



Oklahoma State Department of Health
Creating a State of Health

**LONG-TERM CARE FACILITY ADVISORY BOARD
Regular Meeting**

October 11, 2017 at 1:30 in Room 1102

Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1299

AGENDA

1. Call to Order..... Joanna Martin, Vice-Chair
2. Roll Call.....Lori Bautista
3. Review and Action to Approve/Amend the July 12, 2017 Regular Meeting minutes
..... Joanna Martin, Vice-Chair
4. Licensure, Resident Assessment, Nurse Aide Registry, and Background Check Update
.....James Joslin
Updates on program activity and new developments.
5. Healthy Aging Report Ad Hoc Report.....Dr. Diana Sturdevant
Dr. Diana Sturdevant will provide an update on the healthy aging Ad Hoc committee, to include information on work in the last quarter.
6. Nomination and Election of 2018 officers Joanna Martin, Vice-Chair
7. PROPOSED RULEMAKING RECOMMENDATIONS.....James Joslin
Pursuant to Title 63 of the Oklahoma Statutes, at section 1-1923(D), the Advisory Board shall have the power and duty to: ... 2. Review, make recommendations regarding, and approve in its advisory capacity the system of standards developed by the Department;

Discussion and possible action on approval and/or recommendations for adoption to the Board of Health for the following proposed rules:

- A. CHAPTER 625. CERTIFICATE OF NEED STANDARDS FOR ~~ICF/MR~~ ICF/IID**
- B. CHAPTER 630. CERTIFICATE OF NEED STANDARDS FOR LICENSED NURSING FACILITY BEDS**
- C. CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING**
- D. CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**
- E. CHAPTER 677. NURSE AIDE TRAINING AND CERTIFICATION**

The proposed Chapter revisions will amend numerous sections within these chapters to replace the terms “Mental Retardation”, “Mentally Retarded” and “Qualified Mental Retardation Professional”. This proposal replaces the aforementioned terms with “Individuals with Intellectual Disabilities”, “Individuals with Developmental Disabilities”, or “Qualified

Intellectual Disability Professional”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

In Chapter 675, a scrivener's error omitted the removal of a reference to the old life safety code in 310:675-11-5. This section was amended last year to incorporate the 2012 edition of the Life Safety Code adopted by the Centers for Medicare & Medicaid Services. The amendment to this section addresses this omission by striking the old reference and supporting language applicable to the former code.

In Chapter 677, this action will amend the classification of “Developmentally Disabled Direct Care Aides” to “ICF/IID Care Aides”.

8. Governor Appointments to the LTCFAB..... Joanna Martin, Vice-Chair
9. Long Term Care Service Update.....Mike Cook
10. LTCFAB Annual Report content recommendations.....Mike Cook
11. New Business..... Joanna Martin, Vice-Chair
12. Public Comment
13. Adjourn



LONG-TERM CARE FACILITY ADVISORY BOARD

Regular Meeting

July 12, 2017 at 1:30 in Room 1102

Oklahoma State Department of Health, 1000 NE 10th Street, Oklahoma City, OK 73117-1299

MINUTES

July 12, 2017

1) **Call to Order**

Joanna Martin, Vice-Chair, called the meeting to order at 1:32 p.m.

2) **Roll Call**

Lori Bautista called roll with the following LTCFAB members present: Joanne Alderman, Willie Burkhart; Tracy Chlouber, Dustin Cox; Pamela Humphreys; Patricia Ingram; Adam Jordan; Joanna Martin; Alan Mason; Jim McWhirter; Kay Parsons; Dewey Sherbon; Diana Sturdevant; William Whited and Denise Wilson.

The following LTCFAB members were absent: Christean Bolding; Joyce Clark; Theo Crawley; Andrew Dentino; Terry Ferrel; Ivoria Holt; Jacki Millspough and Wendell Short.

The following guests were present: Michael Cook, OSDH; Don Maisch, OSDH; Sue Davis, OSDH; Natalie Smith, OSDH; Beverly Clark, OSDH; James Joslin, OSDH; John Leon, OFMQ; Mary Brinkley, Leading Age OK; Gina Stafford, OK Board of Nursing; Vicki Kirtley, OSDH; Shelba Murray, Francis Tuttle Tech; Ann Osborne, Francis Tuttle Tech. Center; Andrea Pogue, Pontotoc Technology Center; Melissa Holland, OKALA; Esther Houser, general public; William Martens, general public; Pam Glennie, Senior Dental Care; Julie Myers, OSDH; Natashia Mason, OAHCP and Lori Bautista, OSDH.

Currently, there are four vacancies on the LTCFAB, which consists of 27 members.

A quorum was met with 15 members present.

3) **Review and Action to Approve/Amend April 12, 2017 Meeting Minutes:**

Agenda Item #3

Vote 1

Motion: Approval of the April 12, 2017 Regular Meeting Minutes

Meetings are posted at:

<http://www.health.ok.gov/calendar/mtngs/index.html>

<http://www.sos.state.ok.us/meetings/agencymeets.asp?intAgency=316>

Approved minutes are posted at <http://www.health.ok.gov/calendar/mtngs/ltcab.html>

Motion Made by: Adam Jordan Seconded: William Whited Motion Carried: Yes
 Aye: 15 Abstain: 0 Nay: 0 Absent: 8

Aye: 15 Abstain: 0 Nay: 0 Absent: 8

Joanne Alderman	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Adam Jordan	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Christean Bolding	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Joanna Martin	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Willie Burkhart	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Alan Mason	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Tracy Chlouber	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Jim McWhirter	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Joyce Clark	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Jacki Millspaugh	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Dustin Cox	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Kay Parsons	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Theo Crawley	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Dewey Sherbon	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Andrew Dentino	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Wendell Short	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Terry Ferrel	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Diana Sturdevant	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Ivor Holt	<input type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	William Whited	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Pamela Humphreys	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay	Denise Wilson	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay
Patricia Ingram	<input checked="" type="checkbox"/> Aye <input type="checkbox"/> Abstain <input type="checkbox"/> Nay		Shading = Absent

4) SB774: Amendments to the Residential Care Act: (See sub-section #2 of the Long Term Care Update)

5) Humanity of the Unborn Child Act (Bathroom Signage Bill):

Don Maisch gave an update on House Bill 2797 that was passed May 27th, 2016. The bill requires that all facilities that are licensed by the State Department of Health to place signage in their public restrooms that would have the following statement “There are many public and private agencies willing and able to help you carry your child to term and assist you and your child after your child is born, whether you choose to keep your child or to place him or her for adoption. The State of Oklahoma strongly urges you to contact them if you are pregnant.” Then, a web address would be provided with contact information.

This last April 2017, Senate Bill 30 was approved by the Governor. Now, free standing clinics that complete abortions are the only facilities that would be required to have the signage. Since, this bill was passed, LTC facilities are not required to have the signage.

6) Licensure, Nurse Aide Registry and Background Check Update:

James Joslin went over the departments and projects that he oversees that pertain to the LTCFAB. James provided three reports on the Nurse Aide Registry Statistics: 1) Composite Scorecard for Oklahoma Nursing Homes: Long-stay metrics for the period ending March 31st, 2017; 2) Nurse Aide Registry Fourth Quarter Fiscal Year 2017 Statistics; and 3) Abuse, Neglect, Misappropriation (ANM) Findings through Fourth Quarter FY2017.

The first handout provided by James Joslin was the Composite Scorecard for Oklahoma Nursing Homes: Long-stay metrics for the period ending March 31st, 2017. On the handout, green lights show significant improvement, yellow lights show no significant change and any red lights show

significant decline. We are back below where we were last year. Eight metrics of the 14 showed significant improvement. Four metrics showed no significant change. Two metrics showed significant decline. A summary of the metrics is presented on page two of the handout. The table on page two showed improved performance measures for the following: 1) Self-reported pain; 2) Catheter in bladder; 3) Residents physically restrained; 4) Influenza vaccination; 5) Residents who have depressive symptoms; 6) Pneumococcal vaccination; 7) Urinary tract infections and 8) State Composite Score. The same table showed worsened performance for 1) Low-risk residents who lose control of their bowels or bladder and 2) Residents who need for help with activities of daily living.

James Joslin next presented the Nurse Aide Registry (NAR) Fourth Quarter Fiscal Year 2017 Statistics handout. Nurse Aide Registry Statistics prepared by Vicki Kirtley, where data can be compared quarter to quarter and from year to year. James mentioned that there has been a decrease of 404 LTC aides since 2015. But there have been 1001 LTC aides who have transferred to Oklahoma, which is an increase of 104 from 2016. The data shows that there is a substantial increase in Certified Medication Aides (CMAs), as well as for all of the Advanced CMA Certifications from 2016 to 2017. On page two for certifications from another state, there was a significant increase from FY17Q3 to FY15Q4 from 97 to 127. In the Abuse table on page two, there are corrections to the FY17Q4 for the following: 1) Misappropriation (11 changed to 4); 2) Neglect (13 changed to 11); 3) Physical (4 changed to 2) and 4) Total (28 changed to 17). So, the FY2017 totals will be 1) Misappropriation (37); 2) Neglect (32); 3) Physical (7) and 4) Total (76). James mentioned that the significant change from FY2015 to FY2016 was caused by a backlog. James reviewed the law that had passed about a nurse aide being legally served when any petition is sent to the address on file. The backlog should be cleared out and should be settled into a new normal. James mentioned that suspensions and probations will be included in the NAR quarterly report.

The final handout James Joslin talked about was the Abuse, Neglect, Misappropriation (ANM) Findings through Fourth Quarter Fiscal Year 2017. James said that there were 17 ANM findings where 14 of those were in OK-Screen. All 14 had prior eligible determination in OK-Screen. Of the 14, 6 had minor criminal history offenses. When the employers were contacted to see if they were still employed, all 14 were either discharged at allegation, terminated prior to ANM finding or terminated after ANM finding. Termination dates are tracked.

There were three other topics James discussed. 1) Issues with No call/no shows. There have been meetings about starting a work group about collecting data and solve the problem surrounding no call/no shows. 2) Nurse Aide Certification Cards: The initial certification card will be issued, and then the status will only show up on the internet only. The option could be offered to let the Nurse Aides purchase certification cards. \$33,000 is spent issuing certification cards yearly. \$330,000 could be saved over a 10 year period, if hard copy cards were no longer mailed to nurse aides. Currently, there is an option for the Nurse Aides to be able to print a copy of their cards on their own. 3) Upper Payment Limit and the Supplemental Payment: If a Nursing Home is owned by a Non-State Governmental Entity (NSGE), then it is eligible for an enhanced Medicaid rate aka a supplemental payment. Questions have gone back and forth between CMS and OSDH. Revised management agreements were filed. There were 39 pending applications. Of the 39 pending applications, 37 were ready to be licensed as of June 30th, 2017. As of June 30th, 27 facilities are

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<http://www.health.ok.gov/calendar/mtns/index.html>

<http://www.sos.state.ok.us/meetings/agencymeets.asp?intAgency=316>

Approved minutes are posted at <http://www.health.ok.gov/calendar/mtns/lcab.html>

licensed under the city of Paul's Valley and 10 facilities are licensed under the city of Hugo. CMS may or may not approve the applications that were submitted. There is no notice requirement to let residents know of the change of ownership. If CMS does not approve the applications that were submitted, then based on the operations transfer agreements there will be a reversion to the former licensed operators.

7) Health Aging Report Ad Hoc Report:

Dr. Diana Sturdevant presented the Healthy Aging Report in place of Dr. Dentino. The last meeting was conducted June 20th, 2017. The two objectives for the Ad Hoc Committee are 1) Preventing falls with major injury and 2) Increasing influenza and pneumococcal immunizations among nursing home residents.

The goal is to reduce falls with major injury from 5.3% in September 2014 with an end goal of 3% in June 2019. The fall prevention program was developed in October 2015. The pilot project for the initial set of homes was completed in May 2016. The results indicated net positive results. The third phase of the program will expand to 40 homes. The resulting impacts of the expansion should appear in the MDS (Minimum Data Set) as early as September 2017. As results become available, the committee may consider revising the goal after the results are reviewed.

The results have appeared more quickly for immunizations in nursing homes, than with fall prevention. The activities to improve the percentage of long-stay residents in Oklahoma that are assessed and appropriately given the seasonal influenza and pneumococcal vaccines included: 1) regional meetings; 2) assessment of current practices relative to healthcare worker vaccination; 3) direct support to at least 40 homes; and 4) data analysis to lead future efforts.

Currently, the data indicate improvement in both measures. The percent of long-stay residents given the seasonal influenza vaccine improved from 95.2% in March 2015 to 96% this past March 2017. The initial goal was to be at 96% by March of 2018, and to reach 98% by March of 2019.

The percent of long-stay residents assessed and appropriately given the pneumococcal vaccine improved from 87.6% in March 2015 to 93% this past March 2017. The initial goal for this measure was to improve to 92% by March 2018, with a stretch goal of 94% by March 2019.

Given the success of the immunization pilot program, the committee agreed to replicate these efforts during the next season, instead of developing more interventions.

The Next meeting will be October 11th, 2017, which is prior to the Governor's Healthy Aging Summit.

8) Long Term Care Service Update:

Mike Cook, Director Long Term Care Services, presented the Long Term Care update.

- *1) Rules and Regulations:* The rules and regulations that LTC worked on for Chapters 663, 675 and 680 were passed. The effective date for the rules and regulations is October 1st, 2017.

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For all sets of rules and regulations, there were many changes made for many different areas, which included physical plant, incident reports pertaining to head injuries, freedom of choice for physicians and medical services, emergency response procedures. Changes not included in Chapter 663, but were in both Chapter 675 and 680 were changes pertaining to complaints. Mediums and lows were extended to the next visit. If there is an IJ (Immediate Jeopardy), then LTC will be out within 2 days. If there is a Non-IJ High, then LTC will out within 10 days. LTC has done a great job getting caught up, and staying caught up. LTC puts a limit of 90 days maximum to investigate medium or low level complaints.

- 2) **SB 774 (Moved from agenda item 4):** Mike Cook spoke about SB774 concerning its amendments to the Residential Care Act that was signed into law May 31st, 2017. There are a couple important changes to the following for Residential Care facilities that came from SB 774 being passed: 1) Fees 2) Residential Care required visits is reduced to once a year, rather than three. The same complaint investigation structure remains intact. SB774 will be effective November 1st, 2017. William Whited said that part of the SB 774 states that OSDH shall promulgate rules on when it is appropriate to complete an announced visit. He mentioned that any announced visit should never be counted as an inspection. William also mentioned that the bill changed the requirement that OSDH invite at least one member of one advocacy organization. Mike Cook's response is that there is no intent for LTC to notify facilities of initial visits, revisits and complaint visits or make any changes to the way LTC completes inspections. Occasionally, LTC will conduct pilot surveys where the department will announce their visits to the facilities. Mike Cook said that LTC will continue to invite an advocate to continue to be a citizen observer.
- 3) *Medical Administration Technicians (MATS) and Physical Plant Concerns:* There have been questions about MATS and the Physical Plant amendments in Chapter 675. Mike Cook has requested legal opinion from Don Maisch, general counsel, on MATS and exactly what OSDH has the statutory ability to do in relation to MATS. The questions about MATS concern what duties they can perform and who has the authority to regulate their programs. Questions about medical administration and plant building will be addressed during the visit with CMS in Dallas for the CMS Annual State Agency Director's Meeting scheduled July 18th – 20th, 2017.
- 4) *Centers for Medicare & Medicaid Services (CMS) Update:* There has been a lot going on for 2017. The CMS Annual State Agency Director's Meeting is scheduled July 18th – 20th, 2017 in Dallas. Appendix Z for Emergency Preparedness has been released. CMS is in the process of going to conducting all webinar training. Appendix Q - Guidelines for Determining Immediate Jeopardy is currently being reviewed by CMS. Mike Cook was told at Survey Executives Training Institute (SETI) that a draft for review will be released. An S&C Letter 17-37-NH was released July 7th, 2017 on CMP Policies and the CMP Analytical Tool. Appendix PP has been released along with new F-tags. There will be training on new to old tags and old to new tags.
- 5) *LTC Positions Filled:* 1) Strategic Planner and Compliance Officer: Natalie Smith; and 2) Manager of Survey: Lisa McAlister alongside Debbie Zamarripa. Lisa will be in charge of Assisted Living, Adult Day Care and Residential Care.
- 6) *Provider Training:* Nursing Home Trainings: September 26th, 2017 (Oklahoma City) and October 10th, 2017 (Tulsa). Beverly Clark, LTC Training Coordinator, spoke about the topics that will be covered, which includes Dementia and the CMS updates. AL, RC, ADC Provider training has not been approved for 2017.

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- 7) *New Survey Process*: The training for the new LTC survey process is going to be conducted October 2nd – 5th, 2017 for the OSDH LTC Staff. Implementation of the new survey process would start October 6th, 2017. The survey process has been traditional for half of the 50 states and Quality Indicator Survey (QIS) for the other half. Oklahoma was part of the last group to transfer to QIS. After review, a completely new survey process was developed. The new process is being presented and implemented by all 50 states within a timespan of a month.

9) New Business:

1. *Appoint Nominating Committee for 2018 LTCFAB Officers*: William Whited, Kay Parsons, Diana Sturdevant were appointed to the nominating committee. The Chair for the nominating committee will be William Whited.

10) Public Comment:

1. *Senate Bill 775*: Esther Houser asked about OK SB775 authored by Senator David, which would require nursing facilities to have emergency generators, along with requested clarification about Appendix Z from CMS concerning Emergency Preparedness and having generators to run in case of emergency. Mike Cook mentioned that Appendix Z does not technically state that facilities are required to have emergency generators. But facilities must have an alternate power source that will maintain temperatures to protect patient health and safety, along with maintain food storage, medication storage.

11) Adjournment

The meeting adjourned at 3:15 p.m.

Composite Scorecard for Oklahoma Nursing Homes

Select Long-stay metrics for the period ending June 30, 2017



This score card provides an overview of Oklahoma nursing home performance with comparative data from the region and nation. The data comes from the Minimum Data Set National Repository, which is referred to as MDS 3.0. The data for this score card edition was retrieved on September 6, 2017 for the period ending June 30, 2017. It includes a five quarter review of performance on key quality measures. These 13 metrics comprise the composite score as designated by the Centers for Medicare and Medicaid Services. The composite score is a snapshot of overall quality in nursing homes and is featured as table 14 on the bottom right of the score card. Whether the change from previous to current year for Oklahoma is statistically significant or not is indicated by the traffic light indicator where ‘Red’ indicates change for worse, ‘Yellow’ indicates no significant change and ‘Green’ indicates change for better.

Nine of 14 measures show statistically significant improvement from the same quarter last year (green lights), while one shows a downturn in performance (red light). Among those improving, Table 1 shows declines over each quarter in the percentage of residents who self-report moderate to severe pain. The data now show three consecutive quarters of decline in residents receiving antipsychotic medications (Table 9). This would indicate we have sustained positive movement on this national initiative.

Residents with urinary tract infections continue to decline over each of the last four quarters (Table 13). Oklahoma's rate of bowel or bladder control loss among residents has seen a statistically significant increase over last year but was unchanged from last quarter and remains below the regional and national averages (Table 4). The increase in residents needing help with Activities of Daily Living (ADL), seen in the last quarter, was halted this quarter and a small reduction achieved.

Most importantly, our combined composite score of 8.8% (Table 14) continues to reflect statistically significant improvement. Over the last twelve months, the gap between Oklahoma and the national composite score narrowed from 1.5 percentage points to 1 percentage point. The gap between Oklahoma and the regional composite score also narrowed.

Statistically Significant Change: Previous to Current Year - Oklahoma	
Improved Performance Measures:	Worsened Performance
Self-reported pain (Table 1)	Low-Risk Residents Who Lose Control of Their Bowels or Bladder (Table 4)
Catheter in Bladder (Table 2)	
Residents Physically Restrained (Table 5)	
Residents Receiving Antipsychotic Medications (Table 9)	
Influenza vaccination (Table 10)	
Residents with Depressive Symptoms (Table 11)	
Pneumococcal vaccination (Table 12)	
Urinary tract infections (Table 13)	
State Composite Score (Table 14)	

Note: Statistical significance was determined based on the 95% confidence interval.
 Email QIEShelpdesk@health.ok.gov for more information.

Composite Scorecard for Oklahoma Nursing Homes

Long-stay metrics for the period ending 06/30/2017

Source: Minimum Data Set (MDS) National Repository

Run Date: 09/06/2017

<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>Residents Who Self-Report Moderate to Severe Pain (N=13,226)</p> </div> <div style="width: 55%; text-align: right;"> <p>Table 1</p> <p>Desired ↓</p> </div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th>Jun 2016</th> <th>Sep 2016</th> <th>Dec 2016</th> <th>Mar 2017</th> <th>Jun 2017</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>7.9%</td> <td>7.7%</td> <td>7.3%</td> <td>7.1%</td> <td>6.9%</td> </tr> <tr> <td>Region 6</td> <td>8.1%</td> <td>7.6%</td> <td>6.9%</td> <td>6.6%</td> <td>6.3%</td> </tr> <tr> <td>Oklahoma</td> <td>15.0%</td> <td>14.5%</td> <td>13.0%</td> <td>11.9%</td> <td>11.1%</td> </tr> </tbody> </table>		Jun 2016	Sep 2016	Dec 2016	Mar 2017	Jun 2017	Nation	7.9%	7.7%	7.3%	7.1%	6.9%	Region 6	8.1%	7.6%	6.9%	6.6%	6.3%	Oklahoma	15.0%	14.5%	13.0%	11.9%	11.1%	<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>Residents With Catheter Inserted or Left in Bladder (N=17,119)</p> </div> <div style="width: 55%; text-align: right;"> <p>Table 2</p> <p>Desired ↓</p> </div> </div> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th>Jun 2016</th> <th>Sep 2016</th> <th>Dec 2016</th> <th>Mar 2017</th> <th>Jun 2017</th> </tr> </thead> <tbody> <tr> <td>Nation</td> <td>3.2%</td> <td>3.1%</td> <td>3.0%</td> <td>2.9%</td> <td>2.8%</td> </tr> <tr> <td>Region 6</td> <td>3.7%</td> <td>3.6%</td> <td>3.4%</td> <td>3.3%</td> <td>3.2%</td> </tr> <tr> <td>Oklahoma</td> <td>4.6%</td> <td>4.3%</td> <td>4.0%</td> <td>4.0%</td> <td>4.0%</td> </tr> </tbody> </table>		Jun 2016	Sep 2016	Dec 2016	Mar 2017	Jun 2017	Nation	3.2%	3.1%	3.0%	2.9%	2.8%	Region 6	3.7%	3.6%	3.4%	3.3%	3.2%	Oklahoma	4.6%	4.3%	4.0%	4.0%	4.0%
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Legend N = OK Denominator for current period

Nation

Region

Oklahoma

Statistically significant change for worse from the first to the last period shown

No Statistically significant change from the first to the last period shown

Statistically significant change for better from the first to the last period shown



FY18 1st QTR. NURSE AIDE REGISTRY
LTC Advisory Board 10/11/2017



CURRENT CERTIFICATIONS							
TYPES OF CERTIFICATIONS	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
Adult Day Care (ADC)	29	30	28	28			
Long Term Care (LTC)	38,259	37,614	37,855	38,144			
Certified Medication Aide (CMA)	5,714	5,869	6,068	6,186			
Advanced CMA Gastrology (CMA/G)	2,475	2,609	2,821	2,945			
Advanced CMA Glucose Monitoring (CMA/GM)	983	1,091	1,191	1,244			
Advanced CMA Insulin Administration (CMA/IA)	710	780	862	903			
Advanced CMA Respiratory (CMA/R)	2,556	2,693	2,907	3,027			
Feeding Assistant (FA)	591	653	603	631			
Home Health Aide (HHA)	14,186	13,755	13,839	13,988			
Developmentally Disabled Direct Care Aide (DDDCA)	1,653	1,402	1,268	1,270			
Residential Care Aide (RCA)	98	83	69	65			
TOTALS	67,254	66,579	67,511	68,431			

WALK-INS FOR RENEWAL	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
First Floor - NAR Walk-Ins	4,272	5,009	5,026	1,649			

NEW CERTIFICATIONS/REGISTRATIONS	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
RECIPROCIITY - CERTIFICATIONS INTO THE STATE							
LTC	890	897	1,001	329			
HHA	0	11	6	1			
TRAINING PROGRAM TESTING AND/OR TRAINING							
LTC	5,949	5,183	5,568	1,161			
HHA	2,776	2,403	2,791	664			
DDDCA	206	180	209	35			
RCA	0	0	0	10			
ADCA	2	0	0	0			
CMA	1,121	999	1,102	234			
FA	302	266	230	72			
TOTALS	10,356	9,031	9,900	2,176			

NEW ADVANCED CMA							
CMA-R	460	706	1024	317			
CMA-G	468	688	992	315			
CMA-GM	226	323	399	116			
CMA-IA	153	228	304	93			
TOTALS	1,307	1,945	2719	841			

RETEST	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
Retest - CMA	57	91	148	10			
Retest - LTC	126	274	400	63			

FY18 1st QTR. NURSE AIDE REGISTRY

LTC Advisory Board 10/11/2017

Retest - HHA	35	93	128	18			
Retest - DDCA	0	0	1	0			
TOTALS	218	458	677	91			
RECIPROCITY - CERTIFICATIONS							
VERIFIED FOR ANOTHER STATE	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
Reciprocity - LTC	375	415	417	108			
ABUSE							
	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
Misappropriation	16	41	37	6			
Neglect	9	17	32	5			
Physical	3	12	7	2			
Sexual	1	1	0	1			
Mistreatment	0	1	0	0			
Verbal	1	1	0	0			
TOTALS	30	73	76	14			

TRAINING PROGRAMS							
APPROVED TRAINING PROGRAMS	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
LTCA	119	129	134	131			
HHA	0	0	0	0			
DDCA	11	11	10	10			
RCA	2	1	1	1			
ADC	1	0	0	0			
CMA	47	47	46	49			
CMA/Continuing Education Units(CEU)	35	35	36	36			
CMA/IA	15	20	21	21			
CMA/GM	2	2	4	4			
CMA/R	1	2	2	2			
CMA/RG	23	25	26	26			
CMA/G	0	1	4	1			
TOTALS	256	273	281	281			
ONSITE SURVEYS PERFORMED	FY2015	FY2016	FY2017	FY18-Q1	FY18-Q2	FY18-Q3	FY18-Q4
LTCA	56	119	35	19			
HHA	0	0	0	0			
DDCA	2	12	2	0			
RCA	0	4	0	0			
ADCA	1	0	0	0			
CMA	2	25	16	0			
CMA / CEU	0	22	14	0			
CMA/IA	0	7	5	0			
CMA/GM	0	1	2	0			
CMA/R	0	0	1	0			
CMA/RG	0	12	6	0			
TOTALS	61	196	81	19			



Oklahoma State Department of Health
Creating a State of Health

**Ad Hoc Committee on Healthy Aging
Long Term Care Facility Advisory Board
Executive Summary and Final Reprt
October 11, 2017**

The Ad Hoc Committee on Healthy Aging held their thirteenth and fourteenth meetings on June 20 and October 11 respectively. The Long Term Care Facility Advisory Board members present were Andrew Dentino and Diana Sturdevant. Others present at these meetings were Mary Brinkley, Timothy Cathey, Mike Cook, Terry Cothran, Claire Dowers-Nichols, Hank Hartsell, Alexandria Hart-Smith, Bethany Holderread, Gayla Middlestead, Julie Myers, Teri Round, Crystal Rushing, and Debra Yellseagle.

The committee had two objectives this past year. The first was to monitor the progress of the nursing home fall prevention pilot program designed by the committee last year. The second objective was to formulate an approach to increase concurrently the percent of nursing home residents assessed and appropriately given the influenza and pneumococcal vaccines. The fall prevention pilot has demonstrated initial success with room for refinement. The vaccination initiative is in the information gathering stage. Further details about both initiatives follow.

Fall Prevention Initiative:

Due largely to the collaborative efforts of this ad hoc work group, fewer nursing home residents have experienced falls with major injury in Oklahoma. Collaborative efforts to educate providers and enhance existing projects began in March 2015 and continue to date. The initial project design for a 12-week comprehensive program was completed in October 2015. Collaboration to reduce falls in nursing homes and in the community continued at the 2016 Governor's Summit on Healthy Aging this past April. The baseline for reducing falls with major injury was set at 5.3% (09/30/2014). The trend of falls continued upward, peaking at 5.6%, before work began.¹

AIM Statement for Fall Prevention: To reduce the rate of falls with major injury in Oklahoma nursing facilities starting with a rate of 5.3% in September 2014, moving through 5.0% by June 2016, to 3.0% by June 2019. This effort should improve physical, mental, social, and emotional well-being and functioning of residents of nursing facilities as currently measured in the composite score.

Intervention for Falls:

The fall prevention pilot *It's not OK to Fall* concluded phase two this June. The pilot included four facilities around the Oklahoma City area, and then it expanded to an additional 18 homes across the state. An additional 20 homes will be recruited during the final phase. Due to the intensive nature of the intervention and the opportunity cost experienced by the participants, a limited number of nursing homes will be eligible to participate in this intervention. The program

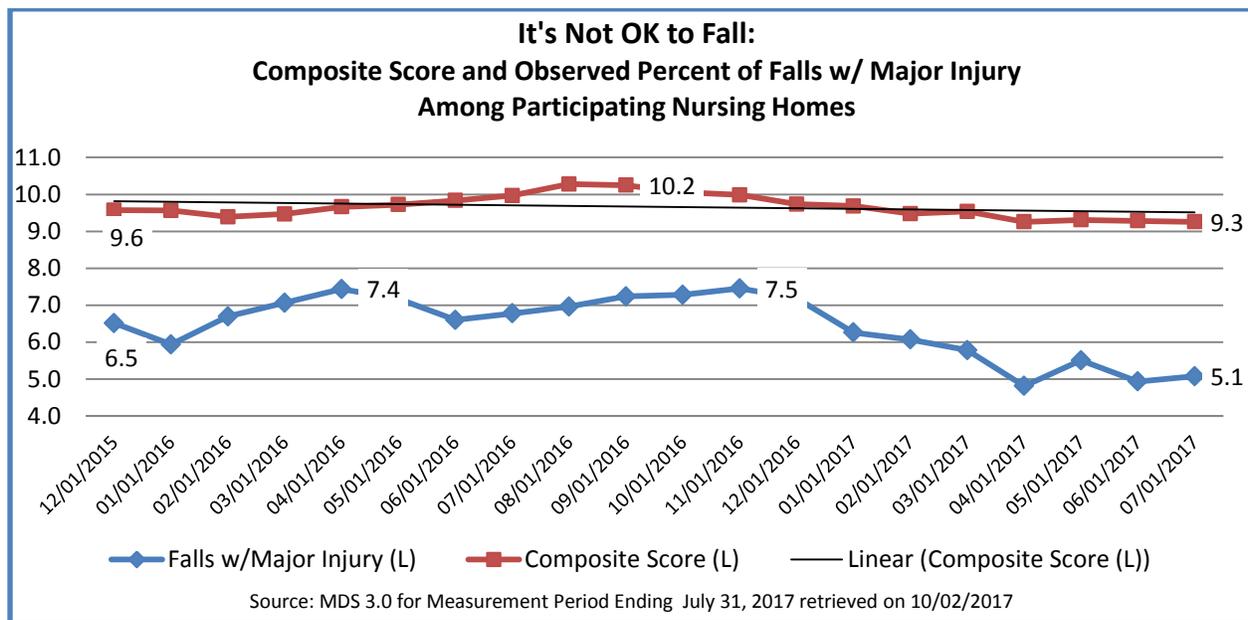
¹ Source: CMS Minimum Data Set 3.0 for Measurement Period Ending July 31, 2017 retrieved on 10/02/2017



employs a multifaceted design that empowers staff through culture change principles. This multifaceted design may have played a role in improving the participants' composite score (a lower score is a better score). The pilot program was presented as a poster at the Surgeon General's 2016 U.S. Public Health Service conference and was well received. The project managers have also presented the fall intervention materials several times in various venues such as conferences and tradeshows.

Results for Fall Intervention:

The preliminary results indicate net positive results. The fall rate of the homes averaged 6.5% (12/31/2015) before the intervention and 5.1% (6/30/2017). The aggregated composite score for pilot homes improved from 9.6 (12/31/2015) to 9.3 (6/30/2017).²



Ad Hoc Committee Recommendation for Fall Intervention:

Project managers should select and use a readiness assessment tool to select facilities so that there is minimal waste of efforts and resources, which might otherwise be caused by attrition. The data should be monitored by the funding source (CMP Fund Program at OSDH) and evaluated for continued funding at the end of phase three.

Continued on the next page

² Source: CMS Minimum Data Set 3.0 for Measurement Period Ending July 31, 2017 retrieved on 10/02/2017



Oklahoma State Department of Health
Creating a State of Health

Vaccination Improvement Initiative:

The Centers for Disease Control and Prevention (CDC) estimates that “between 71 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older and between 54 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in that age group.”³ Additionally, the CDC reports that each year “pneumococcal disease kills thousands of adults, including 18,000 adults 65 years or older. Thousands more end up in the hospital because of pneumococcal disease.”⁴

Therefore the Ad Hoc on Healthy Aging elected to focus on Influenza and Pneumococcal vaccinations in long-term care settings. The data available to measure improvement in this area is limited to nursing facilities. The measures are the percent of long-stay residents appropriately assessed and given the influenza and pneumococcal vaccines as reported in the CMS Minimum Data Set 3.0.

AIM Statement for Vaccinations: As specifically measured by the Minimum Data Set 3.0, the current goals of the ad hoc committee are to increase the percentage of long-stay residents in Oklahoma nursing facilities that are assessed and appropriately given the seasonal influenza and pneumococcal vaccines. Efforts are expected to improve physical, mental, social, and emotional well-being and functioning of residents of nursing facilities as currently measured in the composite score. Starting with a rate for **seasonal influenza** of 95.2% in March 2015, the aim is to improve to 96% by March 2018 with a stretch goal of 98% by March 2019. Starting with a rate for **pneumococcal** vaccinations of 87.6% in March 2015, the aim is to improve to 92% by March 2018, with a stretch goal of 94% by March 2019.

Intervention for Vaccinations:

In the fall of 2016 OSDH tasked a current CMP Fund contractor to assess practices and pilot initial efforts. Results for this measure appear more quickly than with fall prevention. Activities to improve the percentage of long-stay residents in Oklahoma nursing facilities that are assessed and appropriately given the seasonal influenza and pneumococcal vaccines included:

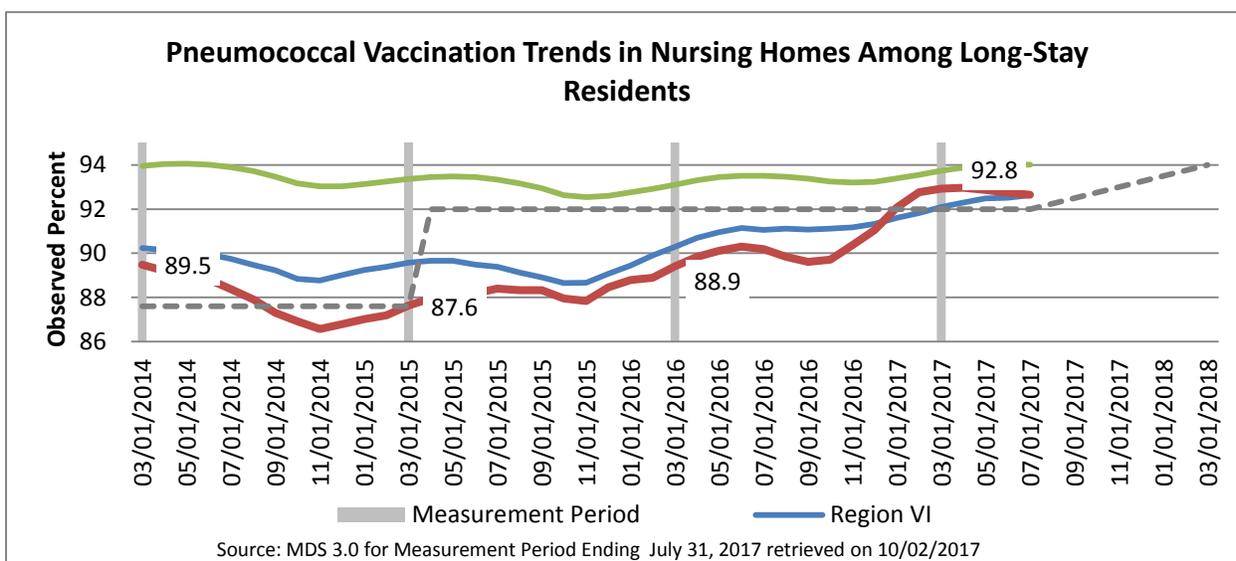
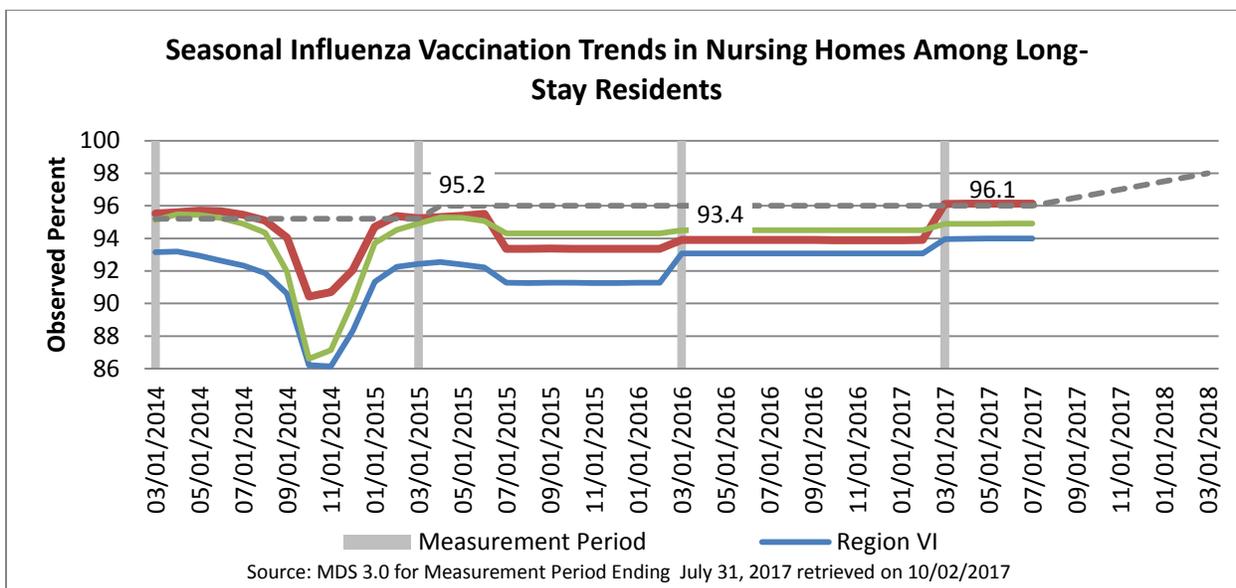
- regional meetings/trainings held in October,
- assessment of current practices (report available),
- direct support to at least 40 homes, and
- data analysis to lead future efforts.

Results for Vaccination Intervention:

Currently, the data indicate improvement in both measures as illustrated in the following graphs. The percent of long-stay residents assessed and appropriately given the **seasonal influenza** vaccine improved from 95.2% in March 2015 to 96.1% this March. The percent of long-stay residents assessed and appropriately given the **pneumococcal** vaccine improved from 87.6% in March 2015 to 92.8% this March. Goals were reached over a year ahead time.

³ <http://www.cdc.gov/flu/about/disease/65over.htm> accessed 9/29/2016

⁴ <https://www.cdc.gov/features/adult-pneumococcal/> accessed 9/29/2016



Ad Hoc Committee Recommendation for Fall Intervention:

Given the success of the immunization pilot, the Committee recommended that OSDH staff replicate these efforts during the next season, instead of developing a more complex, expensive intervention.

Final Committee Recommendations to the Long Term Care Facility Advisory Board: Having met its goals to create effective interventions to reduce the number of falls with major injury, increase the percent of long-stay residents assessed and appropriately given the seasonal influenza vaccine, and increase the percent of long-stay residents assessed and appropriately given the pneumococcal vaccine, the Ad Hoc Committee on Healthy Aging respectfully submits this final report and recommends the closure of the Committee.



**Ad Hoc Committee on Healthy Aging
Long Term Care Facility Advisory Board
Executive Summary and Final Report
October 11, 2017**

The Ad Hoc Committee on Healthy Aging held their thirteenth and fourteenth meetings on June 20 and October 11. The Long Term Care Facility Advisory Board members present were Andrew Dentino and Diana Sturdevant. Others present this year were Deputy Commissioner Henry Hartsell, Jr., Mary Brinkley, Timothy Cathey, Timothy Chrusciel, Mike Cook, Terry Cothran, Claire Dowers-Nichols, Alexandria Hart-Smith, Bethany Holderread, Patricia Ingram, Natasha Mason, Gayla Middlestead, Julie Myers, Teri Round, Crystal Rushing, and Debra Yellseagle.

The overarching goal of the Healthy Aging Ad Hoc was to improve nursing home quality as measured by the Composite Score. The Composite Score is a calculation designated by the Centers for Medicare and Medicaid Services (CMS). It consists of 13 long stay measures from the CMS Minimum Data Set 3.0 (MDS). The calculation for the score is attached to this report. The quality measures and the Composite Score calculation inform the attached OSDH Score Card, which compares Oklahoma's performance to the region and nation. According to CMS, lower composite score values indicate better clinical quality in nursing homes. The national composite score goal is six or less (≤ 6).

Toward the goal of lowering Oklahoma's Composite Score, the Ad Hoc Committee selected two objectives for 2017. The first was to monitor the progress of the nursing home fall prevention program designed by the Committee in 2015. The second objective was to formulate an approach to increase the percent of long-stay nursing home residents assessed and appropriately given the influenza and pneumococcal vaccines. The fall prevention pilot has demonstrated initial success with room for refinement. The vaccination initiative met its goals for improvement ahead of schedule. Further details about the overall progress toward the Composite Score goal and updates for both objectives follow.

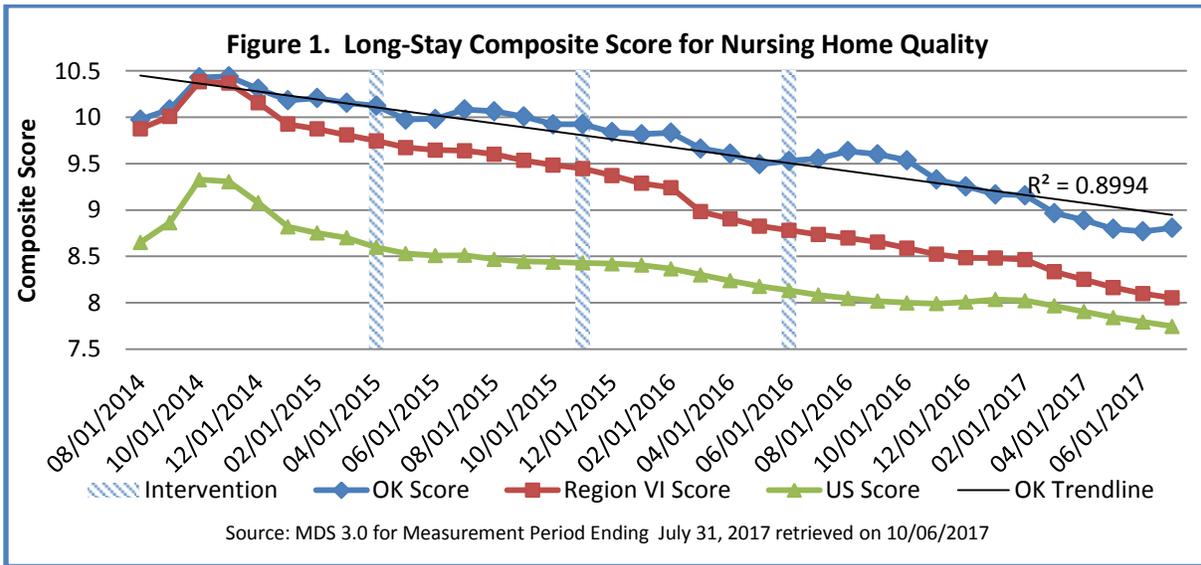
Composite Score

Healthy Aging Ad Hoc Committee AIM Statement: An opportunity exists to improve quality of care delivered in Oklahoma nursing facilities as currently measured in the Composite Score, moving from 10.0 in September 2015, to 8.4 by June 2019. Efforts to do so should increase physical, mental, social and emotional well-being and functioning of residents in nursing facilities. This is important to work on immediately because the composite score represents clinical care measures that are a significant cause of morbidity and mortality.

Composite Score Data: Oklahoma's highest composite score has improved from 10.4 in October 2014 to 8.8 in July 2017, which is a relative improvement of 15.6% in less than three years. The trend line indicates that Oklahoma is on target for meeting the goal of 8.4 by June 2019. The rate of relative improvement from the October 2014 baseline has not been as great

Healthy Aging Executive Summary and Final Report

in Oklahoma as compared to its CMS region or the nation (**Table 1**). However, with the implementation of interventions beginning early in 2015, Oklahoma began to close the gap between itself and the nation. Oklahoma's score remains higher than the regional and national averages as shown in **Figure 1**. The CMS Composite Scores by region are listed in **Table 2** and a map of the CMS regions accompanies the table as **Figure 2**.



	Highest Baseline	Interventions
Baseline Date	10/31/2014	03/31/2015
OK Score	15.6%	13.3%
Region VI Score	22.5%	17.9%
US Score	17.0%	11.0%

State/ Region Code	Composite Score 7-31-2017
9	5.8
2	6.7
1	7.5
US	7.7
3	7.8
4	7.9
6 (OK)	8.1
7	8.2
8	8.4
10	8.5
5	8.5
OK	8.8

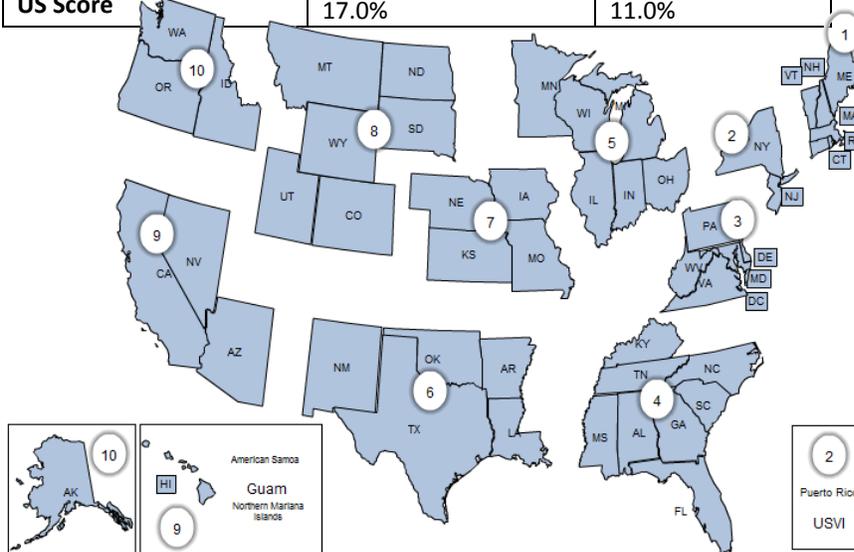


Figure 2. Map of CMS Regions

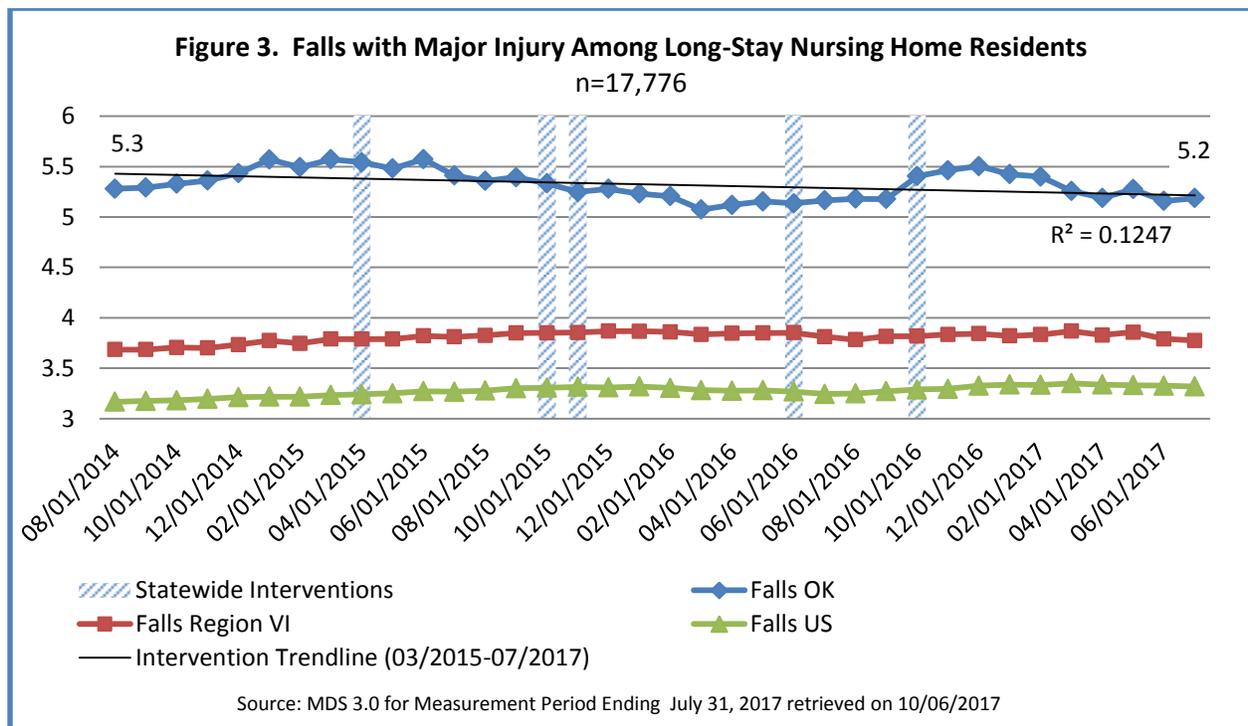
Source: <https://innovation.cms.gov/initiatives/regional-innovation-network/>

Fall Prevention

AIM Statement for Fall Prevention: To reduce the rate of falls with major injury in Oklahoma nursing facilities starting with a rate of 5.3% in September 2014, moving through 5.0% by June 2016, to 3.0% by June 2019.

According to the Centers for Disease Control and Prevention, “one out of five falls causes a serious injury such as broken bones or a head injury. More than 95% of hip fractures are caused by falling, usually by falling sideways. Falls are the most common cause of traumatic brain injuries. Adjusted for inflation, the direct medical costs for fall injuries are \$31 billion annually. Hospital costs account for two-thirds of the total.”¹

Collaborative efforts to educate providers and enhance existing projects began in March 2015 and continue to date. The initial project design for a 12-week comprehensive program was completed in October 2015. Collaboration to reduce falls in nursing homes and in the community continued at the second Governor’s Summit on Healthy Aging in April 2016. After the baseline was set at 5.3% (09/30/2014), the rate of falls continued to increase through December 2014 to 5.6%.² The most recent data on the state’s average fall rates are shown in **Figure 3**.



¹ Source: <https://www.cdc.gov/homeandrecreationalafety/falls/adultfalls.html> accessed 10/06/2017

² Source: CMS Minimum Data Set 3.0 for Measurement Period Ending July 31, 2017 retrieved on 10/02/2017

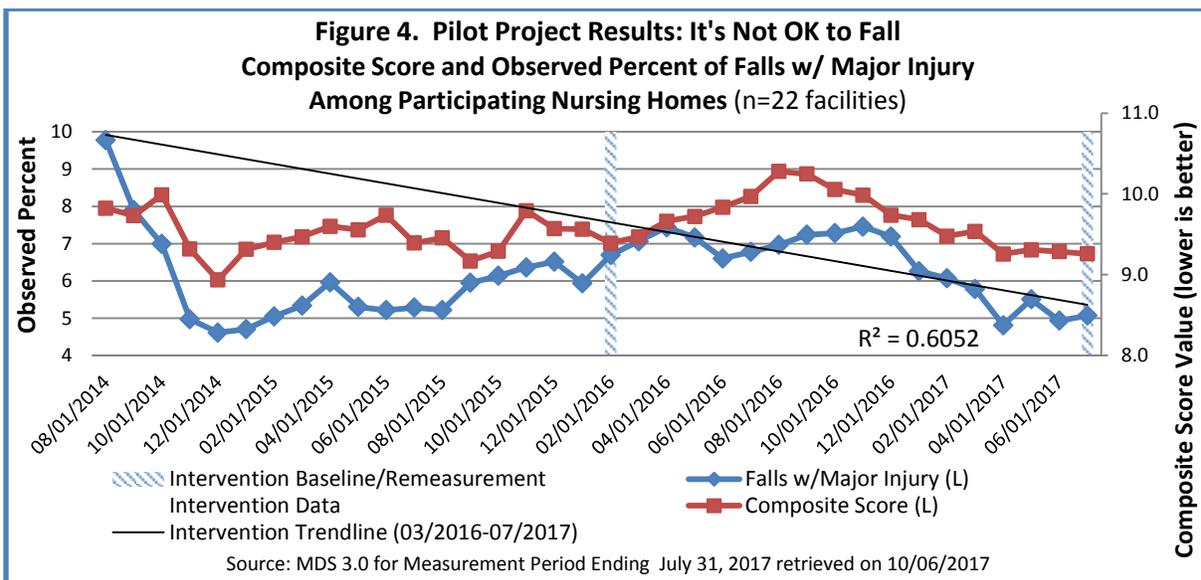
Healthy Aging Executive Summary and Final Report

Intervention for Falls:

Improvement has been achieved among nursing homes participating in the intervention designed by the Ad Hoc Committee. The first phase of the pilot (*It's Not OK to Fall*) included four facilities in the Oklahoma City area, then expanded to an additional 18 homes across the state. Phase two concluded in June 2017. Up to 40 additional homes will be recruited for the final phase. Due to the opportunity cost (intensive education at all levels onsite and during business hours) experienced by the participants, a limited number of nursing homes participate in this intervention. The program employs a multifaceted design of culture change principles. In addition to didactic presentations about the project, the program was displayed as a poster presentation at the Surgeon General's 2016 U.S. Public Health Service conference.

Results for Falls Intervention Pilot:

The preliminary results indicate net positive results. The fall rate of the nursing homes averaged 6.5% (12/31/2015) before the intervention and 5.1% at remeasurement (7/31/2017). The Composite Score for the cohort improved from 9.6 (12/31/2015) to 9.3 (7/31/2017).³ The data source metric has a look back scan of one year, so improvement is not immediately reflected. **Figure 4** details the preliminary falls data from the cohort. The change in the composite score and observed percentage of falls with major injury from baseline (12/31/2015) to current ending period (7/31/2017) was statistically significant.



Ad Hoc Committee Recommendation for Fall Intervention:

Project managers should use an assessment tool to determine facility readiness so that there is minimal waste of efforts and resources, which might otherwise be caused by attrition. The data should be monitored by the funding source (CMP Fund Program at OSDH) and evaluated for continued funding at the end of phase three.

³ Source: CMS Minimum Data Set 3.0 for Measurement Period Ending July 31, 2017 retrieved on 10/06/2017

Healthy Aging Executive Summary and Final Report

Vaccination Improvement

AIM Statement for Vaccinations: Starting with the percent of long-stay nursing home residents assessed and appropriately given the **seasonal influenza** vaccinations of 95.2% in March 2015, the aim is to improve to 96% by March 2018 with a stretch goal of 98% by March 2019. Starting with the percent of long-stay nursing home residents assessed and appropriately given the **pneumococcal** vaccinations of 87.6% in March 2015, the aim is to improve to 92% by March 2018, with a stretch goal of 94% by March 2019.

The Centers for Disease Control and Prevention (CDC) estimates that “between 71 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older and between 54 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in that age group.”⁴ Additionally, the CDC reports that each year “pneumococcal disease kills thousands of adults, including 18,000 adults 65 years or older. Thousands more end up in the hospital because of pneumococcal disease.”⁵

Intervention for Vaccinations:

Based on discussions of the March 2016 data, which indicated decreasing performance in these measures, the Ad Hoc requested an analysis of existing practices in nursing homes. In the fall of 2016 OSDH tasked a current CMP Fund Program contractor to assess practices and pilot initial efforts.

The contractor’s activities to improve the percentage of long-stay residents in Oklahoma nursing facilities that assessed and appropriately given the seasonal influenza and pneumococcal vaccines included:

- Regional meetings/trainings held in October 2016,
- Assessment of current practices (report available from October 2016-March 2017),
- Direct support to at least 40 nursing homes, and
- Data analysis to lead future efforts.

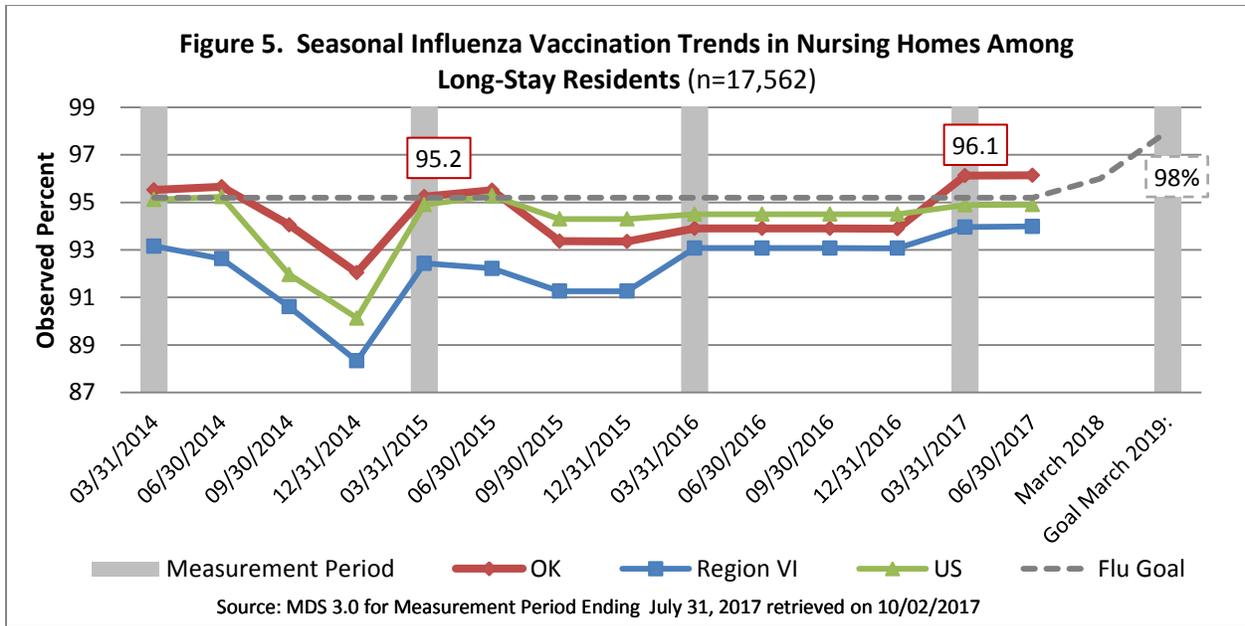
Results for Vaccination Intervention:

Results for this measure appeared more quickly than with fall prevention because it uses a look-back scan of six months (falls have a look-back scan of one year). The Committee anticipated using the data analysis to devise a new intervention or support existing efforts for immunizations. The data indicate improvement in both measures as illustrated in the following graphs. The percent of long-stay residents assessed and appropriately given the **seasonal influenza** vaccine improved from 95.2% in March 2015 to 96.1% March 2017, which exceeds the goal of 96% for 2018. **Figure 5** illustrates the trend from March 2015 through March 2017 and indicates the stretch goal (98%) of this objective.

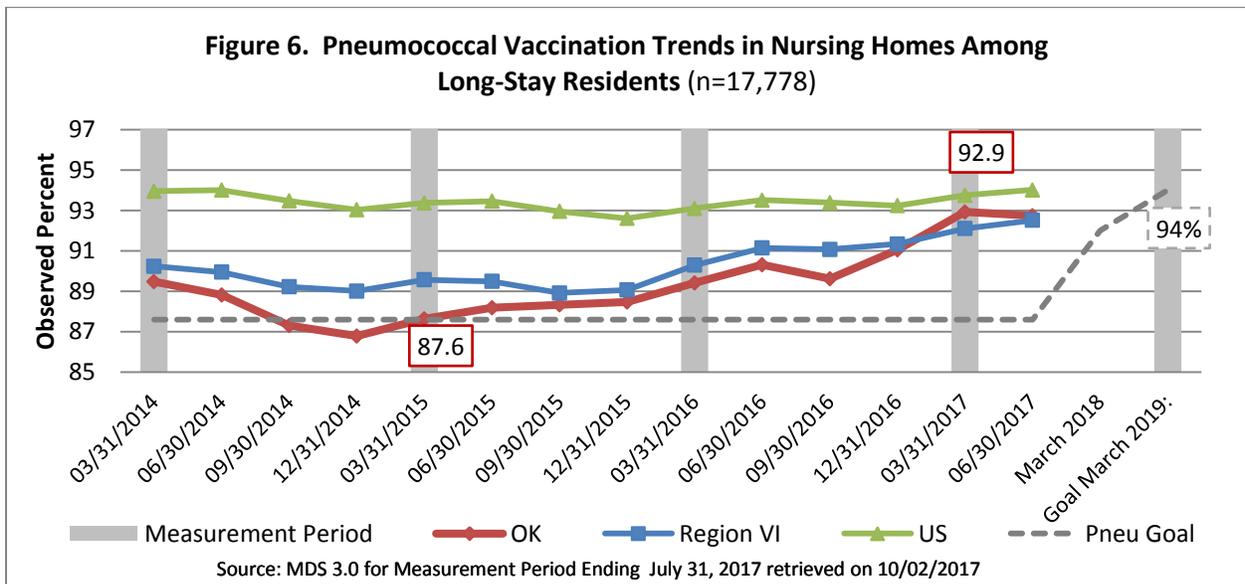
⁴ <http://www.cdc.gov/flu/about/disease/65over.htm> accessed 9/29/2016

⁵ <https://www.cdc.gov/features/adult-pneumococcal/> accessed 9/29/2016

Healthy Aging Executive Summary and Final Report



The percent of long-stay residents assessed and appropriately given the **pneumococcal** vaccine improved from 87.6% in March 2015 to 92.8% March 2017, which exceeded the goal of 92% for 2018. **Figure 6** illustrates the trend from March 2015 through March 2017 and indicates the stretch goal (94%) of this objective.



Ad Hoc Committee Recommendation for Vaccinations Intervention:

Given the success of the immunization pilot, the Committee recommended that OSDH staff should replicate these efforts during the next season, instead of developing a more complex, expensive intervention.

Healthy Aging Executive Summary and Final Report

Final Recommendations from the Ad Hoc Committee on Healthy Aging to the Long Term Care Facility Advisory Board

The Ad Hoc Committee has been successful in achieving many of the aims, as we strive together and improve Oklahoma's composite score for nursing facilities. The increase in key vaccinations and the reduction in serious injuries from falls will have a major impact on improving the health of Oklahomans who reside in these facilities. Specifically, these interventions addressed the following measures:

- Reduce the percent of long-stay nursing home residents experiencing a fall with major injury,
- Increase the percent of long-stay residents assessed and appropriately given the seasonal influenza vaccine, and
- Increase the percent of long-stay residents assessed and appropriately given the pneumococcal vaccine.

The data presented by the OSDH indicates positive results from the interventions, which have in turn contributed to improvement of the Composite Score. Based on the data, Oklahoma is likely to meet the Composite Score goal ahead of schedule. With this success, the Ad Hoc Committee on Healthy Aging respectfully submits this final report and recommends the dismissal of the Committee. The Committee recommends that the Advisory Board request and receive standing data reports on the quality of long term care in nursing homes such as is presented by the Composite Score Card published quarterly by OSDH.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 625. CERTIFICATE OF NEED STANDARDS FOR ~~ICF/MR~~ ICF/IID**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

310:625-1-1 [AMENDED]
310:625-1-2 [AMENDED]
310:625-1-3 [AMENDED]
310:625-1-4 [AMENDED]

SUMMARY:

This action will amend numerous sections within this chapter. The current Rule uses the term “Mentally Retarded”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Individuals with Intellectual Disabilities”. Pursuant to Title 25 of the Oklahoma Statutes (O.S.) at Section 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

The action removes obsolete references to state schools operated by the State Department of Human Services.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Titles 25 O.S. § 40 and 63 O.S. § 1-851.2(A)(7)

COMMENT PERIOD:

November 15, 2017, through December 18, 2017. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through December 18, 2017, submit written comment to the contact person identified below; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 18, 2017, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 314 beginning at 2pm. The alternate date and time in the event of an office closure due to inclement weather is December 20, 2017, in room 1102, beginning at 2pm. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through December 18, 2017, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contract person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available through the contact person identified below or via the agency website at www.health.ok.gov.

CONTACT PERSONS:

Don Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail DonM@health.ok.gov or Kiersten Hamill, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 31272, e-mail KierstenH@health.ok.gov or Kari Holder, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 56265, e-mail KariH@health.ok.gov

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 625. CERTIFICATE OF NEED STANDARDS FOR ICF/MR-ICF/IID

1. **DESCRIPTION:**

This action will amend numerous sections within this chapter. The current Rule uses the term “Mentally Retarded”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Individuals with Intellectual Disabilities”. Pursuant to 25 O.S. § 40 statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

The action removes obsolete references to state schools operated by the State Department of Human Services and updates the reference to 42 CFR Section 442.400, relating to Standards for Payment to Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

Persons directly affected will be residents of nursing and specialized facilities as well as their family members. Additionally, the proposed amendments have the potential to affect numerous other individuals by encouraging respectful language to be used by the general public.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This change in language will promote respect and will have a positive impact on the perception of residents as well as their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is no anticipated economic impact or cost associated with compliance.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**

The cost to the OSDH to implement the amendments will be approximately \$3,300 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented

and enforced by existing OSDH personnel and will not result in an increase in authorized full-time equivalent personnel.

No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**
There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.
7. **ADVERSE EFFECT ON SMALL BUSINESS:**
There is no anticipated adverse effect on small business.
8. **EFFORTS TO MINIMIZE COSTS OF RULE:**
The costs associated with this rule change are minimal and include only the costs of drafting, adoption, publication, distribution and education.
9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**
This change will help foster inclusiveness and acceptance of individuals with disabilities by referring to them as individuals first. The language used in the updated rule is more respectful and will have a positive effect on individuals with intellectual and developmental disabilities.
10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**
If this change is not made, Oklahoma will continue to utilize outdated and nonrespectful language regarding individuals with disabilities. This language has an adverse effect on the individuals as well as their family members.
11. **PREPARATION AND MODIFICATION DATES:**
This rule impact statement was prepared on August 14, 2017.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 625. CERTIFICATE OF NEED STANDARDS FOR ~~ICF/MR~~ ICF/IID**

310:625-1-1. Purpose

This Chapter shall apply to Certificate of Need applications reviewed by the Department for proposed Intermediate Care Facility/~~Mentally Retarded~~ Individuals with Intellectual Disabilities (~~ICF/MR~~) (ICF/IID) beds and implements part of the Long-term Care Certificate of Need Act. This Chapter shall not apply to ~~ICF/MR~~ ICF/IID 16s and smaller facilities.

310:625-1-2. Service area

For review purposes under these standards, the service area for an ~~ICF/MR~~ ICF/IID shall be the ~~Mentally Retarded School Service Region~~ service region or area, as designated by the State Department of Human Services, in which it is located or proposed for location. In the event an application for Certificate of Need is considered for a specialized ~~ICF/MR~~ ICF/IID facility for which only one or two facilities may be needed, or where no service area is designated, in the State, then the Department may treat the entire State as the service area.

310:625-1-3. Burden of proof

It shall be incumbent on each applicant to clearly demonstrate an unmet need for additional ~~ICF/MR~~ ICF/IID beds in the applicable service area and to demonstrate conformance with all standards specified herein.

310:625-1-4. Standards

- (a) No new ~~ICF/MR~~ ICF/IID beds, except ~~ICF/MR~~ ICF/IID 16s and smaller, shall be approved in the service area unless the total number of ~~ICF/MR~~ ICF/IID beds in the service area falls below the following standard: 84 ~~ICF/MR~~ ICF/IID beds per 100,000 general population.
- (b) An application for ~~ICF/MR~~ ICF/IID beds shall not be approved unless the applicant demonstrates familiarity with and understanding of certification standards for an ~~ICF/MR~~ ICF/IID, specified in 42 CFR Section ~~442.400~~ 442.400, relating to Standards for Payment to Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities.
- (c) The identity of the licensed administrator of the existing or proposed facility must be provided by the applicant as a prerequisite to issuance of a Certificate of Need.
- (d) No additional ~~ICF/MR~~ ICF/IID beds, whether proposed through construction or conversion of existing space, shall be approved for any existing ~~ICF/MR~~ ICF/IID unless it has maintained an occupancy rate of at least 95%, based upon a calculation of occupancy reflected in the monthly average daily census reports of the Department of Human Services, or the Department, for the most recent six month period for which official data is available when the application is filed.
- (e) Any ~~ICF/MR~~ ICF/IID beds approved, but not yet in place in the service area, shall be included in the evaluation for determining bed need specified in subsection (a).
- (f) Any existing ~~ICF/MR~~ ICF/IID which proposes an expansion of beds by conversion or construction and which has a record of questionable quality of care, as demonstrated through complaint investigation records, or other means, may be denied a Certificate of Need despite the conformity of the proposal to other standards delineated herein.
- (g) ~~In determining the bed need in subsection (a), the beds at the three state schools are hereby determined to be the number of beds necessary to have a 90% occupancy, based upon a calculation of occupancy reflected in the monthly average daily census reports of the Department~~

~~of Human Services for the most recent six-month period for which official data is available when the application is filed.~~

(h) —The Department shall consider the relationship of a Certificate of Need application to any plan adopted by the Department of Human Services concerning the distribution and allocation of services for ~~mentally retarded or developmentally disabled persons~~ individuals with intellectual or developmental disabilities.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 630. CERTIFICATE OF NEED STANDARDS FOR LICENSED NURSING
FACILITY BEDS**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

310:630-1-1 [AMENDED]

310:630-1-3 [AMENDED]

SUMMARY:

The current Rule uses the term “Mentally Retarded”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Individuals with Intellectual Disabilities”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Titles 25 O.S. § 40 and 63 O.S. § 1-851.2(A)(7)

COMMENT PERIOD:

November 15, 2017, through December 18, 2017. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through December 18, 2017, submit written comment to the contact person identified below; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 18, 2017, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 314 beginning at 2pm. The alternate date and time in the event of an office closure due to inclement weather is December 20, 2017, in room 1102, beginning at 2pm. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through December 18, 2017, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contact person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available through the contact person

identified below or via the agency website at www.health.ok.gov.

CONTACT PERSONS:

Don Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail DonM@health.ok.gov or Kiersten Hamill, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 31272, e-mail KierstenH@health.ok.gov or Kari Holder, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 56265, e-mail KariH@health.ok.gov

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 630. CERTIFICATE OF NEED STANDARDS FOR LICENSED NURSING FACILITY BEDS

1. **DESCRIPTION:**

The current Rule uses the term “Mentally Retarded”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Individuals with Intellectual Disabilities”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

Persons directly affected will be residents of nursing and specialized facilities as well as their family members. Additionally, the proposed amendments have the potential to affect numerous other individuals by encouraging respectful language to be used by the general public.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This change in language will promote respect and will have a positive impact on the perception of residents as well as their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is no anticipated economic impact or cost associated with compliance.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**

The cost to the OSDH to implement the amendments will be approximately \$3,300 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing OSDH personnel and will not result in an increase in authorized full-time equivalent personnel.

No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**

There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.

7. **ADVERSE EFFECT ON SMALL BUSINESS:**

There is no anticipated adverse effect on small business.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:**

The costs associated with this rule change are minimal and include only the costs of drafting, adoption, publication, distribution and education.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**

This change will help foster inclusiveness and acceptance of individuals with disabilities by referring to them as individuals first. The language used in the updated rule is more respectful and will have a positive effect on individuals with intellectual and developmental disabilities.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**

If this change is not made, Oklahoma will continue to utilize outdated and nonrespectful language regarding individuals with disabilities. This language has an adverse effect on the individuals as well as their family members.

11. **PREPARATION AND MODIFICATION DATES:**

This rule impact statement was prepared on August 14, 2017.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 630. CERTIFICATE OF NEED STANDARDS FOR LICENSED NURSING
FACILITY BEDS**

310:630-1-1. Purpose

This Chapter shall apply to Certificate of Need applications reviewed by the Department for proposed licensed nursing facility (LNF) beds. This Chapter establishes review criteria and standards as authorized pursuant to Title 63 O.S. Section 1-851.2(A)(7).

- (1) The Department shall use these standards in considering an application's conformity to the Long Term Care Certificate of Need Act.
- (2) Each applicant who proposes licensed nursing facility beds has the burden to clearly demonstrate conformity to these standards.
- (3) For purposes of this Chapter, licensed nursing facility (LNF) beds shall include all facilities defined under the Nursing Home Care Act, 63 O.S. Section 1-1901 et seq., excluding any facility certified for service to ~~the mentally retarded~~ individuals with intellectual disabilities.

310:630-1-3. Standards

(a) The applicant shall demonstrate that existing licensed nursing facility beds are not and will not be adequate in the service area described in 310:630-1-2, based on the need of the population.

- (1) The applicant shall demonstrate that there are persons who need services in the area but are unable to obtain those services due to the inadequacy of existing LNF facilities in the area.
- (2) The applicant shall demonstrate the probable impact of the proposed beds on the ratio of LNF beds to the number of persons age 75 and over statewide. The applicant must show that the proposed new beds likely will not cause the statewide ratio to exceed 179 beds per 1000 persons age 75 and over, and that the project is consistent with the achievement of an optimal target ratio of 152 beds per 1000 persons age 75 and over.
- (3) The applicant shall demonstrate the probable impact of the proposed beds on the ratio of LNF beds to the number of persons age 75 and over in the service area. No application shall cause an excessive increase in the bed to population ratio of a service area. The determination of whether or not an increase is excessive shall be based on the percentage of increase a project will cause in an area's bed to population ratio, and on a comparison of the area's bed to population ratio against the statewide ratio.
- (4) The most recent population data published at the time the application is filed shall be used. The source of population projections for current and future years shall be based on year 2000 census data as published by the Oklahoma Department of Commerce.
- (5) If the applicant proposes a special service area under 310:630-1-2, then the applicant shall demonstrate that the target population will have access to the proposed services through public or private transportation.

(b) The applicant shall demonstrate that alternative or substitute services are not and will not be available or are and will be inadequate to meet the needs of the population.

(1) An overall mean occupancy rate of 85% should be maintained in LNF beds in the Service Area described in OAC 310:630-1-2.

(A) This mean shall be based upon data from all similarly-licensed facilities in the Service Area using monthly reports filed with the Department of Health, taking into consideration the following:

- (i) any specialized facility for ~~mentally-retarded persons~~ individuals with intellectual disabilities or intermediate care facility for ~~mentally-retarded persons~~ individuals with intellectual disabilities in the area shall be excluded;
 - (ii) in the case of a nursing facility application, any hospital-based skilled nursing unit shown to serve a different health service need shall be excluded;
 - (iii) in the case of a hospital-based skilled nursing unit application, any nursing facility shown to serve a different health service need shall be excluded;
 - (iv) in the case of a facility demonstrating a special service area under OAC 310:630-1-2(b), each facility not shown to be adequate or appropriate to meet the needs of the facility's special population shall be excluded.
- (B) The mean shall be calculated using data for the most recent six month period for which reports are published by the Department of Health, as of the first day of the month during which an application is initially filed.
- (i) Beds reserved for residents who were temporarily absent from facilities for hospitalization or other therapeutic purposes shall be considered to have been occupied.
 - (ii) The area bed capacity used to calculate the occupancy rate shall be reduced by the number of beds that are not available because rooms licensed for multiple occupants have been reserved for single occupants throughout the six-month period.
- (C) In determining the service area's conformity to the occupancy goal specified in this subsection, the Department shall investigate the causes for low-occupancy operation of other facilities in the service area. The Department shall exclude such low-occupancy facility from the service area calculations if the facility has been in operation continuously under the current licensee for twenty-four (24) or more months and:
- (i) The facility's state license or federal certification during the sixty (60) months preceding the filing of the application has been revoked, rescinded, canceled, terminated, involuntarily suspended or refused renewal;
 - (ii) The facility has a history of noncompliance as defined in 63:1-851.1(6); or
 - (iii) The facility has not complied with all lawful orders of suspension, temporary management, or administrative penalty issued by the Department, another state agency, or by the federal Health Care Financing Administration;
 - (iv) The facility's owner, operator, manager, or medical director has been convicted of a criminal offense related to the operation or management of a long-term care facility; or
 - (v) The facility has been assessed an administrative penalty above the level of deficiency with one or more of the following unfavorable factors:
 - (I) The administrative penalty included a citation of immediate jeopardy or actual harm to a resident;
 - (II) The circumstance cited in connection with a civil money penalty or other administrative penalty resulted in the death of a resident; or
 - (III) Multiple civil money penalties, denials of payment, or other administrative penalty have been assessed based on findings of substandard quality of care, actual harm, or potential for more than minimal harm, at the facility within the preceding 60 months.
- (2) The applicant shall demonstrate that the proposed beds are needed in addition to any beds previously approved under the State Certificate of Need laws but not yet in operation in the service area.

- (3) The applicant's demonstration shall include consideration of the adequacy of such alternative services as residential care facilities, Eldercare, home health care, hospice, assisted living and adult day care.
- (c) The applicant shall demonstrate adequate financial resources for the new or expanded long-term care services and for the continued operation thereof.
- (1) Reimbursement shall be structured to realistically provide for care and services to persons living in the service area.
 - (2) The proposed charges shall be in line with the prevailing rate of similar institutions and services within the health service area.
 - (3) The projected utilization rates shall be sufficient to maintain cost-effectiveness.
 - (4) The projected cash flow shall give the proposed project financial viability within three years.
 - (5) The relationship of the institution's assets to liabilities shall not be increased by the proposed project to the point of threatening the financial viability of the institution.
 - (6) The applicant shall supply a cost/benefit analysis to justify the cost-effectiveness of the proposed project.
- (d) The applicant shall demonstrate that sufficient personnel will be available to properly staff and operate the proposed new or expanded long-term care service.
- (1) A proposal to provide new or expanded long-term care service must provide assurances that the appropriate numbers and types of staff will be available to comply with licensure requirements.
 - (2) Professional and paraprofessional staffing of new or expanded long-term care services must not compromise the staffing of existing long-term care services.
 - (3) The applicant shall disclose all current and prior experience in the operation of health care facilities, giving names of facilities, locations, and dates. If the applicant has less than sixty (60) months experience in health care facility operations immediately preceding the filing of the application, then the applicant shall:
 - (i) Provide a plan which details how experienced and competent staffing and leadership, including but not limited to the director of nursing, the medical director, the administrator, and the applicant's policy body, will be placed in charge of facility operations; and
 - (ii) Agree to advise the OSDH, prior to any change in the staffing and leadership during the first six months of operation of the new or expanded facility.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 5. Resident Assessments

310:663-5-3 [AMENDED]

SUMMARY:

310:663-5-3 - The current Rule uses the term “Mental Retardation”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Intellectual Disabilities”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. In order to promote consistency, it is necessary to amend all chapters that contain this terminology, even if those chapters do not equate persons with their condition. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Titles 25 O.S. § 40 and 63 O.S. Section 1-890.3(A)

COMMENT PERIOD:

November 15, 2017, through December 18, 2017. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through December 18, 2017, submit written comment to the contact person identified below; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 18, 2017, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 314 beginning at 2pm. The alternate date and time in the event of an office closure due to inclement weather is December 20, 2017, in room 1102, beginning at 2pm. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through December 18, 2017, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contract person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available through the contact person identified below or via the agency website at www.health.ok.gov.

CONTACT PERSONS:

Don Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail DonM@health.ok.gov or Kiersten Hamill, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 31272, e-mail KierstenH@health.ok.gov or Kari Holder, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 56265, e-mail KariH@health.ok.gov

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING

1. **DESCRIPTION:**

The current Rule uses the term “Mental Retardation”. This term is outdated and may be considered disrespectful. This proposal replaces the aforementioned term with “Intellectual Disabilities”. Pursuant to Title 25 O.S. § 40 ,statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. In order to promote consistency, it is necessary to amend all chapters that contain this terminology, even if those chapters do not equate persons with their condition. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

Persons directly affected will be residents of nursing and specialized facilities as well as their family members. Additionally, the proposed amendments have the potential to affect numerous other individuals by encouraging respectful language to be used by the general public.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This change in language will promote respect and will have a positive impact on the perception of residents as well as their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is no anticipated economic impact or cost associated with compliance.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**

The cost to the OSDH to implement the amendments will be approximately \$3,300 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing OSDH personnel and will not result in an increase in authorized full-time equivalent personnel.

No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**

There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.

7. **ADVERSE EFFECT ON SMALL BUSINESS:**

There is no anticipated adverse effect on small business.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:**

The costs associated with this rule change are minimal and include only the costs of drafting, adoption, publication, distribution and education.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**

This change will help foster inclusiveness and acceptance of individuals with disabilities by referring to them as individuals first. The language used in the updated rule is more respectful and will have a positive effect on individuals with intellectual and developmental disabilities.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**

If this change is not made, Oklahoma will continue to utilize outdated and nonrespectful language regarding individuals with disabilities. This language has an adverse effect on the individuals as well as their family members.

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This will have a positive impact on the residents and their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

11. **PREPARATION AND MODIFICATION DATES:**

This rule impact statement was prepared on August 14, 2017.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING**

SUBCHAPTER 5. RESIDENT ASSESSMENTS

310:663-5-3. Description of resident assessment form

- (a) The admission assessment form shall include but not be limited to the following:
 - (1) resident's identification;
 - (2) disease diagnosis/infections;
 - (3) mental health history, and ~~mental retardation~~ intellectual disability or developmental disability;
 - (4) physical functioning which includes the numbers of persons needed to assist with activities of daily living;
 - (5) incontinence;
 - (6) medications;
 - (7) special treatment and procedures;
 - (8) cognitive function; and
 - (9) signatures and dates.
- (b) The comprehensive assessment includes the following information:
 - (1) physical functional status;
 - (2) mental functional status;
 - (3) customary routine;
 - (4) disease diagnosis;
 - (5) oral/nutritional status;
 - (6) medications;
 - (7) devices and restraints;
 - (8) special treatments;
 - (9) skin condition;
 - (10) psychosocial status;
 - (11) sensory and physical impairments; and
 - (12) medically defined conditions and prior medical history.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

310:675-1-2. [AMENDED]

Subchapter 3. Licenses

310:675-3-1.1 [AMENDED]

Subchapter 9. Resident Care Services

310:675-9-5.1 [AMENDED]

Subchapter 11. Intermediate Care Facilities for Individuals with Intellectual Disabilities – 16
Beds and Less (ICF/IID – 16)

310:675-11-1 [AMENDED]

310:675-11-2 [AMENDED]

310:675-11-3 [AMENDED]

310:675-11-4 [AMENDED]

310:675-11-5 [AMENDED]

310:675-11-6 [AMENDED]

310:675-11-7 [AMENDED]

310:675-11-8 [AMENDED]

310:675-11-9 [AMENDED]

Subchapter 13. Flexible staff-scheduling

310:675-13-12. [AMENDED]

310:675-13-14 [AMENDED]

SUMMARY:

This action will amend numerous sections within this chapter. The current Rule uses the terms “Mental Retardation”, “Mentally Retarded” and “Qualified Mental Retardation Professional”. These terms are outdated and may be considered disrespectful. This proposal replaces the aforementioned terms with “Individuals with Intellectual Disabilities”, “Individuals with Developmental Disabilities”, or “Qualified Intellectual Disability Professional”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

A scrivener's error omitted the removal of a reference to the old life safety code in 310:675-11-5. This section was amended last year to incorporate the 2012 edition of the Life Safety Code adopted by the Centers for Medicare & Medicaid Services. The amendment to this section addresses this omission by striking the old reference and supporting language applicable to the former code.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Titles 25 O.S. § 40 and 63 O.S. Section 1-1942

COMMENT PERIOD:

November 15, 2017, through December 18, 2017. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through December 18, 2017, submit written comment to the contact person identified below; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 18, 2017, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 314 beginning at 2pm. The alternate date and time in the event of an office closure due to inclement weather is December 20, 2017, in room 1102, beginning at 2pm. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through December 18, 2017, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contract person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available through the contact person identified below or via the agency website at www.health.ok.gov.

CONTACT PERSONS:

Don Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail DonM@health.ok.gov or Kiersten Hamill, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 31272, e-mail KierstenH@health.ok.gov or Kari Holder, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 56265, e-mail KariH@health.ok.gov

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 675. NURSING AND SPECIALIZED FACILITIES

1. **DESCRIPTION:**

This action will amend numerous sections within this chapter. The current Rule uses the terms “Mental Retardation”, “Mentally Retarded” and “Qualified Mental Retardation Professional”. These terms are outdated and may be considered disrespectful. This proposal replaces the aforementioned terms with “Individuals with Intellectual Disabilities”, “Individuals with Developmental Disabilities”, or “Qualified Intellectual Disability Professional”. Pursuant to Title 25 O.S. § 40 statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

A scrivener's error omitted the removal of a reference to the old life safety code in 310:675-11-5. This section was amended last year to incorporate the 2012 edition of the Life Safety Code adopted by the Centers for Medicare & Medicaid Services. The amendment to this section addresses this omission by striking the old reference and supporting language applicable to the former code.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

Persons directly affected will be residents of nursing and specialized facilities as well as their family members. Additionally, the proposed amendments have the potential to affect numerous other individuals by encouraging respectful language to be used by the general public.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This change in language will promote respect and will have a positive impact on the perception of residents as well as their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is no anticipated economic impact or cost associated with compliance.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**

The cost to the OSDH to implement the amendments will be approximately \$3,300 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented

and enforced by existing OSDH personnel and will not result in an increase in authorized full-time equivalent personnel.

No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**
There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.
7. **ADVERSE EFFECT ON SMALL BUSINESS:**
There is no anticipated adverse effect on small business.
8. **EFFORTS TO MINIMIZE COSTS OF RULE:**
The costs associated with this rule change are minimal and include only the costs of drafting, adoption, publication, distribution and education.
9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**
This change will help foster inclusiveness and acceptance of individuals with disabilities by referring to them as individuals first. The language used in the updated rule is more respectful and will have a positive effect on individuals with intellectual and developmental disabilities.
10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**
If this change is not made, Oklahoma will continue to utilize outdated and nonrespectful language regarding individuals with disabilities. This language has an adverse effect on the individuals as well as their family members.
11. **PREPARATION AND MODIFICATION DATES:**
This rule impact statement was prepared on August 14, 2017.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

SUBCHAPTER 1. GENERAL PROVISIONS

310:675-1-2. Definitions

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

"Act" means Title 63 of the Oklahoma Statutes, Sections 1-1901 and following as amended also known as the Nursing Home Care Act.

"Allied health professional" means one of the following persons: physician assistant, physical, speech, or occupational therapist, occupational therapy assistant, physical therapy assistant, or qualified social worker.

"Attendant" means the person having control of an animal/pet visiting or in residence in a facility.

"Approval" means the mandatory state government process by which an agency or program is reviewed, and publicly proclaimed, to render a service worthy of note.

"CEP" means the nurse aide competency evaluation program.

"Certification" means the process by which a non-governmental agency, or association, or governmental agency attests that an individual or facility has met certain predetermined standards specified by the certifying body.

"Certified medication aide" means a person who has passed a Department approved program for administering medications.

"Certified nurse aide" means any person who provides, for compensation, nursing care or health-related services to residents of a facility, who is not a licensed health professional and has completed a Department approved training and competency program.

"Charge nurse" means a registered nurse or licensed practical nurse responsible for supervising nursing services on a specific shift.

"Chemical restraints" means the use of a medication for the purpose of discipline, convenience, or in an emergency situation to control mood or behavior and not required to treat the resident's symptoms.

"Consultant registered nurse" means a registered nurse who provides consultation to the director of nursing and administrator concerning the delivery of nursing care for all residents in the facility.

"Denial" means a decision made by the appropriate body to disapprove an application.

"Direct care staff" means nursing, activity, social and therapy staff.

"Director of nursing" means either a registered nurse or licensed practical nurse, who has the authority and responsibility to administer nursing services within the facility.

"Emergency" means, for the purposes of Title 63 O.S. Section 1-1912, a serious, potentially life-threatening or life-endangering situation in which immediate action is necessary to ensure the health, safety, or welfare of residents, and for which the facility:

(A) does not have a plan acceptable to the Department to ensure health, safety or welfare of residents; or

(B) refuses to remedy the situation.

"Health related services" means any medically directed service provided by any person in a facility that may include but is not limited to, the following:

(A) Positioning and turning of residents.

- (B) Self-help skill training.
- (C) Assistance with prosthetic/assistive devices.
- (D) Medication administration.
- (E) Nutrition and hydration.
- (F) Monitoring of resident vital signs.
- (G) Catheter and nasogastric care.
- (H) Behavior modification programs.
- (I) Administering a medically related care plan
- (J) Restorative services.

"In charge" and **"supervision"** means the administrator must have the requisite authorization from the licensee to make those purchases and incur those necessarily attendant debts in order to comply with the rules promulgated by the Board and all pertinent state statutes.

"Inservice education" means activities intended to assist the individual to acquire, maintain, and/or increase competence in fulfilling the assigned responsibilities specific to the employer's expectations.

"Licensed health professional" means one of the following: a physician; dentist, podiatrist, chiropractor, physician assistant, nurse practitioner; pharmacist; physical, speech, or occupational therapist; registered nurse, licensed practical nurse; licensed or certified social worker; or licensed/registered dietician.

"Licensed nurse" means a registered nurse or a licensed practical nurse who is currently licensed by the Oklahoma Board of Nursing.

"Licensed pharmacist" means a person who is a graduate of an accredited pharmacy program and is currently licensed by the Oklahoma Board of Pharmacy.

"Licensed practical nurse" means a person who is a graduate of a state approved practical nursing education program, or who meets other qualifications established by the Oklahoma Board of Nursing, and is currently licensed by the Oklahoma Board of Nursing.

"Licensure" means the process by which the Department grants to persons or entities the right to establish, operate, or maintain any facility.

"Local law enforcement" means:

- (A) The municipal police department, if the facility is within the jurisdiction of any municipality of this state, or
- (B) The county sheriff, if the facility is outside the jurisdiction of any municipality within this state.

"Manager" or "supervisor" means the person or entity which performs administrative services for the licensee. The manager or supervisor is not legally responsible for the decisions and liabilities of the licensee, and does not stand to gain or lose financially as a result of the operation of the facility. The manager is paid a fee or salary for services, and the primary remuneration shall not be based upon the financial performance of the facility.

"Misappropriation of resident's property" means the taking, retention, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal control of a resident, without the effective consent of the resident or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of resident's property.

"Nurse aide" means any person providing nursing or nursing related services to residents in a facility, but does not include an individual who is a licensed health professional, or who volunteers to provide such services without monetary compensation.

"Nurse aide trainee" means any person who has been employed by a facility to provide nursing care or health related services, and is enrolled in but has not completed a Department approved training and competency program.

"Orientation" means the training for a particular job activity given to all employees.

"Perishables" means food supplies, to include dietary supplements and intravenous feedings, medical supplies, and medications.

"Physical restraints" means any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot remove easily, that is not used for the purpose of therapeutic intervention or body alignment as determined by resident assessment and care planning, and which restricts the resident's desired freedom of movement and access to his or her body.

"Qualified nutritionist" is a Department approved person who holds a baccalaureate with major studies in food and nutrition, dietetics, or food service management; has one year experience in the dietetic service of a health care institution; and participates in continuing education annually.

"Registered/licensed dietitian" means a person who is registered as a dietitian by the American Dietetic Association and licensed by the Oklahoma Board of Medical Licensure and Supervision.

"Registered nurse" means a person who is a graduate of a state approved registered nursing education program, and who is currently licensed by the Oklahoma Board of Nursing.

"Registry" means a Department maintained list of individuals who have successfully completed a nurse aide training and competency evaluation program, or a competency evaluation program, approved by the Department.

"Revoke" means to rescind approval of a previous action.

"Specialized facility" ~~means any facility which offers or provides inpatient long term care services on a twenty-four hour basis to a limited category of persons requiring such services, including, but not limited to, a facility providing health or habilitation services for developmentally disabled persons~~ *means any home, establishment, or institution which offers or provides inpatient long-term care services on a twenty-four-hour basis to a limited category of persons requiring such services, including but not limited to a facility providing health or habilitation services for [individuals with intellectual or developmental disabilities] [63:1-1902(11)], infants and/or children, or individuals with Alzheimer's and or dementia residents.*

"Standards of nursing practice" means an authoritative statement that describes a level of care or performance common to the profession of nursing by which the quality of nursing practice can be judged. Standards of nursing practice include both standards of care and standards of professional performance.

"Standards of care" means a description of a competent level of care demonstrated by a process of accurate assessment and diagnosis, planning, appropriate interventions, and predicted patient outcomes. (Appendix B of this Chapter.)

"Standards of professional performance" means a description of a competent level of behavior in the professional role including activities related to quality assurance, education, consultation, research, ethics, resource utilization, accountability, peer review, and interdisciplinary collaboration.

"Suspended license" means a license that is issued for a period not to exceed three years to a facility which has temporarily closed or ceased operations.

"Training and competency evaluation program" means a program approved by the Department to instruct and evaluate individuals to act as nurse aides.

"Transfer" means the move of a resident from one facility to another facility.

"Intra-facility transfer" means the moving of a resident from one room to another within a facility.

"Transfer of ownership" means a change of substantial, or controlling interest, in the ownership of a facility. A change of less than five percent (5%) of the interest of the owner does not constitute a transfer of ownership unless it also results in a change of control of the owner.

"Willful violation" means:

- (A) a pattern of violation of the direct-care staffing requirement;
- (B) a violation of the direct-care staffing requirement in which the facility knew or should have known staffing would be insufficient to meet the requirement yet took no action to avert the violation; or
- (C) the reporting of materially inaccurate or misleading information of direct-care staffing to the Health Care Authority.

SUBCHAPTER 3. LICENSES

310:675-3-1.1. Application for licensure

- (a) No person or entity shall operate a facility without first obtaining a license.
- (b) The applicant shall file a licensure application in a timely manner, on the forms provided by the Department, with a check for the filing fee payable to the Oklahoma State Department of Health. The filing fee is set by statute, and currently is calculated as Ten Dollars (\$10.00) per licensed bed.
- (c) The facility owner shall be the applicant for the license, unless a receiver has been appointed. If there is a receiver, the receiver shall be the applicant.
- (d) If the facility is leased, then the person or entity to whom the facility is leased shall be the applicant. If the lessee does not assume all rights to the facility and the lessor reserves some participatory rights in the operation of the facility, then both entities shall make joint application for the license.
- (e) The applicant for license shall disclose the name, address, and tax identification number of a person or entity who has the legal duties of filing employment tax returns and paying employment taxes with respect to staff required to meet the needs of facility residents, including but not limited to administrators, nurses, nurse aides, certified medication aides, dieticians, nutritionists, food service staff, ~~qualified-mental-retardation-~~ intellectual disability professional, and activities, social services, maintenance and housekeeping personnel.
- (f) An application is not considered to be filed unless it is accompanied by the application fee. The application fee, however, shall not be required from a receiver or temporary manager appointed by, or at the request of, the Department.

SUBCHAPTER 9. RESIDENT CARE SERVICES

310:675-9-5.1. Assessment and care plans

- (a) A resident assessment and an individual care plan shall be completed and implemented for each resident. The care plan shall indicate the resident's current status and accurately identify the resident's needs.
- (b) The written resident assessment and care plan shall be reviewed and updated, at least quarterly, and as needed when the resident's condition indicates.

(c) Efforts shall be made to include the resident and resident's representative in development and implementation of the care planning process.

(1) Resident assessment

(A) The facility shall conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment for each resident's functional capacity.

(B) Each resident shall have an assessment coordinated or conducted by a registered nurse.

(C) Each individual completing a portion of the assessment shall sign, date, and certify the accuracy of that portion.

(D) An assessment shall be completed within fourteen days after admission of the resident.

(E) The resident assessment shall include a minimum data set (MDS) in the form required under 42 CFR 483.20. Each facility, with the exception of Intermediate Care Facilities for ~~the Mentally Retarded (ICF/MR)~~ Individuals with Intellectual Disabilities (ICF/IID), accurately shall complete the MDS for each resident in the facility, regardless of age, diagnosis, length of stay or payment category.

(F) The MDS form shall require the following, as applicable:

(i) Admission assessment;

(ii) Annual assessment;

(iii) Significant change in status assessment;

(iv) Significant correction of prior full assessment;

(v) Significant correction of prior quarterly assessment;

(vi) Quarterly review; and

(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.

(2) Resident pain assessment

(A) Residents shall be screened for the presence of pain at least once every 30 days and whenever vital signs are taken.

(i) Licensed nursing staff shall perform the screening at least once every 30 days. Certified nurse aides may perform the screening more frequently as needed.

(ii) The screening instrument shall grade the intensity and severity of pain using a resident-specific pain scale;

(B) An individualized pain assessment shall be conducted by a registered nurse for each resident:

(i) In conjunction with the admission, quarterly and annual assessments required at OAC 310:675-9-5.1(c)(1)(F); and

(ii) With onset of pain not previously addressed in a care plan or physician's orders.

(C) The goal is to alleviate or minimize pain while assisting the resident to maintain as high a level of functioning as possible. The pain assessment shall include, but not be limited to:

(i) A statement of how the resident describes the pain;

(ii) Intensity and severity of pain graded using a resident-specific pain scale;

(iii) Recent changes in pain;

(iv) Location(s);

(v) Onset and duration of pain, such as new pain within the last 3 days, recent pain within the last 3 months, or more distant pain greater than 3 months;

(vi) Type of pain reported or represented by resident, such as constant or intermittent, and duration or frequency of pain;

(vii) Current pain measured at its least and greatest levels;

- (viii) Aggravating and relieving factors;
 - (ix) Treatment including a review of all therapies, including medication, and the regimen used to minimize pain;
 - (x) Effects of pain and effectiveness of therapy on physical and social functions;
 - (xi) Resident's treatment preferences and emotional responses to pain, including resident's expectations and how resident coped with pain; and
 - (xii) If applicable, refer to pain assessment tool for the cognitively impaired.
- (D) Results shall be recorded in the resident's clinical record showing changes in pain scale and changes in level of functioning. The physician shall be contacted as necessary.
- (E) Pain shall be treated promptly, effectively and for as long as necessary.
- (3) Individual care plan**
- (A) An individual care plan shall be developed and implemented for each resident to reflect the resident's needs.
- (B) The care plan shall be developed by an interdisciplinary team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines determined by the resident's needs.
- (C) The care plan shall include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs identified in the assessment.
- (D) The care plan shall be available to appropriate personnel providing care for the resident.
- (E) An initial care plan shall be completed at the time of admission. The individualized care plan shall be completed within twenty-one days after admission.
- (F) A care plan shall be completed within seven calendar days after the completion of the assessment.

SUBCHAPTER 11. INTERMEDIATE CARE FACILITIES OF 16 BEDS AND LESS FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID-16)

310:675-11-1. Scope

This Subchapter is applicable to small facilities serving ~~the mentally retarded individuals~~ with intellectual disabilities which provide residential accommodations and transitional living training to aid residents in adapting to live in the general society. Resident accommodations are limited to not more than 16 residents, plus any required "live-in" staff. Facilities qualifying under this subsection shall be exempt from other subsections of this Chapter, except for the definitions provided in 310:675-1-2 and as may be specifically referenced in this subsection. In addition to these requirements, all facilities must meet the provisions of the Nursing Home Care Act.

310:675-11-2. Active Treatment

In institutions for ~~the mentally retarded~~ individuals with intellectual disabilities, active treatment requires the following:

- (1) The individual's regular participation, in accordance with an individual plan of care, in professionally developed and supervised activities, experience or therapies.
- (2) An individual written plan of care that sets forth measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experience or therapies necessary for the individual to reach those goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social or vocational level he can presently or potentially achieve.

(3) An interdisciplinary professional evaluation that consists of complete medical, social and psychological diagnosis and evaluations and an evaluation of the individual's need for institutional care; and is made by a physician, a social worker and other professionals, at least one of whom is a qualified mental retardation intellectual disability professional.

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

(5) An individual postinstitutionalization plan, as part of the individual plan of care, developed before discharge by a qualified mental retardation intellectual disability professional and other appropriate professionals. This must include provision for appropriate services, protective supervision, and other follow-up services in the resident's new environment.

(6) Individuals assigned for specific purpose of direct personal care to residents, including those conducting a training program to develop the resident's self-help and socialization skills. Does not include professionals performing duties related to their profession.

310:675-11-3. Qualified ~~mental retardation~~ intellectual disability professional

A person who has specialized training or one (1) year of experience in treating or working with ~~the mentally retarded~~ individuals with intellectual disabilities and is one of the following:

- (1) A psychologist.
- (2) A licensed doctor of medicine or osteopathy.
- (3) An educator with a degree in education from an accredited program.
- (4) A social worker with a bachelor's degree in:
 - (A) Social work from an accredited program; or
 - (B) A field other than social work and at least three (3) years of social work experience under the supervision of a qualified social worker.
- (5) A physical or occupational therapist.
- (6) A speech pathologist or audiologist.
- (7) A registered nurse.
- (8) A therapeutic recreation specialist who:
 - (A) Is a graduate of an accredited program; and
 - (B) If the State has a licensing or registration procedure, is licensed or registered in the State.
- (9) A rehabilitation counselor who is certified by the Committee of Rehabilitation Counselor Certification.

310:675-11-4. Occupancy

Residents selected for ~~ICF/MR-16~~ ICF/IID-16 occupancy shall receive active treatment, and be capable of direction and emergency evacuation from the facility, as determined by a physician or nurse or qualified mental retardation intellectual disability professional.

310:675-11-5. Physical plant

(a) ICF/IID-16 facilities shall be of one hour (minimum) fire resistant construction as approved by the Department and the State Fire Marshal, or shall be fully protected by an automatic sprinkler system approved by the Department and the State Fire Marshal. In addition, ICF/IID-16 facilities shall comply with the requirements of the National Fire Protection Association (NFPA)

101: Life Safety Code, 2012 Edition, adopted in 81 Federal Register 26871 by the Centers for Medicare & Medicaid Services on July 5, 2016 applicable to residential board and care occupancies for small facilities are incorporated by reference. For Medicare or Medicaid certified ICF/IID-16s, the Life Safety Code adopted by the Centers for Medicare & Medicaid Services prevails if there is a conflict between the Life Safety Code and this Chapter.

(b) Prior to issuance of license, the essential operation functions of the physical plant shall be submitted to licensing agency for review and approval. This submittal shall be in such detail as will depict compliance with applicable codes, ~~including emergency evacuation and day to day living accommodations. This submittal shall be accompanied by the applicant's written certification declaring the classification (prompt, slow, impractical) shown for "evacuation capabilities" Chapter 21, LSC 1985 Edition. The certified evacuation classification shall not change without written approval of State Fire Marshal and Licensing Agency. The Department shall receive, prior to each required survey, a written declaration by a physician or nurse or qualified intellectual disabilities professional, stating that each resident qualifies for the evacuation classification, as previously submitted and approved.~~

(c) Each facility must have a license. Any facility licensed under this part shall consist of contiguous construction.

(1) **Resident rooms.** The following requirements shall be provided:

(A) Capacity shall be a maximum of four (4) residents.

(B) Minimum area shall be 80 square feet per occupant in multi-bed rooms and 100 square feet in single bed rooms.

(C) Each resident shall have a minimum of three square feet of closet or locker space which shall contain at least a clothes rod and one adjustable shelf.

(2) **Service areas.** The following shall be provided:

(A) Toilet and bathing facilities shall be provided in an arrangement similar to general domestic residential facilities, except that bathrooms combining toilet, lavatory, tub and/or shower shall be no less than 60 square feet in size.

(B) Bathing and toilet facilities shall be provided on a ratio of one facility for each five residents.

(C) Resident staff offices shall be provided at the facility in sufficient size and number to permit the safe storage and handling of prescription medications used by the individual residents, space for private counseling of residents, space for the business affairs of the ICF/IID-16 to be conducted in private, and space for the maintenance of records pertaining to resident care.

(D) Linen and supply areas shall be provided in a manner which permits the separation of the clean and soiled materials. Clean linen and supplies shall be stored separately from the area in which the soiled materials are collected.

(E) Meal service space shall be provided as follows:

(i) Kitchen. Space for conventional food preparation and baking with sufficient storage for maintaining at least a four day supply of all foods required for a general diet, including cold storage.

(ii) Dining. There shall be 15 square feet per person allocated to permit residents and on-duty staff to dine at the same time.

(iii) Warewashing shall be in accordance with the requirements of the care facilities as stated in Chapter 257 (relating to Food Service Establishments) of this Title.

(F) Housekeeping materials and supplies shall be maintained in a designated area which is apart from the food service and sleeping areas.

(3) **Recreation, lounge and public areas.** Each ICF/IID-16 shall provide interior lounge and recreation space at a rate of no less than 20 square feet per bed. If public visitation areas are included, the lounge and recreation space shall be no less than 25 square feet per bed. Outside recreation lounge areas shall be provided. These areas shall have sufficient lighting to permit utilization after sundown.

(4) **Natural lighting and ventilation of rooms.** All habitable and occupiable rooms or spaces shall contain windows, skylights, monitors, glazed doors, transoms, glass block panels or other light transmitting media opening to the sky or on a public street, yard or court. The light transmitting properties and the area of the devices used shall be adequate to meet the minimum day lighting and ventilating requirements specified herein.

(5) **Window size.** Windows and exterior doors may be used as a natural means of light and ventilation, and when so used their aggregate glass area shall amount to not less than eight percent of the floor area served, and with not less than one half of this required area available for unobstructed ventilation.

310:675-11-6. Institutional and operational relationships

The ~~ICF/MR-16~~ ICF/IID-16 may be free standing in a community or may be on campus with a parent institution. The ~~ICF/MR-16~~ ICF/IID-16 may be an independent ownership and operation or may be part of a larger institutional ownership and operation. In any case, however, the ~~ICF/MR-16~~ ICF/IID-16 may have an effective, continuous relationship with a full scope ~~ICF/MR-16~~ ICF/IID-16 which allows all necessary support and professional services as well as the expeditious transfer of residents if and when necessary.

310:675-11-7. Staffing

(a) The ~~ICF/MR-16~~ ICF/IID-16 shall have available enough qualified staff and support personnel to carry out the residential living, professional and special programs and services for residents as required by their individual needs, and of sufficient size that the facility does not depend on residents or volunteers for services.

(b) Each ~~ICF/MR-16~~ ICF/IID-16 shall maintain at least the minimum direct-care-staff ratios specified in OAC 310:675-13-12(a).

(c) In living units for the severely impaired client, the present and on duty direct care staff ratio would be:

- (1) 1 to 4 from 7:00 a.m. to 3:00 p.m.;
- (2) 1 to 4 from 3:00 p.m. to 11:00 p.m.; and
- (3) 1 to 8 from 11:00 p.m. to 7:00 a.m.

(d) There should be sufficient dietary, nursing, housekeeping and administrative staff to serve the needs of the facility.

310:675-11-8. Administration

All sections of Subchapter 7 of this Chapter shall be applicable to the ~~ICF/MR-16~~ ICF/IID-16 facilities and operations.

310:675-11-9. Resident care services

In accordance with the needs of the residents, Subchapter 9 of this Chapter shall be applicable to the ~~ICF/MR-16~~ ICF/IID-16.

SUBCHAPTER 13. STAFF REQUIREMENTS

310:675-13-12. Direct care staffing

(a) Each facility shall maintain at least the minimum direct-care-staff-to-resident ratios specified in the Act at 63:1-1925.2.

(b) A licensed nurse shall be on duty eight hours a day, seven days a week on the day shift.

(c) If the director of nursing is a licensed practical nurse, a registered nurse shall be employed for at least eight hours per week as a consultant.

(d) There shall be a licensed nurse on duty twenty-four hours per day; provided however, that a facility licensed as a specialized facility for ~~the developmentally disabled~~ individuals with intellectual disabilities shall only be required to provide 24 hour nursing when it has a resident who has a medical care plan. The department may waive this requirement when the facility demonstrates it has been unable, despite diligent effort, to recruit licensed nurses. The Department shall determine that a waiver of this requirement will not endanger the health or safety of the residents.

(e) There shall be at least one certified medication aide on duty when any shift is not covered by a licensed nurse.

(f) At least two direct care staff persons shall be on duty and awake at all times regardless of the number of residents.

(g) Willful violation of the requirements regarding direct-care staff shall be determined based on a review of facility staffing records and interviews with staff, residents, resident family members and/or guardians, and other parties which may have information relevant to the investigation.

The determination by the Department of Health will include, but will not be limited to, the following factors:

- (1) The nature, circumstances and gravity of the violations;
- (2) The repetitive nature of the violations at the facility or others operated by the same or related entities;
- (3) The previous degree of difficulty in obtaining compliance with the rules at the facility or others operated by the same or related entities; and
- (4) Any substantial showing of good faith in attempting to achieve continuing compliance with the provisions of the Nursing Home Care Act.

310:675-13-14. Flexible staff-scheduling

(a) **Implementing flexible staff-scheduling.** Each facility seeking to implement the flexible staff-scheduling provisions of 63:1-1925.2(B)(5) shall request in writing a determination from the Department that the facility is in compliance with the staffing requirements of 63:1-1925.2(B)(3).

(b) **Requirements for eligibility.** Determination of flexible staff-scheduling privileges shall be based on compliance with the requirements at 63:1-1925.2(B)(6) and review of the staffing hours reported to the Oklahoma Health Care Authority. Reports shall be submitted to the Oklahoma Health Care Authority either through electronic mail or three and one-quarter inch diskette in an electronic format approved by that agency. The reviewed hours shall be for the previous three (3) calendar months from the date the request for determination is received.

(c) **Determination of compliance.** A determination of compliance with the requirements at 63:1-1925.2(B)(6)(a)(2)-(4) will be based on staffing reports and surveys for the three (3) months preceding the date the request for determination is received by the Department. For intermediate care facilities for ~~the mentally retarded~~ individuals with intellectual disabilities loss of eligibility shall include findings of non-compliance with the Condition of Participation at 42 CFR 483.430, Facility Staffing.

(d) **Failure to meet the direct care service rate.** Facilities that have been granted flexible staff-scheduling privileges and receive a determination they have not met the direct care service rate shall lose their flexible staff-scheduling privileges until the facility re-establishes their eligibility under the requirements at 63:1-1925.2(B)(6)(b) and (c). *Facilities shall have the right to appeal and to the informal dispute resolution process with regard to penalties and sanctions imposed due to staffing noncompliance.* [63:1-1925.2(E)].

(e) **Loss of eligibility based on surveys or fraud.** Facilities seeking to re-establish flexible staff-scheduling privileges after a loss of eligibility under 63:1-1925.2(B)(7) shall be subject to the requirements at OAC 310:675-13-14(a), (b) and (c). For intermediate care facilities for ~~the mentally retarded~~ individuals with intellectual disabilities loss of eligibility shall include findings of non-compliance with the Condition of Participation at 42 CFR 483.430, Facility Staffing.

(f) **Minimum staff in flexible staffing.** A facility failing to meet the flexible staff-scheduling requirement at 63:1-1925.2(B)(5)(b) shall be ineligible for flexible staff-scheduling privileges until the facility re-establishes their eligibility under the requirements at 63:1-1925.2(B)(6)(b) and (c).

(g) **Notification requirements.** The Department shall notify the facility and Oklahoma Health Care Authority on all decisions of eligibility.

(h) **Re-establishing eligibility.** A facility seeking to re-establish eligibility shall submit a written request to the Department. A request to re-establish eligibility is subject to the requirements at OAC 310:675-13-14(b).

(i) **Shift-based ratios for noncompliant facilities.** This paragraph implements 63:1-1925.2(F)(4).

(1) When the provisions of 63:1-1925.2(F)(1) are in effect, pursuant to 63:1-1925.2(B)(7), the following minimum direct-care-staff-to-resident ratios for non-compliant facilities shall apply in addition to other state and federal requirements related to the staffing of nursing facilities:

(A) From 7:00 a.m. to 3:00 p.m., one direct-care staff to every five residents,

(B) From 3:00 p.m. to 11:00 p.m., one direct-care staff to every seven residents, and

(C) From 11:00 p.m. to 7:00 a.m., one direct-care staff to every thirteen residents.

(2) When the provisions of 63:1-1925.2(F)(2) are in effect, pursuant to 63:1-1925.2(B)(7), the following minimum direct-care-staff-to-resident ratios for non-compliant facilities shall apply in addition to other state and federal requirements related to the staffing of nursing facilities:

(A) From 7:00 a.m. to 3:00 p.m., one direct-care staff to every five residents,

(B) From 3:00 p.m. to 11:00 p.m., one direct-care staff to every six residents, and

(C) From 11:00 p.m. to 7:00 a.m., one direct-care staff to every eleven residents.

(3) When the provisions of 63:1-1925.2(F)(3) are in effect, pursuant to 63:1-1925.2(B)(7), the following minimum direct-care-staff-to-resident ratios for non-compliant facilities shall apply in addition to other state and federal requirements related to the staffing of nursing facilities:

(A) From 7:00 a.m. to 3:00 p.m., one direct-care staff to every four residents,

(B) From 3:00 p.m. to 11:00 p.m., one direct-care staff to every six residents, and

(C) From 11:00 p.m. to 7:00 a.m., one direct-care staff to every eleven residents.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 677. NURSE AIDE TRAINING AND CERTIFICATION**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

310:677-1-2 [AMENDED]

310:677-1-3 [AMENDED]

Subchapter 3. Nurse Aide Training and Competency Examination Program

310:677-3-4 [AMENDED]

Subchapter 5. Nurse Aide Registry

310:677-5-2 [AMENDED]

Subchapter 13. Certified Medication Aides

310:677-13-1 [AMENDED]

Subchapter 15. ~~Developmentally Disabled Direct~~ ICF/IID Care Aides

310:677-15-1 [AMENDED]

310:677-15-2 [AMENDED]

310:677-15-3 [AMENDED]

310:677-15-4 [AMENDED]

310:677-15-5 [AMENDED]

Subchapter 17. Residential Care Aides

310:677-17-1 [AMENDED]

Subchapter 19. Adult Day Care Program Aides

310:677-19-1 [AMENDED]

SUMMARY:

This action proposes to amend numerous sections within this chapter. The current Rule uses the terms “Mental Retardation”, “Mentally Retarded” and “Qualified Mental Retardation Professional”. These terms are outdated and may be considered disrespectful. This proposal replaces the aforementioned terms with “Individuals with Intellectual Disabilities”, “Individuals with Developmental Disabilities”, or “Qualified Intellectual Disability Professional”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

This action proposes to amend the classification of Developmentally Disabled Direct Care Aides to ICF/IID Care Aides. "ICF/IID" is defined to mean an Intermediate Care Facility for Individuals with Intellectual Disabilities.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Titles 25 O.S. § 40 and 63 O.S. Section 1951(B)

COMMENT PERIOD:

November 15, 2017, through December 18, 2017. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through December 18, 2017, submit written comment to the contact person identified below; or may, at the hearing, ask to

present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on December 18, 2017, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 314 beginning at 2pm. The alternate date and time in the event of an office closure due to inclement weather is December 20, 2017, in room 1102, beginning at 2pm. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through December 18, 2017, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contact person identified below or via the agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available through the contact person identified below or via the agency website at www.health.ok.gov.

CONTACT PERSONS:

Don Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail DonM@health.ok.gov or Kiersten Hamill, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 31272, e-mail KierstenH@health.ok.gov or Kari Holder, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-9444 ext. 56265, e-mail KariH@health.ok.gov

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 677. NURSE AIDE TRAINING AND CERTIFICATION

1. **DESCRIPTION:**

This action will amend numerous sections within this chapter. The current Rule uses the terms “Mental Retardation”, “Mentally Retarded” and “Qualified Mental Retardation Professional”. These terms are outdated and derogatory. This proposal replaces the aforementioned terms with “Individuals with Intellectual Disabilities”, “Individuals with Developmental Disabilities”, or “Qualified Intellectual Disability Professional”. Pursuant to Title 25 O.S. § 40, statutes and administrative rules should avoid language that equates persons with their condition and should replace nonrespectful language by referring to persons with disabilities as persons first. Further, national organizations such as the Americans with Disabilities Act National Network, American Association on Intellectual and Developmental Disabilities and Centers for Medicare and Medicaid encourage use of more respectful language that has gained wide acceptance in recent disability laws.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

Persons directly affected will be residents of nursing and specialized facilities as well as their family members. Additionally, the proposed amendments have the potential to affect numerous other individuals by encouraging respectful language to be used by the general public.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

Persons benefiting will include residents and their families as well as owners, operators, staff of nursing homes and specialized facilities and associated professionals. The amendments will encourage residents to be referred to in a more respectful manner. This change in language will promote respect and will have a positive impact on the perception of residents as well as their family members.

The Oklahoma State Department of Health (OSDH) received correspondence from an individual who is concerned about the current language. The individual voiced the desire to have the offensive language removed from use and stated that the terminology is outrageous and unacceptable. Further, she asked if the OSDH could work to improve the way in which individuals with disabilities are referenced within the Oklahoma Administrative Code (OAC).

In November 2006, 25 O.S. §40 was adopted and states that all new and revised administrative rules should replace nonrespectful language. Since 2006, only one section with disrespectful language has been amended to remove the language. In an effort to expedite this process, the OSDH proposes these rule changes to alter the language of all affected sections of the OAC at one time.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is no anticipated economic impact or cost associated with compliance.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**

The cost to the OSDH to implement the amendments will be approximately \$3,300 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing OSDH personnel and will not result in an increase in authorized full-time equivalent personnel.

No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**
There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.
7. **ADVERSE EFFECT ON SMALL BUSINESS:**
There is no anticipated adverse effect on small business.
8. **EFFORTS TO MINIMIZE COSTS OF RULE:**
The costs associated with this rule change are minimal and include only the costs of drafting, adoption, publication, distribution and education.
9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**
This change will help foster inclusiveness and acceptance of individuals with disabilities by referring to them as individuals first. The language used in the updated rule is more respectful and will have a positive effect on individuals with intellectual and developmental disabilities.
10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**
If this change is not made, Oklahoma will continue to utilize outdated and nonrespectful language regarding individuals with disabilities. This language has an adverse effect on the individuals as well as their family members.
11. **PREPARATION AND MODIFICATION DATES:**
This rule impact statement was prepared on August 14, 2017.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 677. NURSE AIDE TRAINING AND CERTIFICATION**

SUBCHAPTER 1. GENERAL PROVISIONS

310:677-1-2. Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. The singular includes the plural as necessary.

"Abuse" means *any intentional physical or mental injury or sexual assault on a resident of a facility; by any person.* [63 O.S. 1991 §1-1902].

"Certified medication aide" means a certified nurse aide who has passed a Department approved program for administering medications.

"Client" means an individual receiving services from a home care agency or employer.

"Clinical skills observer" means a registered nurse, qualified ~~mental-retardation~~ intellectual disability professional, licensed practical nurse, registered pharmacist or other qualified professional who has at least one (1) year experience and has successfully completed a Department approved clinical skills observer training program.

"Commissioner" or "Commissioner of Health" means the Oklahoma State Commissioner of Health, the chief executive officer of the Department.

"Deemed" means meeting specified requirements to qualify for other categories of nurse aide certification.

"Department" means the *State Department of Health.* [63 O.S. 1991, § 1-1902(7)].

"Direct supervision" means a licensed nurse or other qualified individual actually observes a trainee performing tasks.

"Educational based program" means a nurse aide training and competency examination program sponsored by a State approved educational entity including, but not limited to, vocational technical schools, schools of higher learning or State certified educational facilities.

"Employer" means any of the following entities: facilities, agencies or programs including, but not limited to, nursing facilities, specialized facilities, residential care homes, adult day care centers, assisted living centers, or a nurse registry or a home care agency.

"Employer based program" means a nurse aide training and competency examination program sponsored by, or offered in, a nursing facility, a residential care home, an adult day care center, a home care agency, or a specialized facility.

"Entity" means the provider of a Department-approved nurse aide training and competency evaluation program including but not limited to an employer based or an educational based program provider.

"Examination" means a competency examination that includes a written portion and/or a clinical skills portion.

"Health related services" means those services provided to patients, clients, or residents that include but are not limited to the following: personal hygiene, transferring, range of motion, supervision or assistance in activities of daily living, basic nursing care such as taking temperature, pulse or respiration, positioning, incontinent care, identification of signs and symptoms of disease, and behavior management.

"ICF/IID" means an Intermediate Care Facility for Individuals with Intellectual Disabilities.

"Inservice education" means activities intended to assist the nurse aide to acquire, maintain, and/or increase competence in fulfilling the assigned responsibilities specific to the employer's expectations.

"Instructor" means a qualified professional who teaches in an approved training program.

"Licensed health professional" means a physician, dentist, podiatrist, chiropractor, physician assistant, nurse practitioner, pharmacist, physical, speech, or occupational therapist, registered nurse, licensed practical nurse, licensed social worker or licensed registered dietician.

"Licensed nurse" means a registered nurse or a licensed practical nurse that is currently licensed by the Oklahoma Board of Nursing.

"Misappropriation of property" means the taking, misapplication, deprivation, transfer, or attempted transfer to any person not entitled to receive any property, real or personal, or anything of value belonging to or under the legal control of a resident or client without the effective consent of the resident or client or other appropriate legal authority, or the taking of any action contrary to any duty imposed by federal or state law prescribing conduct relating to the custody or disposition of a resident's/client's property.

"Mistreatment" means a negligent act or personal wrong against a resident or client which causes the resident or client actual physical pain, discomfort or mental anguish. This type of personal wrong does not necessarily have to present external or visible signs of existence but does not include actions which are unavoidable.

"Neglect" means a failure to provide adequate medical or personal care or maintenance which results in physical or mental injury to a resident. [63 O.S. 1991, §1-1902.].

"Orientation" means the training for a particular job activity given to a new employee.

"Performance record" means a list of the major duties and skills to be learned in a nurse aide training program and the trainee's performance of each.

"Qualified professional" means an individual qualified to perform training and skills testing in an approved nurse aide training and competency program.

"Reciprocity" means the process that allows a certified nurse aide from another state to be listed in the Department's nurse aide registry.

"Reconsideration" means a process that allows an applicant to obtain reconsideration of an adverse decision on an application by submission of clarifying materials to the original decision-making body.

"Registry" means a Department maintained list of individuals who have successfully completed a nurse aide training and competency examination program or a competency examination program approved by the Department or who have been deemed or waived to meet the requirements.

"Specialized facility" *means any home, establishment, or institution which offers or provides inpatient long-term care services on a twenty-four-hour basis to a limited category of persons requiring such services, including but not limited to a facility providing health or habilitation services for ~~mentally retarded or developmentally disabled persons~~ individuals with intellectual or developmental disabilities*. [63:1-1902(11)]

"Supervised practical training" means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual.

"Trainee" means an individual who is enrolled in and has begun, but has not completed, a nurse aide training program.

"Trainer" means a qualified person who teaches in a nurse aide training and competency examination program.

"Training and competency examination program" means a program approved by the Department to teach and evaluate individuals to work as a nurse aide.

"Waiver" means a process that allows an individual with acceptable qualifications to be placed in the Department's registry without meeting other required qualifications.

310:677-1-3. Applicability

(a) This Chapter shall apply to specified employers, nurse aides, certified medication aides and other unlicensed employees providing health related services, and training and competency evaluation programs.

(b) An employer shall not use an individual as a nurse aide unless the employer has consulted the Oklahoma Nurse Aide Registry to determine whether the individual is listed on the nurse aide registry and whether the individual has no confirmed findings of abuse, neglect or misappropriation of patient/resident/client property.

(c) The Department shall grant an exception to the nurse aide training requirements in 310:677-9-4 for home health aides, 310:677-11-4 for long term care aides, 310:677-13-4 for certified medication aides, 310:677-15-3 for ~~developmentally disabled direct~~ ICF/IID care aides, 310:677-17-3 for residential care aides and 310:677-19-3 for adult day care aides, and allow an individual to sit for the competency examination if the individual submits all information specified on the Training Exception Application (ODH Form 832), which requires the following:

- (1) Individual's full name and personal identifying information;
- (2) Telephone number and address to include street, city, state, and zip code;
- (3) Copy of official transcript documenting classroom and clinical training equal to or greater than the classroom and clinical training as prescribed in 310:677-9-4, 310:677-11-4, 310:677-13-4, 310:677-15-3, 310:677-17-3 and 310:677-19-3; and
- (4) Type of nurse aide training to be excepted.

(d) The Department shall grant to a graduate of an approved practical or registered nurse program located in the United States a waiver to be placed on the nurse aide registry if the following criteria are met:

(1) The individual submits all information specified on the Department's Nurse Aide Training and Competency Evaluation Program Waiver Application (ODH Form 844), which requires the following:

- (A) Individual's full name and personal identifying information;
- (B) Telephone number and address to include street, city, state, and zip code;
- (C) Photocopy of diploma from an approved practical or registered nurse program;
- (D) Type of nurse aide training and competency testing requesting to be waived; and
- (E) Identification of all states, territories and districts of the United States and other countries where the individual has practiced or been licensed, certified or registered as a nurse; and

(2) The individual does not have a denied, revoked or suspended license or certificate or an administrative penalty or disciplinary action imposed by the Oklahoma Board of Nursing or similar agency in another state, territory or district of the United States or in another country, to be evidenced by the individual's attestation.

(e) The Department shall allow a graduate of an approved practical or registered nurse program located outside the United States a training exception and shall be authorized to sit for a nurse aide competency examination if the following criteria are met:

(1) The individual submits the Foreign Graduate Training Exception Application (ODH Form 843), which requires the following:

- (A) Individual's full name;
- (B) Telephone number and address to include street, city, state, and zip code;
- (C) The location outside of the United States where the individual received their nursing education and licensing examination if applicable;
- (D) The type of nurse aide training requesting to be excepted;

- (E) Documentation verifying legal entry and resident status in the United States including but not limited to a photocopy of a Social Security Card, Visa, Green Card or naturalization papers; and
- (F) A photocopy of a certified, translated diploma and transcript in English; and
- (2) The individual does not have a denied, revoked or suspended license or certificate or an administrative penalty or disciplinary action imposed by the Oklahoma Board of Nursing or similar agency in another state, territory or district of the United States, to be evidenced by the individual's attestation.
- (f) An individual who has not completed an approved Oklahoma Nurse Aide Training program and is submitting an application to be included on the Oklahoma Nurse Aide Registry as a certified nurse aide shall submit the following nonrefundable fee with the required completed application:
- (1) Deeming Application, fifteen dollar (\$15.00) fee applicable to each of the following deeming applications except (A) of this paragraph:
 - (A) Home Health Aide ~~Deemed~~ deemed to Long Term Care Aide (ODH Form 755) with no fee required;
 - (B) Home Health Aide ~~Deemed~~ deemed to ~~Developmentally Disabled Direct~~ ICF/IID Care Aide (ODH Form 836);
 - (C) Home Health Aide ~~Deemed~~ deemed to residential Care Aide (ODH Form 837);
 - (D) Home Health Aide ~~Deemed~~ deemed to Adult Day Care Aide (ODH Form 838);
 - (E) Long Term Care Aide ~~Deemed~~ deemed to ~~Developmentally Disabled Direct~~ ICF/IID Care Aide (ODH Form 830);
 - (F) Long Term Care Aide ~~Deemed~~ deemed to ~~residential~~ Residential Care Aide, (ODH Form 831);
 - (G) Long Term Care Aide ~~Deemed~~ deemed to Adult Day Care Aide, (ODH Form 839);
 - (H) ~~Developmentally Disabled Direct~~ ICF/IID Care Aide ~~Deemed~~ deemed to Residential Care Aide (ODH Form 834); and
 - (I) ~~Developmentally Disabled Direct~~ ICF/IID Care Aide ~~Deemed~~ deemed to Adult Day Care Aide (ODH Form 835);
 - (2) Home Health Aide Reciprocity Application (ODH Form 735), \$15.00 fee;
 - (3) Training Exception Application (ODH Form 832), or Foreign Graduate Training Exception Application (ODH Form 843), \$15.00 fee; or
 - (4) Nurse Aide Training and Competency Evaluation Program Waiver Application (ODH Form 844), \$15.00 fee.
 - (5) The fees specified in (1) through (4) of this subsection apply to applications for home health aides, certified medication aides, ~~developmentally disabled direct~~ ICF/IID care aides, residential care aides, and adult day care aides. A fee shall not be charged on an application requesting certification as a long term care aide only.
- (g) An individual who has previously completed a Department approved Nurse Aide Training and Competency Evaluation Program and is unable to renew certification may obtain approval to take a retest by filing a Certified Nurse Aide Retest Application (ODH Form 841) if any of the following criteria are met:
- (1) The individual did not provide eight (8) hours of nursing or health related services for compensation during the twenty-four (24) months prior to expiration of the certification;
 - (2) The individual did not provide eight (8) hours of nursing or health related services for compensation up to twenty-four (24) months after expiration; or
 - (3) The individual's nurse aide certification has been expired for over two (2) years but less than three (3) years.

- (4) A Certified Nurse Aide Retest Application (ODH Form 841) submitted by a home health aide, ~~developmentally disabled direct~~ ICF/IID care aide, residential care aide, or adult day care aide shall be accompanied by a fifteen dollar (\$15.00) nonrefundable fee.
- (5) An individual who fails the approved retest shall be required to retrain before taking any subsequent retests.
- (h) An individual may request a duplicate or amended certification card by submitting a Duplicate or Amended Nurse Aide Card Application (ODH Form 738) with a nonrefundable ten dollar (\$10.00) fee. A fee shall not be charged on an application requesting a duplicate or amended long term care aide certification card.

SUBCHAPTER 3. NURSE AIDE TRAINING AND COMPETENCY EXAMINATION PROGRAM

310:677-3-4. Program requirements

- (a) Before the Department approves a nurse aide training and competency examination program or a competency examination program, the Department shall determine whether the nurse aide training and competency examination program or the competency examination program meets the minimum requirements.
- (b) The Department shall not approve, or shall withdraw approval, of an employer based program when the employer has been assessed the following penalties or actions by the Department:
- (1) License suspended or revoked or had a conditional license issued.
 - (2) An administrative money penalty of five thousand dollars (\$5,000) or more for deficiencies cited under state licensure.
 - (3) Closed or had its residents or clients transferred pursuant to the Department's action.
 - (4) Enforcement actions based on the Department's authority under Medicare and Medicaid certification programs, except for facilities certified as Intermediate Care Facilities for the ~~Mentally Retarded~~ intellectually disabled.
 - (5) For Intermediate Care Facilities for the ~~Mentally Retarded~~ intellectually disabled, repeated enforcement actions based on the Department's authority.
- (c) The Department may withdraw approval of a nurse aide training and competency examination program sponsored by an entity when the following occurs:
- (1) The entity has been determined by the Department to have a competency examination failure rate greater than fifty (50) per cent during a calendar year.
 - (2) The entity no longer meets, at a minimum, the following requirements to be a certified program:
 - (A) The training program falls below the required clock hours of training;
 - (B) The curriculum does not include at least the subjects specified under 310:677-9-4 Home Health Aides, 310:677-11-4 Long Term Care Aides, 310:677-13-4 Certified Medication Aides, 310:677-15-3 ~~Developmentally Disabled Direct~~ ICF/IID Care Aides, 310:677-17-3 Residential Care Aides, and or 310:677-19-3 Adult Day Care Aides;
 - (C) A minimum of 16 hours of specified training for Long Term Care Aides is not provided prior to direct contact with residents;
 - (D) At least sixteen (16) hours of supervised practical training under the direct supervision of a registered nurse or a licensed practical nurse. The sixteen (16) hours does not include the administration of the skills examination.

- (3) The entity uses an uncertified individual as a nurse aide for longer than four months. To use an uncertified individual as a nurse aide for four months or less, an entity must have a temporary emergency waiver approved pursuant to 63 O.S. Section 1-1950.3.
- (4) The onsite review determines the training program is out of compliance with the requirements of 63 O.S. Section 1-1950.1, 1-1950.3 or 1-1951, or OAC 310:677.
- (d) The Department shall withdraw approval of a nurse aide training and competency evaluation program if:
- (1) The entity refuses to permit the Department to make unannounced visits; or
 - (2) The entity falsifies records of competency or training.
- (e) Withdrawal of approval shall be for a period of two (2) years or until the Department is assured through review that the entity complies with the requirements.
- (f) If the Department withdraws approval of a nurse aide training and competency examination program, the Department shall:
- (1) Notify the entity in writing, indicating the reason for withdrawal of approval.
 - (2) Allow the trainees who have started a training and competency examination program to complete the program or allow the trainees who have started the program to transfer to another approved program.
- (g) A program entity may request reconsideration of the Department's decision in accordance to Chapter 2 of this Title and appealed according to the Administrative Procedures Act.
- (h) The entity shall notify the trainee in writing, that successful completion of the nurse aide training and competency examination program shall result in the individual being listed in the Department's nurse aide registry and shall retain a copy of such notice, signed by the trainee, in the trainee's file.
- (i) A trainee shall not perform any services for which the trainee has not been trained and found proficient by an instructor.

SUBCHAPTER 5. NURSE AIDE REGISTRY

310:677-5-2. Registry operation

- (a) The Department shall maintain overall operation of the registry.
- (b) Only the Department may place in the registry findings of abuse, neglect, mistreatment or misappropriation of property.
- (c) The nurse aide registry shall indicate which individuals:
- (1) Successfully completed a nurse aide training and competency examination;
 - (2) Were given a training exception to bypass training requirements and sit for the competency examination;
 - (3) Had the nurse aide training and competency examination program requirements waived;
- or
- (4) Were placed on the Oklahoma Nurse Aide Registry via reciprocity from another state.
- (d) A home health aide, long term care aide, ~~developmentally disabled direct~~ ICF/IID care aide, residential care aide, and adult day care aide shall renew individual certification once every two (2) years. The individual certified as a home health aide, ~~developmentally disabled direct~~ ICF/IID care aide, residential care aide, or adult day care aide shall file a Recertification Application (ODH Form 717). The individual certified as a long term care aide shall file a Recertification Application for Long Term Care Aide (ODH Form 840). Each recertification application requires:
- (1) Personal identifying and contact information for the applicant;

- (2) Documentation that the applicant has provided at least eight (8) hours of nursing or health related services for compensation during the preceding 24 months. On and after July 1, 2008, the documentation shall consist of one of the following:
- (A) A statement signed by the administrator or the administrator's representative for the licensed nursing facility, specialized facility, residential care home, home health or home care agency, adult day care center, assisted living center, continuum of care facility, Oklahoma Department of Veterans Affairs nursing facility, or Oklahoma correctional facility where the applicant provided services;
 - (B) A statement signed by a physician or nurse under whose supervision the applicant provided services; or
 - (C) A check stub, IRS Form W-2 or similar proof of wages paid to the applicant by a licensed nursing facility, specialized facility, residential care home, home health or home care agency, adult day care center, assisted living center, continuum of care facility, Oklahoma Department of Veterans Affairs nursing facility, or Oklahoma correctional facility; and
- (3) An oath of truthfulness and completeness to be signed by the applicant.
- (e) A home health aide, ~~developmentally disabled direct~~ ICF/IID care aide, residential care aide, or adult day care aide shall pay a ten dollar (\$10.00) fee for the processing and renewal of certifications and for replacement of a wallet card for change of name or other reason.

SUBCHAPTER 13. CERTIFIED MEDICATION AIDES

310:677-13-1. General requirements

- (a) An individual shall be able to read, write, and speak English and be certified in good standing as a home health aide, a long term care aide, or a ~~developmentally disabled direct~~ ICF/IID care aide listed in the Department's Nurse Aide Registry, prior to admission to a State approved certified medication aide training program. The Department shall make available an attestation form that training programs may use for admission to certified medication aide training.
- (b) A certified medication aide shall complete at least eight (8) hours of continuing education every twelve (12) months, excluding the first year of certification, from a State approved program. A record of successful completion shall be kept in the certified medication aide's personnel file.
- (c) An employer shall not use as a certified medication aide any individual who does not comply with 63 O.S. Section 1-1950.3(E), OAC 310:677, and the employer's policies and procedures.
- (d) A certified medication aide shall renew certification every 12 months. Recertification requires the following:
- (1) Documentation of completion of at least eight (8) hours of continuing education every twelve (12) months, excluding the first year after certification as a medication aide. Classroom and supervised practical training hours completed by a CMA in a Department-approved advanced training program may count towards the eight required hours of continuing education;
 - (2) Current certification as a long term care aide, home health aide or ~~developmentally disabled direct~~ ICF/IID care aide. CMAs may also be certified in the other two (2) categories in addition to the required certification as a long term care aide, home health aide and ~~developmentally disabled direct~~ ICF/IID care aide; and
 - (3) Current listing in the nurse aide registry.

- (e) The Department shall approve certified medication aide training programs that meet the requirements of OAC 310:677-13-3 through 13-5, and 310:677-13-9.
- (f) The Department shall review, approve or disapprove a Certified Medication Aide Continuing Education Program application and notify the entity of its action within thirty (30) days of the request or receipt of additional information from the applicant.
- (g) The following words or terms when used in this subchapter shall have the following meaning unless the context clearly indicates otherwise:
- (1) "Stable diabetes" means diabetes associated with a blood glucose level consistently between 80 and 140 milligrams per deciliter (mg/dl) fasting and less than or equal to 180 mg/dl after a meal, and/or a Hemoglobin A1c (HbA1c) at or below 7.0 within the last three months.
 - (2) "Unstable diabetes" means:
 - (A) A non-acutely ill person with blood glucose levels more than three times over a six week period that are under 80 mg/dl or more than 140 mg/dl fasting, or more than 180 mg/dl two hours after a meal;
 - (B) A person with diabetes who has prescriptions for both insulin and glucagon;
 - (C) A person with Type I diabetes who experiences hypoglycemia unawareness;
 - (D) A person who is newly diagnosed with diabetes and for whom insulin is prescribed; or
 - (E) A person who has been previously diagnosed with diabetes and now requires insulin administration for management. They may be considered stable again when their glucose is maintained in the stable range specified in subsection (g)(1) of this section, which may include maintaining an HbA1c at or below 7.0.
 - (3) "Newly diagnosed" means a person who now has a diagnosis of either Type I or Type II diabetes, has a new prescription for insulin, has not been diagnosed with diabetes in the past and who does not have stable diabetes.

SUBCHAPTER 15. ~~DEVELOPMENTALLY DISABLED DIRECT~~ ICF/IID CARE AIDES

310:677-15-1. Deemed to meet state certification requirements

- (a) A certified ~~developmentally disabled~~ ICF/IID care aide is deemed to meet the nurse aide certification requirements for the following employers after successful completion of at least sixteen (16) hours of orientation specific to the facility population. Documentation of the sixteen (16) hours of orientation shall be submitted to the Department and the certified ~~developmentally disabled~~ ICF/IID care aide will be placed on the registry as a certified residential care aide or a certified adult day care aide. The employers to which this subsection applies are:
- (1) Residential care.
 - (2) Adult day care.
- (b) The Department shall deem a certified long term care aide or a home care aide who has at least sixteen (16) hours of training specific to ~~the developmentally disabled client population~~ individuals with intellectual or developmental disabilities to meet the requirements for a ~~developmentally disabled direct~~ an ICF/IID care aide. Documentation of the sixteen (16) hours of training shall be submitted to the Department and the certified long term care nurse aide or the certified home care nurse aide will be added to the registry as being certified as a ~~developmentally disabled direct~~ ICF/IID care aide.

310:677-15-2. Instructor qualifications

- (a) The instructor for training ~~developmentally disabled direct~~ ICF/IID care aides shall be a licensed nurse or a qualified ~~mental retardation~~ intellectual disability professional who has at least one (1) year experience in the provision of services in a facility for the developmentally disabled.
- (b) Other personnel from the health professions may supplement the instructor as required by the curriculum.

310:677-15-3. Curriculum

- (a) The ~~developmentally disabled direct~~ ICF/IID care aide training program shall include at least seventy-five (75) hours of classroom and supervised practical training or the equivalent.
- (b) The ~~developmentally disabled direct~~ ICF/IID care aide training program shall include, but is not limited to, each of the following subject areas:
- (1) Ethical conduct.
 - (2) Resident's rights.
 - (3) Principles of safety.
 - (4) Infection control techniques.
 - (5) Nutrition and hydration.
 - (6) Elements and changes of body functions.
 - (7) Basic nursing skills.
 - (8) Communication skills.
 - (9) Mobility.
 - (10) Hygiene, personal care, and comfort.
 - (11) Terminology, principles, and concepts of cognitive impairment.
 - (A) Characteristics of cognitive impairment.
 - (B) Discern between different levels of ~~mental retardation~~ intellectual disability.
 - (C) Principles of assessment tools.
 - (D) Terminology of active treatment.
 - (12) Psychosocial needs.
 - (A) Behavioral management techniques.
 - (B) Identification of psychosocial needs.
 - (C) Death and dying.
 - (D) Recognizing deviant behavior.
 - (E) Socialization skills.
 - (13) Independent living skills.
 - (A) Promoting physical and mental independence.
 - (B) Promoting principles of normalization and community integration.
 - (14) Active treatment components.
 - (A) Interdisciplinary team concepts and roles.
 - (B) Components of individual program plans.
 - (C) Using individual program plans.
 - (D) Proper documentation techniques.

310:677-15-4. Competency and skills examination

- (a) The written or oral examination shall be administered by a Department approved program. The skills examination shall be performed in a facility or laboratory setting comparable to the setting in which the individual will function as a ~~developmentally disabled direct~~ ICF/IID care aide.
- (b) The clinical skills observer shall be a licensed nurse or a qualified ~~mental retardation~~ intellectual disability professional.

310:677-15-5. Recertification

- (a) The training program shall inform the certified ~~developmentally disabled direct~~ ICF/IID care aide that they shall complete a new nurse aide training and competency examination or competency examination if, upon applying for renewal of certification, the nurse aide has not provided at least eight (8) hours of nursing or health related services for compensation during the previous twenty-four (24) months.
- (b) The ~~specialized facility~~ ICF/IID shall ensure that all certifications are current and not expired.

SUBCHAPTER 17. RESIDENTIAL CARE AIDES**310:677-17-1. Deemed to meet state certification requirements**

- (a) The Department shall deem a certified residential care aide to meet the adult day care program aides certification requirements after successful completion of at least sixteen (16) hours of training specific to the facility population.
- (b) The Department shall deem a certified long term care aide, a certified home care aide or a certified ~~developmentally disabled direct~~ ICF/IID care aide who has at least sixteen (16) hours of training specific to the residential care population to meet the requirements for a certified residential care aide. Documentation of the sixteen (16) hours of training shall be submitted to the Department and the certified nurse aide will be listed on the registry as a certified residential care aide.

SUBCHAPTER 19. ADULT DAY CARE PROGRAM AIDES**310:677-19-1. Deemed to meet state certification requirements**

- (a) The Department shall deem a certified adult day care program aide to meet the nurse aide certification requirements for a residential care employer after successful completion of at least sixteen (16) hours of training specific to the facility population. Documentation of the sixteen (16) hours shall be submitted to the Department and the certified adult day care aide will be placed on the registry as a certified residential care aide.
- (b) The Department shall deem a certified long term care aide, a certified home care aide or a certified ~~developmentally disabled direct~~ ICF/IID care aide who has at least sixteen (16) hours of training specific to the adult day care population to meet the requirements for certification as an adult day care aide. Documentation of the sixteen (16) hours of training shall be submitted to the Department and the certified long term care aide, certified home care aide or certified ~~developmentally disabled direct~~ ICF/IID care aide shall be certified as a certified adult day care aide.

Long Term Care Update – October 10, 2017

Long Term Care New Survey Process

- Training Completed October 2nd thru 5th
- Effective Date November 28, 2017

Long Term Care Life Safety Code – Emergency Preparedness

- Are LTC Facilities required to have a generator? Alternate Power Source? Risk Assessment Tool?
- Effective Date November 15, 2017

Long Term Care Investigations – State Fiscal Year 2017

- Nursing Home - 2,918
- Intermediate Care – 245
- Life Safety Code – 681
- State Licensure – 700
- 30 Mandated time frames
- Total Investigations – 4,544 (100% Completed On-Time)

	Nursing Home (Federal)			Nursing Home State Licensure	Veterans Center		Intermediate Care		Nursing Home Life Safety Code	Intermediate Care Life Safety Code		Assisted Living	Residential Care	Adult Day Care	
Number of Investigations	NH - Fed	NH - State	VA	Total		ICF		NH - LSC	ICF - LSC	Total		AL	RC	ADC	Total
Investigations	3	3	0	6		2		3	2	5		13	1	7	21
Initial	263	259	6	528		92		265	92	357		162	83	38	283
Relicense	523	272	12	807		125		268	51	319		159	73	31	263
Follow Up	59	47	3	109		4		0	0	0		8	0	0	8
Complaint IJ	219	174	11	404		1		0	0	0		46	3	0	49
Complaint NIJH	587	468	9	1,064		21		0	0	0		56	19	1	76
Complaint Other	Total	1,654	1,223	41	2,918	245		536	145	681		444	179	77	700
Total Investigations Completed															4,544
Hours per Facility Type	NH - Fed	NH - State	VA	Total		ICF		NH - LSC	ICF - LSC	Total		AL	RC	ADC	Total
Hours	561	0	0	561		134		40	27	67		391	39	60	490
Initial	49,181	0	1,122	50,303		6,164		3,525	1,224	4,748		4,876	3,196	327	8,399
Relicense	10,460	0	240	10,700		1,375		1,742	332	2,074		1,256	861	164	2,282
Follow Up	2,301	0	117	2,418		120		0	0	0		222	0	0	222
Complaint IJ	8,541	0	429	8,970		30		0	0	0		1,274	85	0	1,359
Complaint NIJH	22,893	0	351	23,244		630		0	0	0		1,551	536	8	2,095
Complaint Other	Total	93,937	0	2,259	96,196	8,453		5,306	1,582	6,888		9,571	4,716	559	14,846
Total Hours of Investigations Completed															126,383
10% Reduction in Force				9,620		845				689					1,485
FTE (Full-Time Employee)				6.4		0.6				0.5					1.0

Oklahoma State Department of Health – Furlough October 2017 thru June 2018

- 10 % Reduction in Force – 454 fewer investigations, 12,638 fewer hours of investigations



Oklahoma State Department of Health
Creating a State of Health

October 11, 2017

All Members

The Long Term Care Facility Advisory Board meetings for 2018 have been set. The dates and times are listed below.

10 January 2018, 1:30
11 April 2018, 1:30
11 July 2018, 1:30
10 October 2018, 1:30

Respectfully,

Lori Bautista

Lori Bautista
Administrative Assistant
Long Term Care

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Commissioner of Health
Secretary of Health
and Human Services

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