However, they are not intended as an encouragement to ignore deficiencies when resources are available to correct life-threatening problems.

(1) When construction is complete, the facility shall satisfy functional requirements for a hospice inpatient facility in an environment that shall provide acceptable care and safety to all occupants.

(2) In renovation projects and those making additions to existing facilities, only that portion of the total facility affected by the project shall comply with applicable sections of these standards and with appropriate parts of NFPA 101, 2000 edition, covering New Health Care Occupancies.

(3) Those existing portions of the facility which are not included in the renovation but which are essential to the functioning of the complete facility, as well as existing building areas that receive less than substantial amounts of new work shall, at a minimum, comply with that section of NFPA 101, 2000 edition, for Existing Health Care Occupancies.

(4) Conversion to other appropriate use or replacement shall be considered when cost prohibits compliance with acceptable standards.

(5) When a building is converted from one occupancy to another, it shall comply with the new occupancy requirements. For purpose of life safety, a conversion from a hospital or nursing facility to a hospice inpatient facility or vice versa is not considered a change in occupancy.

(6) When parts of an existing facility essential to continued overall facility operation cannot comply with particular standards, those standards may be waived by the Commissioner of Health if patient care and safety are not jeopardized.

(7) Renovations, including new additions, shall not diminish the safety level that existed prior to the start of the work; however, excess of that required for new facilities is not required.

(d) **Design standards for the disabled.** The Americans with Disabilities Act (ADA) extends comprehensive civil rights protection to individuals with disabilities. The "Uniform Federal Accessibility Standards" (UFAS) also provides criteria for the disabled. Also available for use in providing quality design for the disabled is the International Codes Council (ICC)/American National Standards Institute (ANSI) A117.1 "American National Standard for Accessible and Usable Buildings and Facilities." (ICC/ANSI A117.1)

(1) State and local standards for accessibility and usability may be more stringent than ADA, UFAS, or ICC/ANSI A117.1. Designers and owners, therefore, shall assume responsibility for verification of all applicable requirements and comply with the most stringent standards.

(e) **Nonconforming conditions.** It is not always financially feasible to renovate the entire existing structure in accordance with these standards. In such cases, the Department may grant approval to renovate portions of the structure if facility operation and patient safety in the renovated areas are not jeopardized by the existing features of facility sections retained without complete corrective measures. In major modernization projects and additions to existing facilities, those unrenovated areas that do not comply with NFPA 101 requirements for existing buildings shall be separated from sections to be modernized by fire barriers rated not less than two (2) hour fire resistance and by labeled fire doors of class "B" one and one half (1-1/2) hour construction.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-2. Location

(a) **Access.** The site of any hospice inpatient facility shall be convenient to the public and to service vehicles, including fire protection apparatus, etc.
(b) **Environment.** Quietness and sanitary features of the immediate environment shall be considered in locating a hospice inpatient facility.
(c) The site for a hospice inpatient facility shall conform to all local zoning regulations in cities where zoning ordinances are in effect.
(d) **Security.** A hospice inpatient facility shall have security measures for patients, personnel, and the public consistent with the conditions and risks inherent in the location of the facility. These measures shall include a program designed to protect human and capital resources.
(e) **Availability of utilities.** The facility shall be located to provide reliable utilities (water, gas, sewer, electricity). The water supply shall have the capacity to provide normal usage plus fire-fighting requirements. The electricity shall be of stable voltage and frequency.
(f) **Roads.** Paved or all weather surface roads shall be provided within the property for access to all entrances and to loading and unloading docks for delivery trucks. Vehicular or pedestrian traffic shall not conflict with access to the emergency transport station. In addition, access to emergency transport services shall be located to incur minimal damage from floods and other natural disasters. Paved walkways shall be provided for pedestrian traffic.
(g) **Parking.** Each hospice inpatient facility shall provide not less than one (1) space for each day shift staff member plus one (1) space for every one (1) patient bed. At least two (2) handicap accessible parking spaces, but not less than what is required by the ICC/ANSI A117.1 Standard, shall be provided. This ratio may be increased in areas convenient to the public transportation system or to public parking facilities if proper justification is included and compliance with applicable local codes or zoning standards is achieved. Space shall be provided for emergency and delivery vehicles.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-3. Submission of plans and construction inspection.
(a) Before construction is begun, plans and specifications covering the construction of new buildings or major alterations to existing buildings shall be submitted to the Department for review and approval.
(b) Each construction project submission shall be accompanied by a check for the appropriate review fee based on the cost of design and construction of the project as specified at 310:661-2-7.
(c) All construction project submittals shall be reviewed within 45 calendar days of receipt by the Department.
(d) **Preparation of plans and specifications.**

(1) **Stage one.** Preliminary plans and outline specifications shall be submitted and include sufficient information to establish the following: scope of project; project location; required fire-safety and exiting criteria; building-construction type, compartmentation showing fire and smoke barriers, bed count and services; the assignment of all spaces, areas, and rooms for each floor level, including the basement.
(2) **Stage two.** A proposed construction document shall be submitted that includes final drawings and specifications adequate for proposed contract purposes. All final plans and specifications shall be appropriately sealed and signed by an architect registered by the State of Oklahoma. All construction modifications of approved documents are subject to review and approval, and shall be submitted timely.

(e) **Special submittals.**

(1) **Fast-track projects.** Fast-track projects shall have prior approval and be submitted in no more than four (4) separate packages.

(A) Site work, foundation, structural, under slab mechanical, electrical, plumbing work, and related specifications.
(B) Complete architectural plans and specifications.
(C) All mechanical, electrical, and plumbing plans andspecifications.
(D) Equipment and furnishings.

(2) **Automatic sprinkler-systems.** At least two (2) sets of sprinkler-system shop drawings, specifications, and calculations (if applicable), prepared by the installer, shall be submitted to the

Office of the State Fire Marshal for review and approval prior to installation of the proposed system in the project.

(f) Construction other than minor alterations shall not be commenced until Stage Two plan-review deficiencies have been satisfactorily resolved.

(g) Prior to commencing construction, the hospice shall submit a construction schedule, which includes, as a minimum, the start date, dates that the heating-ventilation air-conditioning (HVAC), plumbing, and medical gas installation (if applicable) shall commence, and projected date of completion.

(h) The completed construction shall comply with the approved drawings and specifications, including all addenda or modifications approved for the project.

(i) A fifty percent (50%) completion inspection and a final construction inspection of the facility shall be conducted by the Department for the purpose of verifying compliance with this subchapter and the approved plans and specifications. The facility shall not allow patient occupancy until a final approval is granted by the Department.

(j) Construction phasing. Projects involving alterations and/or additions to existing buildings shall be programmed and phased to minimize disruptions of retained, existing functions and shall not disrupt or interfere with patient care. Access, exits, and fire protection shall be maintained so that the occupants' safety shall not be jeopardized during construction.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-4. Space occupied by other entities

(a) Areas within the same building as a hospice inpatient facility that are leased to, or occupied by, a separate entity and comply with Health Care Occupancy requirements as specified by NFPA 101, 2000 edition, shall be separated from the licensed hospice by demising partitions that are rated not less than one (1) hour fire resistance. Lease areas that do not comply with Health Care Occupancy requirements as specified by NFPA 101, 2000 edition, shall be separated from the licensed hospice by demising partitions that are rated not less than two (2) hour fire resistance.

(b) Lease areas shall have signage that clearly identifies tenant areas from the hospice inpatient facility area.

(c) The lease between the hospice and the tenant entity shall require that the tenant area shall be:

(1) Maintained to comply with NFPA 101 for Health Care Occupancies;

(2) Included in the hospice's sprinkler systems, fire alarm systems, and fire drills; and

(3) Accessible to representatives of the Department to determine compliance with these standards.

(d) A copy of the executed lease agreement for leased areas shall be submitted to the Department for review as part of the plan approval application process and a current copy shall be available for review by Department staff upon request.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-5. Nursing unit

(a) Patient rooms. Each room shall meet the following requirements.

(1) Maximum room capacity shall be one (1) patient.

(2) Minimum room area exclusive of toilet rooms, lockers, wardrobes, alcoves, or vestibules shall be one hundred twenty (120) square feet. There shall be a minimum of three (3) feet of clearance between beds and obstructions, such as walls. This minimum dimension shall not apply to the head of the bed.

(3) Each room shall be located on an exterior wall and be provided with a window to the exterior. The maximum sill height for the window shall be three (3) feet above finished floor and also be located above exterior lot grade. Windows shall be provided with window coverings to ensure privacy.

(4) Each patient bed shall be served by a nurse's call system and provided with an individual call device immediately accessible to patient, which shall register at the nurse's station. A nurse's call emergency device shall be provided for each patient toilet room, shower, and bathing room. The nurse's call system installed shall be one of the following types.

(A) Conventional UL 1069 hardwired system; or,

(B) Wireless system with individual call pendants or bracelets. These appliances shall activate notification devices at the nurse's station and individual pagers that are carried by staff at all times.

(5) One (1) lavatory or disinfectant wash shall be provided for each patient room.

(6) Each patient shall have access to a toilet room complying with accessibility requirements as determined by the ICC/ANSI A117.1. One (1) toilet room shall contain, at a minimum, a water closet and a lavatory.

(A) Each patient room shall have access to a toilet room without entering or crossing the general corridor.

(B) Toilet rooms shall be equipped with bedpan washing apparatus with flushing attachment and vacuum breaker.

(7) There shall be a minimum of one (1) isolation rooms per hospice inpatient facility. Each room shall contain a lavatory and soap and disposable towel dispensers. Each isolation room shall have access to an accessible toilet room without entering the general corridor.

(8) Each patient shall have a wardrobe, locker, or closet with minimum clear dimensions of one foot ten inches (1'-10") by one foot eight inches (1'-8"). A clothes rod and shelf shall be provided.

(9) Patient rooms shall have general lighting and night lighting. A reading light shall be provided for each patient and at least one (1) light fixture for night lighting shall be switched at the entrance of each patient room. All electrical switches shall be of the quiet operating type.

(10) Each patient shall be provided with a bed complete with springs and a mattress (not rollaway), a chair suitable for the patient, and a bedside table. Cots, sofas, rollaway or similar type beds shall not be used for patients but may be used by family members. A bedside table and over-bed table shall be available for each bedridden patient. A recliner suitable for sleeping shall be provided for each patient in each patient room. Guest rooms used for family member(s) shall be permitted, but shall not be used as patient rooms unless they meet the requirements for patient rooms.

(11) No television surveillance system shall be used to monitor the interior of patient rooms or baths.

(b) Service areas.

(1) The size and disposition of each service area shall depend upon the number and types of beds to be served. Although identifiable spaces are required to be provided for each of the indicated functions, consideration will be given to design solutions, which would accommodate some functions without specific designation of areas or rooms. Details of such proposals shall be submitted for prior approval. Each service area may be arranged and located to serve more than one (1) nursing unit, but at least one (1) such service area shall be provided on each nursing floor. The service areas noted below shall be located in or readily available to each nursing unit:

(A) Nurse's stations with space for nurses' charting, physician charting, and storage for administrative supplies. The distance from the nursing station to the most distant resident room shall not exceed one hundred fifty (150) feet and this distance shall not be interrupted by physical barriers, such as closed fire doors.

(B) A private physician's office shall be provided in each facility.

(C) Lounge and toilet room(s) for nursing staff.

(D) Clean workroom and clean holding room. These may be combined. The clean workroom shall contain a work counter, hand washing station, and storage facilities. The clean holding room shall be part of a system for storage and distribution of clean and sterile supply materials and shall be similar to the clean workroom except that the work counter and hand washing station may be omitted.

(E) Clean linen storage area. This may be provided by a separate closet or fully enclosed area within the clean workroom.

(F) Soiled workroom or soiled holding room. The soiled workroom shall contain a clinical sink or equivalent flushing rim fixture, sink equipped for hand washing, work counter, waste receptacle, and linen receptacle.

(G) Nourishment station. This shall contain a sink equipped for hand washing, equipment for serving nourishment between scheduled meals, refrigerator, and storage cabinets. Ice for

patients' service and treatment shall be located in the nourishment station on each floor and in the kitchen/dining area.
(H) A family room shall be provided by the facility equipped with two (2) compartment sinks, cabinets, microwaves, soap and paper towel dispensers.
(I) One (1) medical equipment storage room shall be provided on each floor.
(J) Parking for stretchers and wheelchairs shall be located out of path or normal traffic.
(K) Patients' bathing facilities. Bathtubs or showers shall be provided at the rate of one for each six (6) beds, which are not otherwise served by bathing facilities within patients' rooms. At least one (1) bathtub shall be provided in each nursing unit or floor. Whirlpool units, which are suitable for bathing purposes, shall be included in satisfying the requirement. Each tub or shower shall be in an individual room or enclosure, which provides space for private use, drying and dressing, and for a wheelchair and an attendant. All fixtures shall be accessible for the handicapped.
(L) Janitor's closet containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(c) Sterilizing Facilities. The hospice inpatient facility shall make provisions for the sterilization of equipment and supplies and shall have available for all staff and visitors, approved OSHA, NIOSH certified dust, mist and fumes (DMF) respirators or respirators affording greater protection. This is required for all entry into rooms occupied by known or suspected infectious tuberculosis patients and others. There shall be minimum of one hundred (100) pairs of gloves and DMF respirators in the facility at all times.
(d) Personal Care Unit. A separate room may be provided for hair care and grooming needs of the patients.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-6. Dietary facilities

(a) The following facilities shall be provided in such size as required to implement the type of food service system selected:
(1) Control station for receiving food supplies.
(2) Storage space including cold storage.
(3) Food preparation as required by the program. Conventional food preparation systems require space and equipment for preparing, cooking, and baking. Convenience food service systems such as frozen prepared meals, bulk packaged entrees, individual packaged portions, or systems using contractual commissary services require space and equipment for thawing, portioning, cooking, and/or baking.
(4) Hand washing facilities in the food preparation area equipped with wrist, knee, or foot controls. Disposable towels shall be provided.
(5) Patient meal service space including facilities for tray assembly and distribution.
(6) Dishwashing shall be in a room or alcove separate from food preparation and serving areas. The dishwashing equipment shall be of a commercial-type with a separate air balance system.
(7) Space for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using areas. A lavatory shall be conveniently available with wrist, knee, or foot controls.
(8) Pot washing facilities with a three (3) compartment sink.
(9) Sanitizing facilities and storage areas for cans, carts, and mobile tray conveyers.
(10) Garbage storage facilities in a separate area, which is easily accessible to the outside for direct pickup or disposal.
(11) Toilet for dietary staff with hand washing facility immediately available.
(12) Janitors' closet for the dietary department shall be located in or adjacent to the department. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies used exclusively for the dietary department.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-7. Administrative and public areas

The following areas shall be provided:
(1) Public lobby area including:
(A) Reception and information counter or desk.
(B) Waiting spaces.(C)Public toilet facilities (handicapped accessible).
(D) Public telephone(s).
(E) Drinking fountain(s).
(2) General or individual offices shall be provided for business transactions, medical and financial records, and administrative functions.
(3) A quiet room for counseling\reflection is required and shall have a minimum of one hundred (100) square feet.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-8. Linen service
(a) If linen is to be processed on the site, the following shall be provided:
(1) Laundry processing room with hand washing facilities and commercial-type equipment, which can process seven (7) days' needs within a regularly scheduled workweek.
(2) Soiled linen receiving, holding, and sorting room with hand washing facilities.
(3) Storage for laundry supplies.
(4) Clean linen storage, issuing, and holding room separate from the soiled linen storage, processing and holding area.
(5) Janitors' closet containing a floor receptor or service sink and storage space for housekeeping.
(6) Sanitizing facilities and storage area for carts, unless a disposable bagging system is used.
(b) If linen is processed off the site, the following shall be provided:
(1) Soiled linen holding room.
(2) Sanitizing facilities and storage area for carts.
(c) Whether linen is processed on or off the site, the laundry shall be physically separated into clean and soiled sections with each section having separate air supplies and exhaust returns to prevent cross-contamination. The hospice shall certify that the off-site laundry satisfies this regulation.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-9. Engineering service and equipment areas
(a) Central Stores. General storage room(s) shall have a total area of not less than five (5) square feet per bed and should be generally concentrated in one (1) area.
(b) Room(s) or separate building(s) for boilers, mechanical equipment, and electrical equipment shall not be used for storage.
(c) Waste Processing Services. Storage and Disposal. Space and facilities shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal or by a combination of these techniques.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-10. Details and Finishes
(a) A high degree of safety for the patients shall be provided to minimize the incidence of accidents with special consideration for patients who will be ambulatory, to assist them in self-care. (b) Hazards such as sharp corners shall be avoided. All details and finishes for modernization projects as well as for new construction shall comply with the following requirements:
(1) All rooms containing bathtubs, sitz baths, showers, and water closets, subject to occupancy by patients, shall be equipped with doors and hardware which will permit access from the outside in any emergency. When such rooms have only one (1) opening or are small, the door shall be capable of opening outwards or be otherwise designed to be opened without need to push against a patient who may have collapsed within the room.

(2) The minimum width of all doors to rooms needing access for beds or stretchers shall be three feet eight inches (3' 8"). Doors to patient toilet rooms and other rooms needing access for wheelchairs shall have a minimum clear width of 32 inches.
(3) Windows and outer doors shall not be left in an open position unless provided with insect screens.
(4) Windows and/or screening devices shall be designed to prevent accidental falls when open.
(5) Door(s) shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width. All door handles shall be approved lever type.
(6) Grab bars shall be provided at all patients' toilets, showers, tubs, and sitz baths.
(7) Recessed soap dishes shall be provided in showers and bathrooms, or soap dispensers may be substituted.
(8) Lavatories and hand washing facilities shall be securely anchored to withstand an applied vertical load of not less than two hundred fifty (250) pounds on the front of the fixture.
(9) Mirrors shall be arranged for convenient use by patients in wheelchairs as well as by patients in a standing position. All lavatories shall have mirrors except those in kitchens.
(10) Paper towel and soap dispensers and waste receptacles shall be provided at all hand washing facilities in public, staff locations and patient areas.
(11) Ceiling heights shall be as follows:
(A) Boiler rooms shall have ceiling clearances not less than two feet six inches (2' 6") above the main boiler header and connecting piping.
(B) Rooms containing ceiling-mounted equipment shall have height required to accommodate the equipment.
(C) All rooms shall not have less than eight foot (8' 0") ceilings except that corridors, storage rooms, toilet rooms, and other minor rooms may be not less than seven feet eight inches (7' 8"). Suspended tracks, rails, and pipes located in the path of normal traffic shall not be less than six feet eight inches (6' 8") above the floor.
(D) Kitchens shall have a minimum eight foot (8' 0") ceiling height and be air-conditioned.
(12) Spaces where impact noises may be generated shall not be located directly over or adjacent to patient bed areas unless special provisions are made to minimize such noise to a Noise Isolation Class (NIC) of not less than forty-five (45).
(13) Rooms containing heat producing equipment (such as boiler or heater rooms, and laundries) shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 10°F. (60C.) above the ambient room temperature.
(14) Indicators shall be placed on all doors leading to hazardous areas, such as knurled knobs or signs.
(15) The hospice shall eliminate fire and smoke hazards. The hospice shall not use pillows, mattresses, pads, padded furniture, carpeting, or other furnishings, which contain urethane foams, which are not fire retardant.

(c) Hospice Finish Requirements

(1) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved. Floors in areas used for food preparation or food assembly shall be water resistant and grease proof. Points in tile and similar material in such areas shall be resistant to food acids. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a no slip surface.
(2) Wall bases in kitchens, soiled workrooms, and other areas which are frequently subject to wet cleaning methods shall be made integral and covered with the floor, tightly sealed with the wall, and constructed without voids that can harbor insects.
(3) Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant. Finish, trim, and wall and floor constructions in dietary and food preparation areas shall be free from spaces that can harbor rodents and insects.
(4) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

(5) Ceilings throughout shall be easily cleanable. Ceilings in the dietary and food preparation areas shall have a finished washable ceiling covering all overhead piping and ductwork; a smooth surface drywall or plaster type ceiling shall be required. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

(6) All buildings that have patients' facilities (such as bedrooms, dining rooms, or recreation areas) or critical services (such as diagnostic or therapy) located on other than the main entrance floor shall have electric or electro hydraulic elevators.

(A) At least one (1) hospital type elevator shall be installed where patients are located on any floor other than the main entrance floor.

(B) Cars and platforms. Cars of hospital type elevators shall have inside dimensions that will accommodate a patient bed and attendants, and shall be at least five feet (5' 0") wide by seven feet six inches (7' 6") deep. The car door shall have a clear opening of not less than three feet eight inches (3' 8").

(C) Leveling. Elevators shall be equipped with an automatic leveling device of the two-way automatic maintaining type with an accuracy of one-half (1/2) inch.

(D) Operation. Elevators, except freight elevators, shall be equipped with a two-way special service keyed switch to permit cars to bypass all landing button calls and be dispatched directly to any floor.

(E) Elevator controls, alarm buttons, controls, and telephones shall be accessible to wheelchair occupants.

(F) Elevator call buttons, controls, and door safety stops shall be of a type that will not be activated by heat or smoke.

(G) At least one (1) elevator should be on the emergency power system of the hospice.

(H) Elevator door closing devices should be timed to accommodate the needs of the residents served.

(I) Field Inspection and Tests. Inspections and tests shall be made and the owner shall be furnished written certification that the installation meets the requirements set forth in this Section and all applicable safety regulations and codes.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-11. Temperature and ventilating systems

(a) An indoor design temperature of 75°F. (24°C.) (winter design conditions) shall be provided for all occupied areas.

(b) All air supply and air-exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at the discharge end of the system. The ventilating systems shall comply with the requirements of the appropriate edition of the International Mechanical Code.

(c) Outdoor air intakes shall be located not less than ten feet (10' 0") from exhaust outlets of ventilating systems, combustion equipment stacks, plumbing vent stacks, or from areas which may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than three feet (3' 0") above ground level, or if installed above the roof, one foot (1' 0") above roof level.

(d) Corridors shall not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, and janitors' closets.

(e) All central ventilating or air conditioning systems shall be equipped with filters. The filter bed shall be located upstream of the air conditioning equipment, unless a prefilter is employed. In this case, the prefilter shall be upstream of the equipment and the main filter bed may be located further downstream.

(f) All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with ASHRAE Standard 52-68. A manometer shall be installed across each filter bed serving central air systems. The filter efficiencies for central ventilation and air conditioning system should follow the table shown on Appendix A.

(g) Exhaust hoods in food preparation centers shall be in compliance with NFPA 96 and the International Mechanical Code (IMC).

(h) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures in working stations to 97°F. (36°C.), Effective Temperatures (ET) as defined by ASHRAE "Handbook of Fundamentals", without creating negative air pressure in any room housing fire equipment.
(i) Where individual mechanical exhaust systems are used to exhaust patient toilets or bathrooms, the individual ventilation fan shall run continuously. All mechanical ventilating equipment including under window and exhaust systems shall operate continuously.
(j) Wall or baseboard electrical heaters shall not be used.
(k) Detectors in central ventilating systems shall be in accordance with NFPA 90A.
(l) All ducts shall be in concealed spaces.
(m) All smoke dampers on any one air conditioning system shall be controlled by unit mounted return air and supply air smoke detectors, which will act to close all of the smoke dampers on that system and stop the fan. Smoke dampers shall also close and the fan shall stop when the fire alarm system is activated and/or the sprinkler system is energized.
(n) All isolation rooms shall have all air directly exhausted to the exterior without recirculation. There shall be a negative pressure relationship between the patient room and adjacent areas. The differential pressure shall be a minimum of 0.01" water gage (2.5 Pa). If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.
(o) Ventilation for all isolation rooms shall provide for a minimum twelve (12) air changes per hour including two (2) air changes per hour of outside air. Patient sleeping rooms shall provide a minimum of two (2) air changes per hour with at least two (2) of these air changes being outside air. Soiled holding and workroom areas shall have a minimum of ten (10) air changes per hour. All other rooms shall comply with the ventilation requirements of the International Mechanical Code as adopted by the State of Oklahoma.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-12. Plumbing and other piping systems

(a) All plumbing systems shall be designed and installed in accordance with the requirements of the appropriate edition of the International Plumbing Code.
(b) Plumbing Fixtures.
(1) The material used for plumbing fixtures shall be of non-absorption and acid-resistant material.
(2) The water supply spout for lavatories and sinks required in patient care areas shall be mounted so that its discharge point is a minimum distance of one (1) inch above the rim of the fixture. All fixtures shall be trimmed with valve, which can be operated without the use of hands. Where blade handles are used for this purpose, they shall not exceed four and one-half (4½) inches in length, except that handles on clinical sinks shall be not less than six (6) inches long.
(3) Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.
(4) Shower bases and tubs shall provide no slip surfaces for standing patients. All towel bars shall be of the handicapped type meeting the two hundred fifty pound (250 lb.) dead load requirement. Shower curtain rods shall be of rigid metal and anchored to insure a two hundred fifty pound (250 lb.) dead load is met.
(5) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.
(c) Water Supply Systems.
(1) Before the facility is used the water supply system shall be approved by the health department.
(2) Backflow preventers (vacuum breakers) shall be installed in hose bibs, janitors' sinks, bedpan flushing attachments, and on all other fixtures on which hoses or tubing can be attached. Two (2) approved reduced pressure backflow preventers in parallel on the domestic water supply are required for sprinkler systems.
(3) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing, and hand washing facilities shall not be less than 105°F. nor exceed 115°F. A low temperature-mixing valve shall be required with an anti-scald device (solenoid valve) down stream from mixing valve.

(d) Water Heaters and Tanks.

(1) The water heating equipment shall have sufficient capacity to supply water at the temperatures and amounts indicated above. Water temperatures shall be tested monthly and the results monitored at hot water point of use or inlet to processing equipment.

(2) The anti-scald device shall be arranged to shut off hot water system two degrees (2°) higher than maximum temperature allowed.

(3) Heater and storage tanks shall be fabricated of corrosion-resistant metal or lined with no corrosive material.

(e) Drainage Systems.

(1) Drainage piping shall not be installed within the ceiling nor installed in an exposed location in food preparation centers, food serving facilities, and food storage areas unless special precautions are taken to protect these areas from possible leakage or condensation.

(2) Building sewers shall discharge into an approved sewerage system.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-13. Electrical requirements

(a) All electrical requirements shall comply with National Electrical Code (NEC) as adopted.

(b) Receptacles (Convenience Outlets)

(1) Patient room. Each patient room shall have duplex grounding type receptacles as follows: one (1) located near the head of each bed; one (1) for television if used; and at least one (1) on each wall.

(2) Corridors. Duplex receptacles for general use shall be installed approximately fifty feet (50' 0") apart in all corridors and within twenty-five feet (25' 0") of ends of corridors.

(c) All receptacles and switches on the emergency power shall be distinctly marked.

(d) All electrical receptacles in wet areas (such as: hair care rooms, bathrooms, kitchens, laundries, physical therapy areas, janitor closets) must be on ground fault interrupter circuits within six feet (6' 0") of any lavatory and all outside plugs.

(e) Emergency Electric Service.

(1) To provide electricity during an interruption of the normal electric supply, the hospice shall be equipped with an emergency power source as required by NFPA 99, NFPA 101, and NEC (NFPA 70) on the premises. It shall have fuel supply either propane or diesel to operate the generator for a minimum of twenty-four (24) hours at rated full load.

(2) The emergency power source shall be automatically connected to the required load within a period of ten (10) seconds after the interruption of the normal power source. This time delay shall be adjustable.

(3) The load for which emergency power shall be supplied are as follows:

(A) Illumination for means of egress as required in NFPA, Standard 101 to produce not less than one (1) foot-candle of light measured at floor level in the center of the corridors.

(B) Illumination of exit signs and exit directional signs.

(C) Duplex receptacle located at head of patient bed.

(D) Nurse call systems.

(E) Power for maintaining telephone communication.

(F) Sump pumps and other equipment required to operate for the safety of major apparatus including alarms.

(G) General illumination and convenience receptacles in the area of the emergency power source.

(H) Paging and speaker systems used for communications during emergency.

(I) Alarm systems including the fire alarm system, water flow alarm devices for sprinklers, fire and smoke detecting facilities, and alarm monitors for non-flammable medical gas systems, except systems which have trickle-charged battery (DC) power.

(J) Illumination lighting in the mechanical rooms serving essential heating, ventilating, plumbing, vacuum, and other essential needs.

(K) Security facilities such as door monitoring.

(L) At least one (1) elevator shall be on the emergency power system of the hospice.
(M) Night lights in patient bathrooms, toilets and patient rooms.
(N) All receptacles and switches served by emergency power shall be color coded (red).
(O) The operation of the emergency electric system shall be demonstrated prior to placing the facility in operation.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

310:661-8-14. Physical plant requirements for facilities with three (3) beds or less

(a) This section shall be applicable to small homes serving three (3) or less residents. Homes qualifying under this section shall be exempt from other sections of this subchapter except as may be specifically referenced in this section.
(b) The requirements of 310:661-8-1 are applicable except as follows:
(1) These requirements are intended as minimum standards for constructing and equipping a hospice inpatient facility projects containing, at a maximum, three (3) beds.
(2) All new and renovation projects shall comply with the applicable sections of International Residential Code as required for residential construction.
(c) The location requirements of 310:661-8-2 are applicable except as follows:
(1) Parking. Off-street parking shall be provided in adequate numbers to prevent overflow to adjacent properties.
(d) Plan submission and construction inspection requirements of 310:661-8-3 are applicable to all hospice facilities containing three (3) beds or less.
(e) The requirements for space occupied by other entities in 310:661-8-4 are applicable to all hospice facilities containing three (3) beds or less.
(f) All physical plant requirements relating to mechanical plumbing and electrical systems shall comply with the applicable requirements for residential construction.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]

APPENDIX A. Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Hospices

Figure 1

Area Designation	Number Filter Beds	Filter Bed No. 1	Filter bed No.2
All areas for inpatient care, treatment, and diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing, etc.	2	25	80
Food Preparation Areas and Laundries	1	25	---
Administrative, bulk storage, soiled holding areas, food preparation areas, and laundries	1	25	---

Note: Additional roughing or pre-filters should be considered to reduce maintenance required for filters with efficiency higher than 75%.

The filtration efficiency ratings are based on average dust spot efficiency per ASHRAE 52.1-1992.

[**Source:** Added at 21 Ok Reg 1303, eff 5-27-04]